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

Date: Wednesday, 1 July 2026

Committee:
Health and Wellbeing Board

Date: **Thursday, 9 July 2026**
Time: **9.30 am**
Venue: **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

Richard Phillips
Service Director – Legal and Governance (Monitoring Officer)

Members of Health and Wellbeing Board

Councillor Ruth Houghton – PFH Adult Social Care & Public Health, Shropshire Council
Councillor Heather Kidd – Leader, Shropshire Council
Councillor Andy Hall – PFH Children & Education, Shropshire Council
Rachel Robinson - Executive Director of Public Health, Shropshire Council/NHS STW ICB
Wendi Shepherd – Deputy Director of Public Health, Shropshire Council
Natalie McFall – Director of Adult Social Services, Shropshire Council
David Shaw – Director of Children's Services, Shropshire Council
Laura Fisher – Head of Housing, Resettlement & Independent Living, Shropshire Council
Vanessa Whatley – Chief Nursing Officer, NHS Shropshire, Telford and Wrekin ICB
Claire Parker – Director of Strategy & Development, NHS Shropshire, Telford and Wrekin
Lynn Millar – Director of Place, STW NHS, STW ICB and Staffordshire & Stoke-on-Trent ICB
Claire Horsfield - Director of Operations & Chief AHP, Shropcom
Ben Hollands – Health and Wellbeing Strategy Implementation Manager, MPFT
Nigel Lee - Group Chief Strategy and Integration Officer, STW Community and Hospitals NHS Group
Paul Kavanagh-Fields – Chief Nurse and Patient Safety Officer, RJAH
Lynn Cawley - Chief Officer, Healthwatch Shropshire
Jackie Jeffrey – Lead Officer, VCSA
Claire Smout - Chief Officer, Partners in Care
Edward Hancox - Superintendent, West Mercia Police

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

When attending this meeting, Members are reminded of the three principles of the Jo Cox Foundation and Compassion in Politics Civility Pledge:

1. *Use a civil and constructive tone in debate*
2. *Act with integrity, honesty and compassion*
3. *Behave respectfully towards others, including those I disagree with*

*(Please note that while we strive to live stream meetings, technical issues may occasionally occur. In the event of a technical disruption, the meeting will be paused to try to resolve the issue. Should it not be possible to resume the live stream, the meeting will proceed as scheduled, and a backup recording will be made available after the meeting. Any disruption to the live stream does not affect the legality of the meeting).

AGENDA

1 Election of new Co-Chair

Cllr Ruth Houghton, Portfolio Holder for Health & Adult Social Care

2 Apologies for Absence and Substitutions

3 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."

4 Minutes of the previous meeting (Pages 1 - 10)

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

5 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 3 July 2026.

6 Neighbourhoods (Pages 11 - 18)

- Introduction to Neighbourhoods
  Rachel Robinson, Executive Director of Public Health (DPH), Shropshire Council & NHS STW

- Neighbourhood Health
  Phil Smith, Chief Officer, Deliver & Integration, NHS STW & SSOT

- Strategic Alignment of Neighbourhood working in Shropshire
  Rachel Robinson, Executive Director of Public Health (DPH), Shropshire Council & NHS STW

7 Healthwatch Shropshire update: 'Access to Medication in Shropshire' and

'Veterans' Experiences of Accessing Healthcare in Shropshire' (Pages 19 - 30)

Lynn Cawley, Chief Officer, Healthwatch Shropshire

8 **Children and Young People JSNA Chapter: Pregnancy and birth** (Pages 31 - 44)

Mark Trenfield, Public Health Intelligence Analyst, Shropshire Council

If you would like a copy of Appendix B (Pregnancy & Birth Chapter) to be emailed to you, please contact Michelle Dulson on 01743 257719

9 **Drug & Alcohol JSNA** (Pages 45 - 60)

Jenny Roach, Senior Public Health Intelligence Analyst, Shropshire Council
Shaun Morris, Drug and Alcohol Strategic Commissioning Lead, Shropshire Council

If you would like a copy of Appendix B (Drug and Alcohol JSNA 2026) to be emailed to you, please contact Michelle Dulson on 01743 257719

10 **2025-26 End of Year Template and 2026-27 BCF Assurance Return** (Pages 61 - 78)

Deborah Webster, Service Manager (Contracts, Quality Assurance, and Business Development), Shropshire Council

If you would like a copy of Appendix B (BCF 2026-27 narrative return) or Appendix C (BCF 2026-27 Numerical Return) to be emailed to you, please contact Michelle Dulson on 01743 257719

11 **STW 5-year Strategic Commissioning Plan - ICB - including HealthHero update** (Pages 79 - 92)

Dr. Lorna Clarson, Chief Officer: Strategy and Improving Outcomes, NHS Shropshire, Telford and Wrekin, NHS Staffordshire and Stoke-on-Trent

12 **Shropshire Council Corporate Plan** (Pages 93 - 104)

Rachel Robinson, Executive Director of Public Health Shropshire Council & NHS STW
Tom Dodds, Strategy and Scrutiny Manager and Statutory Scrutiny Officer, Shropshire Council

13 **ShIPP Update** (Pages 105 - 108)

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

14 **HWBB Progress against targets** (Pages 109 - 112)

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

15 **Pharmacy updates** (Pages 113 - 114)

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

16 **Health Overview & Scrutiny Committee**

Please see most recent meeting papers here:

Agenda for Health Overview and Scrutiny Committee on Thursday, 14th May, 2026, 12.00 pm — Shropshire Council

17 **Any other Business**

- Thanks to Claire Parker, Director of Strategy & Development, NHS STW

This page is intentionally left blank

Shropshire Council

Committee and Date

Health and Wellbeing Board

21 May 2026

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 19 MARCH 2026
9.30AM – 11.50AM

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

Present
Councillor Bernie Bentick – PFH Health & Public Protection (Co-Chair) , Shropshire Council
Councillor Ruth Houghton – PFH Social Care, Shropshire Council
Rachel Robinson - Executive Director, Public Health (DPH), Shropshire Council
David Shaw – Director of Children's Services, Shropshire Council
Natalie McFall – Director of Adult Social Services, Shropshire Council
Laura Fisher – Housing Services Manager, Shropshire Council (remote)
Vanessa Whatley – Chief Nursing Officer for NHS Shropshire, Telford and Wrekin
Claire Parker – Director of Partnerships, NHS Shropshire, Telford and Wrekin
Nigel Lee - Director of Strategy & Partnerships SATH
Ben Hollands – Health and Wellbeing Strategy Implementation Manager, MPFT (remote)
Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Partners in Care

Also present: Lisa Gardner (remote), Damilola Agbato, Clare Davis, Jess Edwards, Gordon Kochane, Shaun Morris, Wendy Bulman, Claire Smout, Deborah Webster, Jess Timmins, Councillor Dawn Husemann

48 **Apologies for Absence and Substitutions**

Tanya Miles – Interim Chief Executive
Councillor Heather Kidd – Leader, Shropshire Council
Claire Horsfield – Director of Operations & Chief AHP, ShropCom
Sam Burton - Acting Head of Service Deliver, Shropshire Fire & Rescue Service
Ed Hancox – Superintendent, West Mercia Police
Simon Whitehouse – CEO, NHS Shropshire Telford and Wrekin & Staffordshire and Stoke-on-Trent

49 **Disclosable Interests**

No interests were declared.

50 **Minutes of the previous meeting**

RESOLVED:

That the minutes of the meeting held on 22 January 2026 be approved and signed as a correct record.

51 **Public Question Time**

No public questions were received.

52 **Shropshire Community Safety Partnership - Annual Report**

The Development Officer for Shropshire's Safeguarding Children's Board presented the Community Safety Partnership Annual Report for 2024–25, which outlined the progress made against the partnership's priorities to tackle crime, address disorder, and reduce re-offending within Shropshire. She explained that the partnership had undergone significant structural change during the year, separating into three distinct boards: the Community Safety Partnership, the Safeguarding Adult Board and the Children's Safeguarding Partnership. This restructuring had enabled each board to maintain a clearer focus on its respective responsibilities.

The Board was informed of several key achievements, including the delivery of serious violence duty projects. These included the West Mercia Women's Aid project, which worked with young people in schools, and the Bright Star project, aimed at supporting individuals on the fringes of serious violence. A diagnostic review of statutory case reviews had also been completed, highlighting strong practice across agencies and emphasising the need for continued creativity in disseminating learning to frontline practitioners.

Members commended the Partnership's achievements and noted the reported reductions in crime, with total crime down by 9.3%, violence without injury reduced by 13%, violence with injury reduced by approximately 25%, hate crime down by over 5%, anti-social behaviour reduced by almost 10%, and re-offending rates showing a further decrease over the past two years.

The Board discussed the importance of the annual report in providing oversight of the Partnership's work and its relevance to Health and Wellbeing Board priorities, particularly in relation to domestic abuse and drugs and alcohol. It was noted that these areas were regularly monitored as part of the Board's governance.

RESOLVED:

To note the contents of the report.

53 **Domestic Abuse**

The Domestic Abuse Strategic Lead presented an update on domestic abuse, outlining progress against Health and Wellbeing Board priorities. Key objectives included strengthening strategic planning, improving partnership governance, embedding survivor voice within processes, and ensuring alignment with statutory duties under the Domestic Abuse Act. A refreshed needs assessment had been completed, identifying prevalence levels, service pressures, gaps in provision, and experiences within rural communities.

The Domestic Abuse Local Partnership Board had reviewed its membership to support more effective decision-making. Improvements had been made in data maturity, with ongoing work to centralise domestic abuse data to assist with dashboard development. Lived experience had been increasingly integrated into service planning, shifting from basic feedback mechanisms to more meaningful co-production.

The partnership strategy had been developed through workshops involving individuals with lived experience and rural expertise. This had resulted in specific commitments to address rural disparities in access, awareness and safety. A public consultation had been undertaken, and the strategy was now being finalised for approval.

Operational forums had been established and were ready to implement the action plans once the strategy was approved. The Domestic Abuse Local Partnership Board was embedding evidence-based decision-making and progressing work towards a centralised data repository. Survivor voice was continuing to be strengthened, supported by the roles of the Lived Experience Officer and an advisory group.

Commissioning practices were evolving, with limited local authority funding available for community-based support and ongoing efforts to pool partnership resources. Survivors had highlighted the importance of perpetrator accountability and the provision of appropriate support to prevent the creation of future victims.

The needs assessment identified mental health as the most common disability experienced by victims, with health services frequently encountering domestic abuse. The role of MARAC (multi-agency risk assessment conference) in supporting high-risk victims was noted. Next steps included finalising the strategy, implementing a three-year action plan, launching a performance dashboard and expanding rural outreach. Risks identified included data gaps, unequal rural access, limited survivor engagement and insufficient representation of LGBT voices.

Recommendations arising from the assessment included strengthening data quality, expanding rural outreach, formalising survivor voice within commissioning processes and enhancing workforce training across sectors.

The Chair asked whether the strategy aligned with violence against women and girls initiatives. The Domestic Abuse Strategic Lead confirmed that it did and noted that the wider Violence Against Women and Girls strategy incorporated sexual abuse and sexual violence considerations.

The Assistant Director for Prevention and Commissioning suggested further collaboration through neighbourhood and play space initiatives, supported by the new neighbourhood framework and left-shift funding of £2.9 million for 2026–27. The Domestic Abuse Strategic Lead welcomed this offer.

The Director of Children's Services expressed support for multi-agency training and data development work, emphasising the need for clarity and consistency around lead practitioner roles and the use of early indicators to support prevention.

The Portfolio Holder for Social Care asked about the timeline for developing the performance dashboard and whether it would capture the relationship between domestic abuse and drug and alcohol misuse. The Domestic Abuse Strategic Lead explained that the dashboard was in development, with quarterly updates being provided to the Domestic

Abuse Local Partnership Board. She advised that further work was required to incorporate external partner data, particularly in relation to drug and alcohol services, to avoid duplication and improve accuracy.

The Chair asked whether the dashboard was accessible to Board members. The Domestic Abuse Strategic Lead clarified that access currently remained limited to Domestic Abuse Local Partnership Board members while development work continued.

The Chair sought clarification regarding the blockers associated with data sharing. In response, it was explained that the primary barrier related to obtaining the necessary permissions from data owners to enable information to be transferred between systems and incorporated into the dashboard. It was further noted that, for external partners, the main challenges concerned data formatting and the ability to share and integrate information effectively in order to produce a single, consistent version of the data.

The Lead Officer for the VCSA asked about opportunities for involvement. The Domestic Abuse Strategic Lead confirmed that voluntary and community sector participation was welcomed at both the operational forum and the partnership board and offered to facilitate appropriate introductions.

The Executive Director of Public Health reiterated the importance of ensuring that domestic abuse services, mental health, and drug and alcohol work were embedded within neighbourhood and hub frameworks, both for strategic alignment and for coordinated workforce training.

RESOLVED:

to support data sharing, enable rural outreach by offering Community spaces, champion survivor-inclusive commissioning practices, and enhance workforce training.

54 **Drug & Alcohol Strategy**

The Drug & Alcohol Strategic Commissioning Lead, Shropshire Council presented an overview of the Drug and Alcohol Strategy, outlining the current service landscape, key data trends and ongoing projects. The Board noted that Shropshire was experiencing the highest number of adults in treatment to date, with more than 1,700 individuals currently receiving support and an increase in young people accessing services. This reflected national and regional trends.

A shift in substance use was reported, with opiate use declining and alcohol and cocaine use increasing among adults. It was further noted that a higher proportion of young people in Shropshire seek support for alcohol compared with national and regional averages.

The number of individuals successfully completing treatment, as well as those disengaging, was rising. Retaining adults during the first 12 weeks of treatment remained a particular challenge.

