Shropshire Council
Legal and Democratic Services
Guildhall,
Frankwell Quay,
Shrewsbury
SY3 8HQ

Date: 10 September 2025

Committee:
Health and Wellbeing Board

Date: **Thursday, 18 September 2025**
Time: **9.30 am**
Venue: **The Council Chamber, The Guildhall, Frankwell Quay, Shrewsbury, SY3 8HQ**

You are requested to attend the above meeting. The Agenda is attached

There will be some access to the meeting room for members of the press and public, but this will be limited. If you wish to attend the meeting please email democracy@shropshire.gov.uk to check that a seat will be available for you.

Please click here to view the livestream of the meeting on the date and time stated on the agenda

The recording of the event will also be made available shortly after the meeting on the Shropshire Council Youtube Channel Here

Tim Collard
Service Director - Legal and Governance

Members of Health and Wellbeing Board

Councillor Bernie Bentick – PFH Health & Public Protection (Co-Chair)
Councillor Heather Kidd – Leader, Shropshire Council
Councillor Ruth Houghton – PFH Social Care
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Fisher – Housing Services Manager, Shropshire Council
Simon Whitehouse – ICB Chief Executive Officer, NHS Shropshire, Telford and Wrekin (Co-Chair)
Claire Parker – Director of Partnerships, NHS Shropshire, Telford and Wrekin
Claire Horsfield – Director of Operations & Chief AHP, Shropcom
Ben Hollands – Health and Wellbeing Strategy Implementation Manager, MPFT
Nigel Lee - Director of Strategy & Partnerships SATH and Chief Strategy Officer NHS STW (ICB)
Paul Kavanagh-Fields – Chief Nurse and Patient Safety Officer, RJAH
Nick Henry – Paramedic & Patient Safety Director WMAS
Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Partners in Care
Jamie Dunn - Superintendent, West Mercia Police

Your Committee Officer is Michelle Dulson
Tel: 01743 257719 Email: michelle.dulson@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosable Interests

Members are reminded that they must declare their disclosable pecuniary interests and other registrable or non-registrable interests in any matter being considered at the meeting as set out in Appendix B of the Members' Code of Conduct and consider if they should leave the room prior to the item being considered. Further advice can be sought from the Monitoring Officer in advance of the meeting."

3 Minutes of the previous meeting (Pages 1 - 8)

To confirm as a correct record the minutes of the meeting held on 19 June 2025 (attached).
Contact: Michelle Dulson Tel 01743 257719

4 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. The deadline for this meeting is 12noon on Friday 12 September 2025.

5 Winter Preparedness & Wellbeing Overview (Pages 9 - 32)

- STW Winter Plan - Draft

  Gareth Wright, Deputy Director of Ops - Urgent & Emergency Care / EPRR, NHS STW

- Vaccination Improvement Plan

  Rachel Robinson, Executive Director – Public Health (DPH), Shropshire Council
  Vanessa Whatley, Chief Nursing Officer, NHS STW,
  Anne-Marie Speke, Head of Service Healthy Population, Shropshire Council

- Winter wellbeing support – inc. Cost of Living

  Amanda Cheeseman, PH Development Officer, Shropshire Council

  The board would welcome an open conversation regarding partner's activity around winter preparedness and wellbeing support

6 **Healthy Ageing & Frailty Strategy** (Pages 33 - 68)

Vanessa Whatley, Chief Nursing Officer, NHS STW

7 **Better Care Fund 2025-26 quarter one report and Explainer** (Pages 69 - 82)

Jackie Robinson, Senior Integrated Commissioning Lead, NHS STW

If you would like a copy of Appendix B (Better Care Fund 2025-26 Q1 reporting template 2024-25) to be emailed to you, please contact Michelle Dulson on 01743 257719.

8 **ICB Update**

Nigel Lee, Director of Strategy & Partnerships SATH and Chief Strategy Officer NHS STW
Claire Parker, Director of Strategy & Development, NHS STW

9 **Draft Pharmaceutical Needs Assessment 2025** (Pages 83 - 88)

Mark Trenfield, Senior Public Health Intelligence Analyst, Shropshire Council

If you would like a copy of Appendix A (Draft Pharmaceutical Needs Assessment (PNA) 2025 – draft report) to be emailed to you, please contact Michelle Dulson on 01743 257719.

10 **Director of Public Health Annual Report 2024-25** (Pages 89 - 122)

Rachel Robinson, Executive Director – Public Health (DPH), Shropshire Council

11 **ShIPP Update** (Pages 123 - 126)

Rachel Robinson, Executive Director – Public Health (DPH), Shropshire Council

Shropshire Council

Committee and Date

Health and Wellbeing Board

18 September 2025

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 19 JUNE 2025
9.30 - 11.30 AM

Responsible Officer: Michelle Dulson
Email: michelle.dulson@shropshire.gov.uk Tel: 01743 257719

Present
Councillor Bernie Bentick – PFH Health & Public Protection (Co-Chair)
Councillor Heather Kidd – Leader, Shropshire Council
Councillor Ruth Houghton – PFH Social Care
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Laura Fisher – Housing Services Manager, Shropshire Council (remote)
Simon Whitehouse – ICB Chief Executive Officer, NHS Shropshire, Telford and Wrekin (Co-Chair)
Claire Parker – Director of Partnerships, NHS Shropshire, Telford and Wrekin
Ben Hollands – Health and Wellbeing Strategy Implementation Manager, MPFT (remote)
Nigel Lee - Director of Strategy & Partnerships SATH and Chief Strategy Officer NHS STW (ICB)
Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
Jamie Dunn - Superintendent, West Mercia Police

Also present: Laura Tyler, Carla Bickley, Paula Mawson (remote), Jess Edwards (remote)

1 **Apologies for Absence and Substitutions**

Tanya Miles – Executive Director for People
David Crosby - Chief Officer, Partners in Care
Clare Horsfield - Director of Operations & Chief AHP, Shropcom

2 **Disclosable Interests**

No interests were declared.

3 **Minutes of the previous meeting**

RESOLVED:

That the minutes of the meeting held on 13 February 2025 be approved and signed as a correct record.

4 **Public Question Time**

A public question had been received from Mr John Palmer. Mr Palmer read his question, and Councillor Ruth Houghton, Portfolio Holder for Social Care provided the response.

A full copy of the question and response provided are attached to the web page for the meeting.

5 **Domestic Abuse**

The Board received the report of the Domestic Abuse Strategic Lead for Shropshire Council which presented key findings from the Shropshire Domestic Abuse Needs Assessment (2022-24) with a focus on the role of the Health and Wellbeing Board in addressing Domestic Abuse.

The Domestic Abuse Strategic Lead presented the key findings from the 2022-24 Domestic Abuse Needs Assessment. She drew attention to the Board's role in shaping a response through a coordinated approach across the health sector and highlighted how the report aligned to the Board's priorities including to reduce inequalities. Finally, she drew attention to the strategic recommendations, the overarching recommendation was to ask the Board to support and task the domestic abuse leads from across all health partnerships to go along to the Domestic Abuse Local Partnership Board in order to strengthen the local response to domestic abuse and reduce the long-term impact for individuals and for services.

The Director of Partnerships, NHS Shropshire, Telford and Wrekin felt that the Domestic Abuse Strategic Lead could be linked into the neighbourhood working particularly around the women's health hubs and she would discuss this with her outside of the meeting. It was felt that more training was needed for primary care and general practice in particular and she agreed to pick this up with her Medical Director and their Education Lead GPs. She would also link the Domestic Abuse Strategic Lead with their Health Inequalities Lead to ensure that inequalities were thought about when looking at domestic abuse.

The Domestic Abuse Strategic Lead referred to the Iris project which aimed to have a trained specialist attached to GP practices who was able to provide direct support to victims of domestic abuse. In response to a question around perpetrators, the Domestic Abuse Strategic Lead explained that there was a community programme focusing on misogyny and youth education in schools which was funded until the end of this financial year.

Picking up on the link between domestic abuse and mental health crises, it was felt that the Midlands Partnership Foundation Trust (MPFT) had a crucial role to play in this area and a query was raised as to whether there been any conversations around the MPFT's support for those who were suffering mental health crisis associated with domestic abuse. In response, the Domestic Abuse Strategic Lead informed the meeting that work was currently ongoing with public health, working with health providers including MPFT around mental health, substance use and domestic abuse to set up protocols to better respond so that there was a quicker response and an easier pathway for people to access. However, it was recognised that the health system was such a wide area that one pathway and one protocol did not fit all.

Following feedback from Age UK that domestic abuse was very under reported in older people, a query was raised as to whether more enhanced data relating to over 65s was available. In response, the Domestic Abuse Strategic Lead reported that the survey currently being undertaken was asking people of all ages, from 7 years old and up to complete it. So far 17 responses had been received from 65–74-year-olds along with two 75+ year olds. She agreed to pass the survey to Age UK for them to take part and provide that information, they had also been invited to attend the market engagement session.

Members of the Board offered their support to the Domestic Abuse Strategic Lead and a brief discussion ensued in relation to the importance of promoting healthy relationships, preventative youth work, and consideration of cultural issues. The Director of Public Health stressed the importance of a continued commitment to the Domestic Abuse Local Partnership Board and for partners to take forward the recommendations contained within the report.

Finally, the Chair felt that this would be a really good topic for an ICB development session.

RESOLVED:

to note the update and task the Domestic Abuse leads from across the Health Partnership/Workforce to come to the Domestic Abuse Local Partnership Board to collaborate, with the aim of strengthening the local response to domestic abuse and reduce its long-term impact on individuals and services.

6 **Draft Pharmaceutical Needs Assessment (PNA)**

The Board received the report of the Public Health Intelligence Analyst which set out the Draft Pharmaceutical Needs Assessment (PNA). He explained that under the Health Act 2009, all Health and Wellbeing Boards had a statutory duty to produce a PNA and the last one that was done was in 2022, so the next one was due to be published by 1 October 2025 following a 60-day public consultation.

The Public Health Intelligence Analyst drew attention to the contents page that showed the areas he had looked at so far. He informed the Board that there were 17 GP dispensing practices and 43 community pharmacies operating in Shropshire, with the dispensing practices tending to be more rural whilst the community pharmacies tended to congregate around the main towns.

There were four less community pharmacies in Shropshire than when the last PNA was done, resulting in more people per community pharmacy in Shropshire than in England. This impact was slightly reduced when including dispensing GP practices but still above the level for England. He then looked at the 9 essential services that all community pharmacies offered along with the advanced and additional services that they could choose to offer. Accessibility and whether residents could get to a community pharmacy in Shropshire within 10 minutes in a car, via public transport or on foot was also considered. The full PNA also looked at the level of activity and number of items dispensed over 12 months and the number of pharmacies that had signed up for the advanced and additional services.

The Public Health Intelligence Analyst took Board members through some of the responses from both the resident and the contractor survey before summing up. If approved by the Board, a 60-day public consultation would then be undertaken before the PNS was published.

The Chair thanked the Public Health Intelligence Analyst for the level of detail contained within the PNS and how it linked back into what it actually meant for communities.

A query was raised about whether there was a pharmaceutical co-ordinating body for Shropshire, and if so, what level of engagement did they have in the provision of comprehensive services particularly in evenings, weekends and overnight and whether SATH had been involved in any of these discussions as they would have pharmacy services which were available in principle for a 24-hour period.

In response, the Public Health Intelligence Analyst explained that as part of the PNA Steering Group, he had worked with Peter Prokopa from Community Pharmacy in Shropshire Group and James Milner who worked with the ICB on pharmacy provision who had had quite a lot of input into this piece of work. However, the hospitals had not been involved because they offered a different level of service than would be expected from a community pharmacy. Concern was raised that as there was no 24-hour provision, some residents and patients may not be able to wait and may end up at the urgent and emergency care centres and a query was raised as to whether a potential solution had been looked at with regard to the availability of pharmacies throughout Shropshire.

In response, the Director of Strategy & Partnerships SATH and Chief Strategy Officer NHS STW (ICB) explained that the ICB's Chief Pharmacist worked with pharmacy leads and it was for him to look at what the opportunities were within the next phase. He queried the level of variances in activity and wondered whether this was due to greater need or possibly greater take up.

The Director of Partnerships, NHS Shropshire, Telford and Wrekin reported that the Local Pharmaceutical Committee for Shropshire had also linked into this work. She clarified that hospitals had no payment mechanism for dispensing FP10 prescriptions. She went on to explain that the PNA was used to determine what services were required in the County, so should they want 24-hour pharmacies, they should be inviting applications for potentially new services should that be a requirement.

A brief discussion ensued in relation to the challenges of access especially in the more rural areas of the County however, the Chair felt that with the publication of the 10-year plan, there was the opportunity to really think about what neighbourhood working meant when you had rural populations especially for the viability of those businesses.

RESOLVED:

To note the contents of the presentation and report and to agree that the PNA can go out for the statutory 60-day public consultation.

7 **The RESET Programme**

The Board received the report of the Public Health Consultant and the Drug and Alcohol Strategic Commissioning Lead which provided an overview of the RESET Programme which provides drug and alcohol treatment for individuals rough sleeping or at risk of rough sleeping.

The Public Health Consultant and the Drug and Alcohol Strategic Commissioning Lead presented the report, they provided some background and gave an overview of the programme, along with its outcomes and impact. The Drug and Alcohol Strategic Commissioning Lead took Board members through the main organisations that were involved. He then discussed the performance metrics as well as the challenges and learning gained from previous years. There was more that could be done however, and he looked at the ambitions for the year and forward planning for 2026-27 in order to get the best value from the money they receive to reach as many people as possible and to offer the best quality of service. Finally, he drew attention to a brief case study which gave an example of the kind of support that people received when they moved through the RESET service.

In response to a query, it was confirmed that the vehicle used by the team was covered by the grant however it had not been used as often as it should have and this would be looked at as part of the wider review to be undertaken and they would look to identify how it can best be utilised in order to help and support those more rural areas. It was suggested that this could link into other neighbourhood working, and with the wider health services and primary care services.

In response to a query around unmet need, the Drug and Alcohol Strategic Commissioning Lead stated that there would always be some measure of unmet need, as, for example, some individuals don't want support at that particular time but it was important to make services available as best they could. By providing clear pathways within RESET, individuals who do not wish to use services such as drug and alcohol support can access other available forms of assistance as part of RESET. Part of the review of the service would look at any difficulties referring into the services, difficulties reaching specific groups of people etc.

In response to a query about the age profile of the people accessing the programme, the Drug and Alcohol Strategic Commissioning Lead agreed to look at this outside of the meeting.

RESOLVED:

To note the contents of the presentation and report.

It was agreed to take Agenda Items 8 (BCF 2024-5 End of Year Template) and 9 (BCF 2025-26 Plan) together.

8 **Better Care Fund - 2024-5 End of Year Template**

9 **Better Care Fund - 2025-26 Plan**

The Board received the reports of the Service Director for Commissioning, which provided a summary of the Better Care Fund (BCF) 2024-26 end of year template for Shropshire and a summary of Shropshire's 2025-26 Better Care Fund Plan for approval by the Board.

The Service Director for Commissioning noted an issue regarding data and performance, resulting in some metrics being inaccurate this year. Efforts were underway to address these problems. The regional and national teams had been informed that, due to these issues, the Council was unable to set precise targets for the current year. A response from the national team regarding approval of this situation was expected from today. It was anticipated that the Council may be required to establish targets for the second quarter, and work would proceed accordingly.

The Chairman suggested that in future it may be helpful to move away from the template and bring some background context along with something for the Board to discuss, so that the Board could better understand and help shape and inform the work going forward.

RESOLVED:

To approve the BCF 2024-25 end of year template and the 2025-26 BCF Plan.

10 **ICB Update**

The Board received an update from the Director of Strategy and Development, NHS STW and the Chief Strategy Officer NHS STW/Director of Strategy and partnerships, SATH.

The Chief Strategy Officer NHS STW/Director of Strategy and partnerships, SATH referred to the Stakeholder Briefing pack which had been circulated. He drew attention to the work being undertaken between SATH and the Shropshire Community Trust to investigate coming together as a group, looking at integration of pathways and supporting that focus and particularly with the advent of the 10-year plan and the focus on neighbourhoods.

He also drew attention to the government's reset programme and the work being undertaken between NHS Shropshire Telford and Wrekin and NHS Staffordshire and Stoke-on-Trent to explore a cluster model in order to reduce costs. Finally, he updated that Board in terms of the 10-year plan.

RESOLVED:

To note the contents of the update.

11 **Health Protection Update inc. immunisations, vaccinations and sexual health**

The Board received the report of the Director of Public Health which provided an overview of the health protection status of the population of Shropshire. It provided an overview of the status of communicable, waterborne and foodborne diseases.

The Director of Public Health highlighted the importance of neighbourhoods particularly in rural communities and the work that needs to be done, along with the difference working in partnership makes and finally the promotion of the services that were available.

She reported that the vaccination rates in Shropshire were higher than England generally but that there were areas of inequalities that needed to be worked on in order to support and protect people and to increase awareness and uptake of these vaccinations and services. It was suggested that the Chair promote this in his Chief Executive's report to the ICB.

RESOLVED:

a. to promote childhood vaccine uptake
b. to promote uptake of seasonal vaccines
c. to promote contraception and regular STI testing

12 **ShIPP Update**

Members noted the ShIPP update, and the Director of Public Health reported that funding had been received for prevention-related work.

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Signed …… (Chair)

Date:

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**18th September 2025**					
Title of report	**Winter Preparedness & Wellbeing Overview**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	
Reporting Officer & email	Rachel.robinson@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working	x		
	Mental Health	x	Improving Population Health	x		
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	x		
	Workforce		Reduce inequalities (see below)	x		
What inequalities does this report address?	Income, disability, age, health, rurality					

1. Executive Summary

This item combines updates from across the system regarding winter preparedness and wellbeing.

Winter Preparedness & Wellbeing Overview

STW Winter Plan

The system winter plan will be presented to the ICB Public Board on 24 Sep 25; requesting approval of the plan, and agreement to submit a statement of Board assurance to NHS England by 30 Sep, which is a national requirement for all ICBs and NHS Trusts this year. The draft ICB report is available as Appendix A. The opportunity is being taken to give HWBB sight of the ICB report out of sequence, rather than delaying to the next meeting on 20th Nov 2025. In turn, there will be the opportunity for any HWBB comments to be taken into the ICB Board discussion.

The key points are as follows, which will be summarised in a presentation to HWBB at this meeting:

- National direction received from NHS England, which frames our approach this year.
- Progress on our UEC pathway Improvement journey and performance against our operational plan objectives, which indicates where focus is required.
- Our Learning from Winter 2024/25, which underpins what we are doing differently this year.
- Why we will be better placed to respond as we enter winter, with enduring high impact change schemes in place.
- Our Winter Plan, by time period, effects to be achieved, with specific interventions to reduce the onset of pressures, our provider key roles in the plan, risks to delivery and maintaining the quality of care we require.
- The basis of providing assurance to the ICB Board and subsequently to NHS England.

Vaccination Improvement Plan

Part of the STW Winter Plan this includes plans to maximise uptake of seasonal vaccinations, information will be discussed to highlight the proposed winter vaccination campaign to support local residents to make informed decisions about vaccination by providing clear, consistent and accessible information, reinforcing confidence, and signposting to services at the point of need. With the strategic focus areas:

- Maximise uptake of seasonal vaccinations (flu, Covid booster, RSV, MMR etc)
- Maintain and build public confidence in the safety and importance of vaccines
- Promote convenience and accessibility – vaccination as simple, quick and local
- Address barriers to uptake through targeted communications and engagement
- Improve reach and impact by engaging diverse communities, including those harder to access
- Utilise NHS England resources to reinforce and amplify local communications – Ensure easy read and translated material for all vaccines, consider use of videos
- Align vaccination messaging with wider system campaigns (Think Which Service, Pharmacy First, NHS App) to ensure consistency and joined-up communications
- Use of data to target resources to greatest areas of need and impact taking an evidence based approach building on best practice in terms of what works

Winter wellbeing support from Shropshire Council and VCSE partners

There are three key messages we want everyone to share:

- If you or someone you know is worried about money or is struggling right now, you are not alone
- There may be simple steps you can take to cut costs or maximise your income
- If you are getting into debt or your mental health is suffering, don't wait to get help

Cost of Living support is available to Shropshire residents:

- VCSE organisations offer general and specific advice and support, online, via telephone and in person.
- The Council hosts Cost of Living web pages, created with the VCSE and other partners, offers information and contacts. Cost of living help | Shropshire Council
- The Household Support Fund (6) that runs from 1st April 2025 until 31st March 2026 offers a range of support including crisis support, free school meals for eligible children, direct council tax account payments to those in arrears and direct support to care leavers. Household Support Fund | Shropshire Council

Further in-person support and signposting is available:

- Shropshire Council's Community Wellbeing Outreach team Community Wellbeing Outreach team | Shropshire Council
- Social Prescribing Social prescribing | Shropshire Council
- Community and Family hubs can support and signpost in person. Community hubs | Shropshire Council.

2. Recommendations

- The Board are asked to take the opportunity to comment on the draft SWT Winter plan in advance of approval by the ICB Public Board
- All partners promote vaccinations to Maximise uptake of seasonal vaccinations
- All partners share key cost of living communications when and where possible.
- All partners consider creating a cost of living section on their website. Could link to Shropshire and Telford and Wrekin webpage or to other cost of living webpages above (i.e. Citizens Advice Shropshire).

3. Report
Please see appendices for reports

Risk assessment and opportunities appraisal (*NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation*)	N/A	
Financial implications (*Any financial implications of note)*	N/A	
Climate Change Appraisal as applicable	N/A	
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
List of Background Papers		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead Ian Bett, Chief Delivery Officer, NHS Shropshire, Telford & Wrekin Vanessa Whatley, Chief Nurse, NHS Shropshire, Telford & Wrekin Rachel Robinson, Executive Director – Public Health (DPH), Shropshire Council Cllr. Bernie Bentick, Portfolio Holder for Health & Public Protection, Shropshire Council		
Appendices Appendix A. STW Winter Plan – Draft Appendix B. Vaccination Improvement Plan – Draft – *to follow*		

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1. ICB 25-09.201– Winter Plan 2025-26 DRAFT

Meeting Name: NHS Shropshire, Telford and Wrekin Integrated Care Board
Meeting Date: Wednesday 24 September 2025
Report Presented by: Ian Bett, Chief Delivery Officer, NHS STW
Report Approved by: Ian Bett, Chief Delivery Officer, NHS STW
Report Prepared by: Gareth Wright, Head of Clinical Operations UEC & EPRR, NHS STW
Action Required: For Discussion and Approval

1.1. Purpose

1.1.1 The purpose of this report is to update the Board on our planning for winter to date, and if content, to seek approval of our Winter Plan.

1.2. Executive Summary

1.2.1. The System UEC Improvement Plan 2025/26 is broadly on track. There are twin aims to support delivery of our operational plan and ensure preparedness for winter on a better footing than previous years. Against the primary performance metrics specified by NHSE committed to in our operational plan, we have achieved significant improvement on the ambulance performance required. We have made progress, but have more to do in order to reduce the time our patients are in our emergency departments. We expect to be back on plan in Q3 following delivery of our programme of improvement work.

1.2.2. Winter planning has gone further and been much earlier this year than last, both locally and nationally, and NHSE direction has been more proscriptive. We submitted our initial winter plan on 1 Aug to NHSE Midlands, who have conducted an assurance visit to our system on 4 Sep, which will be followed by an exercise to test system plans on 17 Sep. Following completion of that process, ICB and Trust Boards have been asked to complete board assurance statements no later than 30 Sep. Our proposed submission is covered in this report.

1.2.3. Detailed work that is progressing includes aligning provider plans with our system-wide approach; refining modelling of the impact upon our performance measures and capacity in the acute hospitals; and having selected where to apply our system interventions to greatest effect, moving them forward at pace.

1.2.4. The effects we intend to achieve are: to decompress our emergency departments; shift more urgent care out of hospitals to the community; maintaining a 'home first' principle for our patients; and minimise delays at each stage of the pathway. This is an ambitious agenda, but we have good grounds for optimism from the delivery of our programme of work that we will enter winter this year from a much stronger start position than previous years.

1.3. Recommendations

1.3.1 The Board is invited to:

- Note the progress of the system UEC improvement programme and delivery of our operational plan.
- Approve the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.
- Agree the submission of our Winter Board Assurance Statement to NHSE no later than 30 Sep, subject to finalisation by the Chair and CEO.

1.4. Conflicts of Interest

1.4.1. No conflicts of interest related to this report.

1.5. Links to the System Board Assurance Framework (SBAF)

1.5.1. Strategic Objective 3 includes: Improving Health and Care – Urgent & Emergency Care.

1.5.2. Strategic Risk No.2b: Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans; due to Escalation costs not reducing as planned due to UEC pressure and links to discharge.

1.6. Alignment to Integrated Care Board

1.6.1. Improve quality of care and patient experience in the UEC pathway. Enhance productivity and value for money.

1.7. Key Considerations

1.7.1. **Quality and Safety:** Achieving the best we can for patient care and outcomes under extreme operational pressure.

1.7.2. **Financial Implications:** UEC Improvement Programme is required to contribute to the System Financial Plan 2025/26, by reducing cost of Escalation capacity and process improvements in Community pathways.

1.7.3. **Workforce Implications:** UEC Improvement Programme is required to contribute to the System Workforce Plan 2025/26, by reducing reliance upon temporary staffing.

1.7.4. **Risks and Mitigations:** Risks to programme delivery are being managed by the UEC Delivery Group; accountable to the System Transformation Group.

1.7.5. **Engagement:** Extensive winter communications plan across broad media sources.

1.7.6. **Supporting Data and Analysis:** Data used in the report is from NHS STW Business Intelligence.

1.7.7. **Legal, Regulatory, and Equality:** Addressing health inequalities will continue to be a deliverable within the UEC programme 2025/26.

1.8. Impact Assessments

1.8.1. **Has a Data Protection Impact Assessment been undertaken?** No

1.8.2. **Has an Integrated Impact Assessment been undertaken?** No, but an Equality & Quality Impact Assessment has been reviewed by our Quality and Inequalities teams, and continues iteration.

1.9. Attachments

1.9.1. NHSE Winter Planning Board Assurance Statement – ICB. This is for approval at this meeting.

2. Winter Planning 2025-26

2.1. Introduction

2.1.1. This report follows on from the presentation delivered to the Board on 30 Apr 25, which updated on delivery last winter and reflected upon UEC improvement achievements in 2024/25. The Board was apprised of our intended approach for 2025/26 as Year 2 of our improvement programme, having learned from the experience of last year. Our winter planning for this year to date was briefed to the Board Development Session on 30 Jul 25, to enable submission of our initial Winter Plan to NHS England on 1 Aug 25.

2.1.2. Performance against the trajectories we have committed to is being much closer monitored this year. Improvements made within our UEC pathway have directly contributed to this and will do more. Our programme of work includes planning across the system to mitigate the predicted increased demands over the coming winter months. We have high impact schemes that will come to fruition, which will enable us to enter winter on a stronger footing than in previous years.

2.2. Background

2.2.1. **National direction – UEC Plan 2025/26.** Ahead of release of the 10 Year Health Plan for England, NHSE published the UEC Plan 2025/26 on 6 Jun 25. A wide-ranging document, which:

2.2.1.1. Confirms **priority focus upon key metrics** that we are closely monitoring in our Operational plan: patients waiting for 4 hours and 12 hours in our emergency departments; Category 2[1] ambulance response; and confirmation of a new standard for ambulance handover delays to be a maximum handover time of 45 minutes.

[1] Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – are to receive an ambulance response within 30 minutes.

2.2.1.2. Provides **direction on preparing for winter**; principally seeking to learn from previous years, with two priority actions:

'Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.'

'Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter.'

2.2.2. **NHSE Midlands direction**. An NHSE Midlands letter was received on 18 Jun, 'Winter 2025/26 Expectations for Planning, Preparedness, and Assurance', which informed the Board update on 30 Jul. We have submitted a winter Key Lines of Enquiry return to the regional team, our initial winter plan on 1 Aug; and hosted senior leadership from the Midlands Region team on a winter assurance visit to our system on 4 Sep. At the time of writing, formal feedback on the latter is awaited, but comments on the day were very positive; welcoming our progress and level of ambition, recognising that delivery is now key.

2.2.3. **NHSE Winter Board Assurance Statements**. On 14 Jul, the National Director of UEC & Operations, Sarah-Jane Marsh, wrote to ICB and Trust CEOs with supplementary guidance. Two specific expectations of all ICBs and Trusts, new this year, are:

- Stress test draft winter plans by participating in an **NHS England-hosted exercise** in September, to be arranged by Regional teams. The latter has been set for 17 Sep, which post-dates the finalisation of this report, so any significant outputs from that event will be covered during discussion.

- By 30 Sep, we are to submit a **Board Assurance Statement** direct to the NHSE national UEC team. The proposed statement is attached to this report, with the current status of actions leading to being able to recommend assurance to the Board are at Appendix 4. If content, the Board is asked to provide approval for submission.

2.2.4. **Improvement acknowledged by NHSE**. We are in Year 2 of our system plan to meet the Undertakings we committed to in May 24, including for operational delivery. What has been well received during our time in the national Recovery Support Programme (RSP), is that as a system, we have had a single, unified plan for improvement and delivery, and stuck to it. Tangible confirmation of achievement is:

2.2.4.1. A certificate of **compliance with the Undertakings** (not just UEC) has been issued by NHSE Midlands, on 18 Jul 25.

2.2.4.2. NHSE Midlands are reviewing whether the conditions have been met for the ICB to **transition out of RSP**. We have provided comprehensive evidence to demonstrate fulfilment of what we committed to do. At the time of writing the decision upon that is awaited.

2.3. System approach to winter 2025-26

2.3.1. **Transition from winter 2024/25**. It is generally expected that winter pressures ease after the turn of the financial year, but a conflation of factors contributed to a challenging exit from winter and start to Q1 in our system:

- **High attendances**. Ambulance conveyances to our hospitals were unusually high in March and April, with a weekly average 9.1% higher than in Dec 24 to Feb 25; and 5.8% higher than Mar/Apr 24. Overall front door attendances at our EDs were also 8.9% higher over the same period; with Type 1 at 2.3% higher.

- Taking the SaTH **Urgent Treatment Centres (UTCs)** contract back in-house resulted in a temporary reduction in activity through the UTCs and the performance achieved. The UTCs and our community Minor Injuries Units when working well, typically achieve over 90% compliance with the 4 Hour standard, which contributes strongly to our overall system performance as well as flow. Low activity through the UTCs displaces activity into our EDs.

- The start of the transition period for our **GP Out of Hours / Care Coordination Centre** provider contract; and the ending of additional capacity within it that had been funded by the national Recovery Support Programme. The effect has been to reduce options to signpost activity away from our hospitals; and in particular to reduce the ambulance service 'call before convey' for an alternative.

- **Ending of System-funded winter schemes** that contributed to flow, notably additional patient transport for discharges and transfers. This affected early outflow from our hospitals; proving the value of the intervention.

2.3.2. **Performance against Plan**. These factors increased and sustained crowding in our EDs, with a concomitant impact upon our primary performance metrics. But we remain largely on track or close to our operational plan. Our improvement programme is responsive to supporting course-correction, and our winter planning has been informed accordingly.

2.3.2.1. **4 Hour standard**. Notwithstanding these adverse pressures, our system performance overall has largely tracked, albeit fallen slightly short of the trajectory we have committed to, as shown in Figure 1 below. Importantly, the ED Type 1 performance has been closer to plan, which is generally harder to achieve than the Type 3 contribution by the UTCs, which will continue improve. The principal contributory factor to adverse 4 Hour performance is crowding in the EDs, with too many patients to be seen by too few clinicians with too few clinical spaces to see them in. It is our main effort to decompress the EDs, and several of our high impact enduring changes – as well as winter-specific schemes – are focused upon this effect.

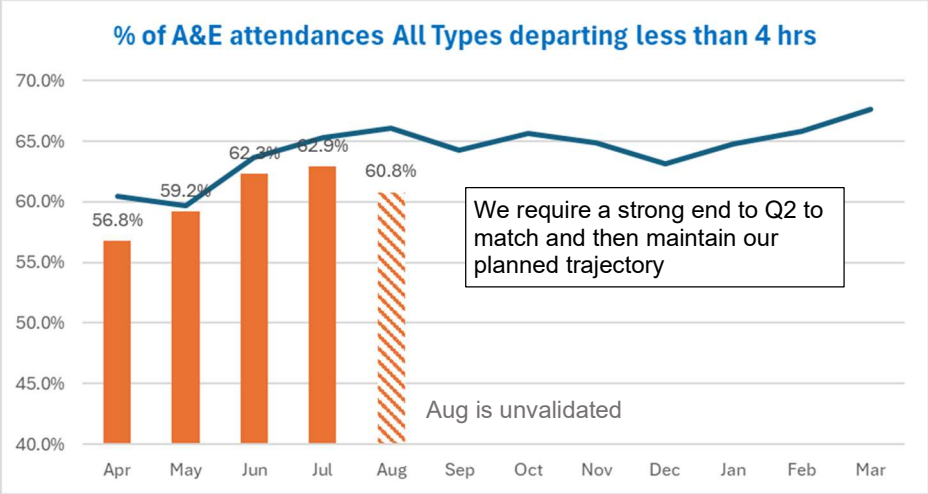


Figure 1: System 4 Hour performance against trajectory

2.3.2.2. **12 Hour waits in EDs**. This remains our area of most significant challenge, as shown in Figure 2. It is a direct result of the crowding in our EDs, which in turn is a product of too many arrivals and insufficient exit flow; not just admissions, discharge or transfer. Progress in the department slows, quality of care is diminished, and safety can be compromised. Corridor care becomes an unwelcome pressure. Approximately 60% of our 12-hour waits are for inpatient beds, with circa 20% routed to ambulatory or short stay settings; and the remainder are either discharged or transferred to other locations (such as a community bed). Additional bed capacity is due to be available on our acute sites in Q3, and several of our other schemes due to come online achieve a bed *equivalence* by providing alternatives to hospital attendance and admission, as well as facilitating more timely discharge and reducing the incidence of readmissions.

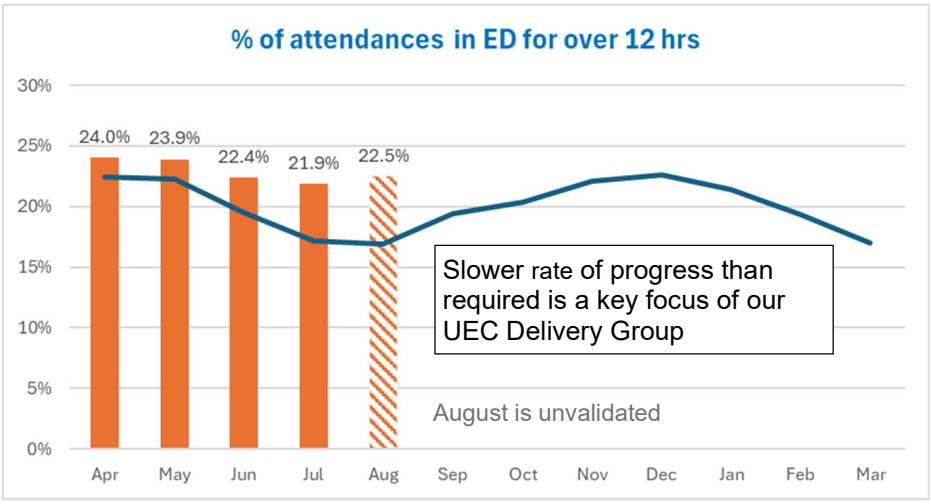


Figure 2: SaTH 12 Hour performance against trajectory

2.3.2.3. **Ambulance handover**. We have committed to an ambitious trajectory that is a 17% improvement on what we achieved each month last year. A new standard was introduced over Q4 of last year, to achieve handover within 45 mins (absolute, rather than average). This has been confirmed in the NHSE UEC Plan, and although not in the planning round so we do not have a trajectory for it, we have

committed to month-on-month improvement. August has been our most compliant month this year to date with 66.2%. Handover performance has a close connection with our financial plan, with potential penalty costs to contribute to WMAS capacity being a topical sticking point in agreeing the WMAS contract being brokered by Black Country ICB as lead commissioner. Figure 3 shows the challenging start in April but subsequent months being closer to our trajectory.

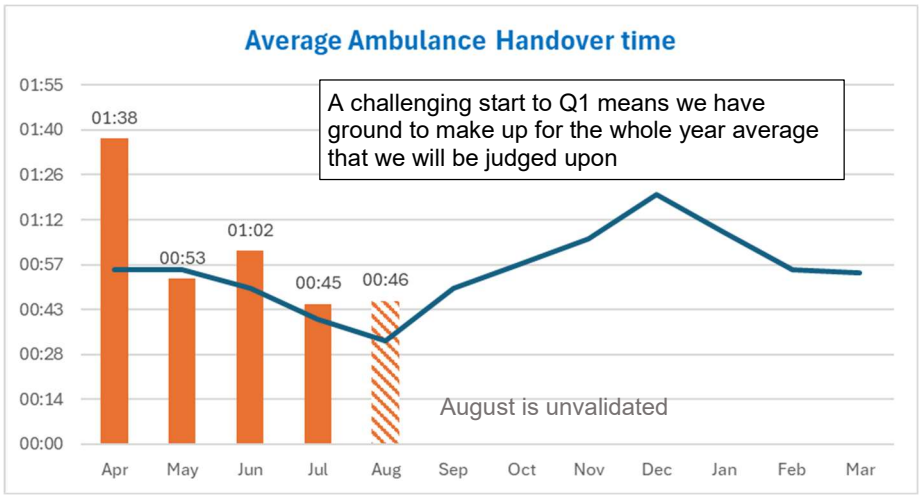


Figure 3: SaTH Ambulance handover performance against trajectory

2.3.2.4. **Ambulance Category 2 response**. This is a system metric that is a shared endeavour with WMAS, being partly a function of the resource deployed by our ambulance service colleagues and timely release of crews following handover at our hospitals, as well as finding alternatives to conveyance in the first place. In 2024/25 our system was one of the top 5 most improved nationally. Figure 4 shows the achievement this year to date.

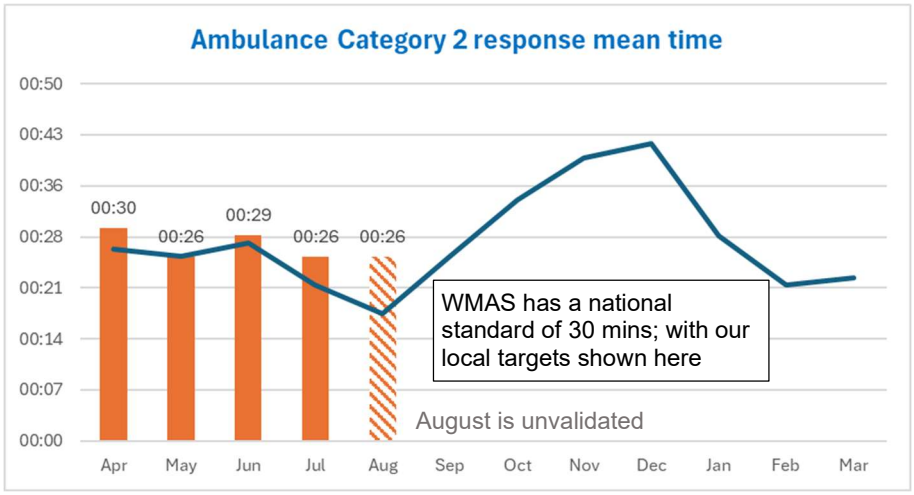


Figure 4: System Ambulance Cat 2 response against Plan

2.3.3. Learning from Winter 2024-25.

2.3.3.1. **System review and learning**. The UEC Delivery Group received a review of our System winter plan 2024/25 on 27 May 25. In summary, our ability to respond was insufficient to counter the progressive pressure that built throughout Nov & Dec 24, culminating

in declaring a system-wide critical incident on 3 Jan 25. It was recognised the significant response from system partners to ensure the incident only lasted for 48 hours. Winter pressures extended into April in terms of demand upon our pathway, which we have made provision for in our planning this year.

2.3.3.2. **NHSE Midlands**. The review of the experience across the Midlands region over winter acknowledged and confirmed the themes we had identified. A key observation made in the NHSE Midlands feedback was:

'*STW has proven it can recover under pressure. The next step is to avoid getting there in the first place*'.

2.3.4. **What we are doing differently.** Considering what has already been covered in this report, our approach has been modified based upon experience, including:

- Nationally and locally, **planning** has started much earlier.
- Our UEC Improvement **programme will complete *ahead of* winter**, not at the tail end of it, in the way intended last year.
- **Provider-specific improvement** programmes are more realistic; and complementary to the overarching system programme.
- We are **involving primary care** to better effect.
- Working with our Local Authorities on our **domiciliary care** provision.

2.3.5. **System-level interventions** will be more focused at the time and places to achieve most impact, rather than spread too thinly.

2.3.6. **Why we will be in a better place this year**. We require a more robust UEC pathway all-year round, with the ability to adjust for seasonal variations. That has been the focus of our Improvement programme. There are high impact changes being made – none of which we had last year – that are not winter-specific and therefore enduring. All these changes will contribute to our main point of effort, which is to decompress our EDs, by reducing attendance and increasing outflow. This includes an integrated out of hospital model for the services delivered by SCHT; reinvesting funds released from repurposing the Rehabilitation & Recovery Units at our acute sites. The principal changes are:

Enduring scheme	**Output intended**	**Timeframe**
Expansion of Urgent Community Response (UCR) to midnight, 7 days a week	ED Attendance avoidance	Nov/Dec
UCR Medical Model via GP cover and oversight	Safer, timelier community-based decision-making	Nov/Dec
Integrated Community services at the Front Door of our Emergency Departments	Redirection of patients into community service alternatives	Sep
2-Hour Domiciliary Care Bridging	ED Admission avoidance by supported discharge	Nov/Dec
Additional Discharge Planning capacity (5 to 8pm, 7 days a week)	Maintain discharge flow beyond core hours	Nov
Care Transfer Hub (CTH) System Manager	Enhanced operational leadership and joint working	Oct

Enduring scheme	Output intended	Timeframe
Additional Weekend Therapy cover for CTH	7-day therapy input for frail / complex patients	Nov
Care Coordination Centre / GP Out of Hours delivery under new contractor	Alternatives to ED, including reduced Ambulance conveyances	Oct
SaTH UTCs brought back in-house	Higher productivity is being incrementally achieved	In place
A modular build comprising 56 additional beds at RSH	38 additional inpatient beds available year-round, plus 18 Winter Flex inpatient beds	Nov/Dec
Reconfiguration of acute medicine beds and assessment areas at PRH (subject to Board approval 11 Sep 25).	Increase outflow options and capacity from ED	Oct/Nov

2.4. Winter Plan 2025-26

2.4.1. **Development of our Plan.** Winter planning has been a workstream in our Improvement programme, enacted from 1 Apr. The UEC Delivery Group has directed the programme, received monthly updates and made decisions on our approach. Our proposed plan has been reviewed and agreed at appropriate waypoints by the system UEC Clinical Advisory Group, the Commissioning Working Group, the System Transformation & Digital Committee ahead of Board on 30 Jul. The sequence of governance checks and balances enabled us to meet the NHSE submission deadline.

2.4.2. **Winter Plan summary.** Appendix 1 is the system winter plan, on a page. It consists of five phases with specific effects intended to match expectation of pressure and response. The phases are summarised in the table below:

Phase	Time period	Effect intended	Summary
1	Jul – Oct 25	**Deliver our programmes**	High impact changes (paragraph 2.3.5 above) will come online at varying points and coordinated to best effect.
2	Ahead of the festive fortnight	**Reduce rising pressure**	Intensive system effort to offset rise in demand and create capacity needed to get through the bank holiday period; which effectively has two 4-day weekends.
3	Early new year	**Recovery**	Having used the capacity, priority is to decompress and rebuild our reserve.
4	Feb – Mar 26	**Sustain our response**	Avoid being over-matched by pressure and set conditions for a strong Mar 26.
5	Mar – Apr	**Transition from winter**	Taper off the winter schemes and start 2026/27 well.

2.4.3. **Command & control.** Against the backdrop of the national and local NHSE / ICB reset, ICBs are required to deliver winter, and we will do so seeking any opportunities to work closer with our ICB cluster colleagues in the Staffordshire & Stoke-on-Trent ICB. Command & control will be exercised through our System Coordination Centre, which is well established and regularly tested in responding to pressures and the unforeseen. Managing the concurrency of UEC pathway winter pressures alongside an EPRR incident is being worked through.

2.4.4. **Applying system interventions**. We will have a tiered response framework this winter, which was welcomed and assured during the NHSE Midlands visit on 4 Sep:

2.4.4.1. **Enduring**. This will be our baseline increase in capacity, comprising what we have now, improved by the high impact changes detailed in paragraph 2.3.5 above. Redistribution of resources to rebalance activity into our Neighbourhoods.

2.4.4.2. **Seasonal**. This will comprise the interventions that we plan and proactively apply in a place and time of our choosing – such as a multi-agency discharge events, a GP at the ED front door, additional capacity in primary care, more patient transport.

2.4.4.3. **Responsive**. If our pre-planned interventions are judged insufficient to mitigate pressure, we will enact focused additional measures to de-escalate and avoid reaching a tipping point that would require an incident-level response. This might include extending opening hours of services; additional clinical decision-making capacity; and enhanced control by senior leadership.

2.4.5. **Allocation of ICB winter funding**. There is no general national funding again this year to resource the response required to winter pressures. We have a system budget of £740k, which is comparable to last year. Where to apply this funding to deliver the effects we require has been informed by review of what worked and what was less impactful last winter. There have been tests of change for the efficacy of schemes, such as transport capacity to be ringfenced for specific purposes. The ability to plan more deliberately is a direct benefit of starting our planning process earlier this year.

2.4.5.1. **Impact areas**. The UEC Delivery Group on 26 Aug agreed the schemes we will fund this year. This is summarised in Appendix 2. It was agreed that we would expect greatest impact from allocating system winter funding to:

- ED attendance and re-attendance avoidance by **Primary Care**, both our general practice and community pharmacy capacity.
- **Patient discharge transport** and enabling earlier facilitated discharge.
- **Communicating** with our patients to reassure, inform and empower their decision-making.

2.4.5.2. Provide a capacity **reserve for de-escalation**, under a response scenario as outlined at paragraph 2.4.4.3 above.

And that we should de-prioritise previous year schemes that have limited proof of delivery.

2.4.5.3. **Distribution of funding**. At the time of this report, providers of the selected schemes are being given authority to proceed. We await a decision on a bid we have submitted for additional funding from a national Respiratory Transformation Programme scheme. If successful, it would enable primary care seasonal respiratory

intervention on a broader basis that we can currently fund as a system. Assurance that we are using our system funding appropriately continues to be by the Commissioning Working Group.

2.4.6. **Winter-specific planning**. There are specific seasonal sub-plans that are well advanced, including:

- **Vaccination programme**, executive lead CMO supported by CNO; being developed by the Directors of Public Health for our population, and by provider leads for staff immunisation and inpatients.

- **Infection Prevention & Control**, executive lead is CNO; we will receive health intelligence input from UKHSA, and response plans by providers.

- Our **Workforce** is under the most pressure of any time of the year with staff fatigue, burnout, winter illness and the imperative to take leave all factors that will be carefully managed.

2.4.7. **Bed demand & capacity**. Our baseline bed model is derived from our Operational Plan 2025/26. This is supplemented by the impacts of our change programme activities (including SaTH modular build) and our winter-specific schemes. We continue to refine modelling of the impacts that could be realised; along with what can be achieved at an appropriate confidence level.

2.4.7.1. **Winter scenario impact effects** are based upon actual experience last year, with two levels 'surge' (1 or 1.5% increase in demand and bed closures) and 'super surge' (2 to 5% increase, depending which metric is affected). Whereas these percentages are not particularly high, such is the nature of current demand upon finely balanced service capacity, they have a cumulative effect over a succession of days if the pressure cannot be eased. Our ability to turn over beds is more significant than absolute numbers.

2.4.7.2. **Assessment**. There are plus and minus shifts intended as we rebalance our bed base, as well as measures that will provide bed equivalence in our high impact schemes. Taking all of this into account, a summary of our demand and capacity is at Appendix 3. Our most challenging month is expected to be December, both in terms of peak demand as well as a number of our change programmes rebalancing capacity and service delivery. Every effort will be made to bring forward, deconflict and coordinate provider changes with system support.

2.4.7.3. Use of **Temporary Escalation Spaces (TES)** will be minimised this winter. TES comprise the use of unfunded or unconventional care spaces, which may include one or more additional patients in inpatient wards, or 'corridor care' in an emergency department. The latter, above all, will not form part of our escalation processes this year.

2.4.8. **System partner key contributions**. Our role as the ICB is to plan and deliver 'a better winter for our patients and staff, as directed in the NHSE UEC Plan

2025/26 published on 6 Jun 25. Key contributions that our system partners are accountable for include:

2.4.8.1. SaTH will deliver the process improvements within their agreed Improvement programme; and reconfigure the acute bed base for greater optimisation of flow through the hospitals.

2.4.8.2. ShropComm will deliver the closure of the Rehabilitation & Recovery Units in order to release resources to reinvest in the Integrated Out of Hospital model. The outcome will be a significant shift of patient activity away from hospital into community settings.

2.4.8.3. RJAH will continue to focus on elective activity and backlog reduction. Over the festive fortnight, fallow capacity will be made available to SaTH to continue elective programme delivery during the forthcoming bed reconfiguration; and ease pressure upon the acute sites at this most demanding point in winter.

2.4.8.4. MPFT will maintain resilience in its community and inpatient mental health services in support of the overall system ambition to drive down unnecessary demand on primary care and acute services.

2.4.8.5. WMAS will maintain ambulance resource availability in accordance with their demand & capacity plan for winter. And bear down upon unnecessary conveyance to hospital, making appropriate use of the 'call before convey' options for lower acuity patients. Close contact is maintained daily between our Ops teams to manage pressure.

2.4.8.6. Health Hero, our provider of single point of access and GP out of hours services with effect from 1 Oct, will collaborate with our system partners to identify and provide alternative to hospital pathway referrals for our patients.

2.4.9. Risks to Quality and delivery. Key risks being managed in our preparedness, all under ICB leadership and command & control interventions are:

- **High impact schemes** being delayed in implementation; for example, estates delays and workforce consultation. There will also be sequencing and concurrency issues to be carefully managed as we make changes to the services we are delivering.

- **UEC Improvement programme** workstreams not delivering the impact envisaged by the start of November; for example more patients being discharged home, has a dependency upon reducing delay-related deconditioning in our hospitals.

- **Insufficient information to inform patient decisions** to select the right service for their needs, other than our EDs. This is the principal focus of our system winter communications campaign, which is in development.

- **The unforeseen** is a daily challenge on the UEC pathway; for example, across the NHSE Midlands region last year there was an earlier onset at higher levels than predicted of Flu.

2.4.10. **Towards Board Assurance of our Plan.** New to this year, although consistent with the direction of travel for more defined accountability, is the requirement for CEOs and Chairs of ICBs and Trusts to complete and submit a Board Assurance Statement (BAS) to the NHSE national team, no later than 30 Sep.

2.4.10.1. A **proposed BAS** is enclosed for ICB Board consideration, with a summary of evidence and rationale for recommending assurance at Appendix 4 of this report.

2.4.10.2. Although the ICB assurance is not an aggregation of our **provider Trusts' statements**, we have been monitoring progress through the system Planning & Performance Group and by the ICB Board meeting on 24 Sep all should have been reviewed by Trust Boards, as follows:

Trust	Board date	Notes
RJAH	3 Sep	BAS was reviewed and supported
SCHT	4 Sep	BAS was approved and will be aligned with SaTH by CEO in Common
SaTH	11 Sep	Not taken place at the time of writing this report
MPFT	11 Sep	Jointly comprises the assurance for Staffordshire & Stoke-on-Trent

2.5. Recommendation

2.5.1. Winter will never be a straightforward period of pressure for our system. But we have come far in setting the conditions for a more resilient UEC pathway, that is more able to absorb and recover from peaks of demand. Provided we successfully deliver the interconnected programmes of work that we have in progress, we should enter winter in a significantly better position than previous years. This will provide our basis to maintain safety and the quality of care that our patients deserve.

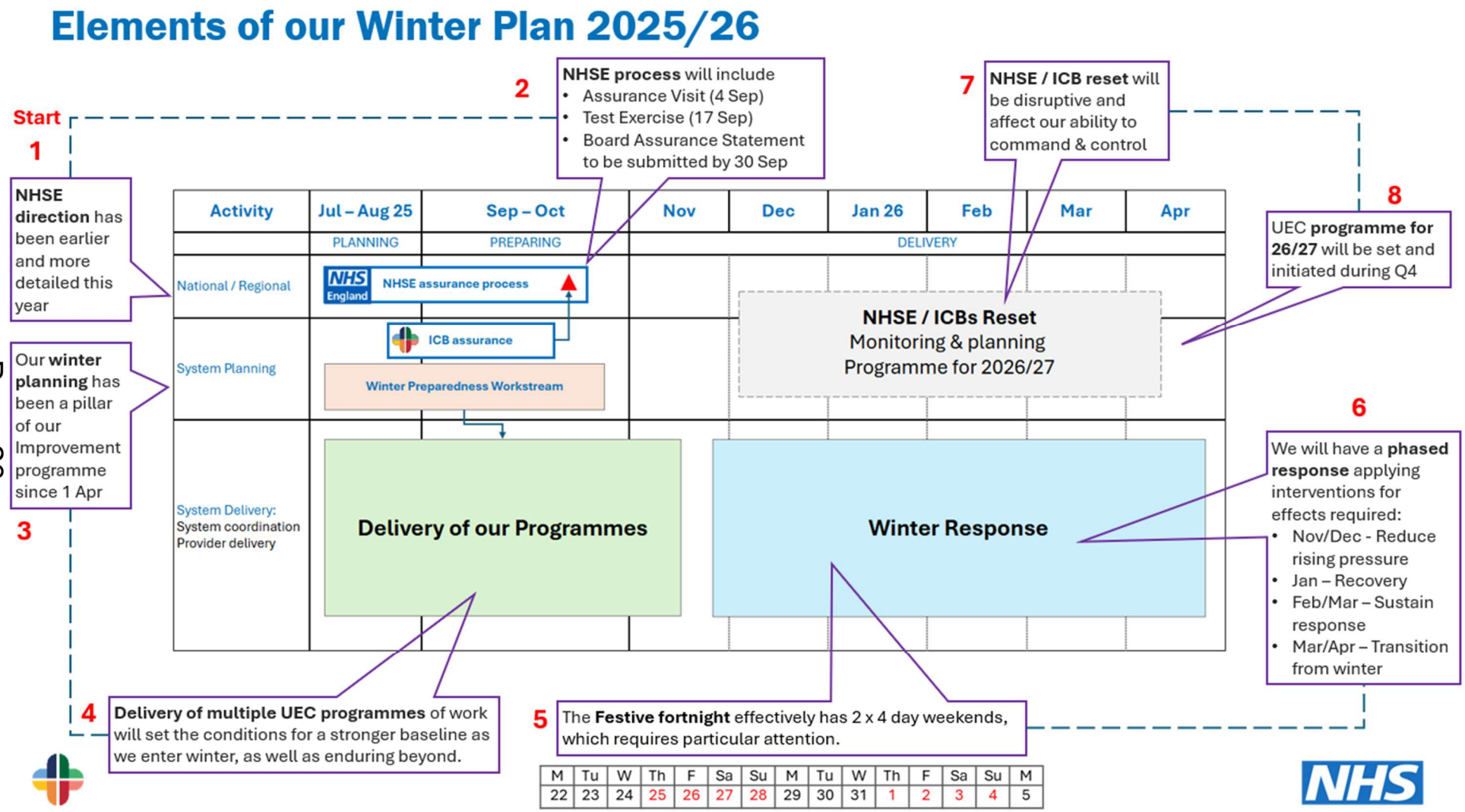
2.5.2. On this basis, the Board is recommended to:

- Note the progress of the system UEC improvement programme and delivery of our operational plan.
- Approve the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.
- Agree the submission of our Winter Board Assurance Statement to NHSE no later than 30 Sep, subject to finalisation by the Chair and CEO.