Members were informed that preparations were underway for recommissioning the service, with a new contract expected to commence in April 2027. Engagement with service users and professionals was ongoing to inform the service specification.

Key projects reported included the RESET service for rough sleepers, community detox initiatives, a review of drug and alcohol-related deaths, and the Blue Light Project aimed at frequent A&E attenders. Work continued to focus on harm reduction, early intervention and education, supported by recent well-attended webinars on ketamine and alcohol.

Challenges highlighted during discussion included data-sharing limitations, engagement with informal community groups, and the need for more integrated work across mental health and education sectors.

The Board emphasised the importance of aligning the strategy with neighbourhood health frameworks, prevention, early intervention and improved data and cross-sector collaboration.

Members raised a number of questions regarding the Drug and Alcohol Strategy. It was noted that the reason why alcohol use among young people in Shropshire was higher than elsewhere remained unclear and was under investigation, with ease of access identified as a possible factor.

A query was raised about the decline in the proportion of adults successfully completing treatment. It was reported that work was ongoing to strengthen engagement and re-engagement processes.

Members asked whether the service liaises with informal urban groups such as rangers or street pastors. It was confirmed that engagement does take place for intelligence-gathering and support.

Questions were raised about how to reach individuals not currently accessing services and promote earlier intervention. It was noted that strengthening harm-reduction and education would be a core focus of recommissioning.

Members asked whether alcohol use among young people could be analysed by locality and whether there was enforcement around alcohol sales. It was confirmed that granular locality data was available and that collaboration with licensing and A&E departments continued. Education and training in schools would be prioritised in future commissioning.

A query was raised regarding pathways between services and A&E and whether data could be used to cross-reference health inequalities. Support for this approach was welcomed, and work was underway to improve pathways and adopt more intelligence-led methods.

Members asked about managing risks for individuals not yet ready for treatment. Training webinars for professionals have been introduced to support these individuals and help build readiness for treatment.

Questions were raised about addressing physical health needs, such as respiratory conditions, within future specifications. Integrated approaches were being developed, including health checks and social prescribing.

A query was raised about engagement with education settings and the sharing of locality data. It was confirmed that detailed data would be included in the JSNA and was available for cross-referencing.

Members asked whether rates, rather than counts, could be used in comparative data. It was confirmed that rate-based comparisons with statistical neighbours were possible through the national drug treatment monitoring system.

The importance of linking the strategy to neighbourhood health frameworks and locality working, including improving referral routes and service awareness, was emphasised and supported by the Board.

RESOLVED:

To note the contents of the report.

55 Mental Health – Suicide Prevention

The Public Health Consultant for Shropshire Council presented an update on suicide prevention work within the county. It was reported that Shropshire continued to experience a higher-than-average suicide rate, the highest within the West Midlands region, with 119 deaths recorded in the most recent three-year reporting period.

Key risk factors associated with suicide were outlined, including relationship breakdown, bereavement, economic pressures, and the impact of both mental and physical health issues. Members were informed that real-time surveillance activity had expanded to 20 partner organisations, enabling earlier identification of concerns and more coordinated responses.

The Suicide Action Group had refreshed its action plan in 2025. The plan prioritises increasing community visibility, reducing stigma, and strengthening local support options. As part of this approach, the Orange Button Community Scheme had expanded, with 171 volunteers recruited across Shropshire.

Updates were provided on ongoing communication and engagement efforts. These include participation in market town events, collaboration with the Samaritans, and the distribution of the “Pick up the phone, you’re not alone” Z-card.

A Member asked whether GP-held information could be utilised to assemble a risk matrix to identify individuals at heightened risk of suicide. In response, it was explained that risk assessment alone was not a reliable predictor, as individuals may present with recognised themes but not take their life, and vice versa. The recommended approach was the use of safety planning, as set out in NHS England’s *Staying Safe from Suicide* guidance.

A query was raised regarding the distribution of signs for help services at locations where suicide attempts occur, and the extent of communication and coordination between local and national support organisations. It was reported that signage was more complex than it appeared, requiring evidence of incidents at specific sites. Although data on suicide attempts remained limited, work with emergency services was ongoing to improve this. It was confirmed that signage was important and was being explored, together with strengthened links with organisations such as the Samaritans.

A Member sought information on available data relating to agricultural workers and farmers, including employment-related pressures, rurality, cost-of-living impacts, and links to military and ex-military communities. The detailed nature of the questions was

acknowledged, and it was confirmed that further information would be provided outside of the meeting.

A request was made for social prescribers and care coordinators to receive the *"Pick up the phone, you're not alone"* Z-card for signposting and training purposes. It was confirmed that the cards were currently being refreshed ahead of Mental Health Awareness Week and would be distributed accordingly, including to social prescribers and care coordinators.

A Member asked about investment in the voluntary sector to support crisis and prevention work, and how voluntary sector data and involvement would be incorporated into neighbourhood development. In response, the crucial role and efficiency of the voluntary sector were acknowledged, and a commitment to continued involvement and investment was confirmed.

It was noted that domestic abuse was not referenced in the national suicide prevention guidance, despite its significant correlation with suicide risk. The importance of survivor engagement and sustained dialogue in shaping future work was emphasised.

RESOLVED:

To note the recommendations contained within the report along with the call to action which included:

- promoting the adoption of safety planning approaches;
- supporting the delivery of suicide prevention training;
- endorsing continued development of the Orange Button scheme; and
- extending the local suicide prevention strategy to align with emerging national priorities.

56 **SEND JSNA**

The Business Intelligence and Insight Manager gave a presentation on the SEND Joint Strategic Needs Assessment (JSNA), a partnership-led piece of work developed across all system partners. The JSNA was structured into eight chapters to support a clear and holistic understanding of children and young people with special educational needs and disabilities in Shropshire. Its purpose was to inform the planning and development of local services, reduce health inequalities through early intervention and prevention, and support delivery through community and family hubs and neighbourhood health initiatives.

The assessment highlighted that over half of the population lived in rural areas, resulting in longer travel times to schools and significant deprivation in access to services. It was reported that 8,653 school-age children have SEND, representing almost 20% of the school-age population, with higher prevalence among males and a concentration within the 11–15 age group. Since the pandemic, there had been a 78% increase in the number of children with Education, Health and Care Plans. Mapping of SEND children living in rural areas was presented, demonstrating implications for cross-border support arrangements.

The most prevalent primary need identified was social, emotional and mental health, followed by speech, language and communication needs. The number of children identified with autistic spectrum disorder had doubled since 2019–20. Educational outcomes for children with SEND were reported to be lower than for their peers, with

higher absence rates as levels of need increase. However, it was noted that most 16–17-year-olds with SEND remain in education or training, exceeding national and regional averages. An increase in the number of SEND children being home educated was also highlighted.

The assessment reported rising numbers of vulnerable children, including those subject to child in need plans and child protection plans, particularly among children with Education, Health and Care Plans. The number of care leavers with SEND has doubled since 2020. Health data showed a higher proportion of males on GP learning disability registers, predominantly aged 15 and over, with clear deprivation gradients and common comorbidities including epilepsy, asthma and obesity. Oral health concerns were also identified, including tooth decay and extractions.

The Director of Children's Services welcomed the inclusion of health and social care data, noting that this had strengthened system-wide conversations and contributed to a more rounded understanding of the needs of children and young people with SEND.

RESOLVED:

To note the recommendations contained in paragraph 2 of the report.

57 BCF – Q3 template

The Service Manager (Commissioning, Quality Assurance and Business Development) for Shropshire Council introduced this item. She informed the Board that approval of the Better Care Fund quarter three template was retrospective due to misalignment with NHS England reporting timescales. It was reported that Shropshire remained on track to meet all national Better Care Fund headline metrics, including emergency admissions, delayed discharges and long-term residential admissions.

The Board were advised that future integration of Better Care Fund planning would align with neighbourhood health planning, providing opportunities for strengthened system collaboration and delivery of shared strategic priorities, although further detail was awaited from the NHS for 2027–28. It was further noted that the Better Care Fund settlement value for 2026–27 remains unchanged from 2025–26, which may result in inflationary pressures.

RESOLVED:

To approve the Better Care Fund 2025–26 quarter three template.

58 Cardiovascular, Renal, and Metabolic (CVRM)

The Director of Strategy and Development at NHS STW introduced this item and gave an update on the Cardiovascular, Renal and Metabolic (CVRM) strategy, which outlined a shift towards a multimorbidity approach by aligning cardiovascular disease, diabetes, hypertension, heart failure and renal disease strategies into a single framework. It was reported that the strategy was approaching the end of its first year, with a detailed report on outcomes and implementation progress to be brought to a future meeting.

The Board was advised that dashboards to monitor key performance indicators were in development. These would focus on prevention activity, including smoking cessation, and measure impacts on kidney disease, hypertension and hospital outcomes such as bed usage and length of stay. Early indications suggested improvements in outcomes, particularly in relation to diabetes-related amputation rates.

During discussion, the Board emphasised the importance of monitoring both health outcomes and impacts on urgent and unplanned care, highlighting the need for integrated, multi-morbid management and the involvement of public health. It was clarified that the recommendations sought endorsement of the strategy and year one milestones, rather than the delivery plan, which would be presented at a later date.

RESOLVED:

To endorse the CVRM strategy; to approve the associated governance arrangements and year one milestones; and to support the development of neighbourhood action plans and the approach to dashboard monitoring.

59 **ShIPP Update**

Members noted the ShIPP update.

60 **Pharmacy updates – for information**

Members noted the Pharmacy updates.

61 **For information on Health Overview & Scrutiny Committee**

Noted.

AOB

The Director of Strategy and Development at NHS STW highlighted the launch of the Neighbourhood Health Framework and advised that a summary would be circulated to Board Members.

<TRAILER_SECTION>

Signed …… (Chair)

Date:

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**					
Title of report	**Strategic Alignment of Neighbourhood working in Shropshire**					
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, Director of Public Health & Interim Deputy Chief Executive, Shropshire Council**					
Which Joint Health & Wellbeing Strategy priorities does this report address?	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?	Neighbourhood working is expected to have a positive impact on reducing inequalities by improving access, experience and outcomes for communities with higher levels of need. This includes rural and deprived communities, children, young people and families, people with mental health needs, frail older people and people living with long-term conditions. The approach should support earlier intervention, targeted outreach, more culturally appropriate and community-led solutions, and stronger place-based action to reduce variation in access and outcomes.					

1. Executive Summary

This paper asks the Board to support the development of a single Shropshire neighbourhood framework and roadmap. The approach builds on previous work started by the Board around the "one Shropshire approach" with existing activity across neighbourhood health, Place Universal Offer (PUO), Youth Transformation, Community and Family Hubs, prevention funding, Children's National reform, Adults' transformation, outreach, Shropshire Local, libraries and VCSE infrastructure. It aligns to national and local ambitions including for example the ICB five-year strategic commissioning plan and Shropshire Councils Corporate Plan and wider partners plans. Digital, data, estates and workforce will act as underpinning enablers of delivery rather than standalone programmes.

The key issue is not whether neighbourhood working should progress, but how Shropshire brings related programmes together into one coherent model that improves access, reduces duplication, strengthens prevention and supports better outcomes for residents. This is particularly important given Shropshire's rural geography, dispersed communities, ageing population, access challenges and variation in local need.

There is already strong progress, including developing Integrated Neighbourhood Teams (INT), Community and Family Hubs including one Health and Wellbeing Centre, growing hub activity including Best Start in Life (BSIL) Hubs, positive resident feedback, and early case study evidence of coordinated support helping people and families access help earlier. However, delivery is currently spread across several programmes and would benefit from a shared framework, there are a few agreed neighbourhood footprints or geographies (of which this may vary depending on the service or focus of work), clear governance, aligned resources and a common outcomes approach.

The Board is therefore asked to agree the strategic direction, support the next phase of alignment work, and request a future decision report setting out the preferred neighbourhood model, governance arrangements, resource implications, delivery roadmap and implementation approach

2. Recommendations

- Note the Health and Wellbeing Board's statutory leadership role in shaping a locally owned Shropshire Neighbourhood Health Plan.
- Agree the strategic direction towards a single Shropshire neighbourhood framework and roadmap, aligned to the national Neighbourhood Health Framework & NHS 10-year plan, Joint Health & Wellbeing Strategy, ShIPP priorities and wider place-based priorities including national children's reforms.
- Support the next phase of work to align existing programmes, governance, resources and delivery arrangements.
- Request a future decision report setting out the preferred model, governance arrangements, resource implications, delivery roadmap and implementation considering the need for a flexible needs led approach.

3. Report

The May 2026 introduction paper set out the national Neighbourhood Health Framework and the Health and Wellbeing Board's role in shaping a locally owned Neighbourhood Health Plan. This paper builds on that foundation by focusing on how Shropshire can align existing neighbourhood-related activity into a coherent delivery framework.

For Shropshire, our approach must reflect the county's rural geography, market towns, dispersed communities, access and transport challenges, increasing complexity of need and aging population. The approach should organise support around natural communities and local relationships, rather than organisational boundaries.

The focus now is to connect existing programmes and reforms into a single local roadmap. This includes:

- Integrated Neighbourhood Teams, Community and Family Hubs and ShIPP prevention funding;
- Family First Partnership, Best Start in Life, Adult Social Care Transformation and Youth Transformation;
- Outreach, Public Health prevention activity, Shropshire Local, Library and mobile offers; and
- VCSE-led community support.

This will need to be underpinned by the enabling conditions required for delivery, including shared data and insight, digital access and directories, workforce development and culture change, and effective use of estates and community assets.