Appendices:

1. STW Winter Plan 2025-26 summary.
2. STW Winter funded mitigation schemes.
3. System bed model 2025-26.
4. Board Assurance Statement evidence and rationale.

Appendix 1 – STW Winter Plan 2025-26 summary



Appendix 2 – STW Winter funded mitigation schemes

System Winter schemes to be funded by ICB 2025/26

Time limited interventions for the winter period.

Scheme	Summary	Outcome expected	Effects intended
Extended Hours of UTC opening	By opening from 0800-midnight daily, we can reduce the number of patients handed back to ED; as well as easing pressure upon general practices.	*Typically 15-20 patients seen in each UTC rather than ED*	ED decompression Reduce pressure on primary care
Primary Care management of rising risk patients	Identify rising risk patients, optimise care, and support, linking with Virtual Ward and acute physicians if necessary. Funding bid pending for Respiratory Transformation Programme.	*Patients de-risked from COPD exacerbation in the community*	ED attendance avoidance
British Red Cross ED support scheme	To provide emotional and practical support to our patients, their families and carers.	*Support to 300-600 patients, subject to final model agreed*	Admission avoidance and ED decompression
System-level Communications	We need to keep our patients informed of their options including Pharmacy First and NHS 111.	*'Think Which Service' broad spectrum campaign*	Influence public and patients
Patient transport capacity	Complete work to ensure we are making best use of what we have, supplementing if the need is proven.	*Additional 1,600 patient journeys for discharges*	Earlier in the day discharge
Enhance our Discharge Medicines Service	Increase the volume of referrals and targeted support to community pharmacies to increase completion rates.	*Bed days saved from approx 15-20 beds equivalence*	Re-admission avoidance
Reserve capacity to meet peaks of demand	A range of pre-planned interventions is needed, within agreed lead times. This may include additional GP capacity in acute settings.	*Focused interventions to deliver double digit impacts*	Ease system pressure at points of greatest need on our pathway

Appendix 3 – System bed model 2025-26

The System Operational Plan 2025/26 provides progressive mitigation of the bed position at SaTH by a range of improvement programme schemes. Added here are the expected impacts of the high impact change programmes and System funded winter schemes (Appendix 2). The mitigations will offset our anticipated adverse bed position. December is our month of highest anticipated pressure, concurrent with enacting changes such as the modular build at RSH becoming available to use.

Physical beds required	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	709	741	721	719	699	683	688	718	740	710	733	684
Surge	709	741	721	719	699	683	711	750	786	754	769	707
Super surge	709	741	721	719	699	683	727	774	818	786	795	723
Beds available												
Overnight G&A available - core	768	768	768	768	768	768	768	796	796	796	796	796
Planned Escalation beds	17	17	17	17	17	17	17	17	45	45	45	45
Total beds	**785**	**785**	**785**	**785**	**785**	**785**	**785**	**841**	**841**	**841**	**841**	**841**
NEL acute beds (including SaTH schemes)	**662**	**662**	**662**	**662**	**662**	**662**	**662**	**735**	**745**	**763**	**763**	**763**
Occupancy assumption	98%	98%	98%	98%	96%	96%	96%	96%	96%	96%	96%	96%
Beds available	**649**	**649**	**649**	**649**	**636**	**636**	**636**	**706**	**715**	**732**	**732**	**732**
Bed gap (after IPC closures)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	-68	-101	-88	-77	-73	-55	-69	-19	-33	3	-6	33
Surge	-68	-101	-88	-77	-73	-55	-92	-51	-79	-41	-43	10
Super surge	-68	-101	-88	-77	-73	-55	-108	-75	-112	-74	-69	-6
System bed mitigations include												
Out of Hospital activity shifts								8	17	18	17	17
System winter mitigation schemes							6	9	13	14	14	14
Residual bed gap	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline	-68	-101	-88	-77	-73	-55	-63	-2	-3	35	25	64
Surge	-68	-101	-88	-77	-73	-55	-86	-34	-49	-9	-12	41
Super surge	-68	-101	-88	-77	-73	-55	-102	-58	-82	-42	-38	25

Appendix 4 – Board Assurance Statement evidence and rationale

By 30 Sep, we are to submit a Board Assurance Statement directly to the NHSE national UEC team. The current status of actions leading to being able to recommend assurance to the Board are detailed here.

Section A: Board Assurance Statement

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Yes	Summarised in this report. Our Plan has been reviewed and assured by NHSE Midlands on a winter assurance visit to our System on 4 Sep.
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan, and this has been reviewed by the Board.	Yes	This has been extensively reviewed with input and iteration between the ICB UEC, Quality and Inequalities team. It will be reviewed on behalf of the Board at the Quality & Performance Committee on 25 Sep.
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	Our Plan has been developed under direction of the UEC Delivery Group, at which all partners are represented, including NHSE Midlands, our Local Authority colleagues and Partners in Care. Engagement with the ambulance service is led by our UEC Improvement Director (formerly of WMAS).
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	A delegation of 9 senior leaders from the ICB and partners across our system will participate in the NHSE-led winter exercise on 17 Sep. The outcome intended is to identify any gaps in our preparedness, to incorporate ahead of the winter period.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Our Chief Delivery Officer is the accountable executive supported by the Deputy Director of Operations in Urgent and Emergency Care.
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Yes	Detailed in the section below
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	This is built into our Plan, and will be assured on behalf of the Board at the Quality & Performance Committee on 25 Sep.

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	Our SCC operates 7 days each week and is the principal daily command & control mechanism to direct and coordinate system-wide response to pressures. Closer alignment will be sought with our Staffordshire & Stoke-on-Trent system cluster partners to ensure any staffing issues are mitigated. Clinical leadership to provide on call support where required from across all system partners.
Section B: 25/26 Winter Plan checklist		
Prevention		
Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	System partnership group has been established (12 Aug) working together to improve all vaccination uptake across STW. Under leadership of Directors of Public Health. All NHS providers, ICB and Local Authorities are included. Will meet fortnightly from the 9th September. Key output is the STW Vaccination Improvement Plan delivery. Our Flu vaccination campaign delivery started 1 Sep for these groups and will run through to 31 Mar 26. Delivered through GP practices, community pharmacies and hospital trusts.
In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	Patients aged 18 years to under 65 years in clinical risk groups (as defined by the Green Book, Influenza chapter 19 e.g. chronic respiratory disease, cardiac disease, diabetes, immunosuppressed) are eligible to receive a flu vaccination as per JCVI guidance. This will start from 1 Oct for these groups.
Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Yes	Our GPs work tirelessly to identify and have plans in place for individual patients. We will have improved options available to support fulfilment of urgent care needs at home with expansion of our Urgent Community Response, backed up by resilient medical oversight. Alternative to hospital pathway referrals will be more available through our care coordination centre / GP out of hours provider from 1 Oct.
Capacity		
The profile of likely winter-related patient demand across the system is modelled and understood, and individual	Yes	Our demand & capacity model for the system includes baseline, surge & super surge scenarios. This incorporates our individual provider elements.

Assurance statement	Assurance recommended (Yes / No)	Evidence / rationale
organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.		This will be stress tested through the NHSE winter exercise process. Our understanding of likely demand will be refined upon receipt of the UK Health Security Agency scenario assessments, expected late September.
Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	These profiles have been built into our Improvement programme throughout. Our Integrated Out of Hospital Model being implemented by ShropComm includes additional discharge planning capacity, 7 days each week. Robust planning on going to mitigate bank holidays over festive period.
Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	Yes	Key point is to maintain elective activity with minimal disruption because of high pressure from the non-elective pathway. We are well placed to achieve this. SaTH is significantly ahead of trajectory on elective waiting time standards. Over the festive period RJAH fallow capacity will be made available to SaTH to continue elective (principally elective orthopaedic) programme delivery including during the bed-base reconfiguration; and ease pressure upon the acute sites at this most demanding point in time.
Leadership		
On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Our ICB on-call cohort will be provided with additional training in October following the NHSE winter exercise to cover the anticipated differences in regional command & control posture this winter, as well as more specific guidance on our intra-system changes to managing pressures. We will work closely with our providers to check – and rebalance if necessary – the overall experience and competencies of the collective on-call on a given day across our system. Key point will be to ensure that we have sufficient clinical leadership.
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is well established in our system, using the SHREWD system that aggregates up to NHSE regional level. Additionally, we are reviewing our escalation triggers to reflect the changes in capacity and out of hospital model we are implementing.

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**18/09/2025**						
Title of report	**Healthy Ageing Strategy**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendations (With discussion by exception)		Information only (No recommendations)		
Reporting Officer & email	**Report Prepared by:** Lorna Watkins, Strategy Development Manager. Lorna.watkins1@nhs.net **Report Presented by:** Vanessa Whatley, Chief Nursing Officer. vanessa.whatley@nhs.net						

Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply				
	Children & Young People		Joined up working	x
	Mental Health	x	Improving Population Health	x
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x
	Workforce	x	Reduce inequalities (see below)	x

What inequalities does this report address?

- Inequalities in health outcomes: People in deprived areas, certain ethnic minority communities, and those with chronic conditions face higher risks of early-onset frailty.
- Inequalities in access to services: Risks of inconsistent implementation and digital exclusion are recognised, with mitigations planned through inclusive service design.
- Disparities by deprivation and ethnicity: The Integrated Impact Assessment identifies these gaps and sets out targeted neighbourhood approaches to ensure inclusivity and equitable service delivery.
- Age-related inequalities: The strategy focuses on the protected characteristic of age, aiming to reduce inequities in healthy life expectancy and quality of life as people get older.

Report content

1. Executive Summary

The Healthy Ageing Strategy sets out a system-wide approach to support residents in Shropshire, Telford and Wrekin to age well. It focuses on prevention, early identification, and coordinated care for those at risk of or living with frailty. The strategy is aligned with national priorities including the NHS 10-Year plan and local strategies such as the JFP (Joint Forward Plan) and Ageing well initiatives. It is built on public health data and shaped by engagement with residents, professionals and community partners.

2. Recommendations

- Note the Healthy Ageing Strategy 2025-2028 fully aligns with both Health and Wellbeing Strategies and ShIPP and TWIPP priorities.
- The Health and Wellbeing Board supports the Healthy Ageing Strategy Implementation

3. Report

Introduction

The report seeks support for a three-year strategy focused on the care and support of individuals who are living with, or at risk of developing, frailty as they age. The strategy sets out a vision for enabling people in Shropshire, Telford and Wrekin to age well—living longer, healthier, and more independent lives. This will be achieved by extending healthy life expectancy, reducing health inequalities, and enhancing quality of life through proactive, personalised, and compassionate care. The approach is rooted in a Place-based, neighbourhood model that empowers communities to thrive at every stage of later life.

The strategy aims to prevent frailty improve outcomes for people living with frailty by:

- Increasing healthy life expectancy
- Reducing health inequalities
- Enhancing the experience of patients and carers
- Slowing the growth in demand for health and care services

To achieve these aims, the strategy sets out the following objectives:

- Improve public and workforce understanding of frailty and awareness of available support services
- Delay the onset of frailty and reduce disparities in its development
- Slow the progression of frailty and address inequities in outcomes
- Enhance the quality of life for individuals with moderate to severe frailty
- Strengthen care coordination and planning for those with severe frailty through better use of digital tools
- Deliver services closer to home through a neighbourhood-based model
- Reduce unplanned care and emergency attendances related to frailty, thereby decreasing avoidable hospital admissions

Background

Shropshire, Telford and Wrekin has a growing population of older people, with significant numbers at risk of frailty. The strategy responds to this challenge with a public health approach and alignment to national and local strategies and priorities.

Frailty is a medical clinical term that refers to a reduction in physical and mental resilience, which increases an individual's vulnerability to adverse health outcomes such as illness, injury, or bereavement. This condition significantly impacts quality of life and is associated with a heightened risk of mortality, disability, dementia, hospitalisation, falls, and the need for long-term care.

It is important to recognise that frailty exists on a spectrum ranging from mild to severe. Many individuals living with frailty continue to lead independent and fulfilling lives, often with varying levels of support. While the likelihood of developing frailty increases with age, it is not an inevitable consequence of ageing. At different points along the spectrum, frailty can be prevented, delayed, reversed, or effectively managed.

Although commonly associated with older age, frailty can also develop earlier in life, particularly among individuals who experience an accumulation of health risks. This strategy primarily addresses age-related frailty, but it also incorporates a preventative focus aimed at younger populations. As the approach evolves, it will retain the flexibility to adapt to a broader range of needs.

Certain groups face a higher risk of early-onset frailty, including those living in socioeconomically deprived areas, some ethnic minority communities, and individuals with chronic health conditions. Given the growing number of people affected by frailty, it has become a national priority. Without a personalised and proactive approach, the increasing prevalence of

frailty poses a significant risk of placing additional strain on urgent and emergency services, as well as on primary care.

Main Body of report

The Healthy Ageing Strategy is structured around five interdependent pillars—**Educate, Prevent, Identify, Manage, and Care**—which together form a comprehensive framework for improving outcomes for people at risk of or living with frailty.

- **Educate:** Focuses on increasing awareness and understanding of frailty among the public, carers, and the health and care workforce. This includes promoting knowledge about prevention, early signs, and available support services, as well as embedding frailty education into professional development programmes.
- **Prevent:** Aims to delay the onset of frailty through targeted interventions, lifestyle support, and proactive outreach. This includes universal prevention offers, such as health education resources and signposting to community-based services, particularly for those aged 50+ who are at increased risk.
- **Identify:** Establishes consistent and reliable methods for identifying individuals at risk of frailty or those already experiencing it. This includes the use of validated assessment tools, shared care records, and population health data to support early detection and personalised care planning.
- **Manage:** Supports individuals with mild to moderate frailty through coordinated care pathways, digital tools, and proactive case management. It also focuses on reducing progression to severe frailty by ensuring timely interventions and equitable access to services.
- **Care:** Enhances support for people with severe frailty and their carers through comprehensive geriatric assessments, advance care planning, and improved end-of-life care. It prioritises dignity, choice, and continuity of care, with a strong emphasis on reducing unplanned hospital admissions and supporting care in preferred settings.

The strategy sets out clear objectives aligned to these pillars, including:

- Reducing the onset and progression of frailty
- Improving quality of life for individuals with frailty
- Reducing reliance on unplanned and acute care services
- Addressing inequalities in frailty outcomes across different communities

To support delivery, the strategy includes a three-year implementation plan with defined milestones for each year. These milestones cover workforce training, digital enablement, service redesign, and community engagement. Progress will be monitored through a robust evaluation framework, which includes both process and outcome measures, such as:

- Uptake of frailty assessments and care plans
- Reduction in emergency admissions related to frailty
- Improvements in patient-reported outcomes and experience
- Reduction in disparities by deprivation and ethnicity

Oversight will be provided by the Healthy Ageing Strategy Steering Group, which will ensure alignment with national guidance, local priorities, and system-wide transformation programmes.

Conclusion

The strategy provides a clear, evidence-based roadmap for improving outcomes for older residents and ensuring the sustainability of health and care services. It reflects the voices of our communities and the commitment of our system partners.

Risk assessment and opportunities appraisal (*NB This will include the following: Risk Management, Human Rights, Equalities,*	An Integrated Impact Assessment has been completed and approved by the Equality Involvement Committee, Health Inequalities and quality team. The Integrated Impact assessment can be sent on request.

Community, Environmental consequences and other Consultation)		
Financial implications (*Any financial implications of note)*	None at this stage however as the Health Ageing Strategy develops, where there is opportunity to draw on external money to support change for aspects of the strategy, we will be proactive in this. Improvements will be tested using quality improvement methodology and where investment is required business cases will be developed and put through usual channels and priority assessments. Overall, this is a cultural change to how we proactively care for older people.	
Climate Change Appraisal as applicable	N/A	
Where else has the paper been presented?	System Partnership Boards	Telford & Wrekin Integrated Place Partnership Board To be presented Shropshire Integrated Place Partnership Board – 16/10/2025
	Voluntary Sector	CP meeting with Chief Officer Group (COG) 25/09 to discuss how best to share with VCSE Partners however key VCSE partners sit on both Place groups and boards.
	Other	System Place Accelerator groups Strategy and Prevention committee Equality and Involvement committee System Strategy & Development Group Quality and performance Committee – 25/09/2025
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Engagement Report and Integrated Impact Assessment can be provided on request.		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead Vanessa Whatley – Chief Nursing Officer, NHS STW		
Appendices *A*ppendix A – STW Healthy Ageing Strategy Final DRAFT for approval Appendix B - Supporting Information for STW Healthy Ageing Strategy		

Healthy Ageing Strategy

2025-2028

DRAFT v4.0

"Not all older people are frail, and frailty is not an inevitable part of ageing."

British Geriatric Society

Contents

Introduction

The Healthy Ageing Strategy aims to create the basis for a cultural change in how we think about and respond to frailty and ageing across Shropshire, Telford and Wrekin. It supports a shift from hospital-based care to care in the community, involving local authorities, voluntary and community organisations, and primary and community health services. It aligns with England's 10-Year Health Plan and local ageing well strategies, all shaped by public engagement.

This strategy takes a public health approach and is built on public health data showing how our population is ageing, how many people may become frail, and how long they live in good or poor health.

Listening to residents and professionals was central to shaping the strategy.

Listening to our residents: How we shaped the Healthy Ageing Strategy

We undertook a consultation of residents and those working in the care of people as they age including health and social care, voluntary and community sector organisations in Shropshire, Telford and Wrekin. Residents and professionals shared valuable insights that have helped shape our approach and a summary of the findings is available on our website.

Our residents clearly told us that they understood the term frailty but preferred to call the strategy, and resulting services, something different that was more inclusive of those who are being prevented from developing frailty though to severe frailty. Some communities found the term particularly upsetting. Although frailty is a medical term which is defined by the British Geriatrics Association as a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves, and we need to use it describe some of the aims of this strategy, we have called the strategy *Healthy Ageing* and will use this terminology wherever practical.

A key message from the engagement was the importance of involving people who are considered frail or needing to age healthily, in decisions about their own care. We intend to plan for this, especially through the shift from hospital to community-based care and healthy ageing (prevention). This supports the view of 69% of residents who felt that frailty is a condition that can be prevented, delayed, or managed with the right care and support. While many associated frailty with reduced mobility, frequent falls, personal vulnerability, and difficulty with daily tasks, they also highlighted broader challenges:

- Limited access to services in rural areas
- Rising costs of non-NHS support services impacting household budgets
- Inconsistent service availability across the county.

When seeking support, residents said they typically turn to their primary care services or someone with lived experience of frailty. In some communities, faith groups play a key role in providing support. However, most participants who thought they should, did not believe they had received a clinical assessment for frailty.

Health priorities varied: those in poorer health focused on accessing healthcare services, while those in better health emphasised staying physically active.

We are deeply grateful to all residents, voluntary and community sector organisations and health and care professionals who contributed to this consultation. We will commit to updating progress on the strategy through our media channels to keep the public informed.

Why is it important to age well?

Ageing well is essential for maintaining a good quality of life. Without proactive support, residents face increased risks of poor health outcomes including disability, dementia, hospital admissions, falls, and the need for long-term care.

Frailty is not a fixed condition; it exists on a spectrum from mild to severe. Many people living with frailty remain independent and lead fulfilling lives with the right support. While the likelihood of frailty increases with age, it is not inevitable. At various stages, frailty can be prevented, delayed, reversed, or managed.

Frailty can also affect younger residents, particularly those with multiple health conditions. The risk of early frailty is higher among people living in deprivation, some ethnic minority groups, and those with long-term health issues.

Our residents have told us that avoiding emergency hospital visits is a priority for them. This aligns with the national NHS goal to support people in managing their health proactively and within their communities, reducing reliance on hospital-based care. This is a move known as the hospital-to-community shift.

Frailty is a national priority because the number of people at risk is growing. This increase brings greater demand for health and care services. Living for years—or even decades—in poor health leads to personal suffering, pressure on families, and strain on health and social care systems.

Evidence shows that once frailty becomes established, its progression can accelerate. As frailty increases, so do care needs and associated costs. That's why delaying its onset and managing it effectively is vital, not only for the wellbeing of our residents but also for the long-term sustainability of health and care services, both financially and environmentally.

How this links to other local and national work?

Figures 1 shows how this strategy will improve healthy ageing and frailty in STW fitting with local and national priorities, and the relationship with other strategies that aim to prevent and support those with conditions related to frailty.

Figure 1

Links to Shropshire, Telford & Wrekin Strategic Priorities	**Links to National Policies and Initiatives**
• All Age Autism Strategy • Dementia Vision Pathway • Health and Care Pathways Development (Hospital Transformation Programme and Local Care) • Long Term Conditions Strategy • Musculoskeletal Transformation Programme • Shropshire HWBB Priorities • Shropshire Integrated Place Partnership Priorities • Shropshire Plan • Shropshire Preventions Framework • Shropshire, Telford & Wrekin Commissioning Priorities • Shropshire, Telford & Wrekin Joint Forward Plan	• Be Proactive: Proactive care for older people with frailty – British Geriatrics Society • Chief Medical Officers Annual Report 2023: Health in an ageing society • Geriatric medicine – Getting it Right First Time • NHS 10year Plan • NHS England Personalised Care • NHS Neighbourhood Guidelines • NHS Proactive Care: Providing care and support for people living at home with moderate or severe frailty • Skills for Health Frailty Framework

• Shropshire, Telford & Wrekin Neighbourhood Approach • Telford & Wrekin Ageing Well Strategy • Telford & Wrekin Health Wellbeing Strategy • Telford & Wrekin Integrated place partnership Priorities • Telford & Wrekin Vision 2032 • Urgent Emergency Care Improvement Plan	

How many people are affected?

Shropshire, Telford and Wrekin is currently home to around 118,000 over 65-year-olds, which is expected to increase to around 162,000 by 2035. We estimate there are around 45,000 people aged over 65 living with mild frailty, 19,000 moderately frail and 6,000 with severe frailty. More details about the local population and estimated numbers living with frailty, are provided in the accompanying Supporting Information.

In Shropshire, Telford and Wrekin we have a larger proportion of people aged over 65 than nationally (22% compared to 18% across England), along with significant numbers at risk of earlier onset frailty, such as people who live in deprivation and those from Pakistani and Bangladeshi communities. On average our residents live the final 17-22 years of life in poor health, and there is a gap of up to 12 years between the healthy life expectancy of the most and least deprived. So, reducing the number of years lived in poor health, particularly for the most deprived who live the longest in poor health, is where the opportunity lies for improving quality of life for our residents whilst slowing the growth in health and care costs.

What will we do?

This strategy aims to address healthy ageing and co-ordinated healthcare support to those with frailty who are resident in our population aged over 65, and those over 50 who are at higher risk of early frailty as a priority. However, some of the aims of the strategy means that younger people and those with lower risk may benefit.

The Healthy Ageing Strategy is organised into five pillars that show how we will tackle healthy ageing. These are

- educate,
- prevent,
- identify,
- manage and
- care.

Through these pillars we will address the feedback from our residents including avoiding fragmented care, improving the recognition of frailty and looking at any gaps in services. Our health and care professionals told us that where digital can help it should be enabled but we also recognise that our residents told us not everybody is confident with accessing digital services for their healthcare needs so we will make adjustments for this.

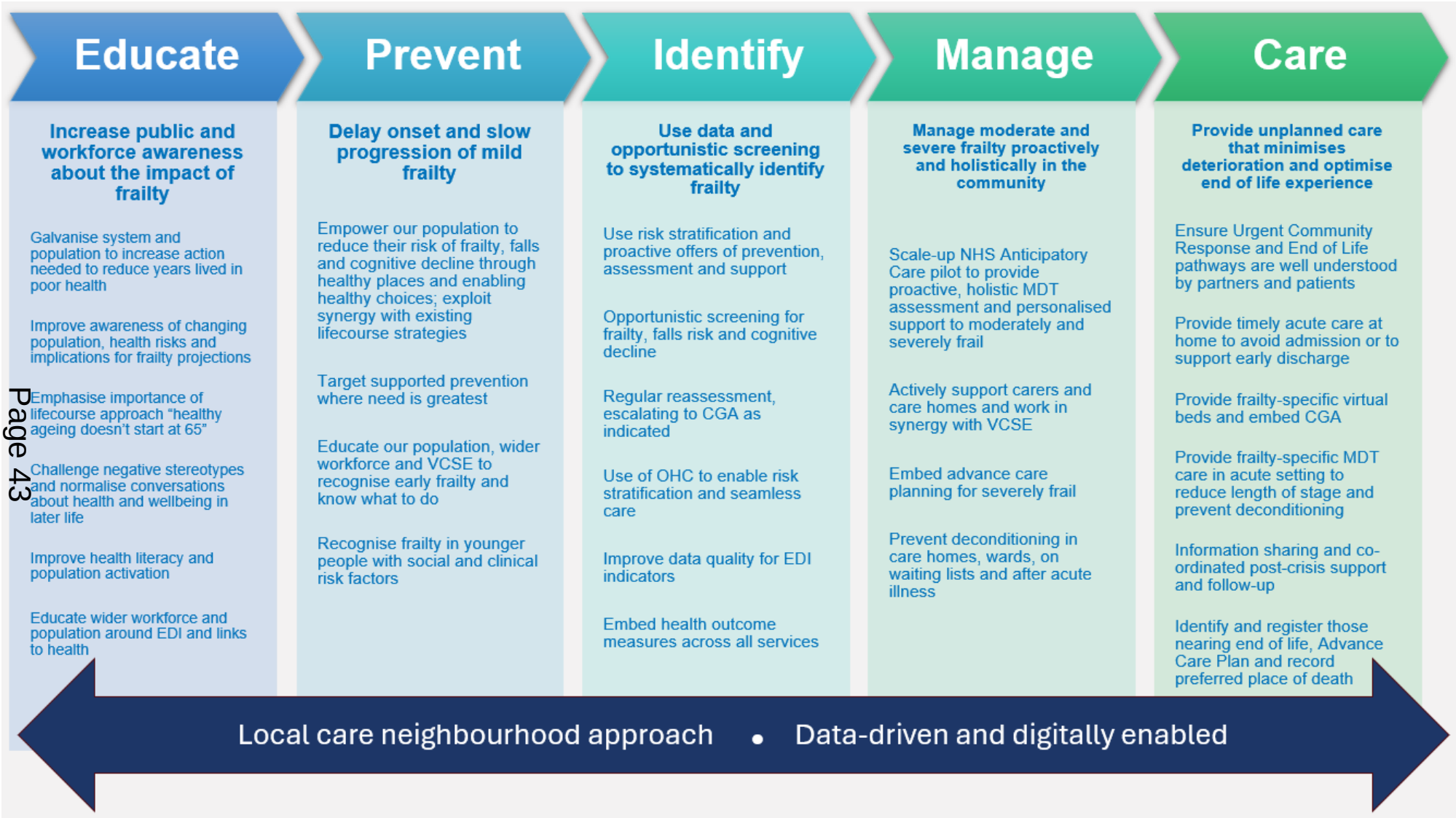
We recognise that healthy ageing must be inclusive of all communities, including neurodiverse residents and those from the LGBTQ+ community. Residents with learning disability and autism may experience barriers to accessing health and care services and may be at increased risk of early frailty due to co-occurring physical and mental health conditions.

Similarly, older LGBTQ+ residents may face unique challenges such as social isolation, historical discrimination, and reduced access to culturally competent care.

Our strategy will ensure that services are designed and delivered in ways that are sensitive to these needs, drawing on the All-Age Autism Strategy and working with community partners to promote equity, dignity, and personalised support for all. This includes ensuring assessments and care plans reflect individual identity, lived experience, and preferences, and that staff are trained to provide inclusive care.

The ambitions relating to each of these pillars are set out in the illustration below.

The Five Pillars of our Healthy Ageing Strategy



Our objectives are described in the box below.

1. Improve understanding about healthy ageing

Increase public and workforce understanding of the impact of frailty and how to prevent, delay, identify and manage it.

2. Delay and level-up the onset of frailty

Increase the proportion of residents **who** are at risk of fraily or mildly frail, compared to moderately or severely frail

Reduce the variation in the deprivation and ethnic profile of frail adults, both in the proportion who are frail and the average age of frailty onset.

3. Slow down and level-up the progression of frailty

Increase the proportion of moderately frail adults with a frailty assessment score and co-produced care plan recorded in a shared-care record enabling improved access to information.

Reduce the proportion of moderately frail adults progressing to severe frailty

Reduce variation in the deprivation and ethnic profile of frail adults, both in the proportion who are moderately frail and the average age of moderate and severe frailty onset; reduce disparities in the recording of a clinical frailty assessment score and care plan

4. Improve and level-up quality of life for people with moderate & severe frailty

Increase the quality of life of those with moderate or severe frailty and reduce variation

5. Improve and level-up care for people with severe frailty and their carers

Increase the proportion of severely frail adults with a comprehensive geriatric assessment tool (CGA) , care plan, case co-ordinator, advance care plan, ReSPECT plan, preferred place of death recorded, and death occurring in their preferred setting.

Reduce ethnic and deprivation disparities in the above

6. Reduce and level up need for unplanned care among those with frailty

Reduce the number of people living with frailty requiring unplanned care

Reduce the proportion of people living with frailty admitted to hospital for unplanned care

Reduce disparities by deprivation and ethnicity in unplanned care among those with frailty

How will we know we are making progress?

By the end of the 1st year of the strategy

- We will develop ways to reliably identify those at risk, or with, frailty and establish baselines for improvement.

- We will try different approaches to test ways of changing the way we organise and join up services to support healthy ageing, this includes co-production and our workforce using a quality improvement methodology. We will evaluate these projects to make sure we use our resources well and meet the needs of our residents with good results using measurements and the experience of those who use the services.

- We will look at the opportunities that digital services can offer to our workforce and our residents and how we might use these, especially to plan care. We will be aware that not all residents are confident with digital tools and plan for this too.

- We will develop our data sharing arrangements, and how we measure improvement to lay the foundations for the strategy. This will include developing a set of impact metrics to ensure we meet our aims and objectives and provide a solid evaluation of the changes.

- We will understand the population needs at Place and neighbourhood levels which will help us plan for the different needs of our residents.

- We will develop an education and training programme for our system involving our education and lived experience experts.

By the end of the 2nd year,

- We will be using assessment tools to assess those residents who are at risk or living with frailty consistently.

- We will be using proactive care pathways which are being evaluated to ensure they are effective.

- We will co-ordinating the care of our residents.

- We will have increased awareness and educational interventions to support the workforce.

- We will understand some of the improvements identified in year 1 and how to scale them up.

- We will have interventions in place at neighbourhood level aimed at our rural communities and those communities where there is deprivation, or where there a need to level up health services for those at risk or with frailty.

- We will have implemented relevant digital tools.

- Provide a universal prevention offer including a proactive invitation to those at risk of frailty and mildly frail adults over 50 to access an online health education resource; signpost to local statutory and VCSE offers for supported self-management of frailty risk factors.

By the end of the 3rd year,

- We will continue the work of year 1 and 2 to continue to drive improvement in services and outcomes of our population.
- We will have evaluated our progress and be able to describe the outcomes of the interventions to educate, prevent, identify, manage and care for those at risk of or living with frailty. This will be including the experiences of residents, their carers, and the workforce.

Implementation of the strategy will be overseen by the Healthy Ageing Strategy Steering Group with strong links with our local authorities, voluntary and community partners, NHS Trusts and primary care. The Steering group will ensure strategy remains dynamic and updated in line with any significant change to national guidance.

How will we monitor progress?

Progress towards achieving the objectives and meeting our milestones will be reviewed at the end of each year. At the end of the 3-year strategy implementation period progress will be assessed, with particular focus on outcomes. Process outcomes are indications of progress towards achieving longer term shifts in overriding objectives such as the median age of frailty onset, reduced proportion of the cohort progressing to m and impact on those with moderate and severe frailty, and reduced inequity in the experience of frailty. Successes, challenges and learning will inform a further review of the Healthy Ageing Strategy, to support sustainable funding arrangements.

Successful delivery of this strategy will

- Put in place the steps needed to extend healthy life expectancy
- Reduce inequalities
- Improve outcomes and experience of care for those with frailty as we test new ways of working
- Reduce growth in demand for health and care services

Conclusion

This Healthy Ageing Strategy sets out our commitment to supporting coordinated healthcare and promoting healthy ageing for residents across Shropshire, Telford and Wrekin. Our focus is on those aged 65 and over, as well as residents over 50 who are at higher risk of early frailty.

The strategy outlines our system-wide approach, including clear objectives and milestones aimed at improving the lives of people experiencing deteriorating health in older age. Our goal is to help residents extend the number of years they spend in good health, maintaining independence and wellbeing for as long as possible.

In addition to improving outcomes for Shropshire, Telford & Wrekin residents, this strategy supports the efficient and effective use of health and care resources, aligning with the NHS 10-Year Plan and the national shift from hospital-based to community-based care, and from analogue to digital services.

To support the development of this strategy, we have drawn on a wide range of public health data and insights. Supplementary documents are available on our website and by request, including:

- Healthy Ageing Strategy: Supplementary Information
- Healthy Ageing Strategy: Results of Public and Professional Consultation
- Healthy Ageing Strategy: Equality Impact Assessment

We would like to extend our sincere thanks to the residents, voluntary and community sector partners, and health and social care professionals who contributed to this strategy. We are also grateful for the continued support of the Healthy Ageing Strategy Steering Group, who will lead the coordination and delivery of this important work.

References

British Geriatric Society; 2014; Fit for frailty: Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings - published by the British Geriatrics Society and the Royal College of Nursing in association with the Royal College of General Practitioners and Age UK. fff2_short.pdf accessed 21st August 2025

NICE; 2015: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset: NICE guideline Reference number:NG16; Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset accessed 21st August 2015

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Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthy Ageing Strategy

2025-2028

Supporting Information

Our population

Table 1. The population context in Shropshire, Telford and Wrekin

	Shropshire	Telford & Wrekin
Total population (thousand)	324	186
Population age 65 and over (thousand)	84 in 2023 (117 by 2035) 26% (above national average of 18%*)	34 in 2023 (45 by 2035) 18% (same as the national average*)
Life expectancy at birth	80 for males 84 for females (above national average of 79 for males, 83 for females)	78 for males 82 for females (below national average of 79 for males, 83 for females)
Healthy life expectancy at birth	63 for males 67 for females (above the national average of 62 for males and 63 for females)	58 for males 60 for females (below national averages of 63 and 64)
Years of life lived in poor health	17 for males 17 for females	20 for males 22 for females
Gap in life expectancy at birth between the most and least deprived areas	5.5 years for males 3.5 years for females (below national average of 9.7 for males, 7.9 for females)	8.8 years for males 6.4 years for females (below national average of 9.7 for males, 7.9 for females)
Gap in healthy life expectancy between most and least deprived areas	4 years males 3 years females	12 years males 12 years females

Risk Factors

As a multi-factorial condition, frailty is associated with a wide range of correlates including[1]:

- Polypharmacy
- Deficits in vision and hearing
- Impaired memory and cognition
- Social isolation

- Physical inactivity
- Poor balance and falls
- Smoking and excess alcohol consumption
- Mood disorders
- Financial stress
- Poor nutrition

We have estimated the number of people aged over 65 in STW living with risk factors for frailty (Table 2), based on prevalence estimates from the scientific literature. These figures do not take into account local population characteristics which may differ from the samples used to estimate prevalence (for example ethnic mix, deprivation, rurality) and prevalence estimates are not available for the co-occurrence of risk factors, which increases frailty risk. As such these figures should be taken as an approximate illustration of the scale of the challenge, and its inexorable growth, and the important risk factors to target. For example, we estimate that there are around 47,000 over 65 year olds taking five or more medications, and that this will rise to 65,000 by 2035. Some other examples are 35,000 over 65s falling at least once a year, nearly 30,000 with hearing loss, 26,000 drinking more than the recommended amount of alcohol and 20,000 who are lonely some or all of the time.

Risk Stratification

The Electronic Frailty Index (eFI) is a validated method of using existing information from coding in primary care records to identify patients who are likely to be frail, and to estimate the level of frailty, based on a 'cumulative deficit model' which counts coding relating to 36 deficits including symptoms, signs, disease, disabilities and abnormal test values[2]. A greater number of these deficits means a higher eFI score and a prediction of more severe frailty. Higher eFI scores are linked with increased risk of mortality, emergency admission and care home admission at 1, 3 and 5 years, with risk increasing approximately linearly with increasing frailty: compared to fit over 65s, the hazard ratio for mortality, emergency admission or care home admission is approximately double for the mildly frail, triple for the moderately frail and quadruple for those with severe frailty[3].

Whilst eFI scores do not correlate strongly with clinically assessed frailty, clinical assessment is infeasible at the scale needed within available resources and priorities, and at a population level eFI is a good predictor of negative outcomes and therefore suitable for risk stratification. It is therefore recommended that eFI is used as the method for estimating the likely number of frail adults in our population, and as the basis for identifying eligible patients for proactive offers of care. However, due to the fact it provides a prediction of frailty status, and is validated for the over 65 cohort only (whereas frailty onset is commonly younger in population groups at highest risk, such as those living in deprivation), additional routes into care offers should also be established. These routes should include referrals from relevant professionals and the use of eligibility criteria that

recognise the need to intervene earlier and more actively for those in CORE20+ groups. An estimation of the approximate number of older adults in eFI frailty categories in STW is shown in Figure 1.

Table 2. Estimated number with frailty risk factors among the population aged over 65 in Shropshire and Telford & Wrekin

	Prevalence	Estimated number in 2023 (projected in 2035)*		
		STW ICS	Shropshire	Telford & Wrekin
Overweight	75% overweight or obese[4] 30% obesity	88,000 (121,000) overweight 35,000 (49,000) obese	63,000 (88,000) 25,000 (35,000)	25,000 (34,000) 10,000 (14,000)
Memory loss	40% age-associated memory impairment[5,6] 15% mild cognitive impairment[7]	47,000 (65,000) memory impairment 18,000 (24,000) mild cognitive impairment	34,000 (47,000) 13,000 (18,000)	13,000 (18,000) 5,000 (7,000)
Polypharmacy	31% aged 65-74; 50% aged 75+[8]	47,000 (65,000) taking 5 or more medications	34,000 (47,000)	13,000 (18,000)
Inactive	29% aged 65-74; 52% aged 75+[9]	47,000 (65,000) inactive	34,000 (47,000)	13,000 (18,000)
Falls	30%[10]	35,000 (49,000) falling annually	25,000 (35,000)	10,000 (14,000)
Depression	25%[11]	29,000 (40,000) depressed	21,000 (29,000)	8,000 (11,000)
Hearing loss	25% mild or worse hearing loss in the better ear[12]	29,000 (40,000) mild or worse hearing loss	21,000 (29,000)	8,000 (11,000)
Excess alcohol	Increasing risk drinkers 22% age 65-74; 15% age 75+[13] Higher risk drinkers 5% age 65-74; 2% aged 75+[14]	22,000 (30,000) increasing risk drinkers 4,000 (6,000) higher risk drinkers	16,000 (22,000) 3,000 (4,000)	6,000 (8,000) 1,000 (2,000)
Visual loss	14% 'low vision' (visual acuity <6/18 in better eye)[15]	17,000 (23,000) with low vision or worse	12,000 (16,000)	5,000 (7,000)
Loneliness	11% some of the time aged 65-74; 17% aged 75+ 3% always or often[16]	16,000 (23,000) lonely some of the time 4,000 (5,000) lonely always or often	12,000 (16,000) 3,000 (4,000)	5,000 (6,000) 1,000 (1,000)
Smoking	7.6%[17]	9,000 (12,000) smokers	6,000 (9,000)	3,000 (3,000)
Underweight	3%[18]	4,000 (5,000)	3,000 (4,000)	1,000 (1,000)

*rounded to the nearest thousand. Assumes constant prevalence and local prevalence is comparable to national evidence-based prevalence estimate

Denominators from Office for National Statistics 2023 mid-year population estimates and 2018-based projections

STW ICS	Shropshire	Telford & Wrekin

Population over 65 in 2023 (2035)	117,890 (161,855)	84,358 (116,829)	33,532 (45,026)
Population 65-74 in 2023 (2035)	60,372 (82,692)	42,332 (58, 685)	18,040 (24,007)
Population 75 and over in 2023 (2035)	57,518 (79,163)	42,026 (58,144)	15,492 (21,019)

The estimates in Figure 1 are based on an assumption that 45% of over 65s are fit, 35% mildly frail, 15% moderately frail and 5% severely frail, in line with the original validation sample of over 900,000[2] adults and consistent with the frailty profile of a second external sample of over 450,000 adults[3]. However, longitudinal research found that an increasing proportion of people entered moderate and severe frailty categories over an 11 year study period, with concomitant decreases in the proportion with no frailty or mild frailty[19]. In the period 2006-2017 the proportion of the population in the severe frailty category increased from 5 to 15%, and those with moderate frailty increased from 15 to 23% of the 2.2 million patients studied. Figure 2 shows the modelled impact on healthcare costs of increasing frailty severity within the population, added to the projected population growth. Note that the cost figures themselves are limited in scope to primary and secondary healthcare (social care costs not included), and the unit cost data is from 2016-17. It is therefore included to illustrate the potential magnitude of risk from not intervening to delay the onset and progression of frailty, rather than for budgeting purposes. Details of the model assumptions are available on request.

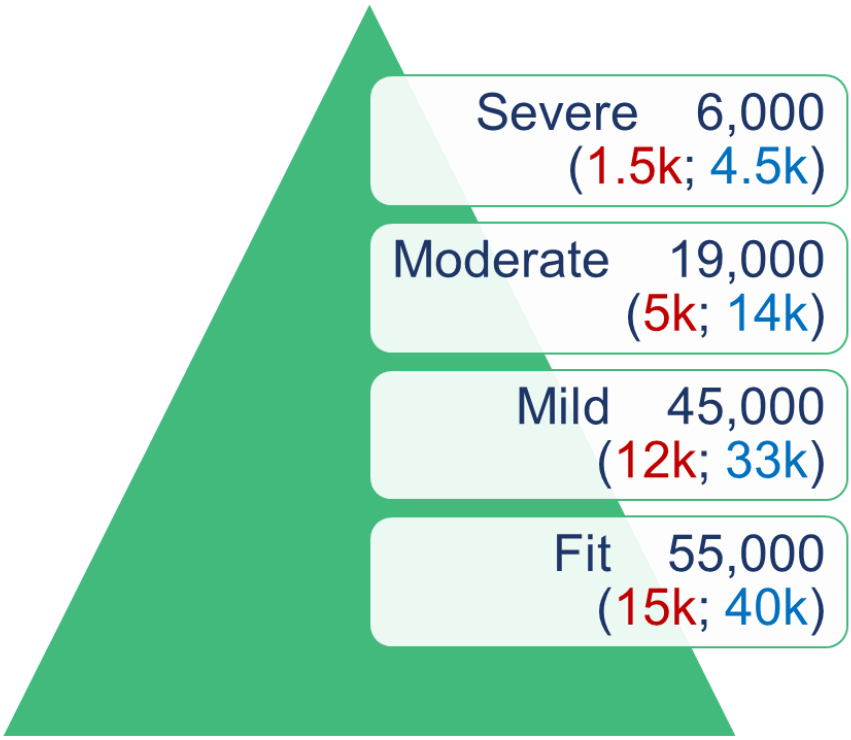


Figure 1. Estimated number of adults falling into eFI frailty categories in STW
Red = Telford and Wrekin residents; Blue = Shropshire residents

Frailty interventions

Studies of community-based interventions for reversing frailty progression found that **physical activity**, particularly **group exercise classes**, as well as **nutritional** and **cognitive** interventions were all effective, with a greater effect when offered in combination[20-27].

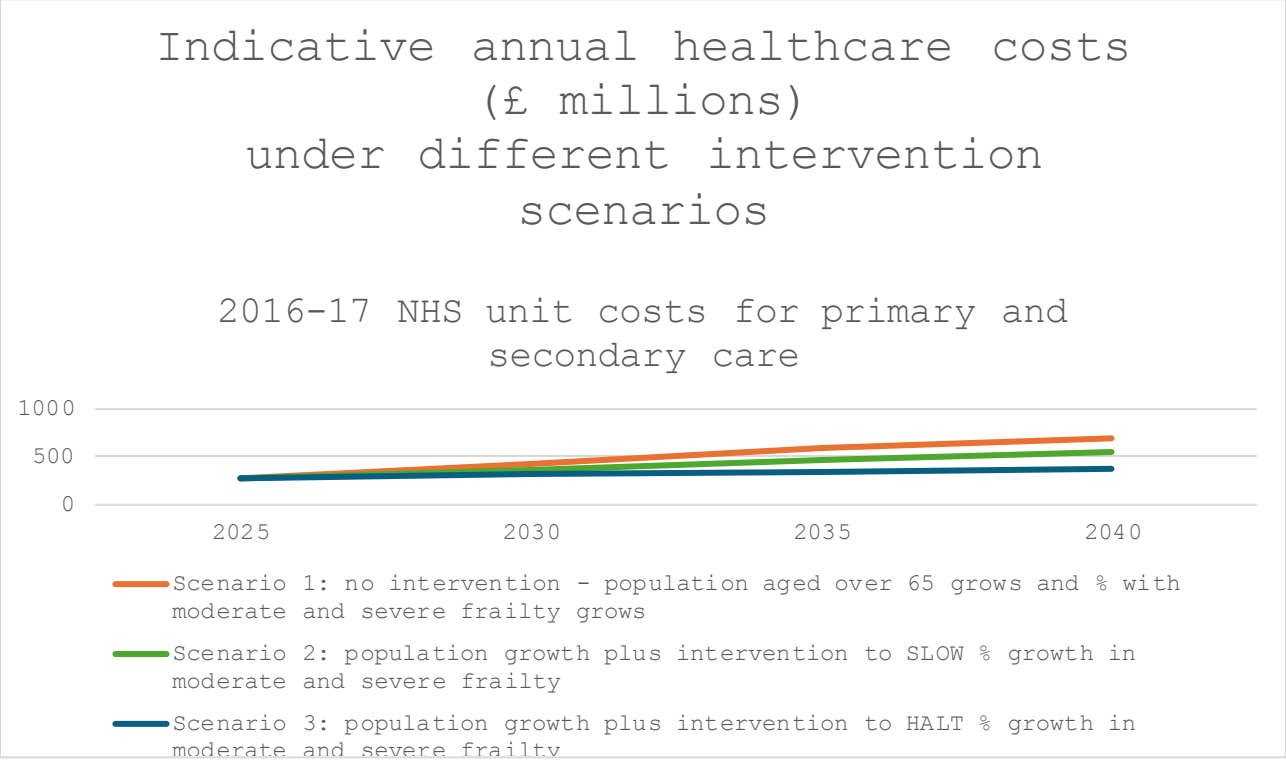


Figure 2 . Illustration of cost implications of different population frailty scenarios

Data from over 8,000 participants aged 50 and over from the English Longitudinal Study of Ageing (ELSA) was analysed over a 12 year follow-up period, to identify potential determinants of frailty and frailty progression[27]. Findings suggest there may be scope to reduce both frailty incidence and progression by **reducing obesity** and sedentary behaviour, increasing the intensity of **physical activity**, and improving success of **smoking cessation** tools. There is evidence that **multicomponent exercise programmes** combining strength, balance and aerobic training are most effective[25] and that intensity of physical activity is important: ELSA participants who reported vigorous activity at least once a week had significantly reduced frailty progression over a 10-year period but mild physical activity was insufficient to slow progression[26]. Analysis of ELSA data also revealed a dose-response relationship between progression of frailty over ten years and increasing frequency of **cultural engagement** (visits to the cinema, theatre and museums every few months or more frequently), after adjusting for confounders[28]. The authors conclude their findings are consistent with calls for multimodal, multifactor, community approaches to supporting health in older age. Interventions to support **mental, cognitive and emotional health** are considered to be particularly important as older adults may be less likely to engage with exercise and nutrition interventions if mental wellbeing is not also addressed[26], and a Japanese study of frailty progression among community-dwelling older adults found that lower levels of **health literacy** were a predictor of frailty progression over a 4-year follow-up period[29].

Frailty prevention

Interventions are needed to improve understanding of the range of risks and protective factors for healthy ageing amongst our middle-aged and older population, and to improve uptake of risk-reducing evidence-based interventions offered by health services, local authority and VCSE partners, in line with STW's local care neighbourhood approach (Figure 3).

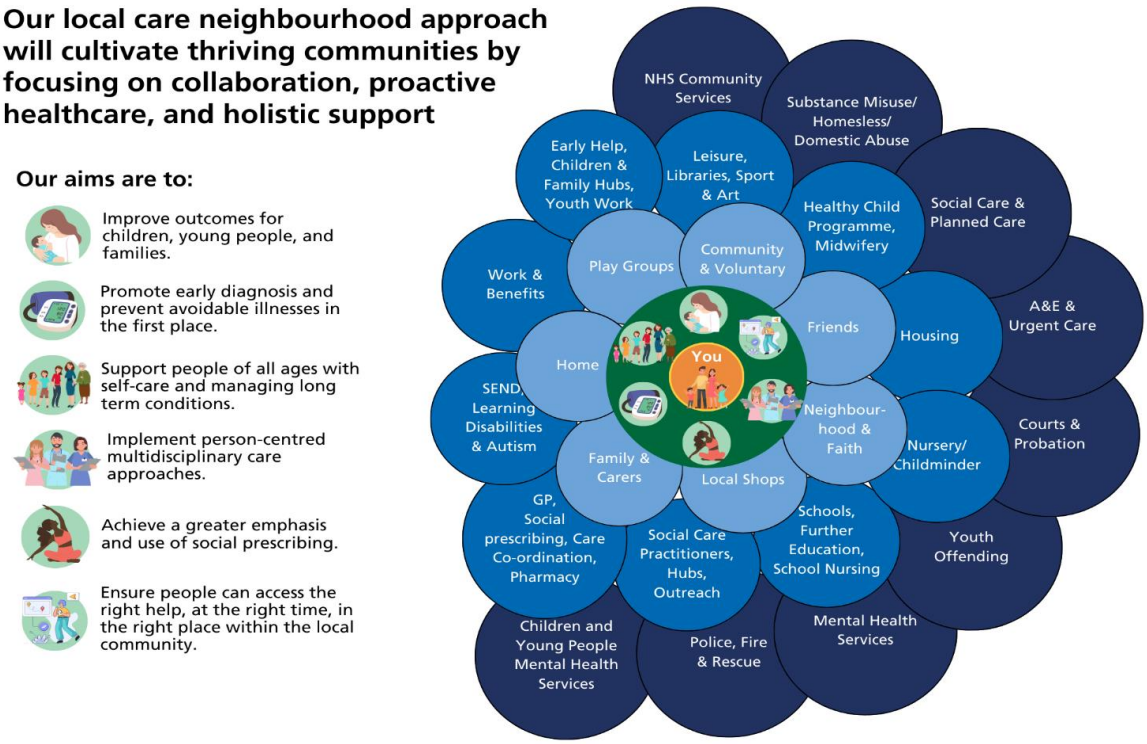


Figure 3. STW Local Care Neighbourhood Approach

The principle of proportionate universalism means that intervention should be offered to all residents with a more intensive offer of support for those at risk of health inequality. To delay the onset and slow the progression of early frailty, a digital health education resource to support self-guided risk management is recommended as a universal offer, due to the large number in this cohort, with additional support from health coaches to increase uptake of interventions[30-32] among CORE20+ residents who are at risk of early frailty, prolonged disability and premature mortality.

Digital inclusion

The risk of excluding members of the cohort who are less likely to access digital offers must be acknowledged and mitigated. Rates of engagement with the internet have increased steadily since data collection began in 2013[33]: by 2020, 85% of those aged 65-74 had used the internet in the past 3 months, and 55% of those aged 75 and over. Rates have increased most markedly

among older adults, and it is reasonable to assume they will continue to increase as more digitally-skilled cohorts age. However, in 2020, 11% of 65-74 year olds had never used the internet and 38% of those aged 75 and over. Rates of internet use are 10% lower among disabled people aged 65-74 compared to non-disabled people, and 15% lower over the age of 75. Among Bangladeshi adults of any age, a further 10% have never used the internet compared to the general adult population, and the disparity for older Bangladeshi adults may plausibly be greater than this. At age 65-74, rates of internet usage are 2% lower among women than men, widening to a 10% gap over age 75. People in socially and economically deprived communities are also more likely to be digitally excluded[34].

The pattern of digital exclusion to a large extent mirrors the pattern of health inequalities in older age. This reinforces the need to augment the offer to CORE20+ groups with health coaching in addition to initiatives that support digital inclusion. Without concerted and appropriately tailored efforts to reach groups most at risk of poor health in older age, a solely digital approach may compound the health gap. However, a population approach to digital self-management could make an important contribution for a large number of digitally engaged older people. With the ageing of cohorts who are already digitally engaged, it is anticipated that rates of digital exclusion will continue to fall, although we must continue to recognise and monitor the uneven pattern of digital exclusion and inequalities in frailty

Frailty management

For the smaller cohort of those with moderate frailty, a community-based workforce should provide frailty assessment using a validated clinical tool as part of a holistic assessment of need, co-produce care plans with patients supported by a multi-disciplinary team, make referrals, and enable access to relevant statutory and VCSE offers. As frailty progresses, Comprehensive Geriatric Assessment (CGA) is recommended as the backbone of a case-management approach to ensuring the needs of those with severe frailty, whether living in the community or in a care setting, are recognised and managed. CGA is a structured tool to assess medical, psychological and functional capability in order to develop a co-ordinated and holistic care plan. Evidence suggests that CGA can reduce the risk of unplanned hospital admission for those living with frailty in the community, as well as improving medication, patient functioning, and quality of care[35,36]. In acute services, use of CGA by a dedicated multi-disciplinary team for the assessment and management of patients with frailty, can reduce admissions, length of stay and improve outcomes[37-39]. Figure 4 summarises the key components of high quality frailty care in community and hospital settings[40].