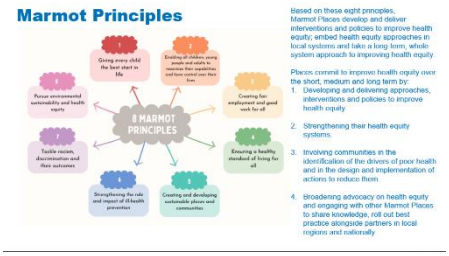
What Do We Mean by Neighbourhoods

For the purposes of this report, a neighbourhood is a recognisable local area or footprint that reflects natural communities, population need and existing local relationships. The presentation describes neighbourhoods as a “location with meaning”: places where people live, bring up their families, work, access support and spend their leisure time. In Shropshire, this means recognising rural geography, market towns, dispersed communities, local assets and the places residents already use to access support.

Our ‘One Shropshire’ approach reflects our collective understanding that neighbourhood working is broader than neighbourhood health alone. It is not a separate organisational structure or a building-based model alone. It is the primary delivery footprint for integrated, population-focused care and support, enabling partners to work together around people and communities rather than organisational boundaries, and to tailor support around how people live their lives.

In practice, Shropshire’s approach should:

- Provide a common geography for planning and delivery, aligned to natural communities and where appropriate to Primary Care Network (PCN) footprints
- Bring together health, local authority, providers, VCSE partners and communities as a connected “team of teams”.
- Support whole-person and whole-family approaches, with a focus on prevention, early help, proactive care and reducing inequalities.
- Use Community and Family Hubs, outreach, local assets and continuous community engagement as practical routes into support.
- Marmot approach - [Building fairer towns, cities and regions: Insights from Marmot Places | Local Government Association]



<u>The Shropshire model should therefore be built around</u>

- Integrated Neighbourhood Teams and stronger multidisciplinary working.
- Community and Family Hubs, BSIL, Primary Care and core public infrastructure assets as visible local access points.
- VCSE and community partners as equal and sustainable system partners.
- A test-and-learn approach, using local insight, population health data and learning from Shropshire’s National Neighbourhood Implementation Programme (NNHIP).
- Ask Assist Act (AAA) – How Can I Help. Shropshire Council, with local voluntary and community sector partners, has developed Ask-Assist-Act training for frontline practitioners and volunteers to support residents’ health and wellbeing. The training uses a nationally recognised Ask-Assist-Act approach and builds confidence in supporting person-centred conversations, understanding needs, and connecting residents to local services. It has been piloted ahead of wider roll-out and impact evaluation.

Current Position

There is strong system-wide support for neighbourhood working and broad agreement on the core features of the approach. Partners recognise the importance of local access points, VCSE partnership, stronger multidisciplinary working, prevention, early intervention and reducing inequalities.

Related programmes are already progressing across the system, including but not limited to Integrated Neighbourhood Teams, Community and Family Hubs, ShIPP prevention funding, Family First Partnership, Best Start in Life, Youth Transformation, Adult Social Care Transformation, Shropshire Local outreach, early help and VCSE-led community support.

The current challenge is that these programmes are not yet consistently aligned through a single vision, roadmap, governance route or shared delivery plan. This creates risks of fragmented delivery, duplication, unclear accountability, inconsistent use of resources and limited collective impact.

Programme area	**Partner Lead**	**Contribution to neighbourhood working**	**What alignment means for the Board**
Integrated Neighbourhood Teams / NNHIP	System Partners	Supports multidisciplinary working, proactive care, population health management and better coordination for people with complex needs, frailty and long-term conditions.	Provides the health and care delivery architecture for neighbourhood working and supports the locally owned Neighbourhood Health Plan.
Community and Family Hubs	Shropshire Council	Provides visible local access points for prevention, early help, family support, adult support, health visiting, social care advice, housing, employment and community activity.	Enables a practical hub-and-spoke model that improves access, reduces duplication and supports all-age neighbourhood delivery.
ShIPP prevention funding and VCSE infrastructure	ShIPP / VCSA	Strengthens community capacity, supports voluntary and community sector delivery, and enables targeted prevention activity shaped around local need.	Positions the VCSE as a core partner and supports a more equitable prevention offer across Shropshire.
Best Start in Life, Family First and SEND reform	Shropshire Council / NHS partners	Aligns children's services, early help, family support, parenting, home learning, SEND and whole-family support through local hubs and neighbourhood pathways.	Supports early intervention, improved family outcomes and clearer alignment between children's transformation and neighbourhood delivery.
Adult Social Care Transformation	Shropshire Council	Supports pre-front door, front door and demand management approaches through earlier advice, strengths-based support, Let's Talk Local, carers support and links to community assets.	Connects prevention and independence with neighbourhood delivery, helping reduce escalation and support people to remain well at home.
Public Health prevention, outreach and health inequalities work	Shropshire Council Public Health	Brings prevention, JSNA insight, health checks, vaccination and immunisation opportunities, mental health, substance misuse, sexual health and wider determinants into neighbourhood planning.	Ensures the framework is evidence-led, inequalities-focused and linked to population health outcomes.
Shropshire Local, libraries, mobile and outreach offers	Shropshire Council	Uses trusted local access points, library transformation, digital and face-to-face support, mobile provision and outreach to reach rural and dispersed communities.	Supports improved access, particularly in rural areas, and helps balance building-based provision with outreach.

Underpinning enablers: digital, data, estates and workforce	System partners led by NHS STW	These are not standalone programmes. They enable delivery by supporting shared insight, digital directories and access routes, workforce development, culture change, estates alignment, co-location and better use of existing public and community assets.	Ensures the neighbourhood model is deliverable in practice and that programmes are supported by the practical infrastructure needed to work as one system.

Next Steps

The proposed direction of travel is to establish a single Shropshire neighbourhood framework and roadmap, bringing existing programmes into a clearer delivery architecture with Programme Management support and oversight through existing governance routes to Health & Wellbeing Board. This should support consistent countywide priorities while retaining flexibility for local footprints, natural communities and levels of need.

This would include three linked areas of work:

- A shared framework and roadmap that defines neighbourhood & community footprints locally, sets out intended outcomes, and links clearly to HWBB priorities, ShIPP, the JSNA and the Joint Health and Wellbeing Strategy.
- Aligned delivery programmes that bring together Integrated Neighbourhood Teams, Community and Family Hubs, ShIPP prevention funding, outreach, early help, Family First Partnership, Best Start in Life, SEND reform, youth transformation, Adult Social Care Transformation, Public Health prevention activity, Shropshire Local, libraries, mobile and outreach offers and VCSE-led community support into a more coherent local offer.
- Underpinning enablers for delivery including workforce, data, digital, estates, community engagement, financial alignment and shared evaluation. These should support and enable delivery across the neighbourhood model, rather than being treated as separate standalone programmes.

Taken together, this would create a single, recognisable neighbourhood offer for residents and partners, reduce duplication, improve access and experience, and provide clearer accountability for delivery and outcomes.

The framework should be underpinned by:

- a shared STW system-wide purpose and agreed principles;
- commitment to working together in the best interests of residents;
- shared leadership and governance;
- a shared population health approach using data and local insight;
- collaboration rather than single-service delivery;
- reduced duplication and reliance on short-term solutions; and
- a willingness to cede control where appropriate to achieve better outcomes.

To support delivery, the framework should include both an operational alignment mechanism and a strategic governance route. The operational mechanism, potentially through the existing arrangements, would bring services together to identify requirements, map activity and assets, manage dependencies and avoid conflicting decisions. A strategic layer would provide oversight, resolve trade-offs, agree escalation routes and ensure that statutory responsibilities are recognised where they need to take precedence. This will require all relevant services and partners to actively contribute to the alignment work and may require dedicated coordination capacity to maintain momentum.

The intended approach is an all-age, life-course approach that provides a practical front door to universal, prevention and early help services for children, families, adults and older people. It should also support:

- integrated multidisciplinary working for children, families and adults with more complex needs;
- support for people living with long-term conditions, frailty and escalating risk; and
- outreach and mobile offers for rural communities where transport, digital access and distance from services can create barriers.

Next Steps:

- Develop a draft Shropshire neighbourhood framework and roadmap.
- Engage with wider partners and stakeholders
- Map existing programmes, activity and investment, including Community and Family Hubs, Integrated Neighbourhood Teams, Best Start, Family First, Youth Transformation, Adult Social Care Transformation, Public Health prevention, outreach and VCSE-led community support, alongside the underpinning enablers required for delivery, including estates, digital, data and workforce.
- Develop a proposed governance model, including roles, responsibilities and reporting routes.
- Assess delivery implications, including the underpinning workforce, estates, digital, data and VCSE infrastructure requirements.
- Develop a shared outcomes and evaluation approach, drawing on JSNA, service data, resident feedback, activity data and case study evidence.
- Establish an operational alignment process through existing structures to map service requirements, assets, activity, risks and dependencies, with escalation into the agreed strategic governance route where alignment cannot be achieved.
- Return with a formal decision paper setting out the preferred model and implementation approach.

Risk assessment and opportunities appraisal	The main risk is that neighbourhood-related programmes continue to develop separately, leading to duplication, inconsistent access, unclear accountability and reduced collective impact. There is also a risk that delivery expectations exceed available capacity, particularly where coordination, data, estates, workforce and VCSE infrastructure are required to support implementation. These risks will be mitigated through a single framework and roadmap, clearer governance and escalation routes, shared use of data and insight, and continued engagement with communities and partners. The approach presents a significant opportunity to improve access, strengthen prevention, reduce inequalities and make better use of existing local assets and relationships.
Financial implications	There are no immediate financial decisions requested through this paper. The next phase of work will need to map existing investment, resources and delivery capacity across relevant programmes, including health, local authority, VCSE, estates, digital, data and workforce requirements. A future decision paper will set out any resource implications, opportunities for alignment, potential efficiencies and any additional capacity required to support delivery.
Climate Change Appraisal as applicable	The proposed approach has the potential to support positive climate impacts by improving access to local support, making better use of existing community and public sector assets, and reducing unnecessary travel where services can be delivered closer to home or through outreach, mobile and digital routes. Further work will consider estates, transport, digital inclusion and community access implications to ensure that delivery supports both

	environmental sustainability and equitable access across rural and dispersed communities.	
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	

List of Background Papers

- Shropshire Health and Wellbeing Board Neighbourhood Health introduction paper, May 2026.
- NHS Neighbourhood Health Framework and NHS 10 Year Health Plan.
- Shropshire Joint Health and Wellbeing Strategy.
- Shropshire Integrated Place Partnership priorities and prevention funding papers.
- Shropshire Integrated Care Board Five-Year Strategic Commissioning Plan.
- Shropshire Council Corporate Plan.
- Joint Strategic Needs Assessment and local inequalities evidence.

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

Cllr Ruth Houghton, Portfolio Holder for Adult Social Care and Health
Cllr Rosie Radford, Deputy Portfolio Holder - Adult Social Care and Health

Appendices
N/A

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	9th July 2026						
Title of report	Healthwatch Shropshire reports: 'Access to Medication in Shropshire' and 'Veterans' Experiences of Accessing Healthcare in Shropshire'						
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	Lynn Cawley – Chief Officer Healthwatch Shropshire lynn.cawley@healthwatchshropshire.co.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	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?	Digital, rural and the experience of veterans						

Report content:

Due to the timing of this meeting, Healthwatch Shropshire (HWS) is bringing two reports to the Board. The first is the 'Access to Medication in Shropshire' Report that was triggered by feedback shared with HWS by Shropshire Councillors regarding ongoing concerns raised by their constituents around timely and efficient access to often lifesaving medication as a result of increasing demands on pharmacy staff, including the impact of 'Pharmacy First' and closure of the Prescription Ordering Direct service by NHS Shropshire, Telford and Wrekin to be replaced by increased use of the NHS App.

The second report is the result of our work with Shropshire Council's Armed Forces Outreach team to enable us to speak to veteran's face to face about their experiences of NHS services and the impact if any, of initiatives like 'Veteran Aware' hospitals and 'Veteran Friendly' GP practices.

1. Executive Summary

Healthwatch Shropshire undertook targeted engagement with veterans across Shropshire during July–August 2025 to understand their experiences of accessing healthcare services. Working alongside the Shropshire Council Armed Forces Outreach team, Healthwatch gathered feedback from 25 veterans attending community outreach sessions across the county. The findings provide an important insight into how effectively local health services are meeting the needs of veterans and fulfilling commitments under the Armed Forces Covenant.

The report highlights that veterans' experiences of healthcare are mixed. While many participants spoke positively about individual staff, local mental health services and the support provided through Armed Forces Outreach, there were recurring concerns about inconsistency, poor communication between services, lack of awareness of entitlements, and over-reliance on veterans having to advocate for themselves.

The strongest theme identified was confusion surrounding identification as a veteran. Many veterans reported they did not understand why they should disclose their veteran status, what practical difference it would make, or whether doing so improved access to services. Some participants stated they had never been asked about military service by healthcare providers, while others reported inconsistent recognition of their veteran status between GP practices and hospitals. Veterans also described frustration with the complexity and inconsistent use of NHS coding systems relating to veteran status, with many questioning whether the coding delivered any meaningful benefit in practice.

A further key finding was the lack of reliable information sharing between healthcare providers. Veterans reported that important information, including veteran status, PTSD diagnoses and service-related conditions, was not always visible across different parts of the NHS. This often resulted in individuals repeatedly having to explain traumatic experiences or advocate for their needs during referrals and treatment pathways. Participants highlighted that such processes can be particularly difficult for those experiencing mental ill-health or crisis.

The report also identified gaps in awareness and understanding of veterans' healthcare entitlements, both among veterans themselves and frontline healthcare professionals. Veterans described receiving inconsistent advice regarding priority treatment, prescription exemptions and access to specialist support services. Those transitioning from military to civilian life reported particular difficulties accessing healthcare during discharge periods, with some describing situations where neither military nor civilian services accepted responsibility for their care.

Healthwatch Shropshire concludes that current systems too often rely on veterans to self-identify and self-advocate. This creates a risk that the most vulnerable individuals — particularly those who are isolated, unwell or experiencing mental health difficulties — are least likely to access the support available to them.

NHS Shropshire, Telford and Wrekin Integrated Care Board welcomed the report and formally supported the recommendations. The ICB recognised the need for improved understanding of veterans' healthcare entitlements, more effective identification processes, and stronger implementation of "Veteran Friendly" and "Veteran Aware" standards across local healthcare services.

2. Recommendations

The report makes six key recommendations for local health and care partners:

1. Introduce routine identification of Armed Forces service across GP practices, hospitals and community services.
2. Simplify and standardise the recording of veteran status within NHS systems.
3. Improve communication and information sharing between GP and hospital services.
4. Strengthen staff understanding of veterans' healthcare entitlements and improve public information for veterans.
5. Improve support and continuity of care during transition from military to civilian life.
6. Build on existing good practice locally, particularly specialist outreach and mental health support.

3. Report: links to both reports here:

HWS Access to Medication in Shropshire

HWS Veterans' Experiences of Accessing Healthcare

Risk assessment and opportunities appraisal		
Financial implications		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
List of Background Papers: as above – **HWS Access to Medication in Shropshire** **HWS Veterans' Experiences of Accessing Healthcare**		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead **-**		
Appendices Appendix A. Healthwatch update – presentation		

This page is intentionally left blank

Report 1: Access to Medication in Shropshire

healthwatch Shropshire

Background and Purpose:

In 2019 Pharmacists told us of '**national concern** about the stress on Pharmacists with increased responsibility, increased disturbances throughout the day."

Early 2025 we reported on the **impact of the introduction of Pharmacy First** in early 2024. Aswell as positive experiences we heard about 'the impact the additional demand on pharmacy staff was having on waiting times for prescriptions to be dispensed'

Later in 2025 local Councillors reported ongoing concerns from Shropshire residents about delays in getting medication and the POD service closed

Previous reports by HWS

- Experiences of accessing Primary Care Services in Shropshire | Healthwatch Shropshire (2020)
- Shropshire Pharmacy services and Consultations | Healthwatch Shropshire (2025)

"Patients are understandably very concerned as their health, and in some cases, their lives depend on timely access to medication." Shropshire Councillor

So what?

healthwatch Shropshire

Key findings:

- **45%** said the **NHS App** made ordering and receiving prescriptions *quick and easy*.
- **20%** praised the **speed and helpfulness** of their local pharmacy.
- **20%** reported **unacceptable waiting times** for prescriptions to be processed or collected.
- **10%** described the **prescribing system as confusing or inefficient**.

A small number of responses described **multiple pharmacy trips**, stock issues and communication gaps.

Recommendations:

1. **Improve waiting times** and reduce delays (e.g. between prescription and dispensing)
2. **Address system inefficiencies**, (e.g. communication, information sharing)
3. **Explore ways to reduce stock shortages** leading to multiple trips
4. **Address variation in experience** across different pharmacies and areas (e.g. out of hours services)
5. **Address health inequalities** and improve information for the public (e.g. entitlements and use of technology)

Report 2: Veterans' Experiences of Accessing Healthcare in Shropshire

healthwatch Shropshire

Background and Purpose

Healthwatch Shropshire partnered with Shropshire Council Armed Forces Outreach Team

Face-to-face engagement was carried out across community outreach venues

25 veterans shared their views with us

Approximately 14,800 veterans live in Shropshire and 6,285 in Telford

NHS organisations have responsibilities under the Armed Forces Covenant

Veterans reported:

- Confusion about why they should identify as veterans
- Inconsistent recognition of veteran status across services
- Limited understanding of NHS veteran coding systems
- Inconsistent understanding of veterans' entitlements among professionals
- Poor communication between GPs and hospitals
- Repeated need to explain service history and traumatic experiences
- Gaps in support during transition from military to civilian life

Mental Health and Information Sharing

healthwatch Shropshire

Key Concerns Raised

Veterans highlighted:

- PTSD diagnoses and veteran status not always visible across services
- Distress caused by repeatedly recounting traumatic experiences
- Reliance on individuals to self-advocate
- Lack of awareness of specialist veteran services
- Risk that vulnerable veterans may "slip through the net"

Positive feedback was also received regarding:

- Local mental health services
- Armed Forces Outreach support
- Staff with specialist knowledge and lived experience

Key message:
Systems should not depend on veterans being well enough to navigate services independently

Recommendations

healthwatch Shropshire

Healthwatch Shropshire Recommendations

1. Make asking about Armed Forces service routine
2. Simplify recording of veteran status
3. Improve communication between GP and hospital services
4. Strengthen understanding of veterans' healthcare entitlements
5. Improve support during transition from military to civilian life
6. Build on existing good practice locally

Suggested organisational priorities:

- **Consistent identification processes**
- **Better information sharing**
- **Workforce awareness and training**
- **Improved veteran communications**
- **Stronger partnership working**

"Some [professionals] know about it, and some don't, and that's the problem." Veteran

NHS Response and System Commitment

NHS Shropshire, Telford & Wrekin ICB Response

The ICB welcomed the report and findings

Supported all six recommendations

Recognised need for:

- Better understanding of veteran healthcare entitlements
- Improved recording of veteran status
- Stronger implementation of Veteran Friendly and Veteran Aware standards

Commitments included:

- Continuing to promote Veteran Aware accreditation
- Working with primary care, trusts and VCSE partners
- Building on effective local practice and partnership working

I found the other day as I needed to check my medical records that my veteran status and PTSD diagnosis was right at the top of my medical record, it was great to see…

It would be really good to have a system that works and communicates as no one wants to introduce themselves as a diagnosis.

Conclusion and Board considerations

The report demonstrates that:

- Veterans value the care and support they receive
- Experiences remain inconsistent across the healthcare system
- Current systems rely too heavily on self-identification and self-advocacy
- Improved coordination and awareness could significantly improve access and outcomes

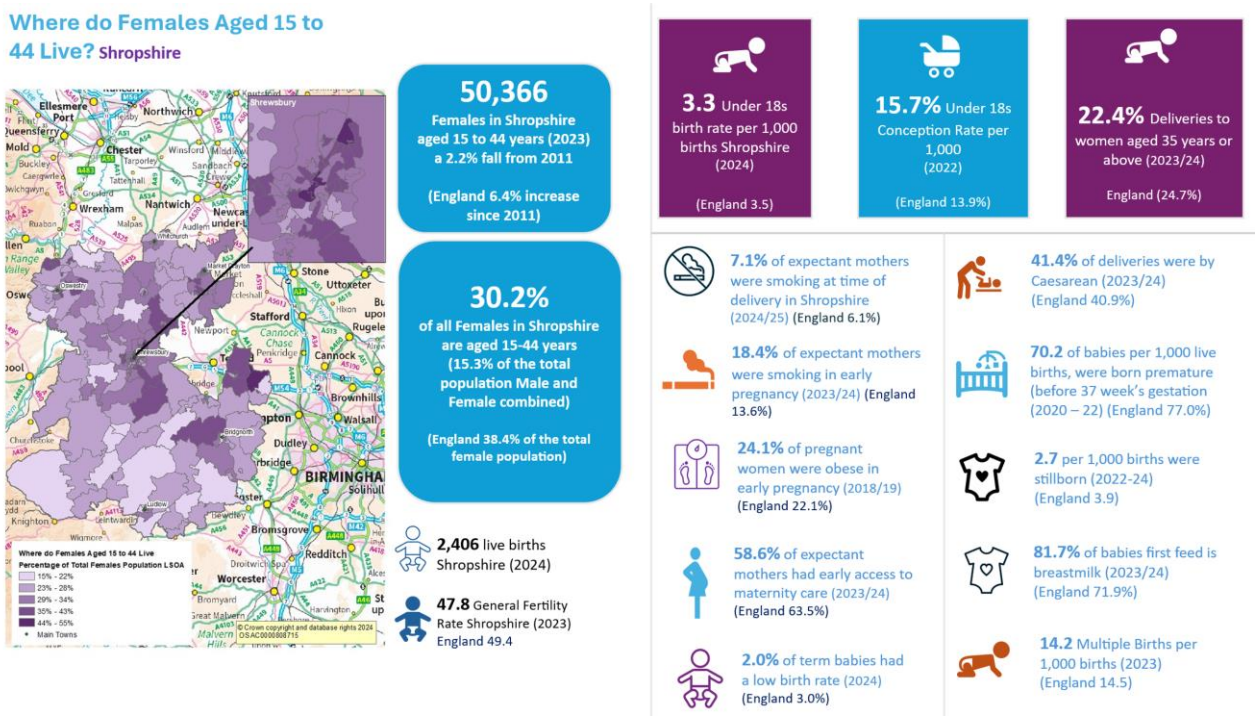
Board considerations:

- How can system partners strengthen identification of veterans?
- Are current information-sharing processes effective?
- How will veteran awareness be embedded across services?
- How can transition support and communication be improved?

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**						
Title of report	Children and Young People JSNA Chapter: Pregnancy and birth						
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	Jess.Edwards@shropshire.gov.uk Mark.Trenfield@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				
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities				
	Workforce		Reduce inequalities (see below)	x			
What inequalities does this report address?	Inequalities in health outcomes (physical and mental health), service provision, access and the conditions in which Shropshire's children are born, grow, live and learn. The following individual characteristics and societal factors have been addressed where data is available: - protected characteristics under the Equality Act 2010 -socio-economic status and deprivation -vulnerable or inclusion health groups -geography						

Report content:



1. **Executive Summary**

The JSNA provides a detailed understanding of the needs of children, young people and families in Shropshire to inform the direction and development of local services, with a view to reducing health inequalities through identification, prevention and early intervention. Due to the vast scope of this product, Shropshire's Children and Young people JSNA is structured as a 'JSNA pack', comprising of individual chapters for each stage of the life course:

Core JSNA chapters

1. Population and context for children and young people – published on Shropshire's website
2. Maternity (pregnancy & birth) – in progress focus of this report
3. Early Years (0-4 years) - published on Shropshire's website
4. School aged children (5-11 and 12-16 years) – in progress
5. Young people (16-19 years) – in progress

This report outlines several key indicators of pregnant women and newborn's health and wellbeing in Shropshire, including key health outcomes, measures of safety and welfare and wider health determinants. It is designed to support local discussions about key issues and challenges related to the health and wellbeing of children and young people.

This report has been thoroughly reviewed by the Early Help & Prevention Partnership Board and SEND Quality Assurance Group and were well received. Recommendations were jointly developed and are presented to the Partnership. We are seeking approval of the chapter and feedback and endorsement of the recommendations.

The chapter was presented in draft format at various boards in 2025, including the health and wellbeing board, but was not published as a review was taking place into maternity services. This review has now finished, and this chapter has been updated with new data where available.

2. Recommendations

Recommendations are based on the Areas of Need highlighted in the pregnancy and birth (Appendix 2, page 7):

1. To continue to monitor and reduce teenage conception rates
2. To increase the number of women who are booked by midwifery within the first 10 weeks of pregnancy
3. To continue to ensure that throughout pregnancy and giving birth, parents receive appropriate personalised care for their individual needs so that we are responsive to equality, diversity and inclusion.
4. To improve data collection of modifiable risk and vulnerability factors during pregnancy – to include excess weight, smoking status at booking, alcohol consumption, drug use, folic acid supplement use, healthy start vitamins, mental health, domestic abuse and neurodivergence and physical and learning disabilities.
5. To increase the rates of vaccination in pregnant women against influenza and pertussis
6. To increase access to services to support healthy pregnancy within local communities
7. To look into and address concerns raised where there are repeat pregnancies and where children become looked after within the same family unit
8. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.
9. To increase breastfeeding initiation rates, to achieve World Health Organisation Baby Friendly Initiative (BFI) accreditation
10. To continue to monitor and improve **infant mortality and stillbirth rates**, by addressing modifiable factors such as maternal obesity, smoking, safer sleeping, parenting support etc.

11. To monitor levels of referrals for early help from midwifery to ensure appropriate early support is provided to reduce the risk of escalation to statutory children's social care.

3. Report

Since April 2013, Local Authorities have been responsible for commissioning public health services for school-aged children. This presents new opportunities for bringing together a robust approach for improving outcomes for young people across both health and local authority led services.
This report outlines several key indicators of children and young people's health and wellbeing in Shropshire, including key health outcomes, measures of safety and welfare and wider health determinants. From this, areas of need have been identified from the evidence base and recommendations have been jointly produced with partners and stakeholders.

Objectives
Given the broad range of needs and services for pregnant women and newborns, this report is not an in-depth review of any one specific service but instead aims to provide an overview.
The objectives of this chapter of the Children and Young People's needs assessment therefore are to include the following:

- To describe the population profile of women of child-bearing age - please also see the Population and Context chapter
- To identify risk factors that impact on maternal, infant and child health outcomes - please also see the Population and Context chapter
- To provide an overview of the wider determinants of health and their impact on the pregnant women and new-borns- please also see the Population and Context chapter
- To identify relevant national guidance and local policy in relation to pregnant women and babies
- To provide an overview of the health and wellbeing of pregnant women and new-borns
- To provide an overview of current service provision and assessment of outcomes including gaps in relation to domains impacting on pregnant women and new-borns outcomes; physical, psychosocial and emotional, cognitive and language development
- To identify vulnerable, and/or at-risk groups
- To identify gaps, barriers, and unmet needs in current service provision
- To provide evidence-based recommendations to ensure that the needs of pregnant women and new-borns are met in Shropshire

The JSNA key findings for this age group are detailed below:

Doing well (lower or better than the national average)

- Premature births (less than 37 weeks' gestation) - has been significantly below England for the last 4 years and is the lowest in the West Midlands region

- Low birth weight of term babies – has been significantly below England for 4 out of the last 5 years and is the second lowest in the West Midlands region

- Low birth weight of all babies - has been below England since 2010 and has been significantly below England in the most recent year and is the lowest in the West Midlands region

- Baby's first feed breastmilk – has been significantly above England for the last 5 years since the definition of this was altered and is the highest in the West Midlands region

Areas for improvement (worse than the national average)

- Early access to maternity care – Shropshire's performance is significantly lower than the national average and the West Midlands region.