Figure 4a. Frailty: research shows how to improve frailty care in the community (NIHR)[35]

Figure 4b. Frailty: research shows how to improve frailty care in hospital (NIHR)[35]

SMART Objectives

1. Delay and level-up the onset of frailty

a. Increase % of >65s in eFI fit or mild over 10 yr period; years 1-5 slow reduction in % who are fit/mild

b. Reduce disparities in % of cohort and median cohort age by deprivation and ethnicity

2. Slow and level-up progression to severe frailty

a. Increase % moderately frail with i) frailty assessment score recorded in shared-care record, ii) co-produced holistic care plan in shared-care record

b. Reduce % of >65s progressing to eFI severe over 10 yr period; years 1-5 slow increase in % eFI severe

c. Reduce disparities by deprivation and ethnicity in objectives 2a-b; Reduce median age of moderate frailty by deprivation and ethnicity

3. Improve and level-up quality of life for people living with moderate frailty

a. Increase moderate frailty cohort median quality of life score after implementing holistic care plans

b. Reduce disparities by deprivation and ethnicity in median QoL scores among moderately frail

4. Improve and level-up quality of life for people living with severe frailty and their carers

a. Increase % severely frail with i) CGA, ii) holistic care plan and iii) case co-ordinator

b. Increase cohort median quality of life score after CGA and implementing co-produced holistic care plans

c. Increase carer and patient median satisfaction scores among the severe frailty cohort

d. Reduce disparities by deprivation and ethnicity in objectives 4a-c; Reduce median age of severe frailty by deprivation and ethnicity

5. Reduce and level up need for unplanned care among those with frailty

a. Reduce number of people living with frailty i) requiring unplanned care for all causes, ii) requiring unplanned care as a result of a fall, iii) attending A&E for all causes, iv) admitted for unplanned care

b. Reduce % of unplanned care episodes leading to admission among those with frailty; reduce % of falls resulting in admission for frail patients

c. Reduce disparities by deprivation and ethnicity in objectives 5a-b

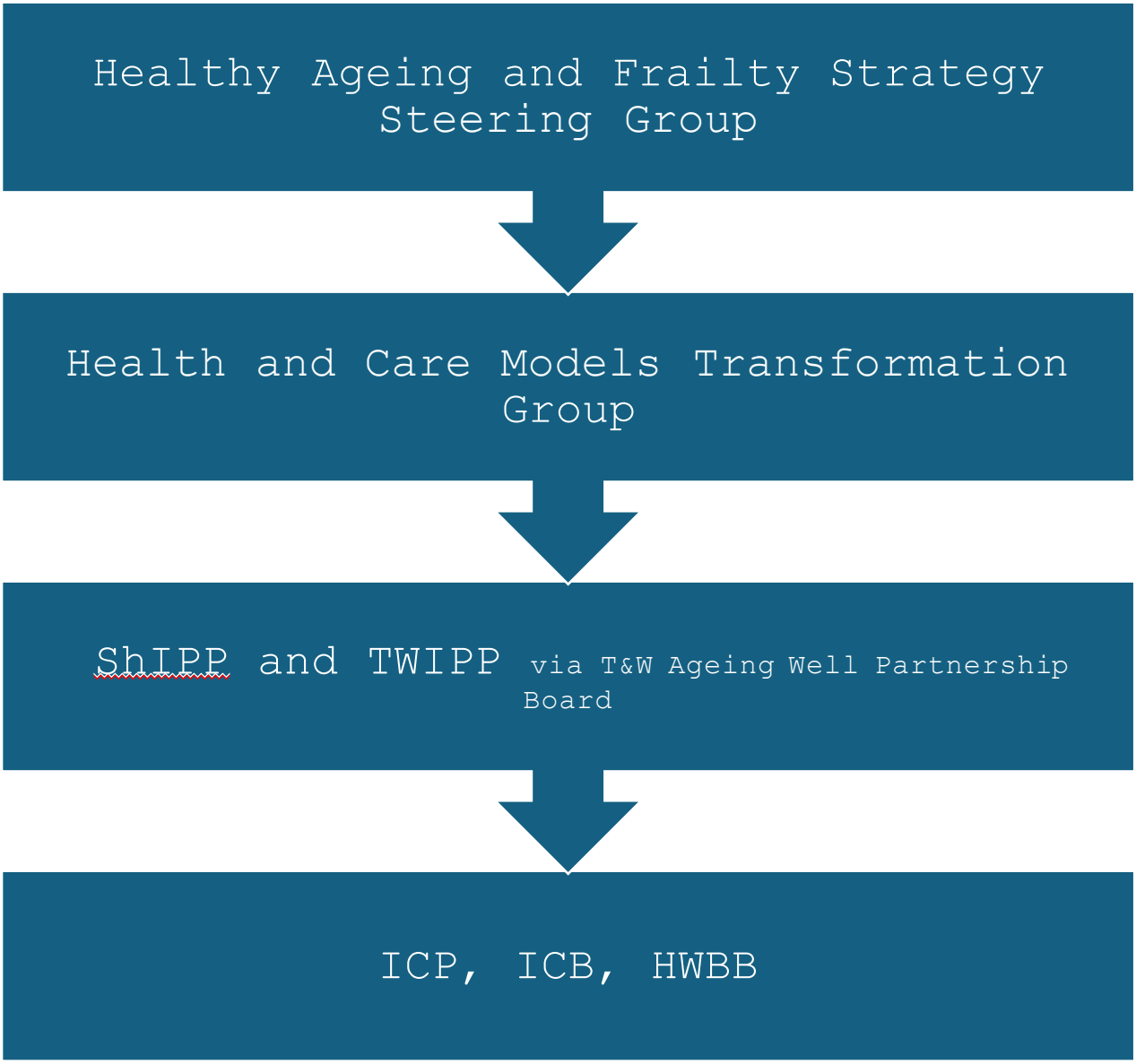
6. Support at end of life and level up end of life care

a. Increase % of severely frail with i) advance care plan, ii) ReSPECT plan, iii) preferred place of death recorded, iv) death in preferred setting

b. Reduce disparities by deprivation and ethnicity in objective 6a

Governance

Implementation of the strategy will be overseen by the Healthy Ageing Strategy Steering Group, reporting to the Local Care Transformation and HTP Models of Care Group, and from there into ShIPP and TWIPP. A working group for each pillar will report to the steering group.



Links to national policies and strategies

NHS Long Term Plan

NHS England » Personalised care

Skills for health Frailty-framework.pdf

Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK

Geriatric medicine - Getting It Right First Time - GIRFT

Be proactive: Proactive care for older people with frailty | British Geriatrics Society

NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty

Links to local policies and strategies

- Joint Forward Plan
- STW Neighbourhood Approach
- Telford and Wrekin HWB Strategy
- T&W Ageing Well Strategy
- TWIPP Priorities
- Shropshire HWBB priorities
- Shropshire Plan
- Shropshire Prevention Framework
- ShIPP Priorities
- Long Term Conditions Strategy
- Palliative and End of Life Care Strategy
- Falls Strategy

Abbreviations

ACP	Advance Care Plan
CGA	Comprehensive Geriatric Assessment
eFI	Electronic Frailty Assessment
FAU	Frailty Assessment Unit
HWBB	Health and Well-Being Board
ICB	Integrated Care Board
ICS	Integrated Care System
MDT	Multi-Disciplinary Team
OHC	One Health and Care record (synonymous with SCR)
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SCR	Shard Care Record or Summary Care Record
ShIPP	Shropshire Integrated Place Partnership
SMART	Specific, measurable, achievable, relevant and timely (objectives)
STW	Shropshire, Telford and Wrekin
TWIPP	Telford and Wrekin Integrated Place Partnership
VCSE	Voluntary, Community and Social Enterprise

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**18 September 2025**					
Title of report	**Better Care Fund (BCF) presentation and 2025-26 quarter one template**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Jackie Robinson, Senior Integrated Commissioning Lead Jackie.robinson16@nhs.org					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working		x	
	Mental Health	x	Improving Population Health		x	
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities		x	
	Workforce	x	Reduce inequalities (see below)		x	
What inequalities does this report address?	Access to services, particularly for carers, people living in rural areas, older age adults and people who need support from health and social care.					

1. Executive Summary

At the previous Health and Wellbeing Board (HWBB) members asked for a presentation on the Better Care Fund (BCF) programme to give Board members wider insight into the programme and the services that contribute to performance that is reported in quarterly templates to NHS England.

In addition, this report provides a summary of the Better Care Fund (BCF) 2025-26 quarter one template for Shropshire. In line with national conditions, the approval of the Health and Wellbeing Board (HWBB) chairs was obtained prior to submission, and retrospective endorsement is sought from HWBB.

2. Recommendations

It is recommended that:

- HWBB notes the BCF programme presentation (see appendix A).
- HWBB endorses the BCF 2025-26 quarter one template (see appendix B).

3. Report

3.1. Policy Framework

The Better Care Fund policy framework 2025 to 2026 sets out the Government's aims for 2025-26:

- To be a first step in a broader shift to align with the government's Health Mission and the shift to a neighbourhood health approach.
- To better support patients and service users by enabling people to live more healthy and independent lives for longer.
- To support hospital flow and positively contribute to the NHS' ability to move towards constitutional standards.
- To make the BCF work better for local authorities and the NHS by reducing administrative burdens and providing greater flexibility to meet BCF objectives.

In line with the government's vision for health and care, the BCF Policy Framework also sets out the vision, funding, oversight and support arrangements, focused on two overarching objectives for the BCF in 2025-26:

- reform to support the shift from sickness to prevention.
- reform to support people living independently and the shift from hospital to home.

A national condition is for quarterly templates to be completed, approved by the local HWBB and submitted to the national BCF Team. The deadline for submission of the quarter one template was 15 August 2025. In line with national conditions, the approval of the Chairs of Health and Wellbeing Board (HWBB) was obtained prior to submission.

3.2. 2025-26 BCF Plan

On 19 June 2025, HWB approved Shropshire's 2025-26 BCF Plan. This consists of:

- A narrative plan.
- A planning template which articulates the goals for the metrics which are used locally and nationally to monitor progress towards the Plan.
- An intermediate care (including short-term care) capacity and demand plan.

For 2025-26 there are three headline metrics:

- Emergency admissions (emergency admissions to hospital for people aged over 65 per 100,000 population).
- Discharge delay (average length of discharge delay for all acute adult patients, derived from a combination of proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) and, for those adult patients not discharged on their DRD, average number of days from the DRD to discharge).
- Residential admissions (long term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population).

As reported throughout 2024-25, Shropshire and Telford Hospital NHS Trust's (SaTH's) data is inaccurate/incomplete due to the implementation of a new EPR system. The issue is expected to continue until 2025-26 quarter two. This meant that it was not possible to include an accurate metric plan for emergency admissions as part of the 2025-26 BCF Plan.

The discharge delay metric is new for 2025-26. The System does not yet record data in a way that enabled metric planning for the 2025-26 BCF Plan. This is being addressed and will be resolved in quarter two to enable metric planning and performance reporting for quarters three and four.

National assurance with a local condition has been received for the 2025-26 BCF Plan. The condition is:

Review the goals set for discharge and emergency admission metrics and, if necessary, adjust in light if improvements in the quality of data used to inform these goals, finalised ICB operational plans and the need to maximise delivery against BCF objectives.

This review will take place at the end of quarter two, when data quality has been tested.

3.3. Performance

In the absence of data to report performance for the metrics, narrative has been used to provide assurance of performance.

Emergency admissions

The Short Term Assessment and Reablement Team (START) continues to prevent unnecessary hospital admissions.

A refresh of the Urgent and Elective Care Programme at SaTH took place in June 2025 to ensure that the focus is on delivery of improvement to reduce risk to patient safety and to ensure patients receive their care in the right place. The Direct Access workstream specifically looks at admission

avoidance and sits within the Capacity and Flow Programme within SaTH. There is also a workstream looking at emergency department processes.

Delayed discharges
Locality data for the average number of days from No Criteria to Reside status to discharge shows that improvement has been made when comparing 2025-26 quarter one performance to 2024-25 quarter one performance.

Residential admissions
Locality data shows strong performance, with a quarter one outturn of 78 people admitted to residential and nursing care homes against a target of 100 people.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Demand and capacity continue to be a key area of focus and monitoring as demand increases. Due to SaTH's implementation of the ERP system, performance relating to the metrics doesn't accurately reflect performance, but continues to be monitored using local systems.	
Financial implications (Any financial implications of note)	Financial updates are included in the quarter 1 template (see appendix 2). There is no assurance of funding for 2026 onwards.	
Climate Change Appraisal as applicable	Climate change appraisal is carried out as part of commissioned activity.	
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

None

Cabinet Member (Portfolio Holder)

Councillor Ruth Houghton, Cabinet Member for Adult and Children Social Care

Appendices

Appendix A. Better Care Fund – presentation
Appendix B. Better Care Fund 2025-26 – Q1 reporting template

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Integrated Care System
Shropshire, Telford and Wrekin

Shropshire Council

NHS
Shropshire, Telford and Wrekin

The Better Care Fund (BCF) Programme

September 2025

Purpose

- What is the Better Care Fund (BCF) programme?
- The pooled budget
- Expenditure by service type
- Performance metrics for 2025-26
- A focus on data in 2025-26
- Who to contact

What is the Better Care Fund (BCF) Programme?

The Better Care Fund (BCF) programme supports local systems to deliver the integration of health, housing and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

It requires systems to enter a pooled budget arrangement and agree an integrated spending plan.

The BCF national overarching objectives for 2025-26 are:

- reform to support the shift from sickness to prevention.
  - Support complex health and care needs.
  - Use of home adaptations and technology.
  - Support unpaid carers.
- reform to support people living independently and the shift from hospital to home.
  - Prevent avoidable admissions.
  - Timely and effective discharge.
  - Reduction in use of long-term care.

The pooled budget

- A partnership arrangement whereby NHS organisations and local authorities contribute a nationally determined amount of funding into a single, shared budget (the pooled budget) that is then used to commission or deliver health and social care services.

- The value of the pooled budget in Shropshire is £50 million. This is made up of three separate contributions:

  - NHS minimum contribution (£30.5 million) – comes from baseline funding.

  - Local Authority minimum contribution (£15 million) – comes from baseline funding plus discharge funding, which is expected to be spent on reducing hospital discharge delays.

  - Disabled Facilities Grant (£4.5 million) - paid to local authorities and ringfenced to housing adaptations to enable people to stay well and remain living independently for as long as possible.

Expenditure in 2025-26 by service type (1 of 2)

Proactive care	Home adaptations and technology	Carers
• Prevention and advice grants to third sector • Early help interventions • BeeU service • Autism West Midlands – outreach and support groups • Mental health Social Workers • Social work practitioners for frailty • Alzheimer's link/support worker • Personalised care staff employed by GPs and Primary Care Networks	• Home adaptations funded using the Disabled Facilities Grant • Mediquip community equipment loan service	• Carer support service • Hospital-based cares lead/link worker
£6 million	• £8 million	• £0.3 million

Expenditure in 2025-26 by service type (2 of 2)

Preventing hospital admission	Timely hospital discharge	Reducing the need for long term care
• Occupational therapy • Residential and nursing care placements • Brokerage • Short Term Assessment and Reablement (START) service • Social Workers in community social work teams • Staffing for accidental and emergency minor injuries pathway • British Red Cross' Positive Lives • Mental health crisis support • Two Carers in a Car • Mental health crisis accommodation	• Hospital social work teams • Social Workers to facilitate Continuing Healthcare(CHC) assessments • CHC placements • Section 17 Discharge Liaison Workers • Social Worker capacity in intermediate care services • Frailty Assessment Unit • Therapy and nursing • End of life services • Severn Hospice • Domiciliary care • Reablement	• Hope House respite
£14 million	£22 million	£0.2 million

Performance metrics for 2025-26

The 2025-26 performance metrics focus on admission avoidance, effective discharge processes and ensuring community interventions both are effective and reduce the need for long term care.

Performance is tracked nationally, and data is shared across systems through a dashboard.

There are three headline metrics, each with two supporting indicators:

- **Emergency admissions to hospital**
  - Admissions of chronic ambulatory care conditions
  - Falls related admissions
- **Average length of discharge delay**
  - Proportion of people discharged on their Discharge Ready Date
  - Average number days of delayed discharges
- **Long term admissions to care home**
  - Percentage of people discharged to their normal place of residence
  - Proportion of people who, after reablement, need no further on-going care

A focus on data in 2025-26

In 2025-26, there is a focus on using data to inform future direction, with the following aims:

- To set metric plan targets for 2025-26.
- To inform metric planning for 2026 onwards.
- To monitor and report progress of the BCF Programme locally and nationally, including progress towards the national BCF policy outcomes.
- To enable early action to be taken where performance is off target.

Who to contact

For more information about the BCF programme, please e-mail:

Jackie Robinson, Senior Integrated Commissioning Lead
jackie.robinson16@nhs.net

Jessica Timmins, Integrated Commissioning Manager
jessica.timmins3@nhs.net

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SHROPSHIRE HEALTH AND WELLBEING BOARD Report							
Meeting Date	**18th September 2025**						
Title of report	Draft Pharmaceutical Needs Assessment 2025						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)		
Reporting Officer & email	Mark Trenfield Mark.trenfield@shropshire.gov.uk						
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working	x			
	Mental Health		Improving Population Health	x			
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities				
	Workforce		Reduce inequalities (see below)	x			
What inequalities does this report address?	Inequalities in the county regarding access to pharmacy provision, and variation in the services that they offer.						

Report Content:

1. Executive Summary

The production and publication of a Pharmaceutical Needs Assessment (PNA) became a statutory requirement in the Health Act 2009. Following the abolition of Primary Care Trusts (PCT) in 2013 this statutory responsibility was passed to Health and Wellbeing Boards (HWBB) by virtue of the National Health Service (NHS) Pharmaceutical and Local Pharmaceutical Services (Amended) Regulations 2013, which came into force on 1st April 2013. The requirement is to publish a PNA at least every 3 years; there have been four previous PNAs in 2011, 2015, 2018 and 2022 (deadline was extended due to the impact of COVID-19). This PNA is due to be published by 1st October 2025

The PNA should highlight the needs for pharmaceutical services in the area, current provision of services, identify gaps and unmet needs and in consultation with stakeholders make recommendations on future developments that are required. The PNA will be used by organisations including Integrated Care Boards (ICB) and the Local Authority (LA) to plan and commission future services.

The PNA is a key document used by local area teams to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies and is also used by commissioners reviewing the health needs within their area and to identify if any services can be commissioned through community pharmacies.

Pharmacies play an important role in the health system, not just the dispensing of medicines, but now providing additional clinical services, and as they are one of the first points off contact, they can improve people's health and wellbeing and also reducing health inequalities. There are more pharmacies in Shropshire than there are GP practices, and they are more accessible, including for those who might otherwise not access health services.

Shropshire HWBB considers community pharmacies to be a key public health resource and recognises that they offer potential opportunities to commission health improvement initiatives and work closely with partners to promote health and wellbeing.

Before publishing the PNA, there is a statutory requirement to hold a 60-day public consultation, and this period was from 27th June 2025 until 26th August 2025. The purpose of the consultation is to identify the views of the statutory consultees, other stakeholders and members of the public on whether the PNA addresses the necessary and important issues.

Local Context

This PNA Covers the Shropshire Local Authority area; it together with Telford and Wrekin Council both form the geography which that is coterminous with NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB).

Key demographic messages for Shropshire

- Shropshire is a diverse, large, predominately rural inland county with a wide range of land use, economic activities, employment and social conditions

- Shropshire's population was increasing more slowly than England between 2000 and 2020 (using ONS population estimates) but increase more sharply between 2020 and 2022. Much of the Shropshire population growth has been due to migration.
- Shropshire has a relatively high concentration of people in the older age groups. In 2023, 54.2% (52.7% in 2020) of the County's residents were aged 45 or over, 26.2% were aged 65 and above, and 3.6% were aged 85 and above, when compared to England this was 44%, 18.7% and 2.5% respectively (ONS 2024 Estimates).
- Shropshire, like many parts of the country, has an ageing population, with the median population age now 48.5 compared to 40.5 in England.
- Lower-Level Super Output areas in Harlescott, Monkmoor and Ludlow East wards are the three LSOAs with the highest deprivation levels within Shropshire. All three fall within the top 10% of most deprived LSOA areas within England. Looking at whole wards, the three most deprived wards within Shropshire are Monkmoor, Harlescott and Castlefields & Ditherington, (ONS 2019)
- 42.6% of Shropshire's population is classified as being 'Urban' and 57.4% as 'rural and has an overall population density of just over 101 persons per square kilometre, compared to 433 in England. Population density is particularly sparse in the South West of the county (39 persons per square kilometre).

Access to pharmaceutical services

- There are currently 43 community pharmacies and 17 dispensing GP practices in Shropshire. located throughout the county in towns, market towns and larger villages. Most community pharmacies are close to GP practices providing choice and convenience for patients.
- Approximately 91% of residents are within a 10-minute car journey of a community pharmacy or dispensing GP practice. However, there are greater challenges for those without access to cars, with only 48% of the population within 10 minutes of one using public transport on a weekday morning.
- As much of Shropshire is very rural, many localities are supported by GP practices that dispense to patients that are outside of a 1.6km radius of a community pharmacy. Dispensary opening hours usually reflect the opening times of the practice. Dispensing doctors offer a dispensing service to help fulfil the pharmaceutical needs of the patients in these areas but don't offer the full range of pharmacy services that community pharmacies offer, that help reduce pressure on GP appointments.
- Most pharmacies opening times generally mirror those of the GP practices, however while most pharmacies open for at least some of the day on a Saturday, there are only 2 pharmacies that open after 6pm on a Saturday and there are only 6 pharmacies open at all on a Sunday in Shropshire, and only 4 pharmacies that open past 6pm on a weekday. There are no 24-hour pharmacies in Shropshire.
- There appears to be reasonable access to some services commissioned by Public Health in Shropshire, such as emergency hormonal contraception, however, some of these services do not operate at all pharmacies, and for some pharmacies that offer those services, activity is very low.
- In addition to these pharmacies and dispensing GP practices in Shropshire there are also 54 community pharmacies in other local authorities in England and 7 in Wales that are within 5 kilometres of Shropshire's borders which could offer pharmacy services to Shropshire residents. Several of these pharmacies are open past 6pm on a weekday, (mostly in Telford and Wrekin), most are open on a Saturday and 8 of them are open on a Sunday (7 in Telford and Wrekin and 1 in Cheshire).

Current pharmaceutical provision

- The distribution of pharmacies per head-of-population, with or without dispensing GP practices, is of a lower ratio than the national average.

- Compared to the 15 other local authorities that are deemed comparable to Shropshire, Shropshire's ratio of patients per pharmacy is the second highest (only lower than central Bedfordshire) based on their most recent PNAs, although when dispensing GP practices are included in this comparison, Shropshire is the sixth highest. Shropshire has a significantly higher proportion of dispensing GP practices than the rest of England due to its rurality, and while they provide a vital pharmaceutical supply function for patients unable to access a community pharmacy, they are unable to offer the enhanced and advanced services community pharmacies can, which is a gap for Shropshire residents.
- The number of pharmacies has reduced by 4 since the previous PNA and therefore the ratio has increased. The locations of the pharmacies that closed were 1 in Shrewsbury town centre, 1 in Shrewsbury Meole Brace retail park, 1 in Church Stretton and 1 in Ludlow.
- In 2024/25, there were over 6.5 million items prescribed by Shropshire GP practices, and nearly 300,000 (4.5%) were dispensed at distance selling pharmacies, with the highest percentage of items prescribed that were dispensed at distance selling pharmacies being from Station Drive in Ludlow, with 16% of all items (34,107). No data is currently available for previous years, but this could have an impact on community pharmacies or be an impact of one pharmacy in Ludlow closing in this time period. It may be necessary to assess whether the increased use of distance selling pharmacies is reflected of patient choice or due to an unmet need for additional community pharmacy provision
- There is only one 100-hour pharmacy in Shropshire, as opposed to three in the previous PNA, this pharmacy is in Oswestry.

- Some advanced and locally commissioned pharmacy services are only provided by a small number of pharmacies, if at all. While pharmacies will dispense some appliances in some circumstances in their usual business, no pharmacy in Shropshire is actually signed up to the 'dispensing appliances' service although this service is available by a national contractor in Telford and Wrekin.

Gaps in pharmaceutical provision

- Weekend and night access - There isn't pharmacy provision in Shropshire for 24 hours 7 day a week and there is limited provision on Sundays, particularly in the South of the county. There is also limited provision after 6pm on weekdays and Saturdays, although where necessary the supply of medicines could be made by out of hours teams. While there are several pharmacies that are open later on weekdays and Saturday nights and on Sundays in Telford and Wrekin primarily, this does not seem to be the case in pharmacies close to the south of Shropshire or in Wales.
- Threats to viability of community pharmacies – Research commissioned by NHS England showed that large amounts of community pharmacies were loss making and whilst changes to community pharmacy funding have helped with this, there is still a shortfall and pharmacies are still closing. The effects of losing a community pharmacy in a rural area would be greater particularly if there are no other community pharmacies nearby to deliver the slack, while dispensing GP practices and distance selling pharmacies could absorb supply work, they would not be able to deliver the full pharmacy services.

Opportunities for future development

- Visibility of services - The resident survey highlighted that there were several services that community pharmacies provide, but the respondents didn't necessarily know that the pharmacy provided them. Likewise, there are some services that the pharmacies offer but activity was very low. Some of the services offered are quite new and have

not benefitted as expected from the lack of referrals in many places. However, there may need to be a more detailed review as to whether there are specific gaps in provision.

- Increase in pharmacies signing up for services – The contractor survey highlighted a willingness for those contractors to provide more services if they were commissioned, if they were not always providing them or were intending to provide them.

Further investigation and consideration may become necessary to evaluate if there is enough pharmacy provision given the projected growth of the population in future as growth between 2022 and 2032 is expected to be 7.89% - 26,268 people, although as this would be spread across the whole county this might mitigate the impact.

Recommendations

1. Raise the visibility of some of the new services offered by pharmacies to increase awareness and usage.
2. Consider the impact of healthcare transformation - The recently published 10-year health plan outlines community pharmacies key role in the management of long-term conditions, prevention, and deeper integration into neighbourhood care teams. As such, there will be a period of transformation within the pharmaceutical provision, primary care and neighbourhood health and it might be necessary for an interim review of services if necessary

2. Report Recommendations

That the committee notes the contents of the presentation and report

3. Main Report

Please see:
Appendix A. Pharmaceutical Needs Assessment (PNA) 2025 – draft report

Risk assessment and opportunities appraisal	N/A	
Financial implications	N/A	
Climate Change Appraisal as applicable	N/A	
Where else has the paper been presented?	System Partnership Boards	ShIPP, HWBB
	Voluntary Sector	
	Other	

List of Background Papers - NA

Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead

Rachel Robinson, Executive Director – Public Health (DPH)
Cllr Bernie Bentick, Portfolio Holder for Health & Public Protection

Appendices

Appendix A. Draft Pharmaceutical Needs Assessment (PNA) 2025 – draft report

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**18th September 2025**						
Title of report	**Director of Public Health Shropshire, Annual Report 2024/2025**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	Y	Information only (No recommendations)		
Reporting Officer & email	Rachel Robinson, Executive Director of Public Health Rachel.robinson@shropshire.gov.uk						
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	Y	Joined up working	Y			
	Mental Health	Y	Improving Population Health	Y			
	Healthy Weight & Physical Activity	Y	Working with and building strong and vibrant communities	Y			
	Workforce		Reduce inequalities (see below)	Y			
What inequalities does this report address?	Inequalities in Public Health						

1. Executive Summary

This report provides a summary of the latest Director of Public Health Annual Report for Shropshire. Directors of Public Health have a statutory duty to write an annual report on the health of their population and the Local Authority a requirement to publish it. The Director of Public Health Annual Report is an evidence-based vehicle for informing local people about the health of their community, as well as providing necessary information for decision makers in local health services, authorities and communities on health gaps and priorities that need to be addressed

The Annual Report 2024/2025 provides a comprehensive overview of the health and wellbeing of Shropshire's communities. The report highlights the current patterns of health and wellbeing, the priorities for 2025 and beyond, and the progress made on previous recommendations. It emphasizes the importance of collaborative efforts to address health gaps and priorities and reflects on the improvements that can be made when working together.