- Folic acid supplements taken before pregnancy – Shropshire's performance is significantly lower than the national average and has been for the previous 3 years, although there are concerns about the data quality issues affecting the numbers recorded.

- Smoking in early pregnancy - Shropshire's rates are significantly higher than both England and the West Midlands and is second highest in the West Midlands region, although there are concerns over the data quality for this indicator.

- Admissions of babies under 14 days. There seems to be a large data quality issue with this indicator as the Shrewsbury and Telford NHS Hospital trust did not submit complete HES maternity data for the financial year ending 2023

- Emergency admissions for gastroenteritis (0-4 years) - Shropshire's rate of emergency admissions is significantly higher than England and has been since 2012-13, apart from the year of the pandemic 2020/21 and is the seventh highest in the region.

Delivery of the JSNA recommendations will be undertaken and monitored and further updates on delivery and impact will be brought to the Partnership.

Risk assessment and opportunities appraisal	None	
Financial implications	None	
Climate Change Appraisal as applicable	None	
Where else has the paper been presented?	System Partnership Boards	• ShIPP • Early Health and Prevention Partnership Board • Children's Safeguarding Children Board • LMNS (Jan 25) • Health and Wellbeing Board (Feb 25)
	Voluntary Sector	
	Other	

List of Background Papers - NA

Cabinet Member (Portfolio Holder):
Cllr Ruth Houghton**,** Portfolio Holder for Health & Social Care (Adults), Shropshire Council

Appendices:
Appendix A. CYP JSNA Maternity chapter - presentation
Appendix B. CYP JSNA Pregnancy and birth chapter: Draft report
Members of HWBB: report provided separately as attachment, due to size of document
For public (through website): document can be provided on application to louisa.jones@shropshire.gov.uk

Shropshire Council

Children and Young People JSNA

Pregnancy and Birth Chapter

Key Findings

May 2026

Aims & objectives

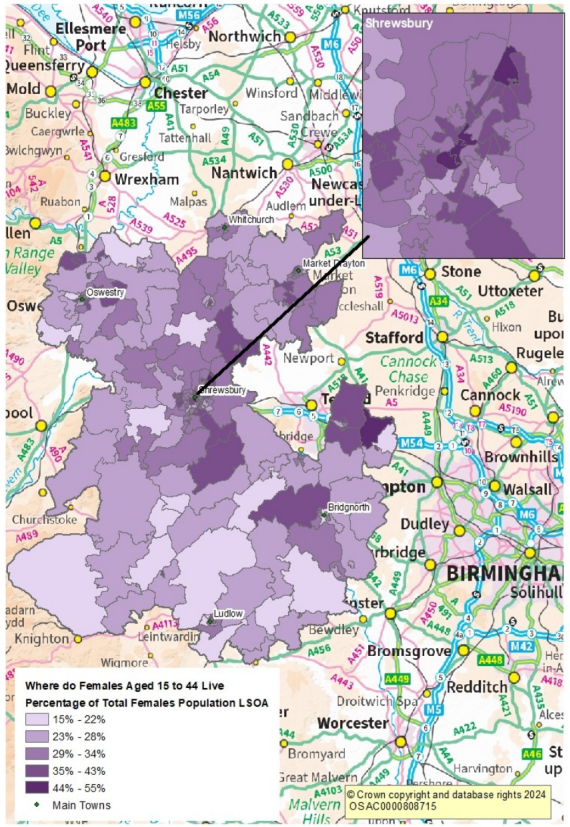
This JSNA chapter will provide a **detailed understanding of the needs of pregnant women and newborn babies in Shropshire to inform the direction and development of local services**, with a view to reducing health inequalities through identification, prevention and early intervention.

This report is not an in-depth review of any one specific service, but instead aims to:

- describe the **population profile** in Shropshire- please also see the Population and Context chapter
- provide an overview of the **wider determinants** of health and their impact on pregnancy and their babies- please also see the Population and Context chapter
- identify relevant **national guidance and local policy** in relation to pregnant women and babies
- provide an **overview of the health and wellbeing of pregnant women and babies**
- identify **vulnerable** and/or at-risk groups
- provide evidence-based **recommendations** to ensure that the needs of this population are met in Shropshire

Contents

Where do Females Aged 15 to 44 Live? Shropshire



50,366
Females in Shropshire aged 15 to 44 years (2023) a 2.2% fall from 2011

(England 6.4% increase since 2011)

30.2%
of all Females in Shropshire are aged 15-44 years (15.3% of the total population Male and Female combined)

(England 38.4% of the total female population)

2,406 live births Shropshire (2024)

47.8 General Fertility Rate Shropshire (2023) England 49.4

3.3 Under 18s birth rate per 1,000 births Shropshire (2024)

(England 3.5)

15.7% Under 18s Conception Rate per 1,000 (2022)

(England 13.9%)

22.4% Deliveries to women aged 35 years or above (2023/24)

England (24.7%)

7.1% of expectant mothers were smoking at time of delivery in Shropshire (2024/25) (England 6.1%)

18.4% of expectant mothers were smoking in early pregnancy (2023/24) (England 13.6%)

24.1% of pregnant women were obese in early pregnancy (2018/19) (England 22.1%)

58.6% of expectant mothers had early access to maternity care (2023/24) (England 63.5%)

2.0% of term babies had a low birth rate (2024) (England 3.0%)

41.4% of deliveries were by Caesarean (2023/24) (England 40.9%)

70.2 of babies per 1,000 live births, were born premature (before 37 week's gestation (2020 – 22) (England 77.0%)

2.7 per 1,000 births were stillborn (2022-24) (England 3.9)

81.7% of babies first feed is breastmilk (2023/24) (England 71.9%)

14.2 Multiple Births per 1,000 births (2023) (England 14.5)

Child and Maternal Health Fingertips Profile - Pregnancy and Birth Topic

Targets are the national average.

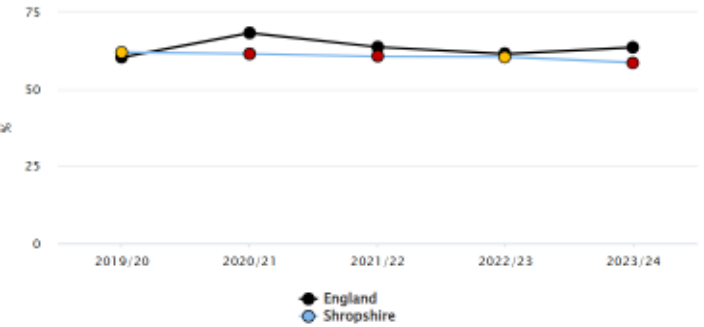
See the full report document for trends and comparator information for each of these metrics.

Indicator	Period	Shropshire			West Midlands	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Fertility and demographic information									
General fertility rate	2023	↓	2,427	47.8	53.0	49.4	30.8		67.2
Under 18s conception rate	2022	→	82	15.7	15.9	13.9	34.4		5.1
Under 18s births rate	2023	→	9	1.6	3.4	3.0	10.9		0.7
Deliveries to women aged 12 to 17	2023/24	→	-	*	0.6%	0.6%	-	*Insufficient number of values for a spine chart*	-
Deliveries to women aged 35 years and above	2023/24	→	65	22.4%*	21.2%	24.7%	14.2%		47.8%
Deliveries to women from ethnic minority groups	2023/24	→	10	3.4%*	34.6%	27.9%	2.1%		74.5%
Planning and preparation for pregnancy									
Early access to maternity care	2023/24	→	1,515	58.6%	61.2%	63.5%	16.6%		84.7%
Folic acid supplements taken before pregnancy ⚠	2023/24	↓	40	1.5%	8.0%	19.7%	0.5%		56.2%
Smoking in early pregnancy ⚠	2023/24	–	420	18.4%	13.0%	13.6%	-	*Insufficient number of values for a spine chart*	-
Obesity in early pregnancy ⚠	2023/24	–	-	*	28.7%	26.2%	-	*Insufficient number of values for a spine chart*	-
Smoking status at time of delivery	2024/25	↓	164	7.1%	6.2%	6.1%	13.2%		2.2%
Pregnancy and birth									
Stillbirth rate New data	2022 - 24	–	20	2.7	4.4	3.9	6.9		1.5
Premature births (less than 37 weeks gestation)	2020 - 22	–	547	70.2	82.6	77.0	106.8		52.3
Low birth weight of term babies	2024	→	44	2.0%	3.2%	3.0%	5.2%		1.7%
Low birth weight of all babies	2023	→	148	6.1%	8.1%	7.4%	11.2%		4.5%
Very low birth weight of all babies	2023	→	16	0.7%	1.3%	1.1%	2.4%		0.3%
Deliveries by caesarean section	2023/24	↑	120	41.4%*	40.2%	40.9%	56.2%		29.3%
Infant mortality rate	2022 - 24	–	29	3.9	6.1	4.2	8.7		1.2
Multiple births	2023	→	34	14.2	13.4	14.5	5.4		25.3
Admissions of babies under 14 days	2023/24	→	165	569.0*	99.4	88.7	679.2		16.3
Breastfeeding									
Baby's first feed breastmilk ⚠	2023/24	↑	1,720	81.7%	69.7%	71.9%	41.3%		94.3%
Breastfeeding prevalence at 6 to 8 weeks	2024/25	–	1,155	*	*	55.6%*	-	*Insufficient number of values for a spine chart*	-
Emergency admissions for gastroenteritis (0 to 4 years)	2023/24	→	125	88.7	80.3	67.6	243.2		12.6
Emergency admissions for lower respiratory tract infections (0 to 4 years)	2023/24	↑	295	209.4	201.6	207.7	486.3		80.9

The full report will go into depth for the ‘amber’ and ‘red’ indicators. Some of these are old data, but we have been able to get more up to date data

Source: Child and Maternal Health Profile, Fingertips, OHID

Early access to maternity care



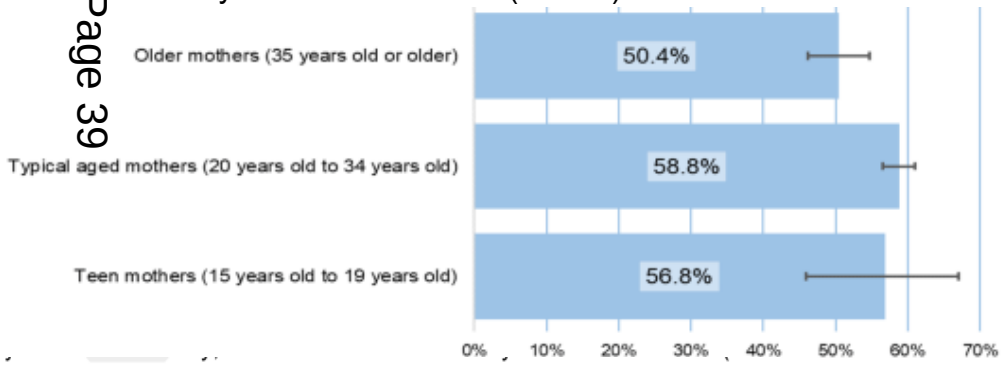
Recent trend: ➡ No significant change

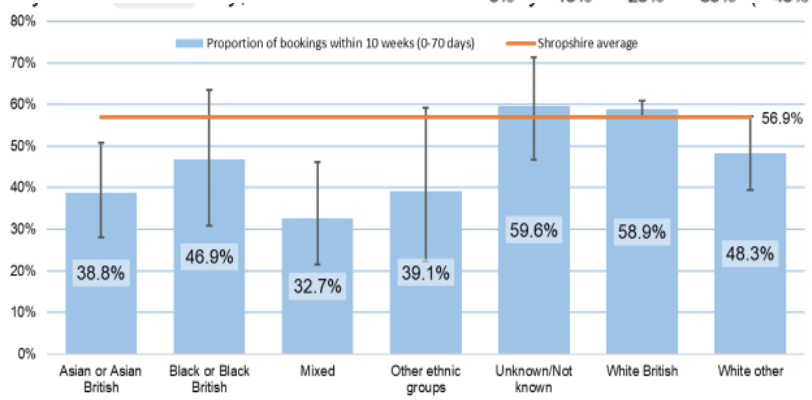
Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2019/20	●	1,710	62.0%	60.2%	63.8%	-	60.3%
2020/21	●	1,705	61.4%	59.6%	63.2%	-	68.2%
2021/22	●	1,615	60.6%	58.8%	62.5%	-	63.6%
2022/23	●	1,600	60.5%	58.5%	62.2%	-	61.4%
2023/24	●	1,515	58.6%	56.6%	60.4%	-	63.5%

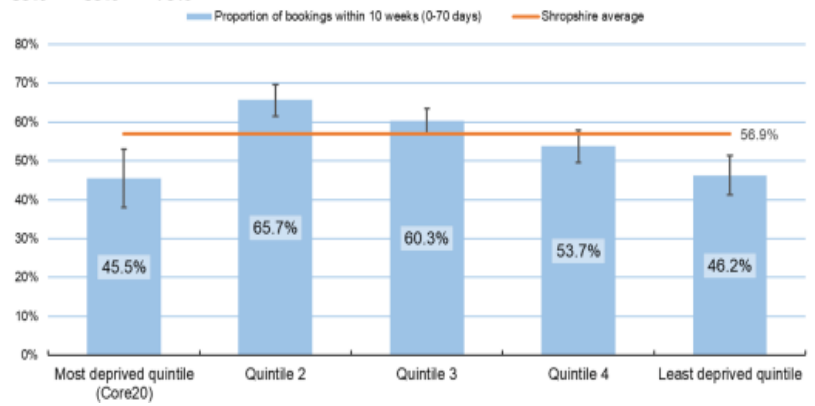
Source: OHID, based on NHS England data

Indicator Definitions and Supporting Information

Proportion of mothers recording their antenatal appointment within 10 weeks of gestation, 2023-24.
Source: Maternity Services Data Set (MSDS)







- 58.6% of pregnant women had their booking appointment with a midwife within 10 completed weeks of their pregnancy in 2023/24 - 1,515 pregnant women.
- **Significantly lower** than England's rate of 63.5% and the West Midlands of 61.2% and lowest among its statistical neighbours whose data was published.

Local analysis using 23/24 data from the national Maternity Services Data Set, identified 2,464 bookings, with 56.9% having the first booking appointment within 10 weeks.

- Statistically similar rates between those Under 20, those aged 20-34 and those aged 35+.
- Those with a White British ethnicity (59%), had a statistically similar rate to most other ethnicities.
- Mothers from the least and most deprived neighbourhoods, were the least likely to have recorded a booking within 10 weeks..

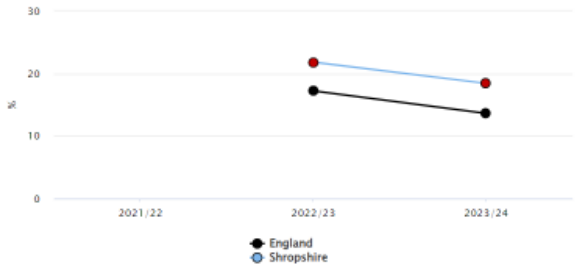
Further work needed to understand reasons

% Smoking in early pregnancy

The Shropshire profile does not show this as a ‘red’ but within the indicator, it shows that in 2023/24 Shropshire’s figure (18.4%) is significantly above England’s rate (13.6%) and West Midlands regional figure (13.0%) and is second highest among nearest neighbours, although there are concerns about the data quality of this indicator.

The LMNS maternity dashboard reports that 10.5% of mothers from Shropshire booked onto maternity services during the 2023-24 period were recorded as smokers at the time of their first antenatal booking. Further analysis of this showed:

- Significantly higher rate in those who were ‘White British’ (11%) and ‘White other’ (12%) compared to just 2% of mothers from all other ethnicities.
- Whilst teen mothers (aged under 20) were identified as having the largest rate (18%), there was no statistically significant different between those aged 20-34 (10.7%) and those 35 or over (8.8%), due to the smaller number of pregnancies in the teens
- Deprivation is a key driver of tobacco use with 26.6% of mothers from the most deprived quintile, significantly higher than other quintiles, compared to just 5% in the least deprived quintile.

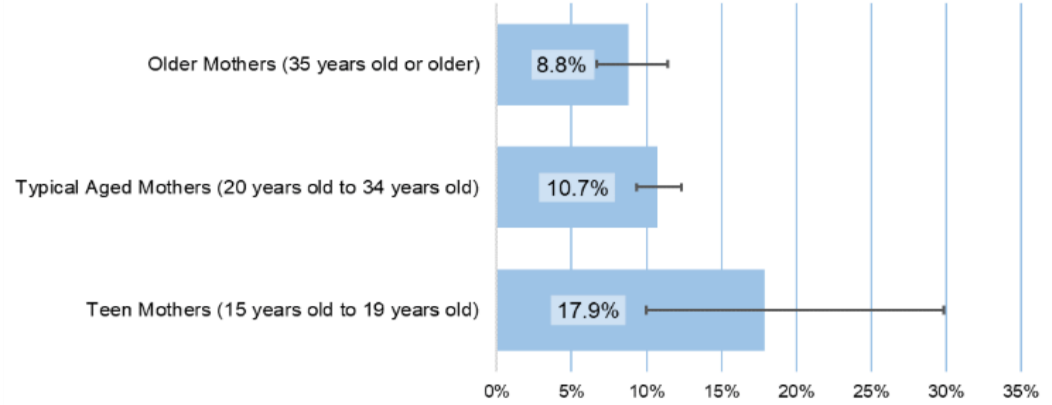


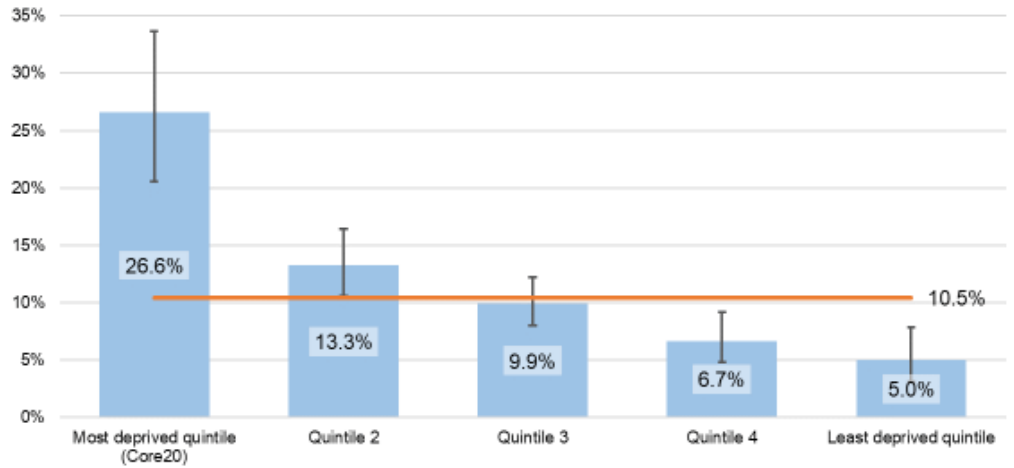
Recent trend: Could not be calculated

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2022/23	●	470	21.8%	20.1%	23.6%	17.0%	17.2%
2023/24	●	420	18.4%	16.9%	20.1%	13.0%	13.6%

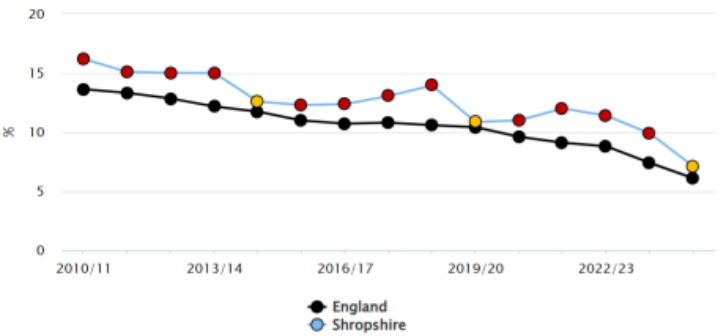
Source: OHID, based on NHS England data

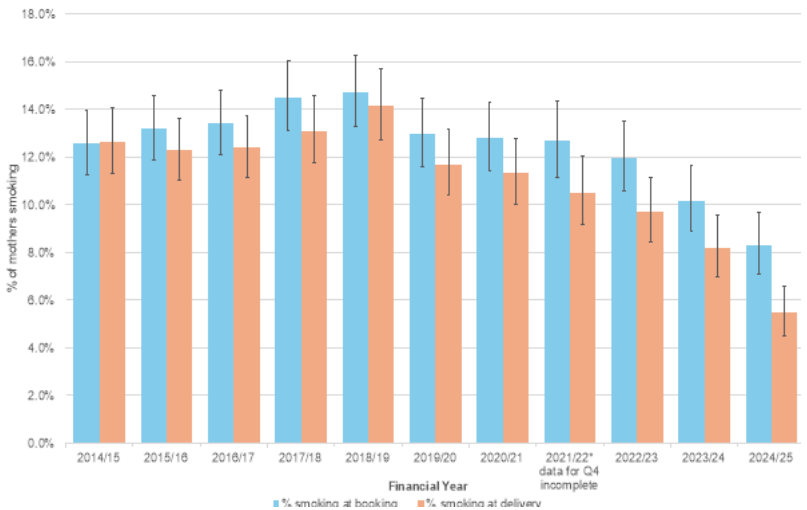
Indicator Definitions and Supporting Information

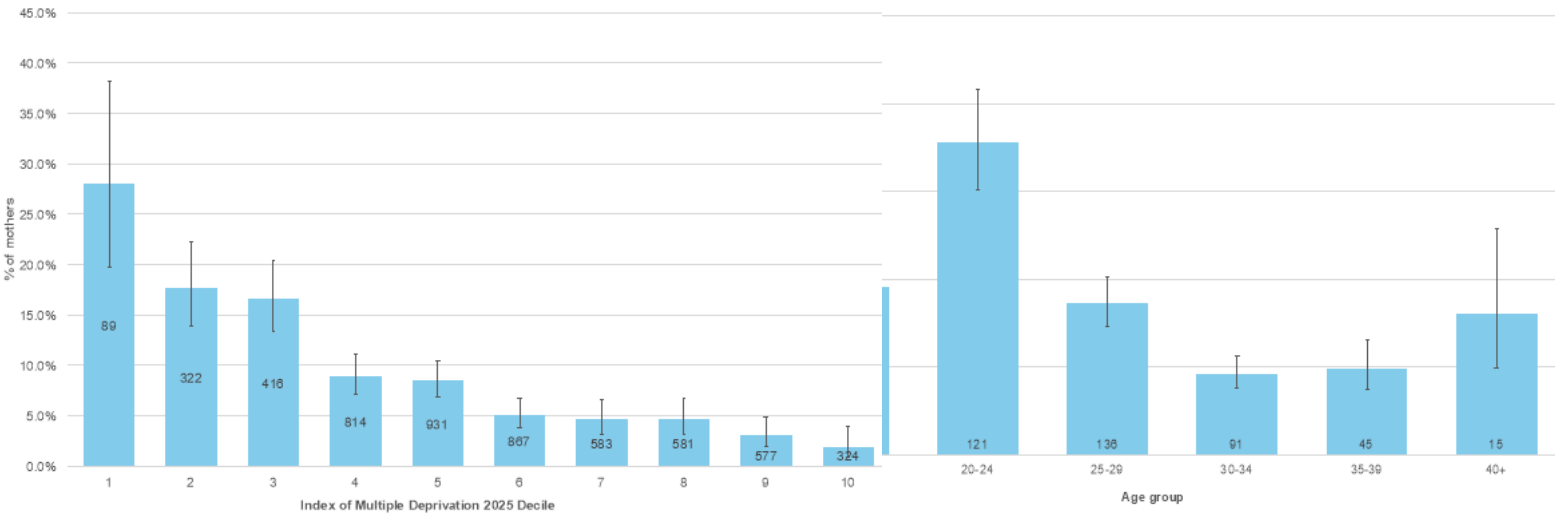




% Smoking status at time of delivery







- In 2024/25, Shropshire rate was 7.1%, which is statistically similar to England for the first time since 19/20.
- Shropshire is 5th highest in West Midlands, and 4th highest among its statistical neighbours.
- Shropshire has mostly been above the England rate since 10-11, this year's figure is lowest on record.

Data from SATH for those resident in Shropshire who delivered showed:

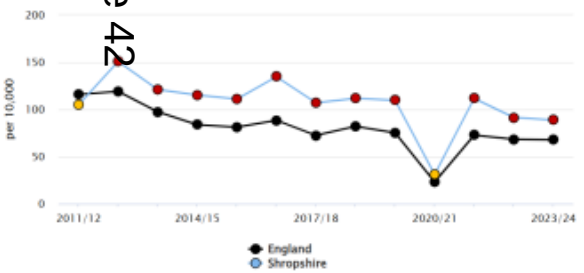
- Smoking rate for this cohort were 5.5% for 2024/25
- For this cohort, smoking rates were reducing
- Reduction between booking and delivery - in 24/25 at booking it was 8.3%, at delivery 5.5% - 58 women were smoking but became non-smokers.

3 years of SATH data were analysed:

- Significantly higher rates among 20-24 age group (17.8%, 121 smokers), while rates in those aged 30-34 and 35-39 were significantly lower than the Shropshire average (4.6% and 4.9% respectively).
- Significantly higher rate in the three most deprived deciles, while rates in the least 5 deciles were significantly below the Shropshire average.

Emergency Admissions for Gastroenteritis (0 to 4) rate per 10,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	20,725	67.6	66.7	68.6
West Midlands region (statistical)	→	2,710	80.3	77.2	83.3
Telford and Wrekin	↑	175	164.0	141.5	191.2
Walsall	↑	225	123.7	107.5	140.4
Herefordshire	→	100	121.5	96.6	145.1
Wolverhampton	→	165	95.0	82.1	111.9
Birmingham	↑	670	89.8	83.0	96.8
Solihull	↑	100	88.8	72.2	108.0
Shropshire	→	125	88.7	73.8	105.7
Stoke-on-Trent	→	140	87.3	74.0	103.7
Sandwell	→	170	75.3	65.2	88.4
Staffordshire	→	305	69.9	62.3	78.2
Warwickshire	→	215	66.9	57.7	75.9
Worcestershire	→	150	51.4	44.1	61.1
Dudley	→	75	41.6	32.3	51.6
Coventry	→	90	41.5	34.2	52.1



Recent trend: → No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2011/12	●	165	104.9	90.1	122.8	-	115.8
2012/13	●	235	150.7	130.9	169.9	-	119.0
2013/14	●	185	121.0	105.4	141.1	-	97.4
2014/15	●	175	115.1	97.5	132.1	-	83.7
2015/16	●	165	110.9	93.4	127.8	-	81.2
2016/17	●	200	134.5	115.9	153.8	-	88.4
2017/18	●	160	107.1	92.3	126.4	-	72.5
2018/19	●	165	111.7	96.6	131.8	-	82.0
2019/20	●	160	109.6	92.0	126.5	-	75.2
2020/21	●	45	31.0	22.6	41.5	-	23.0
2021/22	●	160	111.6	95.6	131.0	-	72.6
2022/23	●	130	91.5	77.7	110.1	-	68.4
2023/24	●	125	88.7	73.8	105.7	-	67.6

- Rate in Shropshire 88.7 per 10,000, in 2023/24. **Significantly above** England's rate of 67.6, but statistically similar to West Midlands 80.3. Statistically similar to all nearest neighbours

- Shropshire has been statistically higher than England for 11 of last 12 years, exception being 20/21, but rate has been decreasing in last 3 years.