The report is structured into sections that describe the health and wellbeing patterns across Shropshire, the reasons for shorter life expectancy in different stages of life

The role of communities/neighbourhoods in improving health is receiving increasing, and long-overdue, attention in health policy and practice. As part of this shift in focus, as a health and care system, we need to take the role communities can play in improving and sustaining good health seriously, working at the neighbourhood and community level where the link to communities is strongest. This report summarises all the information gathered around our communities in Shropshire through the place based JSNAs, the opportunities, engagement and actions agreed to improve outcomes and signposts to further information to inform our work with communities moving forward. It highlights the similarities and differences in our diverse County and opportunities to improve healthy life expectancy for our residents.

2. Recommendations

The report includes several key recommendations aimed at improving health and wellbeing in Shropshire:

- **Place Based/Neighbourhood/Community Working**: Renewing the commitment to local place plan/neighbourhood-based working to improve health and wellbeing. Recognizing the essential role communities play in delivering improved outcomes and shifting investment into services that support communities, including the voluntary and community sector.
- **Alignment**: Assessing and aligning with the government's neighbourhood guidance and the current development within Shropshire around community hubs and JSNA intelligence to align future services and directives.
- **Intelligence Led**: Improving the evidence base to understand and monitor rural outcomes, engaging with communities in developing and delivering community-led action plans.
- **One Shropshire**: Continuing to work together as one community of partners to serve Shropshire residents, enabling communities and the voluntary sector to take a central role in service development.

3. Report

The report is divided into several sections that provide detailed insights into the health and wellbeing of Shropshire's communities:

- **Patterns of Health & Wellbeing across Shropshire**: This section includes tables and figures that inform about the health and wellbeing of communities, highlighting areas of priority action for public health, the Health and Wellbeing Board, and the Integrated Care Partnership.
- **Patterns of Health in our Populations**: This section discusses the factors that contribute to shorter life expectancy and the importance of focusing on preventative interventions targeting the wider determinants of health.
- **Patterns of Wellbeing across Shropshire Communities**: This section summarizes the health and wellbeing in Shropshire's communities, providing a summary of the actions agreed with those communities to improve outcomes.
- **Previous Recommendations Progress Review**: This section provides an update on the progress made on the previous recommendations, highlighting the continued efforts to address health and wellbeing concerns collectively.
- **Conclusions and Recommendations**: This section provides the context to understand the issues impacting life expectancy and health and wellbeing in Shropshire, the inequalities these can generate, and the actions needed to address them.

Risk assessment and opportunities appraisal (*NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation*)	The Annual Report seeks to address inequalities and rural inequalities in our communities and neighbourhoods across Shropshire. It challenges all our partners to take a Person-Centred approach when working with Shropshire people and highlights the need to come together and work collaboratively to reduce inequalities and improve outcomes for local people.	
Financial implications (*Any financial implications of note)*	None directly associated with this paper.	
Climate Change Appraisal as applicable	None directly associated with this paper.	
	System Partnership Boards	

Where else has the paper been presented?	Voluntary Sector	
	Other	
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead Cllr Bernie Bentick, Portfolio Holder for Health and Public Protection, Shropshire Council		
Appendices Appendix A - DPH Annual Report 2024 -25		

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Director of Public Health Shropshire Annual Report 2024/2025

Health and Wellbeing in Shropshire's Communities

"Floreat Salopia" – May Shropshire Flourish

Rural Health in Shropshire

Contents:

Foreword

I am very pleased to share with you, this my fourth annual report since becoming Shropshire's Director of Public Health in 2019.

My Annual Report provides a vehicle for informing people about the health and wellbeing of our communities as well as providing information for local and national decision makers on health gaps and priorities that still need to be addressed. The report also provides us an opportunity to pause and reflect on the improvements that can be made when we work collaboratively.

This report describes the current patterns of Health and Wellbeing across Shropshire in section one and the priorities for 2025 and beyond. Section two, highlights some of the reasons for shorter life expectancy across different stages of people's lives in Shropshire. Section three summarises health and wellbeing in Shropshire's communities and provides a summary of the actions agreed with those communities to improve outcomes. The final sections provide an update on the previous recommendations and continued progress to address health and wellbeing concerns with key services collectively.

Rachel Robinson, Executive Director of Public Health

Acknowledgements: Harry Wallace, Jess Edwards, Clare Hamer, Gordon Kochane, Paula Mawson, Anne-Marie Speke, Claire Sweeney
JSNA led by Penny Bason, Hannah Thomas, Amanda Cheeseman, Mark Trenfield and all our Community Wellbeing Team past and present
Designed by: Shropshire Council's Communications Team.
Data sources: This report utilises the most recently available published information from a variety of data sources, these are available on the council's website www.shropshire.gov.uk If you would like this information in a different format, please contact 0345 678 9000

Section 1: Patterns of Health & Wellbeing across Shropshire

This chapter contains a small number of tables and figures to inform people about the health and wellbeing of our communities as well as providing information for local and national decision makers on health gaps and priorities that still need to be addressed.

Image 1 below shows where Shropshire's latest rates are worse compared to the England average across measures relating to the wider determinants of health, health improvement, health protection and premature deaths. *Source: Public Health Outcomes Framework*

This highlights a number of areas of priority action for Public Health, Health and Wellbeing Board and the Integrated Care System:

Children and Young People: Children Looked after, reception children achieving a good level of development, emergency admissions and Infant Mortality

Diabetes diagnosis

Mental Health including dementia

Health Checks

Section 2: Patterns of Health & Wellbeing in our Populations

In my previous reports I described how research shows that as little as 10% of our health and wellbeing is impacted by the health and care we receive. The below diagram summarises what factors make the biggest contribution to lives being cut short and highlights the importance of focusing on preventative interventions, particularly targeting the wider determinants of health.

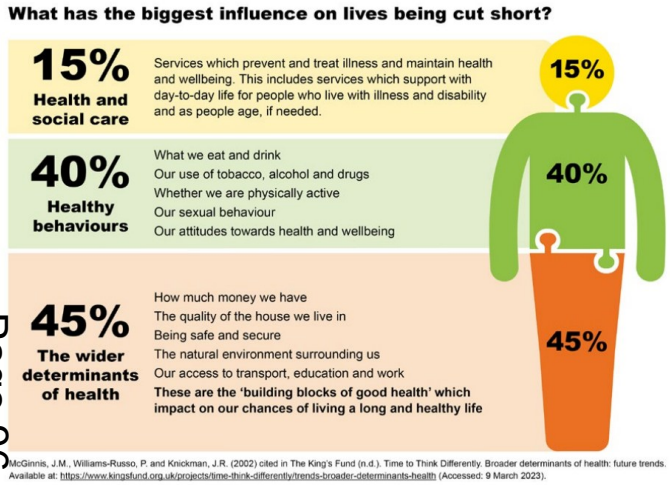


Image 3: The factors of health and wellbeing and Shropshire Profile 2025

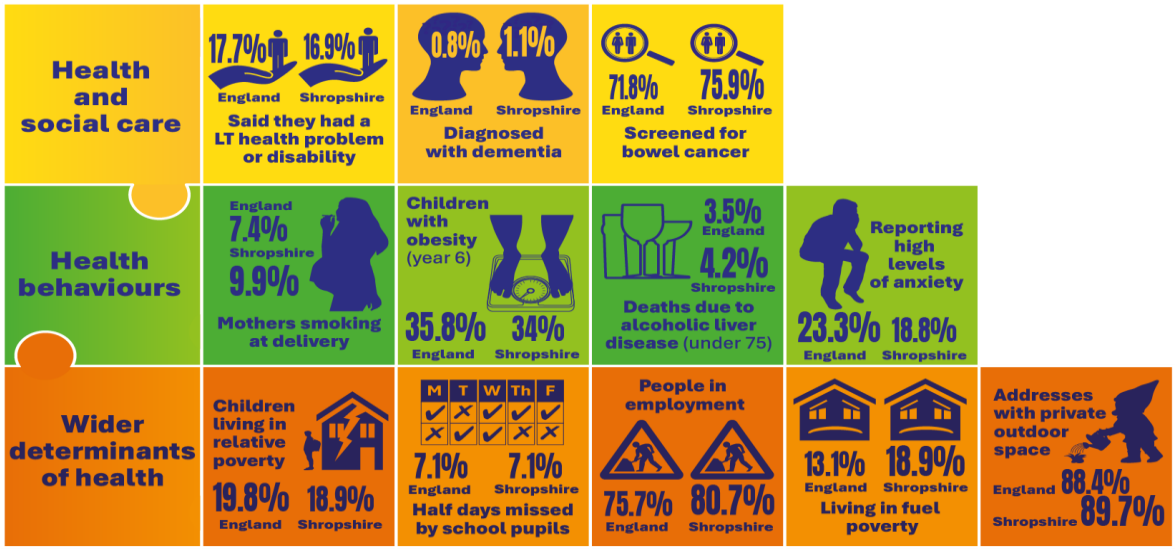
We know from a report by OHID that if mortality rates were to improve by 2% in all age groups from 2017 to 2019 levels, and self-reported health prevalence remained constant, HLE would increase by 0.1 years. If prevalence of self-reported good health were to improve by 2% in all age groups, and mortality rates were to remain constant, the increase in HLE would be 1.3 years.

Source: Adapted with permission from the DPH Annual Report 2024 for County Durham accessed April 2025 and Outcomes framework

Image 2: What has the biggest impact on health and wellbeing.

This highlights that any approach to improving health and wellbeing in our Shropshire population and communities, alongside health and social care impacts, must also consider improvements in healthy behaviours and the wider determinants of health. Image 3 highlights some areas where we would want to focus and should be considering at different life stages, population subgroups and geographies or communities to target resource and action to make the biggest impact.

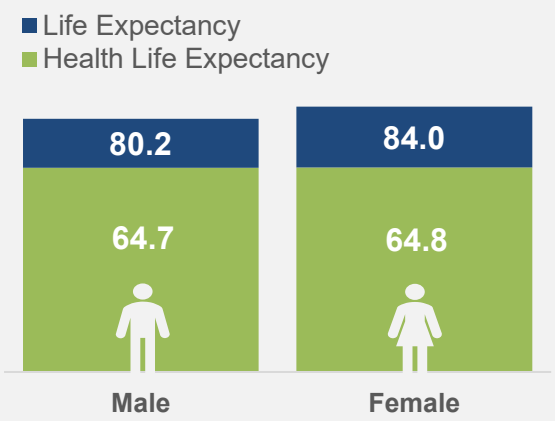
Source: The Director of Public Health Annual Report 2024 for County Durham accessed April 2025



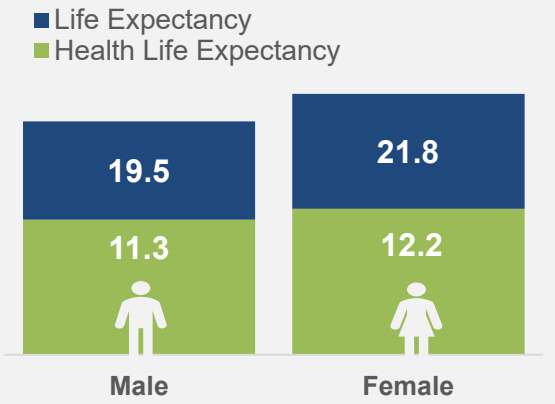
Patterns of Life Expectancy

Multiple factors influence individuals' life expectancy and outcomes: characteristics including those protected in law, such as **sex**, **ethnicity** or **disability**, **socio-economic factors** (income, deprivation, housing, employment and education). Socially excluded groups, for example, people experiencing homelessness and geography. These are described in the following pages for Shropshire.

Graph 1: Life expectancy **at birth (2021-23)**



Graph 2: Life expectancy **at 65 (2021-23)**



Graph 1, 2 and Table 1: Life expectancy and health life expectancy in Shropshire **by gender and age**
Source: ONS.

In Shropshire, women live on average 4 years longer than men but spend the same amount of time in good health (approx. 65 years). This is longer compared to the national healthy life expectancy of

Among those over 65 (Graph 2), the gap in life expectancy reduces to 2.3 years, with women living longer than men. The gap in years spent in good health is also nearly a year longer among females. Healthy life expectancy by age and gender are shown in Table 1

Table 1 shows the change in life expectancy compared to 10 years ago. Male and female healthy life expectancy has reduced in England over time. This has not been reflected in Shropshire among men. Women, however, have seen a reduction in healthy life expectancy overall but by less than what was seen nationally.

Table 1. 10 Year change		Life expectancy at birth			Healthy Life Expectancy at birth		
		2011-13	2021-23	Change (years)	2011-13	2021-23	Change (years)
Shropshire	**Male**	80.0	80.2	**0.2**	64.6	64.7	**0.1**
	Female	83.7	84.0	**0.3**	65.5	64.8	**-0.7**
England	**Male**	79.3	79.1	**-0.2**	63.0	61.5	**-1.5**
	Female	83.0	83.1	**0.1**	63.9	61.9	**-2.0**

Compared to 10 years ago, women over 65 now live over one year longer in good health compared to 10 years ago and men 7 months longer, despite the overall reduction in quality of life Change in healthy life expectancy over the last 10 years varies significantly by age and gender, with the greatest rise in over 55s (Table 1)

Life expectancy varies based on where you live and how deprived that area is.

Map 1 and 2 show life expectancy in neighbourhoods across Shropshire. *Source: ONS*

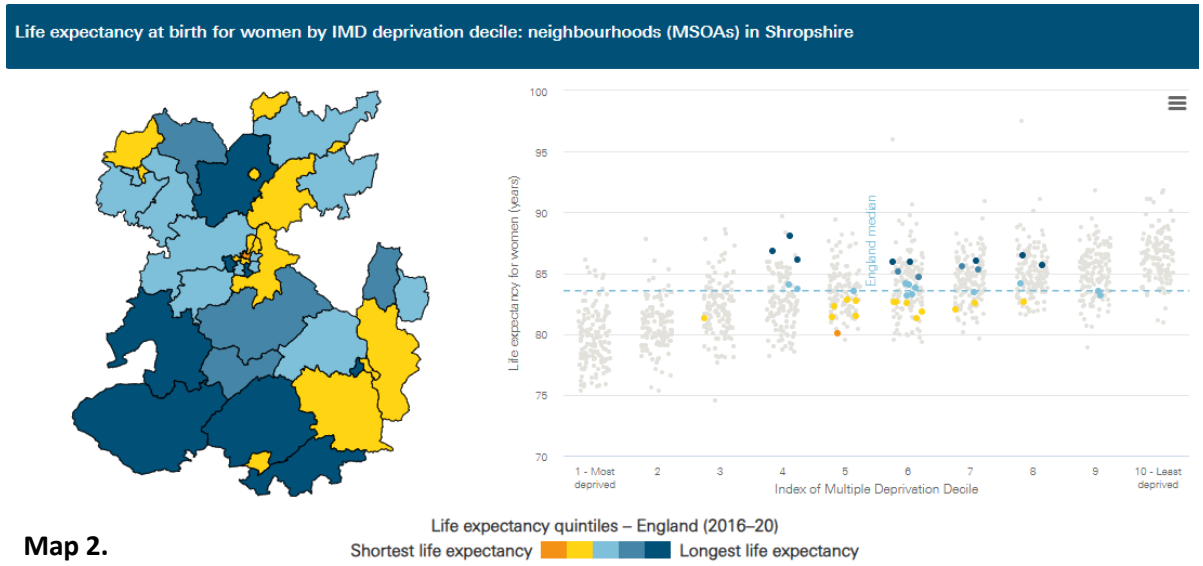
Source: The Health Foundation Local Authority Dashboard: [Local authority dashboard | The Health Foundation]

Women living in Copthorne & Bowbrook (IMD 8) **live 3.4 years longer** than those living in the Harlescott Grange area (IMD 3), which is approximately 4 miles apart within Shrewsbury.

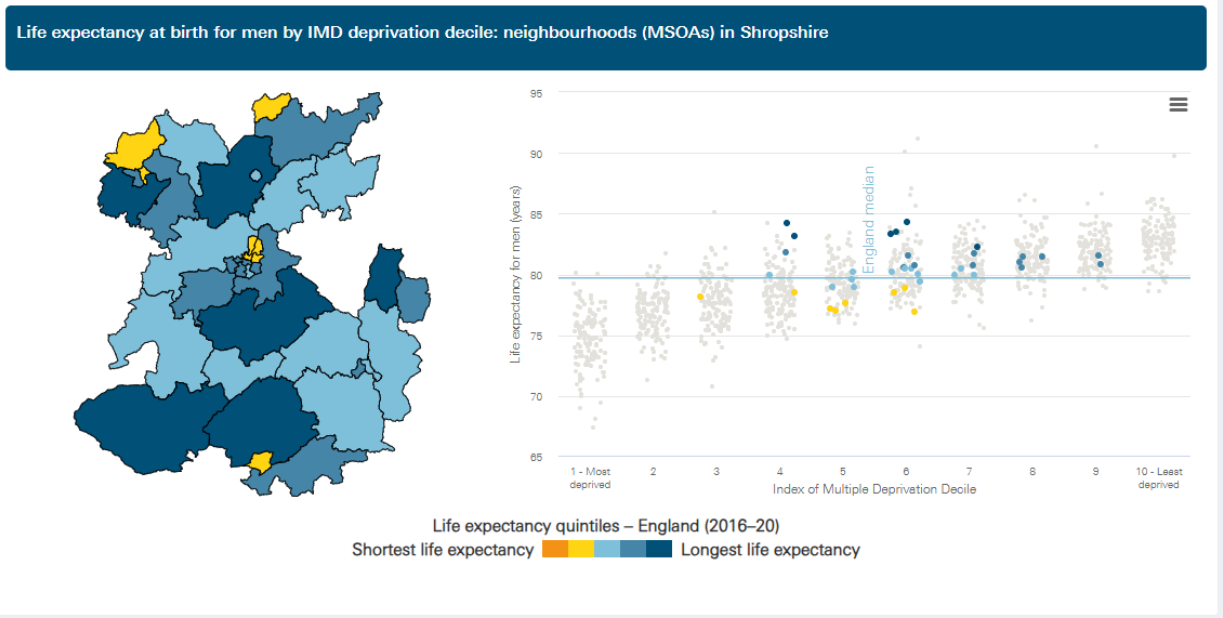
Women living in the most deprived MSOA of Shropshire, Shrewsbury Greenfields, can expect to live to 80 years old, three years less than women living in the least deprived area of the county, Shrewsbury Meole and Kingsland, who expect to live to 83 (Map 1).

In the most deprived MSOA of Shropshire, Shrewsbury Harlescott Grange, men can expect to live for 77 years, 4 years shorter than men living in the least deprived area of Shropshire (Shrewsbury Meole and Kingsland) who have a life expectancy of 81 years (Map 2).

Map 1.



Map 2.



Graph 5: Breakdown of the life expectancy gap between the most and least deprived quintiles of Shropshire by cause of death, 2020 to 2021
Source: ONS

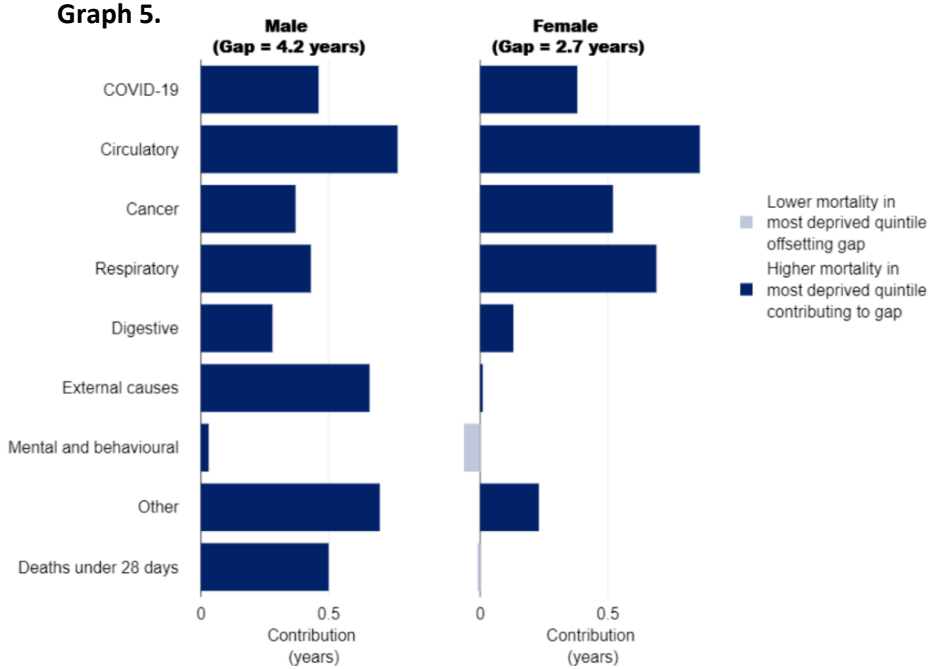
Graph 5 shows the diseases which contribute to the gap in life expectancy between the most and least deprived areas in Shropshire.

During 2020-21, people living in the least deprived areas of Shropshire are estimated to live 4.2 years (males) and 2.7 years (females) longer compared to those living in the most deprived areas.

In males, circulatory disease is the main contributor to the gap in life expectancy between the least and most deprived deciles.

The same is true for females. Tobacco is the risk factor making the largest contribution to years of life lost for both sexes followed by high body mass index (BMI), high cholesterol and high blood pressure.

Graph 5.



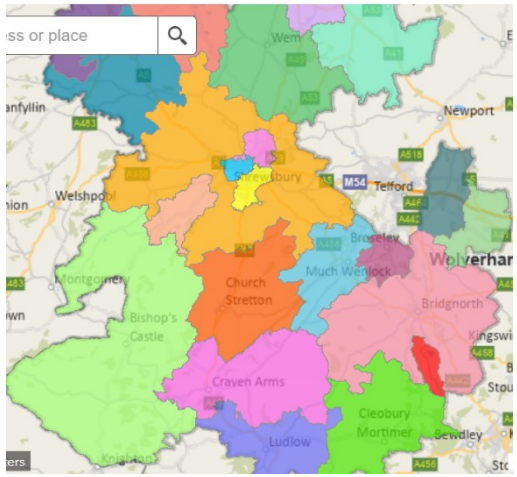
Rural Inequalities and Life Expectancy: Health inequalities can be defined as; *'avoidable differences in health outcomes between groups or populations- such as differences in how long we live, or the age at which we get preventable diseases or health conditions*[7]' However, inequalities in outcomes experienced by those in rural areas can differ; a report published in 2022 by the University of Central Lancashire (UCLAN)[6] utilised a variety of measures to identify the inequalities experienced by rural populations in England. The report highlights the significance of rural health inequalities, often linked to hidden deprivation and the barriers that are unique to rural living groups in accessing essential services.

Contributing factors to rural health inequalities were identified as:[6]:

Deprivation
Unemployment
Suicide rates (male farmers)
Workforce and recruitment challenges
Road accidents
Poor access to services
Mental Health
Substance use
Poor living conditions
Obesity
Poor access to healthcare
Limited transport
Digital connectivity
Ageing population
Loneliness & Social isolation

To understand the implications, challenges and opportunities for this in Shropshire please visit the 2023/24 annual report.

Section 3: Patterns of Health & Wellbeing across our Communities



"The role of communities in improving health is receiving increasing, and long-overdue, attention in health policy and practice – the need for this focus has been underlined by experiences during the Covid-19 pandemic". As part of this shift in focus, as a health and care system, we need to take the role communities can play in improving and sustaining good health seriously, working at the neighbourhood and community level where the link to communities is strongest.
Source: Kings Fund Communities And Health

Shropshire is a large and diverse county, with some similarities but also significant difference by location. In Shropshire we have 18 distinct communities, these are mostly focused on a market town and its surrounding rural communities. Since COVID-19 we have been working with each community in turn to understand the health and wellbeing needs and the determinants of health in these communities. Collecting information at a local level lets us know more about the local health and wellbeing picture of each area. This includes things that are working well, things that need improving and where services and resources should and can be placed now and in the future. By asking each area separately we can better support our residents at a local level with local issues that affect and matter most to them. This includes working together with local organisations such as voluntary and community groups, schools and colleges, GP practices, local businesses, and Town and Parish Councils to gain local knowledge, insight, and connections. To connect with communities, especially those who are often not well heard and unrepresented with the most areas of unmet need and at the highest risk of worse outcomes. We can then work together to highlight and best use the strengths, capacity, and knowledge of all the partners involved to look at actions and possible solutions. This is referred to as an asset-based approach.

While the following pages will provide a summary of each area in turn, the documents also highlight several key themes across the County:

Access to Health Services: A recurrent theme across the majority of our communities (17), focusing on improving access to NHS dentists, community healthcare, GP services and addressing issues related to hospital and emergency services.
Children & Young People (CYP): Another recurrent theme across the majority of our communities (15), including improving youth services, activities, and future opportunities, also providing support for children and young people to be present and safe in communities.
Mental Health: A key theme across the majority of our communities (15) affecting health and wellbeing, identifying the need for better and earlier mental health support and services across all age ranges.
Transport & Infrastructure: A key theme to improve accessibility, as better transport links and infrastructure are seen as essential for accessing services and overall community wellbeing. This is a theme in 12 of our communities, including Market Drayton, Cleobury Mortimer and Ellesmere
Crime and Safety: Improving community safety, the perception of safety and reducing crime rates which impact community cohesion and wellbeing is a key theme in 11 of our communities including Shrewsbury, Bridgnorth and Ludlow
Cost of Living: The rising cost of living is a concern in 12 of our communities across Shropshire including Highley, Pontesbury & Minsterley and Whitchurch, including the need for information on support available and early intervention to prevent crisis.
Housing: A key theme in 10 of our communities including Bishop Castle, Craven Arms, Albrighton and Church Stretton. The focus is on affordable housing, improving housing suitability and quality and addressing housing-related challenges.

Albrighton and Surrounding area at a glance

Health and Wellbeing Index

Overall Albrighton has more positive outcomes than other areas of Shropshire for healthy people and economy including good transport links and housing. However, within each of those areas there are a number of challenges around the environment and education and access to learning and work.

yeh

Image 1: Albrighton compared to communities in Shropshire

Source: Various Place Based JSNAs

Image 1

How does Albrighton overall compare to the 17 other areas?

Strengths

- Equality
- Cost of living vulnerability
- Transport, Mobility and Connectivity
- Housing and Occupancy

Challenges

- Environment
- Education and learning access
- Economy, work and employment

Engagement

Feedback from the community raised some very positive feedback regarding health services and access to these and outdoor space but access to hospital services and education proves challenging. "Excellent service from Drs, Telephone contact is difficult due to number of people on the phone"

“Melville club is fantastic, Nature Reserve is wonderful but is not accessible for the elderly. "

"Our village dentist takes NHS, which is wonderful, and we still have an independent optician, which is great.

Our local hospital is the Princess Royal in Telford, which has really poor access. It's slow to get to by bus, or a mile walk from Wellington train station, and if you drive you cannot park there during the day."