Local analysis from HES shows actual number of emergency admissions for 23/24 is very similar to year before and year after, but 25/26 likely to be higher. Combining years 22-23 to 24-25:

- 30% of admissions for children under 1 and 27% aged 1 year old
- 31% of admissions from the middle deprivation quintile, 25% from the 2nd most deprived and 21% from the second least deprived quintile
- 53% of the admissions were for 'viral intestinal infection, unspecified and 43% were 'gastroenteritis and colitis of unspecified origin'

Number of emergency admissions for gastroenteritis (0 to 4 years) in Shropshire, 2018-19 to November 2025. Source: Hospital Episode Statistics

18-19	19-20	20-21	21-22	22-23	23-24	24-25	25-26* up to Nov 25
159	153	45	158	127	126	122	110

Recommendations

More detail can be found in the full report.

1. To continue to monitor and reduce teenage conception rates
2. To increase the number of women who are booked by midwifery within the first 10 weeks of pregnancy
3. To continue to ensure that throughout pregnancy and giving births, parents receive appropriate personalised care for their individual needs so that we are responsive to equality, diversity and inclusion
4. To improve data collection of modifiable risk and vulnerability factors during pregnancy – to include excess weight, smoking status at booking, alcohol consumption, drug use, folic acid supplement use, healthy start vitamins, mental health, domestic abuse and neurodivergence and physical and learning disabilities
5. To increase the rates of vaccination in pregnant women against influenza and pertussis
6. To increase access to services to support healthy pregnancy within local communities
7. To look into and address concerns raised where there are repeat pregnancies and where children become looked after within the same family unit
8. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.
9. To increase breastfeeding initiation rates, to achieve World Health Organisation Baby Friendly Initiative (BFI) accreditation
10. To continue to monitor and improve **infant mortality and stillbirth rates**, by addressing modifiable factors such as maternal obesity, smoking, safer sleeping, parenting support etc.
11. To monitor levels of referrals for early help from midwifery to ensure appropriate early support is provided to reduce the risk of escalation to statutory children's social care

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**					
Title of report	**Drug & Alcohol JSNA**					
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	Jennifer Roach - Jenny.roach@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address?	Children & Young People	x	Joined up working			
	Mental Health	x	Improving Population Health		x	
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce		Reduce inequalities (see below)			
What inequalities does this report address?	Inequalities and disparities in health outcomes, service provision and access to services					

Report content:

1. Executive Summary

This paper presents to HWBB the Drug and Alcohol Joint Strategic Needs Assessment (JSNA). We are seeking approval of the JSNA and endorsement of the recommendations. Upon approval, the JSNA will be published on Shropshire Council's public facing website.

Please note that some figures in this report have been rounded, and in some cases small numbers have been adjusted, to protect confidentiality and reduce the risk of deductive disclosure. As a result, percentages may not always sum exactly to 100% and totals may not always match precisely.

Objectives

This Joint Strategic Needs Assessment (JSNA) has been developed to inform commissioning of community-based alcohol and drug treatment and recovery services in Shropshire. It will guide the development of relevant partnerships by the Shropshire Council Drug and Alcohol Team, and provide an evidence base to support the development of services which best meet the needs of the Shropshire population.

The JSNA is focused on the needs of Shropshire residents who use alcohol, drugs or other substances in a manner of irregular harmful misuse or dependence, regardless of whether they are already in contact with treatment services.

A variety of data sources have been used to inform the JSNA, including the local treatment services database and the National Drug Treatment Monitoring System (NDTMS) reports, scientific literature and Government reports. The JSNA would also not have been possible

without input from stakeholders and professionals who offered their time, experience and wisdom to the project.

This assessment compares current and changing performance data against regional and national benchmarks, and outlines recommendations for consideration in future commissioning of services.

This Needs Assessment will:

- Provide an overview of the population living in Shropshire most at risk, including trends and needs
- Provide an overview of the wider determinants affecting outcomes for people, particularly those most at risk
- Provide an overview of current service provision and assessment of outcomes including gaps
- Make recommendations for future commissioning in the context of the changing landscape of health and social care delivery in Shropshire

Key findings:

Treatment activity and substance trends - Adults

- **1,615 adults** accessed treatment between April 2024 and March 2025, a **1.2% increase** on the previous year (1,595).
- **Alcohol-only clients** account for **41%** of all adults in treatment, significantly higher than the West Midlands and England (both 30%).
- **Opiate treatment** accounts for **32%** of adults in treatment, lower than the West Midlands (48%) and England (42%), and has declined steadily since 2018.
- **Non-opiate only treatment** makes up **14%** of adults in treatment, higher than the West Midlands (10%) and slightly above England (13%).
- **Non-opiates with alcohol** account for **13%** of adults in treatment, broadly in line with England (14%).

Recent growth is mainly driven by **alcohol-only** and **non-opiates with alcohol** presentations.

Treatment activity and substance trends – Young people

- **115 children and young people** accessed treatment between April 2024 and March 2025, a **28% increase** on the previous year.
- **Cannabis** remains the main primary substance among young people in treatment, accounting for **56%**. This is significantly lower than the England average of 71%.
- **Alcohol** accounts for **30%** of young people in treatment, double the England average of 15%.
- There are signs of increasing **ketamine** presentations in recent years

The recent increase in young people accessing treatment appears to be driven mainly by **alcohol-related presentations**.

Patterns by age and sex

Drug Treatment

- Males make up the majority of adults in drug treatment (**69%**)
- The proportion of males in treatment increases with age, indicating greater ongoing need in older age groups
- The proportion of females in drug treatment falls with age

Alcohol Treatment

- Males make up the majority of alcohol-only clients (**58%**)
- Female representation in alcohol treatment is highest in ages 18 to 29 and 50+ (both 45%)

Protected characteristics

- Treatment cohorts are overwhelmingly **White British/White (98%)**, higher than the national figure (88%).

Substances driving treatment in Shropshire

- **Alcohol** accounts for **59%** of substances driving adult treatment in Shropshire, whether alone or alongside another substance.
- Alcohol-related treatment demand is higher in Shropshire than England overall (**59% vs 52%**).
- Opiate (not crack cocaine) accounts for **19%** of substances cited in Shropshire, similar to England (20%).
- Cocaine accounts for **17%** of substances cited in Shropshire, similar to England (16%).

Referral pathways

- **Self-referrals** are significantly higher in Shropshire than England (**62% vs 55%**).
- Referrals from health services and social care fell from **25%** to **21%** compared with the previous year.

Geography and access

- The highest numbers of people in treatment are in **Shrewsbury** and some northern and south-eastern parts of the county.
- Lower recorded engagement in many rural areas may reflect transport barriers, fewer treatment locations, and difficulties accessing online services.

Unmet treatment need

- **Crack-only** unmet need is highest at **77%** in Shropshire, slightly above England (76%)

- **Opiates-only** unmet need remains high at **57%**, similar to England (56%)
- **Alcohol** unmet need is lower in Shropshire than England (**69% vs 73%**), suggesting comparatively better access to treatment
- Young people aged 15 to 24 have much higher unmet need for opiate treatment (**90%**) than England (77%)
- **Males** consistently have higher unmet need across substance groups

Mental health co-occurrences

- Unmet mental health need among people in treatment has **fallen** from 29% in early 2023 to **21%** in March 2025
- Shropshire has historically had a higher level of unmet mental health need for those in drug and/or alcohol treatment than England, but the gap is narrowing
- **Males show higher unmet mental health treatment need –** 23% vs 18% of females

New presentations

- **895 new presentations** were recorded between April 2024 and March 2025, split almost evenly between drug (49%) and alcohol (51%)
- **83%** of new alcohol presentations and **76%** of new drug presentations were already receiving treatment for their mental health need
- Most already receive mental health support, mainly from **GPs** and **community mental health teams**.

Parents/carers in treatment

- **22%** of alcohol clients live with children, similar to the national figure (21%)
- Females are more likely than males to be **parents living with children** (**27% vs 16%**)

2. Recommendations

Recommendation	Rationale
	Alcohol accounts for a larger share of local treatment demand than regional and national comparators: 41% of adults in treatment in Shropshire are alcohol-only clients, compared with 30% in both the West Midlands and England. Alcohol is also the most commonly cited substance driving adult treatment overall (59% in Shropshire vs 52% in England), and recent growth has been driven mainly by alcohol-only and non-opiates with alcohol presentations
Sustain specialist provision for people with opiate and crack-related need	Although opiate treatment accounts for a smaller share of adults in treatment locally (32% in Shropshire compared with 42% in England), unmet need remains high for some drug groups. Crack-only unmet need is estimated at 77% in Shropshire, slightly above England (76%), while opiates-only unmet need is 57%, similar to England (56%). These findings indicate a continued need for specialist provision despite lower overall treatment proportions

Strengthen early intervention, prevention and treatment pathways for children and young people	Between April 2024 to March 2025, 115 children and young people accessed treatment in Shropshire, a 28% increase on the previous year. Cannabis remains the main primary substance among young people in treatment (56%), but alcohol accounts for 30%, which is double the England average of 15%. Local data also suggest rising ketamine use and a more varied pattern of substance use among young people
Improve equity of access across rural communities	Shropshire is a predominantly rural county, with 57.4% of the population living in rural areas. The report shows the highest rates of people in treatment are concentrated in Shrewsbury and some northern and south-eastern parts of the county, while many rural areas fall into the lowest engagement bands. This pattern may reflect practical barriers including travel, service location and difficulties accessing online support
Strengthen the local response to co-occurring mental health need	Co-occurring mental health need is a prominent feature of local demand. Between April 2024 to March 2025, 70% of new alcohol presentations and 71% of new drug presentations were recorded as having a mental health need. Although unmet mental health need among people in treatment has fallen from 29% in early 2023 to 21% in March 2025, it remains an important issue and is higher among males than females (23% vs 18%)
Target unmet need and inequalities more systematically	Unmet need varies across substance groups and population groups. Crack-only unmet need is estimated at 77%, opiates-only unmet need at 57%, and young people aged 15 to 24 have particularly high unmet need for opiate treatment at 90%, compared with 77% in England. The report also notes that males consistently have higher unmet need across substance groups, suggesting the need for more targeted outreach and engagement
Embed family-focused and safeguarding approaches within treatment pathways	A notable proportion of adults in treatment are parents living with children. The report shows that 22% of alcohol clients live with children, similar to the national figure of 21%, and females are more likely than males to be parents living with children (27% vs 16%). This supports the need for family-focused pathways, safeguarding links and joined-up support for parents in treatment
Improve retention, successful completion and recovery outcomes	The report identifies a deterioration in some treatment exit outcomes. Between April 2024 and March 2025, 785 adults exited treatment; of these, 320 successfully completed treatment, 380 dropped out or left, and 15 died. Successful completions accounted for 41% of exits, while dropouts accounted for 48%, representing a fall in successful completions and a rise in dropouts compared with 2023/24
Strengthen whole-system partnership working	The report highlights that substance-related need is closely linked to wider determinants and service systems. It identifies co-occurring mental health need among most new presentations, notes rural access barriers, and includes specific sections on housing and homelessness, employment, criminal justice, vulnerable groups and wider harms. This supports a whole-system response rather than a treatment-only model

3. Report

Risk assessment and	

opportunities appraisal		
Financial implications		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	System Partnership Boards	• SSCP Community Safety Partnership Board • ShIPP
	Voluntary Sector	
	Other	• Drug & Alcohol Service Recommissioning Project Board • Tackling Drug & Alcohol Partnership
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead		
Appendices Appendix A. Drug & Alcohol JSNA - presentation Appendix B. Drug and Alcohol JSNA 2026 *Members of HWBB: report provided separately as attachment, due to size of document* *For public (through website): document can be provided on application to louisa.jones@shropshire.gov.uk*		

Shropshire Council

Drug and Alcohol Joint Strategic Needs Assessment (JSNA) Summary

May 2026

Author: Jenny Roach, Senior Public Health Intelligence Analyst

What is a JSNA (Joint Strategic Needs Assessment)?

"A shared assessment of local health and wellbeing needs"

What is it?

- Combines data and community insight
- Shows the "big picture" of need

Who it involves?

- Local authority
- NHS partners
- Community and voluntary sector

What does it look at?

- Health outcomes (physical and mental)
- Wider determinants (housing, employment, deprivation)
- Service use and access
- Inequalities across groups and access

Why does it matter?

- Ensures decisions are evidence based
- Targets resources where need is greatest
- Helps reduce health inequalities

What is it used for?