Opportunities and Key Actions

albrighton-interim-high-level-action-plan.pdf

- Youth support services and provision
- Community mental health provision
- Community support for healthy ageing and early intervention
- Transport links and accessibility

https://next.shropshire.gov.uk/jsna-albrighton

Bishop's Castle and surrounding area at a glance

Health and Wellbeing Index

Bishop's Castle has a more elderly population than the rest of Shropshire with the 2nd highest percentage of it's population that are above pension age – 35.3% compared to 30.5% in Shropshire overall.

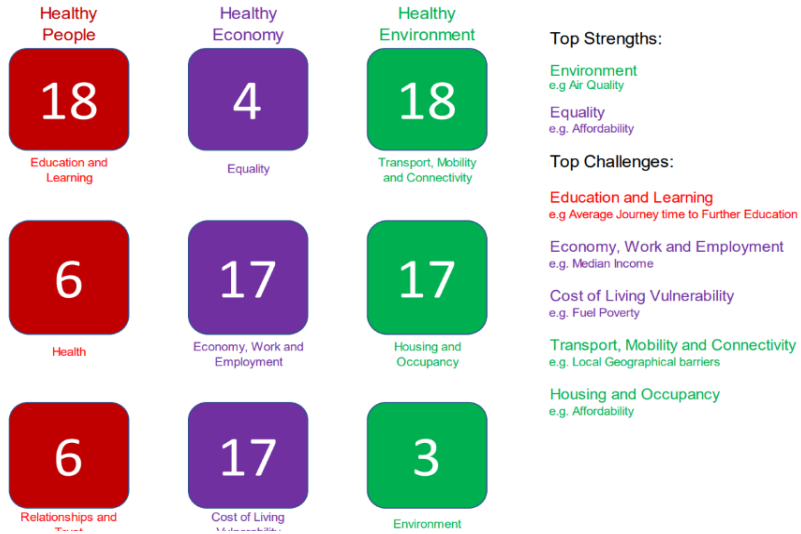
Whilst the health and wellbeing index overview on image 2 rated Bishop's Castle as the 6th best place plan area for Health, on closer examination, some indicators revealed that the Bishop's Castle place plan area had the longest average journey time in minutes to a GP and also to a hospital, which is not helped by it being the largest place plan area at over 52,000 hectares so not everyone has the same level of access.

Image 2: Bishop's Castle compared to communities in Shropshire

Source: Various Place Based JSNAs

Image 2

How does Bishop's Castle compare to the other 17 areas?



Engagement

The top theme of what is important to Bishop's Castle residents in terms of making an area a good place to live in was "Health Services", and this was the second top theme in term of what can be improved in Bishop's Castle. "Closure of local hospital due to staff shortages, delays & access to hospital services in Shrewsbury, distance from Bishops Castle to hospital services, lack of local mental health services" The most frequent issue raised around needs at both a community and personal/family level was access to GP services and secondly issues related to accessing hospital services, with a number of respondents mentioning the closure of the local hospital and the long distance in order to get to the nearest hospital. Ambulance times were also mentioned frequently.

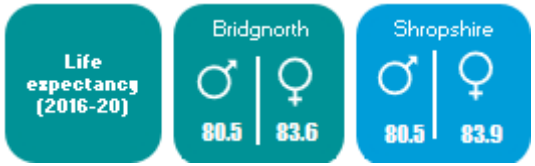
Opportunities and Key Actions

bishops-castle-action-plan.pdf

- Development of a community hub
- Undertake a housing stock survey
- Community hospital services
- Mitigation of digital exclusion

https://next.shropshire.gov.uk/jsna-bishops-castle

Bridgnorth and surrounding area at a glance



Health and Wellbeing Index

Overall the area is generally better than the Shropshire average for equality and the cost of living vulnerability, but worse in terms of the environment. Other concerns raised included mental health, children and young people. Strengths in the area included access health Services and cost of living vulnerability.

Image 3: Bridgnorth compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

In the engagement, residents overall praised GP services; "Access to our excellent GP services is essential. Our local services are patient focused and do not hide behind technology to screen access. However, for secondary care services residents commented that the Princess Royal Hospital in Telford is very important as its closest to where we live but they are overstretched and need more funding.
"Bridgnorth is lucky to have amazing facilities and staff with the doctors, maternity services and the hospital. "
"Dentistry - there are a few surgeries to choose from in the area."

Opportunities and Key Actions

[bridgnorth-interim-high-level-action-plan-1.pdf]

- Youth support services
- Joint awareness communication campaign
- Flood prevention and support
- Local air quality management plan

Image 3

How does Bridgnorth compare to the other 17 areas?

Group	Definition	Label
1st quartile	Top 25% of the 18 Place plan areas	Best
2nd quartile	Areas that lie between 25% and 50% in the rankings	Better than average
3rd quartile	Areas that lie between 50% and 75% in the rankings	Worst than average
4th quartile	Worst 25% of the 18 Place plan areas	Worst

Strengths

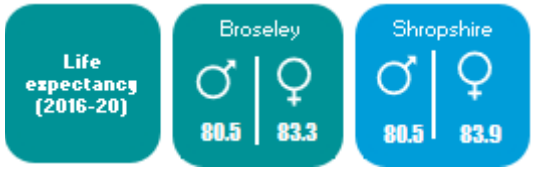
- Equality
- Cost of Living Vulnerability
- Health

Challenges

- Environment
- Transport, Mobility and Connectivity
- Relationships and Trust

https://next.shropshire.gov.uk/jsna-bridgnorth

Broseley and surrounding area at a glance



Health and Wellbeing Index

Overall the Broseley area was poorer than the majority of Shropshire in terms of equality and in terms of the cost of living vulnerability, but health, housing and occupancy and transport are generally better than the rest of Shropshire.

Image 4: Broseley compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

There was a wide range of views from the engagement such as " there is a dentist - but limited NHS availability"
There were some positive comments around the local surgery but also areas of suggestions around improved communications with the community "Local surgery is excellent and works in conjunction with the pharmacy "
" More hospitals, more social care"

Opportunities and Key Actions [broseley-interim-high-level-action-plan.pdf]

- Support community bus Service
- Mental health support services
- Multi agency initiatives addressing anti-social behaviour
- Attract families and young people

Image 4

How does Broseley compare to the other 17 areas?

Strengths

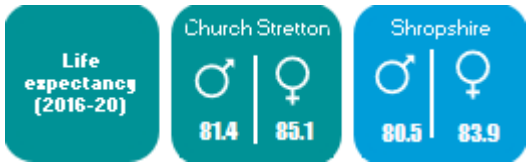
- Transport, Mobility and Connectivity
- Housing and Occupancy
- Health

Challenges

- Equality
- Cost of Living Vulnerability
- Relationships and Trust
- Environment

https://next.shropshire.gov.uk/jsna-broseley

Church Stretton and surrounding area at a glance



Health and Wellbeing Index

Overall, health, the environment and the cost of living vulnerability are generally better in Church Stretton than the rest of Shropshire, however, education & learning access and the economy, work & employment are worse than the rest of Shropshire.

Image 5: Church Stretton compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

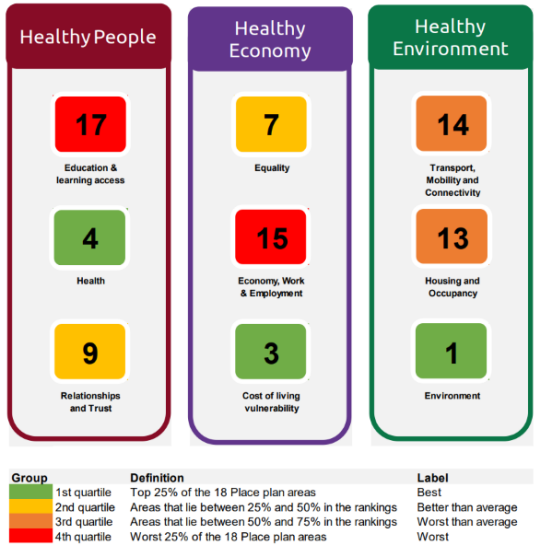
"The medical centre staff are great and I appreciate the efforts they make trying to get a doctor's help to you, even when they are obviously swamped with work. The telephone appointments work well." "Excellent dentist in church Stretton always accommodates myself and my young family when required.
"Needs to be more clinics and call ups for general health checks. Also better access for mental health support "
"Health services provided locally at the Mayfair/ health and wellbeing centre saves travel to Shrewsbury/ Telford Vaccines administered locally "
"More 'in community' services closer to hand - lots of elderly people with lots of appointments having to rely on public transport to get to places like Shrewsbury, Ludlow & Telford is very difficult."
"Would be nice for some extra support with mental health and for younger babies and infants i.e. breastfeeding support group "
Access and signposting support for young people with additional needs. General health 'check up' clinics do not happen as they should which are good, preventable measures. Early stages of health issues are missed as a result."
"Complete lack of bus public transport during evenings and all day Sundays"

Opportunities and Key Actions [interim-high-level-action-plan-church-stretton.pdf]

- Youth support services
- Mitigation of digital exclusion
- Mayfair Centre services
- Community-based health provision

Image 5

How does Church Stretton compare to the other 17 areas?



Strengths

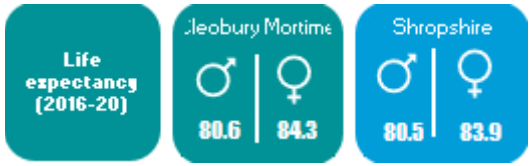
- Environment
- Cost of Living
- Health

Challenges

- Education and learning access
- Economy, Work and Employment
- Transport, Mobility and Connectivity
- Housing and Occupancy

https://next.shropshire.gov.uk/jsna-church-stretton

Cleobury Mortimer and surrounding area at a glance



Health and Wellbeing Index

Overall, relationships and trust, health, equality and the cost of living vulnerability are better in Cleobury Mortimer than they are in the rest of Shropshire, but transport, mobility and connectivity is particularly worse in Shropshire, as is education & learning access and the economy, work & employment

Image 6: Cleobury Mortimer compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

Access to quick medical Assistance when needed, wait times are horrendous in the area! "
Age related problems. Treating conditions rather than the person as a whole"
No plan to expand services (school, doctors etc) yet planning to build a substantial number of houses"
"Not having easy access to NHS dentistry."
"We are fortunate to have an excellent medical centre. The biggest issues are waiting times for non urgent procedures which impact lifestyle "
"Youth mental health due to isolation from friends and potential friends due to lack of an public transport and danger of cycling on south Shropshire lanes and sharp slopes.

Opportunities and Key Actions [cleobury-mortimer-interim-high-level-action-plan.pdf]

- Youth support services
- Transport and accessibility
- Support for mental health and long-term conditions
- Affordable housing and housing stock appraisal

Image 6

How does Cleobury Mortimer compare to the other 17 areas?

Strengths

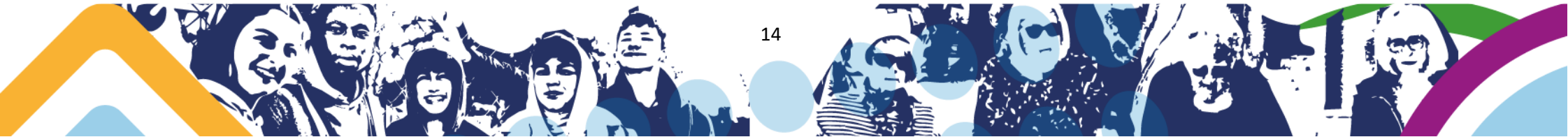
- Relationships and Trust
- Equality
- Cost of Living Vulnerability
- Health

Challenges

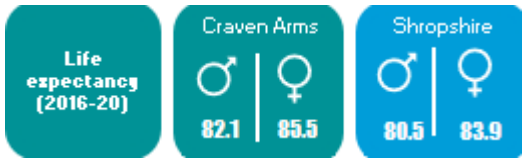
- Transport, Mobility and Connectivity
- Education and learning access
- Economy, Work and Employment
- Housing and Occupancy

17

https://next.shropshire.gov.uk/jsna-cleobury-mortimer



Craven Arms and surrounding area at a glance



Health and Wellbeing Index

Overall Craven Arms is better than Shropshire for relationships and trust, however it is worse than Shropshire especially for housing and occupancy, and for transport, mobility and connectivity.

Image 7: Craven Arms compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

"Craven Arms GP surgery is generally good. However very poor access to NHS Dentistry. "
"Good and friendly care on hospital wards"
"GP hospitals District nurses are over worked"
"Lunts chemist in craven arms do a great job in increasingly pressured conditions
Access to NHS dentists; confidence in ambulance service and A&E; more doctors at local surgeries"
Give option for electronic everything re appointments, letters, and consideration to working people. Time off work costs us in pay loss. So after hours /extended hours services."
"In rural areas these needs to be incentive to attract new and young health workers, with good job prospects and hope that financial funding will improve "

Image 7

How does Craven Arms compare to the other 17 areas?

Strengths

- Relationships and Trust
- Environment

Challenges

- Housing and Occupancy
- Transport, Mobility and Connectivity
- Cost of Living Vulnerability
- Education and learning access
- Health

Opportunities and Key Actions [craven-arms-interim-high-level-action-plan.pdf]

- Youth support services
- Transport and accessibility
- Appropriate burial sites for all communities
- Housing stock appraisal

https://next.shropshire.gov.uk/jsna-craven-arms

Ellesmere and surrounding area at a glance

Health and Wellbeing Index

Overall the index shows that Ellesmere is in the middle for all indicators, doing slightly better for education & learning access, relationships and trust and economy, work & employment.

Image 8: Ellesmere compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

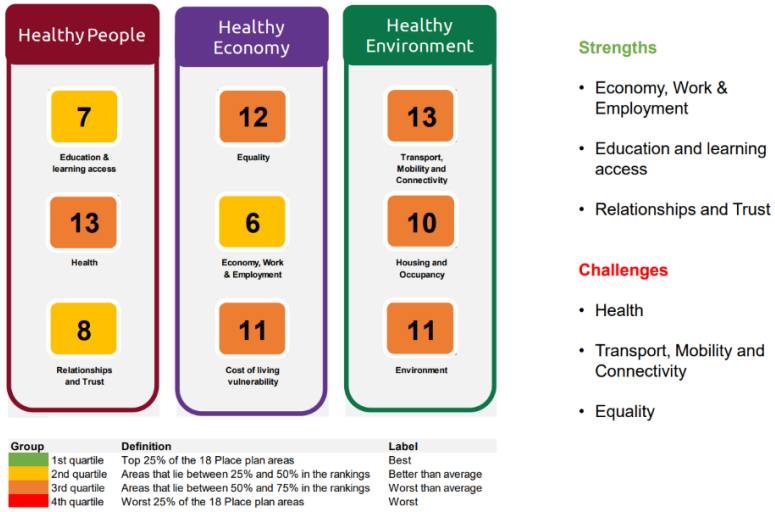
"Very good local GP's, especially if there is an urgent problem. We have 2 week referral for cancer I experienced this and it was excellent"
"Many of the villagers go to Chirk in Wales. I run the St. Martins volunteer car service. We take patients to Chirk, Wrexham, Shrewsbury hospitals and surgeries there is no accessible public transport to these major health centres from St Martins. "
"Oswestry has good services, but getting into Oswestry can be difficult. Good train links but shouldn't have to get a train to everywhere. "
"We have access to an NHS dentist for the children.
"We need more doctors or GPs who know about women's health. There is a demand for support groups in the SY4 postcode for those who struggle with fertility and / or women's health and there is a severe lack of support."
"Hospital is quite far and in very poor shape (see latest A&E doc by Channel 4 based in Shrewsbury
"A community health centre should be replaced it closed 4 years ago."

Opportunities and Key Actions [ellesmere-interim-high-level-action-plan.pdf]

- Transport and accessibility
- Total Triage System
- Multi-agency response and action on drug concerns
- Mental health support

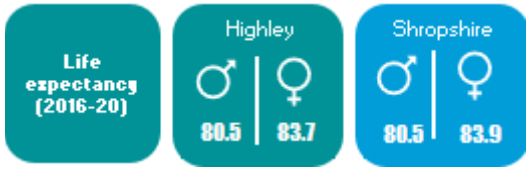
Image 8

How does Ellesmere compare to the other 17 areas?



https://next.shropshire.gov.uk/jsna-ellesmere

Highley and surrounding area at a glance



Health and Wellbeing Index

Overall Highley was better than most parts of Shropshire when it came to housing and occupancy and relationships and trust but was particularly worse than Shropshire in terms of equality, health and cost of living vulnerability. The data and the stakeholder engagement revealed particularly challenges for the area in terms of access to primary care.

Image 9: Highley compared to communities in Shropshire
Source: Various Place Based JSNAs

Image 9

How does Highley compare to the other 17 areas?

Engagement

"A fundamental part of positive health & wellbeing is the need to feel safe & secure in your home and local environment; driven by perceived risk of harm and the reality of crime rates in the village"
"For the past 2 years the school has bought in external services that offer mental health help & advice and can fast track some issues to be able to access specialist services. We also have a trained mental health lead that deals with low level mental health issues. We feel that this is very important, especially in the teaching sector where stress is the highest factor for absence.
"We are aware of the increased need to support our community with MH related issues and are aware that this demand puts a strain on agencies in Shropshire."
Regarding Mental Health – "Services for young children are overwhelmed and it is difficult to get immediate advice. Waiting lists are getting longer & longer & therefore the children & parents are not getting the help they need

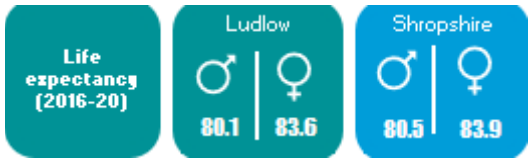
Opportunities and Key Actions

highley-high-level-actions.pdf

- GP and Health and Wellbeing Centre
- Development of a community hub
- Cost of Living support
- Youth support services and provision

https://next.shropshire.gov.uk/jsna-highley

Ludlow and surrounding area at a glance



Health and Wellbeing Index

The index shows that Ludlow was the worst place plan area in terms of health and relationships and trust and was also worse than the majority of Shropshire in terms of housing and occupancy but was better than most parts of Shropshire for education & learning access.

Image 10: Ludlow compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

Lack of NHS dentists in the area and the need for more NHS dental practice "No NHS dentists available, and private fees are too expensive so as a result family dental health is poor and losing teeth as a result." Many residents reported not being able to see a dentist or were not registered:
Many residents reported travelling out of the area for services: "Easier access to GP services and more clinics and outpatient facilities locally, not having to travel to Shrewsbury or Hereford"
"Pharmacy provision has been poor since the beginning of the pandemic, though is improving. More services, including diagnostic services, should be provided locally reducing the journeys to Shrewsbury and Hereford which are often difficult for people with limited mobility." Positive comments:
"Good doctors surgery but need more doctors to replace retired GPs" Ludlow Community Hospital was also a focus:"
Excellent Community hospital , but with limited range of facilities/treatments, need it to be kept open and increase/ enhance services. Good responsive doctors. Access to support services for health and wellbeing would be much better understood and accessed with a central hub, that can refer on to appropriate support and services"

Image 10

How does Ludlow overall compare to the 17 other areas?

Strengths

- Education and Learning Access e.g. Average journey time to Further Education
- Environment e.g. Access to Outdoors
- Transport, Mobility and Connectivity e.g. Local Geographical barriers

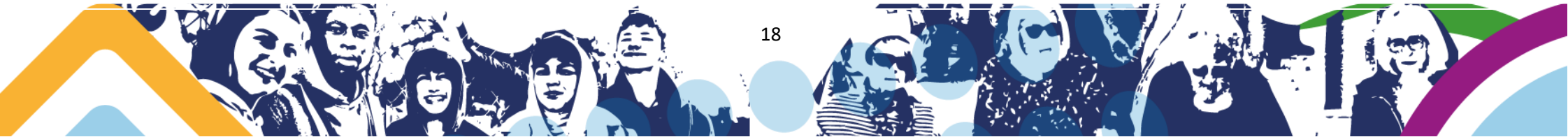
Challenges

- Relationships and Trust e.g. Crime Rate
- Housing and Occupancy e.g. Affordability
- Health e.g. Disease Prevalence

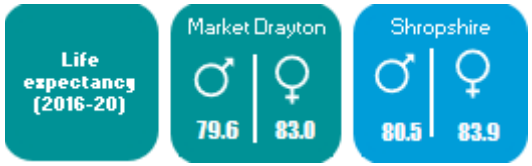
Opportunities and Key Actions [ludlow-interim-jsna-action-plan.pdf]

- Development of a community hub
- Multi-agency response and action on crime and anti-social behaviour
- NHS dentist availability and accessibility
- Health service access, including sexual health outreach clinic

https://next.shropshire.gov.uk/jsna-ludlow



Market Drayton and surrounding area at a glance

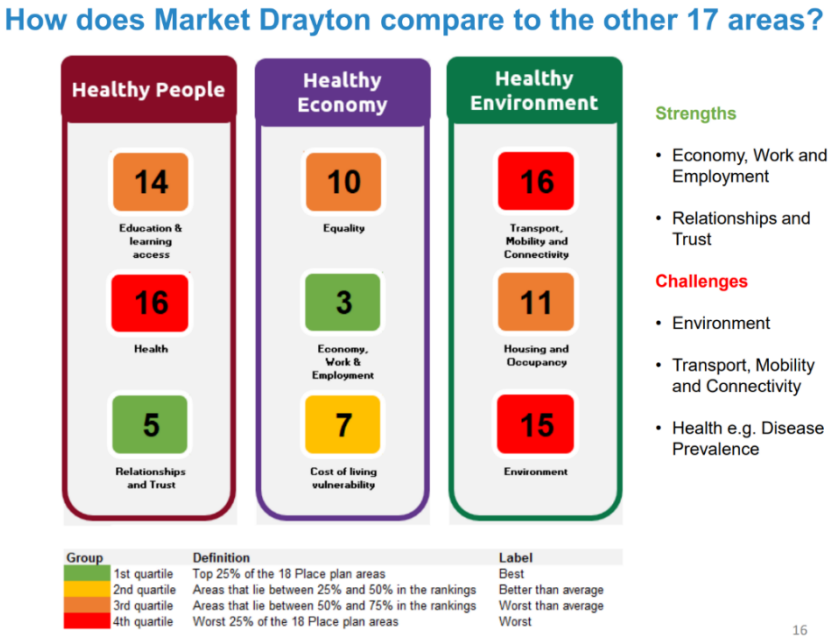


Health and Wellbeing Index

Overall Market Drayton is generally better for economy, work & employment and relationships and trust than the majority of Shropshire, but was worse for Health, transport, mobility and connectivity and the environment.

Image 11: Market Drayton compared to communities in Shropshire
Source: Various Place Based JSNAs

Image 11



Engagement

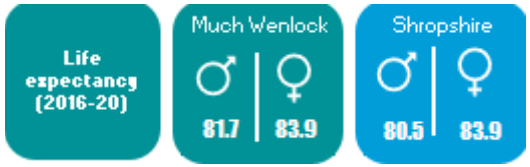
No National Health dentist, people on low wages can not afford to go private
Since I've moved here 2 and a half years ago, I have not been able to register with an NHS dentist
Dentists who offer NHS needs looking at I have to drive to Newport for my NHS dentist
Doctors are over-stretched and not accessible. We have to make an hour-long round trip to see a dentist
Great doctors/nurses and staff. Problems are the same as all over the country, lack of appointments! I don't understand why there cannot be later opening for those who are unable to attend during work hours. Plus weekend opening for people who work unsociable hours.

Opportunities and Key Actions [market-drayton-action-plan.pdf]

- Development of a community hub
- Community covenant
- Youth support services and provision
- Transport links and accessibility

https://next.shropshire.gov.uk/jsna-market-drayton

Much Wenlock and surrounding area at a glance



Health and Wellbeing Index

Overall, Much Wenlock was better than Shropshire across the health, equality, environment and housing and occupancy domains, but was the worst place plan area for the economy, work & employment domain.

Image 12: Much Wenlock compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

There were concerns raised around NHS dentists, however some positive comments around the practice “Very good doctors, able to get appointments when needed", "The district nurse is easily accessible "
However with more housing being built and more in the pipeline they will be unable to cope."
Walk in centre at Bridgnorth is great"

Opportunities and Key Actions

[much-wenlock-interim-high-level-action-plan.pdf]

- Youth support services and provision
- Transport and connectivity links
- Training and employment services
- Cost of living support

Image 12

How does Much Wenlock compare to the other 17 areas?

Group	Definition	Label
1st quartile	Top 25% of the 18 Place plan areas	Best
2nd quartile	Areas that lie between 25% and 50% in the rankings	Better than average
3rd quartile	Areas that lie between 50% and 75% in the rankings	Worst than average
4th quartile	Worst 25% of the 18 Place plan areas	Worst

Strengths

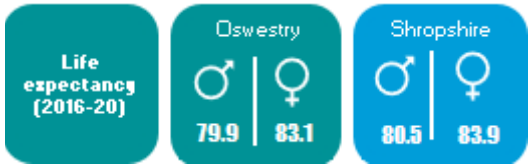
- Equality
- Health
- Environment
- Housing and Occupancy

Challenges

- Economy, Work & Employment
- Cost of Living Vulnerability
- Relationships and Trust

https://next.shropshire.gov.uk/jsna-much-wenlock

Oswestry and surrounding area at a glance



Health and Wellbeing Index

Overall, Oswestry is better than most of Shropshire for education and learning access and does well on economy, work and employment and housing & occupancy, however while the health domain is in the lower half of place plan areas there were issues identified when it came to access to Health, Mental Health, Children & Young People (CYP) and Child & Maternal Health

Image 13: Oswestry compared to communities in Shropshire
Source: Various Place Based JSNAs

Image 13

Engagement

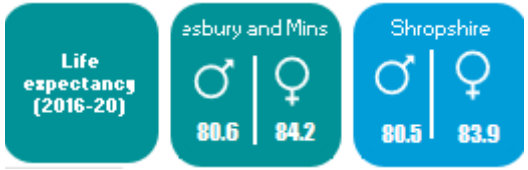
"No maternity services in Oswestry, had to deliver in Telford. No NHS dentistry in Oswestry."
"No surgery in the village - To get to chirk on public transport you have to go to Oswestry then chirk. 4000 people in Shropshire registered at Chirk"
"No surgery. If you need any hospital attention you need to go to Shrewsbury or Telford. Impossible if you don't drive. If you're a widow it's a bit grim. Closed the cottage hospital in Oswestry. Not many buses and expenses
"Lack of doctors surgery and public transport. Nearest surgery Chirk - nearest bus stop for Chirk around a mile. I am 78 years old, suffering from arthritis and cancer and cannot walk more than a few yards with the aid of a stick. I am not alone - many local residents have similar problems. It is not acceptable in a village of this size not to have access to medical facilities, particularly with the number of new houses currently being built. Why wasn't the provision of surgery premises mandated in the plans of one of these new estates in order to attract or retain a GP practice? The introduction of telephone consultations - particularly difficult for the elderly with hearing problems."
"Public transport bus cut from half hourly to hourly"
"The stress of rising costs of living and impact on emotional health"

Opportunities and Key Actions **oswestry-action-plan.pdf**

- Development of a community hub
- Integrated practitioner teams
- Youth support services and provision
- Peer support networks e.g. parents and carers

https://next.shropshire.gov.uk/jsna-oswestry

Pontesbury, Minsterley and surrounding area at a glance



Health and Wellbeing Index

Overall the area is in the top quartile for relationships and trust, transport mobility and connectivity, housing and occupancy and environment, but is in the lowest quartile for education & learning access and economy, work & employment.

Image 14: Pontesbury & Minsterley compared to communities in Shropshire
Source: Various Place Based JSNAs

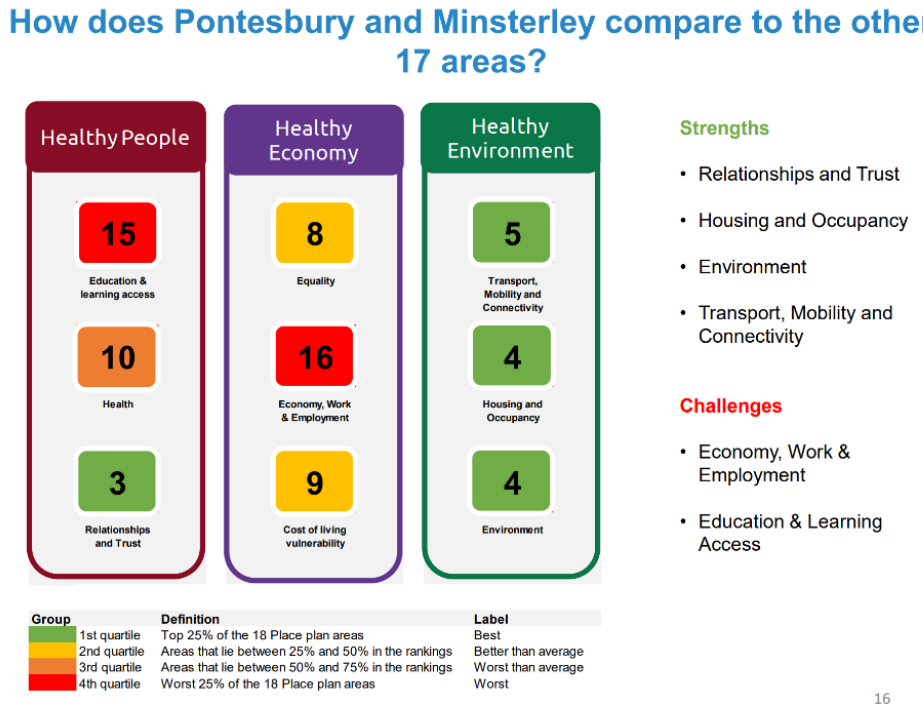
Engagement

Doctors appointments are incredibly difficult to get, approx. 4 weeks wait at present. A488 is dangerous with cars swerving onto the opposite side of the road to avoid potholes, some repairs have been undertaken last week but nowhere near enough sadly."
"GP sees patients quickly if urgent" "It's close by, has a pharmacy on-site"
"Lunts Pharmacy is good and helpful"
"More dentists- we travel an hour to see a dentist. The maternity provision needs starting from scratch. I wasn't aware there were school nurses
"Should be necessary to match services to the number of people in any area. Too often we are told that services will come when large numbers of new housing is introduced - this does not work."
"Better choice for nurseries, before and after school clubs (cost)"

Opportunities and Key Actions [pontesbury-minsterley-interim-high-level-action-plan.pdf]

- Youth support services and provision
- Family support services and provision
- SEND support services and provision
- Transport links and accessibility

Image 14



https://next.shropshire.gov.uk/jsna-pontesbury-minsterley

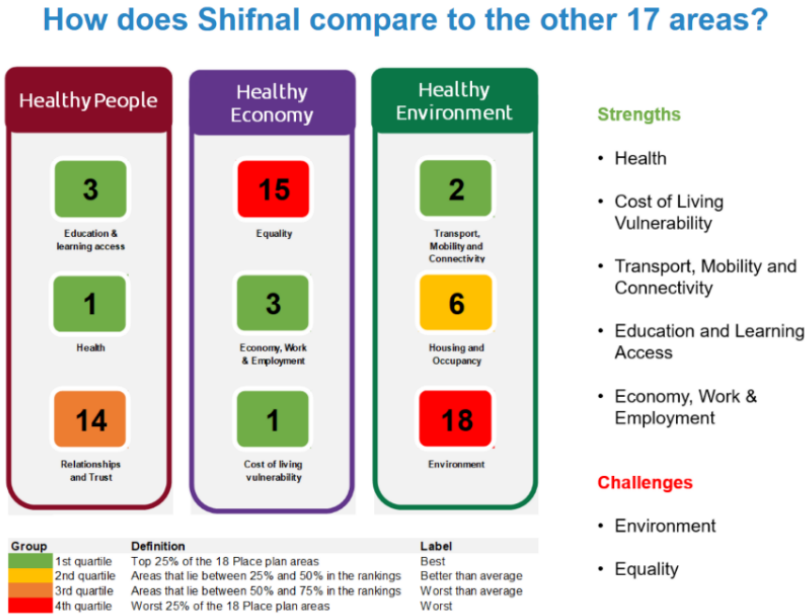
Shifnal and surrounding area at a glance

Health and Wellbeing Index

The Shifnal area is the top place plan area in terms of health and the cost of living vulnerability domains and is also in the top quartile for transport, mobility and connectivity, education & learning access and economy, work & employment, however, it has the worst outcome for environment and is in the lowest quartile for equality

Image 15: Shifnal compared to communities in Shropshire
Source: Various Place Based JSNAs

Image 15



Engagement

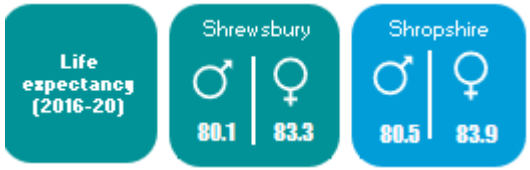
"Dentist is very good, although private.
"The Sexual Health Clinic at Bishton Court"
"Seen improvement at doctors for appointments sometimes with new online system"
"Surgery is hard to get to from bottom of town. Cannot get appointments in Shifnal which is difficult as I don't drive"
"Able to easily access GP The Doctors surgery respond to complaints"
"Communication between all health professionals needs to improve!"
"There needs to be a pelican crossing or traffic lights on the main road leading to the doctor's surgery - new one"
"Ridiculous wait time and triage system, midwives unable to identify clear tongue ties for both children in the hospital, zero NHS dentists in the local area."
"More doctors appointments Blood tests at surgery"
"NHS dentist Access to adequate Mental health support for young people and adults A&E to remain in Telford and Shrewsbury We have accepted the unacceptable in terms if A&E and ambulance services (not the staff but politically)"

Opportunities and Key Actions **shifnal-interim-high-level-action-plan.pdf**

- Transport links and accessibility
- Undertake appraisal of mental health need and services
- Youth support services and provision
- Community health and social care services

https://next.shropshire.gov.uk/jsna-shifnal

Shrewsbury and surrounding area at a glance



Health and Wellbeing Index

Overall, the environment and relationships & trust domains in Shrewsbury are the second lowest domain compared to other areas of the County but it has the highest levels of transport, mobility & connectivity, as well as the economy, work & employment domains. For the Shrewsbury JSNAs the area was divided into three sub areas due to the variation in the population and size.

Image 16: Shrewsbury compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

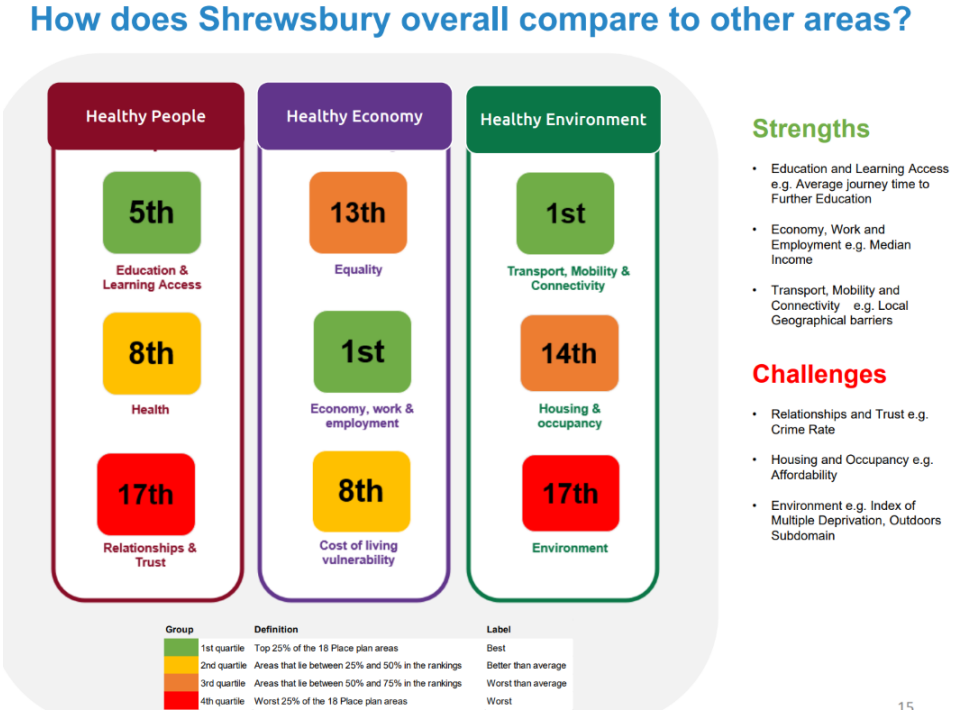
Some particular concerns were raised by residents and communities in the engagement including that there are no defibrillators in Meole Brace or Meole Village, that there is poor access to young people's Mental health services, GP services in parts of Shrewsbury and high levels of car dependency and lack of sustainable transport options and lack of a

Opportunities and Key Actions

Shrewsbury-interim-high-level-action-plan.pdf

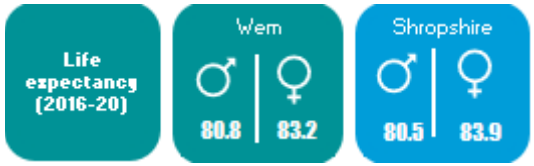
- Development of a community hub
- Youth support services and provision
- Transport links and accessibility equity
- Affordable housing and healthy housing
- Multi-agency response and action on crime and anti-social behaviour

Image 16



https://next.shropshire.gov.uk/jsna-shrewsbury

Wem and surrounding area at a glance



Health and Wellbeing Index

The Wem place plan area is in the lowest quartile for education & learning access, and the highest quartile for equality, but the other domains are in the middle.

Image 17: Wem compared to communities in Shropshire
Source: Various Place Based JSNAs

Engagement

Limited transport with “no bus service at all in whixall - nearest hospital is 40 minutes away - whitchurch hospital should be open more. very difficult to see a cp” “Access to the Drs and health care has really gone downhill since before covid. Having to repeatedly order prescriptions for long term medication monthly is particular irksome and a waste of the drs time. “ “Roads are in a shocking condition, GP appointments are hard to get, therefore is no NHS dental access at all, too much litter in the countryside “ Too few spaces for NHS dentist should people want to change, too much gatekeeping to access doctors, most of which is technology based giving older people access issues. Transport is difficult for people without cars and expensive, taxi service is minimal in rural areas compounding the transport issue for older People "More health support in schools as GP's are full up "

Image 17

How does Wem overall compare to the 17 other areas?

Strengths

- Equality

Challenges

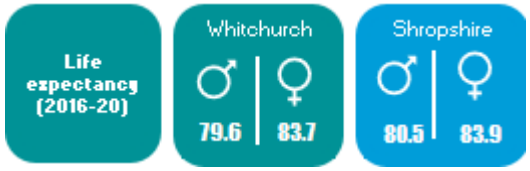
- Education & learning access

Opportunities and Key Actions [wem-interim-high-level-action-plan.pdf]

- Mitigation of digital exclusion and connectivity challenges
- Develop community integration and cohesion
- Youth support services and provision including SEND
- Transport links and accessibility equity

https://next.shropshire.gov.uk/jsna-wem

Whitchurch and surrounding area at a glance



Health and Wellbeing Index

The Whitchurch area had the best education and learning access at the time of this presentation, with the economy, work and employment domain in the top quartile, however, health, relationships and trust, cost of living vulnerability and housing and occupancy were among the lowest rankings in the county. Health Services, Housing & Cost of Living, Crime and Safety and Lack of Activities came up as issues.

Image 18: Whitchurch compared to communities in Shropshire
Source: Various Place Based JSNAs

Image 18

Engagement

Lack of ambulance and doctors services"
There is only one GP practice that is already oversaturated to serve the whole area that's still growing. There are no cost-effective leisure facilities in a reasonable distance/ accessible for the area. "
"Being able to access appointments with a doctor within suitable time frame. Having to wait up to a month for a non-urgent appointment is too long. "
Overwhelmed GP services and resulting long waits for all but urgent appointments "
"Health issues associated with cost of living - i.e. due to not using heating as frequently or affording as healthy meals "
Access to Mental health services - waiting lists are very long"
"Employment and support for vocational work"
"Lack of free early years groups and early help support"
"Mental health issues following Covid"

Opportunities and Key Actions [whitchurch-action-plan.pdf]

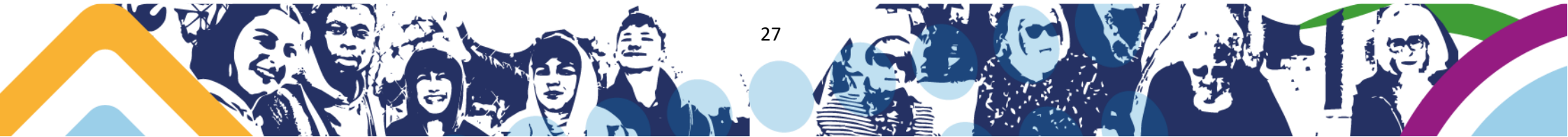
- Youth support services and provision
- New swimming pool and leisure centre
- Community mental health support
- Communicate all available community activities and groups
- Affordable housing and healthy housing

https://next.shropshire.gov.uk/jsna-whitchurch

Section 4: Previous Recommendations Progress Review

The previous DPH Annual Report 2023/24 had a focus on rural health and wellbeing in Shropshire and particularly the often hidden inequalities in rural communities. The report shows the need to more fully understand impact of living in rural areas on the health and wellbeing of our communities if we are to both embrace the strengths and work with communities to tackle some of the real challenges faced on a daily basis. It highlighted the need to continue to strive as both a Council and wider system to prevent and reduce inequalities, whether they arise from rurality or other determinants of wellbeing. The recommendations seek to highlight specific areas of action and further action identified by the current overview of health and wellbeing in Shropshire provided within the report.

Recommendation	Summary Detail	Update
Recommendation 1 – Rural Proofing	That all partners take account of and assess the Governments rural guidance for policy makers and analysts of the effects of policies on rural areas and use the Rural Proofing Toolkit for a new service or policy.	Through the work of the Health Overview and Scrutiny Task and Finish Group, this is in place with partners agreeing to take account of the toolkit and regular updates and reports are received by committee.
Recommendation 2 – Prioritise and develop community-based interventions	That all statutory partners with health and wellbeing responsibilities, recognise the essential role communities play in delivering improved outcomes across Shropshire and specifically in our rural population	This is a core programme of work within STW and is aligned across Shropshire Council. Work continues to seek investment in the voluntary sector through Shropshire Integrated Place Partnership and the Health and Wellbeing board and other external grants to support health checks and social prescribing in our more rural communities. Continues to be an area of focus
Recommendation 3 – Place Based/ Neighbourhood Working	Given the variety and variation of villages, hamlets and towns across Shropshire, partners renew their commitment to Local Place Plan/Neighbourhood Based Working, to improve health and wellbeing.	This is a core programme of work within STW and is aligned across Shropshire Council and Health Partners in the neighbourhood working and customer journey The NHS 10-year plan – includes this shift
Recommendation 4 – Intelligence Led	Improving the evidence base to understand and monitor rural outcomes is essential to underpin all our decision making across HWBB partners.	Completion of al place based JSNAs in 2025. Continuation to build the Population Health Management approach including risk stratification and local place-based data such as the JSNA
Recommendation 5 – Infrastructure solutions	Continue to recognise and support the transport and infrastructure challenges in rural areas and develop innovative solutions to address these needs.	We are now using data to drive performance and ensure the right treatment is carried out at the right time to prevent future deterioration of the network. Analysis and commercial focus on defect data capture has allowed for better decision making and budget allocation.



Section 5: Conclusions and Recommendations

Living in Shropshire provides residents with many opportunities; Shropshire's beautiful countryside and strong sense of community provide a strong foundation for achieving health and wellbeing outcomes which are better than many. However, while overall outcomes are good, there are hidden inequalities in our communities and specific challenges including poorer access to services, continuing concerns regarding mental health in our communities, services for children and young people, poor housing and increased vulnerability through the cost-of-living crisis.

Life expectancy (how long you live) and healthy life expectancy (how long you live in good health) are important measures of the overall health of our residents. In Shropshire, life expectancy overall is higher than the England average, however, there is significant variation. This means in some of our towns and villages residents life expectancy and healthy life expectancy are significantly lower because of the differences in the environment where they were born and live. These stark health inequalities are unfair and avoidable.

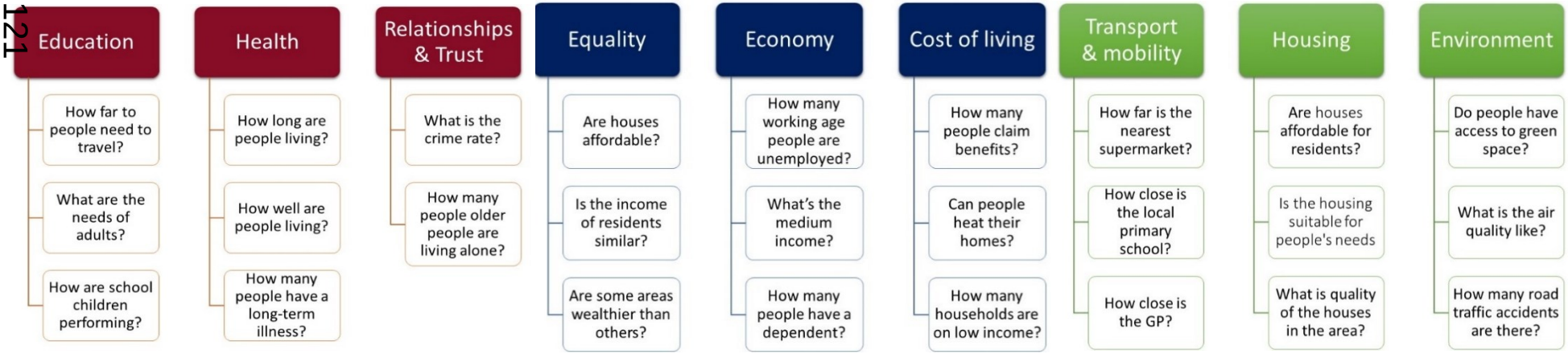
This report provides the context to understand the issues that impact on life expectancy and health and wellbeing in our communities, the inequalities these can generate in Shropshire and how we can continue to address them and seeks to shift the conversation to a more balanced one. The recommendations seek to highlight specific areas of action and further action identified by the engagement with communities in the JSNA. The action plans highlight work already in progress, good practice in interventions, services, collaboration and engagement. Implementation of further actions and for scaling up and sustainability of the current actions will continue to improve outcomes.

Recommendation	Summary Detail
Recommendation 1 – Place Based/ Neighbourhood/ Community Working	Given the variety and variation of villages, hamlets and towns across Shropshire, partners renew their commitment to Local Community/Neighbourhood Based Working, to improve health and wellbeing. That all statutory partners with health and wellbeing responsibilities, recognise the essential role communities play in delivering improved outcomes across Shropshire. That we continue to shift investment into our communities and services that support our communities including the Voluntary and Community Sector
Recommendation 2 - Alignment	That all partners take account of and assess the Governments neighbourhood guidance and align to the current development within Shropshire around Community Hubs and the JSNA intelligence to align future services in our distinct and varied neighbourhoods and build on the current work and programmes already in place but at scale.
Recommendation 3 – Intelligence Led	Improving the evidence base to understand and monitor rural outcomes is essential to underpin all our decision making across HWBB partners. That we continue to engage with our communities in developing and delivery of our community led action plans with a collective ownership, including our understanding of rural inequalities.
Recommendation 4 – One Shropshire	Continuing to work together as one community of partners to serve our residents of Shropshire, asking how can we help? Enabling communities and the voluntary and community sector to take more of central role in the development of our services and work.

Appendix: Place Plan Index Definitions

The index uses several indicators to rank each place plan area out of the 18 place plan areas across 9 categories in 3 different domains

- Education and learning access includes: average journey times to primary schools, secondary school and further education, and indicators from the index of multiple deprivation relating to adult skills and children and young people.
- Health includes: several indicators related to disease prevalence on primary care registers, children's vaccination rates, prevalence of obesity in reception and year 6, life expectancy and measures related to pregnant women.
- Relationships and trust: includes measures related to various crime rates, pensioners living alone, and percentage of young people
- Equality: includes lower quartile house price affordability, income ratios and
- Economy, work and employment: includes unemployment of working age people, business rates, income levels and indicators from the index of multiple deprivation related to income deprivation of older people and income deprivation of children
- Cost of living vulnerability: includes lower quartile income levels, claimant counts from the department of work and pensions and the levels of households that are fuel poor
- Transport mobility and connectivity: includes indicators from the index of multiple deprivation related to the geographical barriers
- Housing and occupancy: includes the mean housing affordability, the percentage of households that have enough rooms for the people who live within them and have central heating, and indicators from the index of multiple deprivation related to barriers to housing and services
- Environment: includes the index of multiple deprivation related to the outdoors sub-domain which includes air quality and road traffic accidents



"Floreat Salopia" – May Shropshire Flourish

Director of Public Health Shropshire

Annual Report 2024/2025

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**18.09.25**						
Title of report	**Shropshire Integrated Place Partnership (ShIPP) Update**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)		Information only (No recommendations)	x	
Reporting Officer & email	Rachel Robinson Rachel.robinson@shropshire.gov.uk						
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People	x	Joined up working	x			
	Mental Health	x	Improving Population Health	x			
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x			
	Workforce	x	Reduce inequalities (see below)	x			
What inequalities does this report address?	The ShIPP Committee works to reduce inequalities and encourage all programmes and providers to support those most in need.						

Report content

1. **Executive Summary**
   The purpose of Shropshire Integrated Place Partnership (ShIPP) is Shropshire's Place Partnership Committee.
   It is a partnership with shared collaborative leadership and responsibility, enabled by ICS governance and decision-making processes. Clinical/care leadership is central to the partnership, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities.
   It is expected that through the programmes of ShIPP, and routine involvement and coproduction local people and workforce can feed ideas and information to inform and influence system strategy and priority development.
   The new governance of the ICB has named ShIPP as a formal subcommittee of the ICB Board.
   This report provides an update of discussions in July 2025.

2. **Recommendations** – N/A

3. **Report**

Meeting Name: Shropshire Integrated Place Partnership (ShIPP)
Meeting Date: 16th July 2025
Report Presented by: Andy Begley, Shropshire Council, Chief Executive
Report Approved by: Andy Begley, Shropshire Council, Chief Executive
Report Prepared by: Rachel Robinson, Shropshire Council, Executive Director, Public Health
Action Required: For assurance and discussion

1. Summary of Key Discussions and Decisions

1.1 ShIPP meets Bi-monthly, with the last meeting on the 16th July. The meeting focused on the ShIPP Accelerator Group particularly on the governance arrangement

& ToR update. The group also reviewed the ShIPP Terms of Reference & approval of ShIPP Annual Report to ICB 2024-25. The main discussion items focused around the Energize STW - Place Universal Bid and ShIPP Prevention Funding Update, both funding for Shropshire to take forward key priorities. In addition there was a STW GP Board introduction and "Think twice, order right" ICB Medicine Wasters Campaign.
1.2 The meeting was quorate
1.3 No conflict of interests declared
1.4 The meeting was well attended

2. Recommendations to the Board

2.2.1 The Board is asked to note the following briefing report from the Shropshire Integrated Place Partnership.

- The approved the governance arrangement proposal & ToR update from the ShIPP Accelerator Group.
- Amended Terms of Reference (using the ICB additions) were approved by the committee and the ShIPP Annual Report to the ICB 2024-25
- ShIPP will be integral to the governance, development and reporting of the Energize STW - Place Universal Bid which will seek to deliver increases in active behaviours and reduction in inactivity levels though a whole-system approach to place working is adopted.
- Prevention Funding process is proceeding and will report back to the October meeting.
- Dr Jess Harvey & Dr. Charlotte Hart introduced the STW GP Board
- Anam Jivraj presented the "Think twice, order right" ICB Medicine Wasters Campaign to the committee
- The Vaccination Improvement Action Plan and Frailty Strategy Listening Event were discussed as part of any other business.

3. Key Risks and Mitigations

There were no risks raised at this meeting

4. Performance and Assurance

4.1 **Assure** - positive assurances and highlights of note:

- **ShIPP Accelerator Group – Governance arrangement proposal & ToR update**: The committee approved the amendments to the ShIPP Accelerator Group's governance and ToR.
- **ShIPP Terms of Reference update (following ICB additions) & approval of ShIPP Annual Report to ICB 2024-25:** the committee approved the amendments to the ToR suggested by the ICB and the ShIPP Annual Report to the ICB 2024-25. It was suggested that the ToR also be put out for review in the light of the NHS 10-Year plan and development of neighbourhood health implementation, results will be reported back to a later meeting
- **Energize STW - Place Universal Bid:** the committee agreed that ShIPP become part of the governance, development & reporting process for the Place Universal bid. It was also agreed that links would be explored to other projects and funding streams that could compliment the place-based investment. Members of the committee stepped up to be part of the ongoing bid process, starting with an initial stakeholder meeting on 4th August.
- **ShIPP Prevention Funding Update:** the prevention funding process is progressing with the application deadline being moved to the 1st August. Bids will be bought to the October ShIPP meeting for discussion. The committee supported the virtual sign off of Social Prescribing and VCSE Capacity Support bids already discussed.

- **STW GP Board introduction:** the committee was introduced to the STW GP Board. There was discussion around representation, scope of the board and links with community pharmacy.
- **"Think twice, order right" ICB Medicine Wasters Campaign**: a presentation was given regarding the comms campaign aimed reducing medication waste from unnecessary repeat prescriptions. This was endorsed by the committee.
- **Any other Business:**
  - **Vaccination Improvement Action Plan:** the vaccination improvement plan was submitted to NHS England and will be updated iteratively. A task and finish group will be set up to continue the work, members were invited to attend.
  - **Frailty Strategy Listening Event:** the second listening event will be held at Guildhall on 2nd October.

5. Alignment to ICB Objectives and Core Functions

5.1 The committee's discussion directly aligns with the Joint Forward Plan's key elements of:

- Taking a person-centred approach (including proactive prevention, self-help, and population health to tackle health inequalities and wider inequalities).
- Improving place-based delivery, having integrated multi-professional teams providing a joined-up approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.
  - ShIPP is a crucial part of the development and delivery of the Joint Forward Plan and ShIPP's new strategy & priorities have been developed with the ICB Strategy Team and our other partners.

6. Next Steps & Forward Plan

6.1

- **The ShIPP ToR** will be put out for review in the light of the NHS 10-Year plan and development of neighbourhood health implementation, results will be reported back to a later meeting.
- **Energize STW – Place Universal Bid**: members are asked to join the stakeholder meeting on 4th August.
- **Vaccination Improvement Action Plan**: members were offered the opportunity to be part of the working group
- **Frailty Strategy Listening Event**: members were asked to attend the second listening event if appropriate, to be held in Guildhall, Shrewsbury on 2nd October.

Risk assessment and opportunities appraisal	-	
Financial implications	-	
Climate Change Appraisal as applicable	-	
Where else has the paper been presented?	System Partnership Boards	ICB Board
	Voluntary Sector	
	Other	

List of Background Papers N/A

Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead

Rachel Robinson – Executive Director of Public Health

Cllr Bernie Bentick - Shropshire Council Portfolio Holder for Health and Public Protection

Appendices None