- Identifies key issues and unmet need
- Highlights who is most affected
- Provides evidence for priorities and decisions

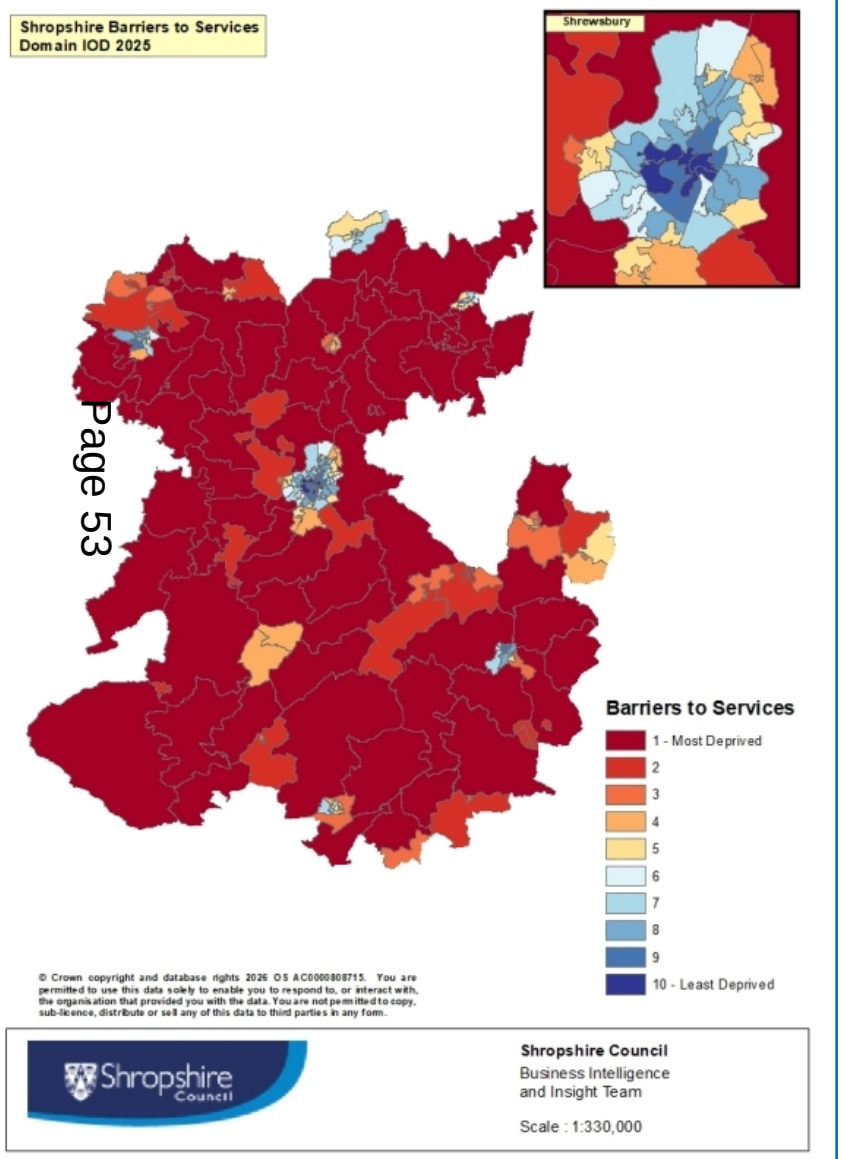
Key message

The JSNA tells us:

- What are the problems?
- Who needs support?
- What should we do next?

Risk factors, deprivation and rural inequality

Index of multiple deprivation – Barriers to Housing and Services



52% less deprived than England
(overall IMD position)

57.4% rural population

Most deprived LA for service access
(Barriers to Housing and Services)

31.8% of LSOAs *in 10% most deprived for access*

Low overall deprivation – but high rural access inequality

Shropshire is generally less deprived than England overall, but many communities face barriers to housing, services and transport that shape access to drug and alcohol support

Why this matters for treatment access

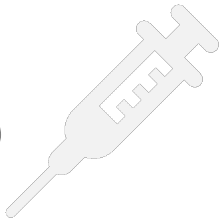
Only 55.9% of households can access a GP within 15 minutes by walking or by public transport

Distance, transport and service access are key drivers of unequal engagement with drug and alcohol support in rural communities

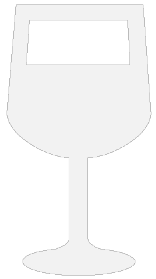
Shropshire's level of need

latest data as at March 2025

Drugs



Alcohol



Prevalence

1,366
OCU users
aged 15-64
rate of **7 per 1,000**, lower than nationally 2022/2023

58%
unmet Need
England 53%

3,009
Alcohol
Dependent adults (18+)
rate of **11.4 per 1,000**, lower than nationally 2019/2020

69%
unmet Need
England 73%

Burden

Drug misuse poisoning admissions
14.7 *per 100,000, England* ***17.5*** *per 100,000 2023/2024*

33
Drug misuse deaths
3.7 per 100,000, England 5.8 per 100,000 2022-2024

Alcohol specific conditions admissions
392 per 100,000, *England 612 per 100,000 2023/2024*

40
Alcohol specific mortality
11.2 per 100,000, England 13.8 per 100,000 2024

Source: NDTMS

Red = worse, orange = similar, green = better than national average

Drug and Alcohol Clients

Adults, April 2024 – March 2025

Please note: some of the percentages may not total to 100% due to rounding for deductive disclosure

960 in treatment for support with drugs

655 in treatment for support with alcohol

Drug

69% Male | 31% Female

Alcohol

58% Male | 41% Female

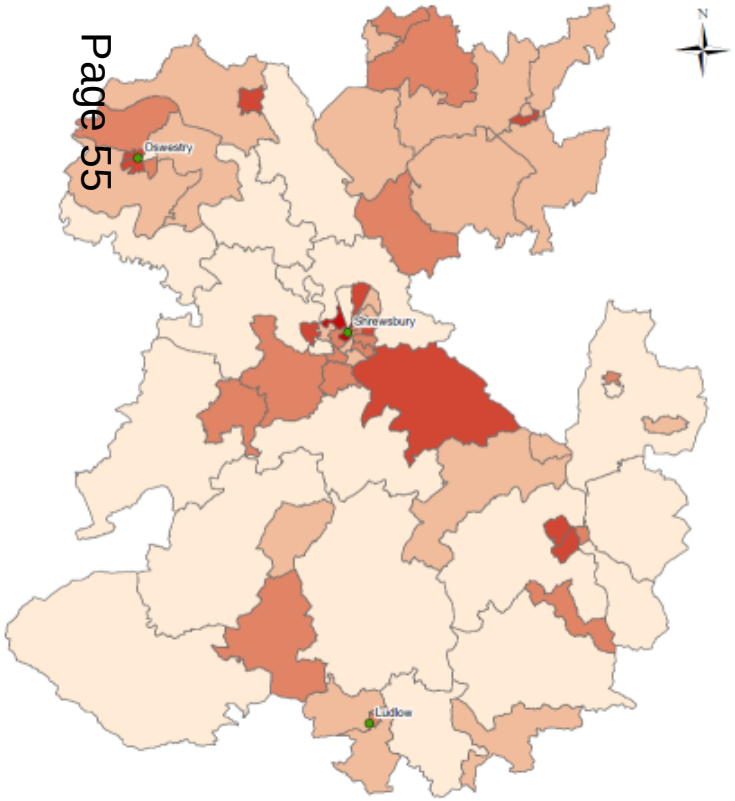
Drug

Age 50+ most **males** and age **18 to 29** most **females** in treatment

Alcohol

Age **18 to 29** most **males** and **age 18 to 29** and **50+** most **females** in treatment

Distribution of clients (Nov 2025)



895 new presentations, 49% drug and 51% alcohol

21% of those in treatment had an **unmet mental health treatment need** *(22% in England)*

37% were in **paid work** *(29% in England)*

22% of adults in alcohol treatment are living with children (England 21%)

41% successfully **completed treatment** (England, 46%)

2% of adults waited more than 3 weeks for drug and/or alcohol treatment (England, 1%).

41% non-opiate users successfully completed (England, 49%).

32% opiate users successfully completed (England, 23%).

47% alcohol-only users successfully completed (England, 58%).

Young people in treatment April 2024 to March 2025

115
Young people in Treatment

Male
73%

Female
30%

70% of **males** are aged **15 and under**

80% of **females** are aged **15 and under**

Please note: some of the percentages may not total to 100% due to rounding for deductive disclosure

95 new presentations, 73% male and 26% female

73% of young people who are newly presenting are in mainstream education *(61% in England)*

Majority (32%) of new presentations referred in by health services *(Majority nationally is education system, 33%)*

89% are living with parents or other relatives *(England 87%)*

96% successfully **completed treatment** *(England, 85%)*

56% have been in treatment for under 12 weeks *(England, 45%)*

10% of young people are living in care *(6% nationally)*

Cannabis is the most cited primary substance (**56%** vs 71% nationally)

Alcohol is the second most reported (primary) substance problem (**30%** vs 15% nationally)

What is working well in Shropshire

More adults accessing treatment

1.2% increase year on year

(April 2024 – March 2025)

More CYP supported

115 CYP accessed treatment
(28% increase)
(April 2024 – March 2025)

Fast access to care

Only 2% waited over 3 weeks for treatment. Better than previous years, and similar to the national average

Strong alcohol- only treatment engagement

Higher alcohol entry than England

Strong engagement with under 14's

Higher proportion than nationally

Employment outcomes

Higher employment rates among people in treatment.
Higher than nationally

Improving mental health support

Unmet mental health need reduced to 21%

(between 2023 and 2025)

Targeted housing investment

RESET and supported accommodation options, strengthened links with housing providers

Accessible harm reduction

Needle syringe programme coverage across north, central and south Shropshire

Shropshire's areas of need

High unmet drug treatment need

Particularly for crack-only, opiate-only and dual opiate & crack users

Ages 15 to 24

Much higher unmet opiate need than England average

Crack-only unmet need 35 to 54

Higher than England for adults aged 35 to 54

Rural access gaps

Lower engagement in rural areas linked to transport and distance

Mental health need (males)

Higher unmet mental health need, especially ages 18 to 29

Treatment drop-out

More adults leaving treatment than successfully completing

Alcohol and gender inequality

Lower engagement among younger women; higher access later in life

Housing instability (people who use drugs)

Higher housing problems and urgent need compared to people who use alcohol

Male alcohol-related harm

Alcohol related harm remains higher among males

Stakeholder & service user engagement

Challenges

Opportunities

"SMART groups have been a lifeline. I look forward to coming"

"A level of wellbeing support/mental health support based within the service would be beneficial as so many of the clients have mental health concerns. Opportunities to chat and open-up about mental health/emotional wellbeing would be positive"

Good staff and service

Opening times work well

Improved service helpful for repeat users

Group sessions are helpful

Communication is good, they will text me, email me, write things down, whatever works for me to remind me

After service needs improvement

Text reminders before group meetings are appreciated

They will check in if you miss an appointment.

Turnover of key workers unhelpful

I have built the group timing into my routine

Recommendations

- Strengthen the local response to co-occurring mental health need
- Strengthen early intervention, prevention and treatment pathways for children and young people
- Target unmet need and inequalities more systematically
- Sustain specialist provision for people with opiate and crack-related need
- Maintain a strong response to alcohol-related harm
- Embed family-focused and safeguarding approaches within treatment pathways
- Strengthen whole-system partnership working
- Improve retention, successful completion and recovery outcomes
- Improve equity of access across rural communities

Choose an item.

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund 2026-27
Narrative return

Introduction and guidance

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the BCF Exchange:

- **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.

- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.
- The deadline for completing this narrative return is **19 May 2026.**
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

	Shropshire
HWB	Shropshire HWB
ICB	NHS Shropshire, Telford and Wrekin ICB

1. **Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Priorities for BCF funding map to the 10 Year Health Plan for England and align with Shropshire's Health and Wellbeing Strategy and the System's 5 Year Strategic Commissioning Plan, which itself is shaped by local Joint Strategic Needs Assessments (JSNAs) and the System's Integrated Strategic Needs Assessment (ISNA), Population Health Improvement Plan (PHIP), Clinical Strategy and Core20PLUS5 Framework. These documents drive the System's strategic focus on five major shifts over the next five years: hospital to community, analogue to digital, sickness to prevention, improving access, and value and productivity. Together, these shifts will enable a more proactive, joined-up and community-focused health and care system.

Through integrated commissioning, BCF resources are targeted at services that demonstrably reduce crisis demand, support independence at home, and improve outcomes for people with long term conditions, frailty and dementia, while addressing health inequalities at a neighbourhood level, delivered through integrated neighbourhood teams.

Investment focuses on admission avoidance, timely hospital discharge, reablement and support for unpaid carers, recognising the county's rurality, ageing population and increasing complexity of need.

Shropshire's National Neighbourhood Health Programme journey is underway, with Shropshire's integrated teams refining plans and taking the next steps towards developing local, joined-up, preventative care for priority patient groups.

Planned BCF expenditure for 2026-27 broadly maintains continuity of core services that are critical to admission avoidance, discharge and reablement. Where changes in spend are proposed, these will reflect learning from service reviews, emerging demand and capacity pressures, and alignment with neighbourhood health development rather than withdrawal of effective provision.

Any reprofiling of funding is managed jointly by the ICB and local authority to ensure continuity of service delivery, with transitional arrangements in place where required. Partners have prioritised maintaining frontline capacity and avoiding disruption to people receiving care, particularly during periods of system pressure.

HWB has reviewed demand and capacity across intermediate care pathways, drawing on system data on hospital flow, discharge pathways and reablement outcomes. This assessment highlights sustained demand for pathway 1 support, increasing complexity of need, and the importance of community based reablement in reducing length of stay and preventing long-term residential admissions.

The System-wide Multi-year Transition Programme to improve urgent and elective care has three pillars; Community Urgent Care, Acute Flow, Streaming and Care Co-ordination. This Programme is driving improvements in discharge ready date performance, which data shows has been consistently above regional and peer averages.

A notable change in discharge ready date delay was reported during November 2025, a position that continued into December (from local insights). This was caused by the decommissioning of Rehabilitation and Recovery Unit (RRU) beds from the acute provider that were being utilised for intermediate step-down capacity. As a result of closure, the activity being supported by the RRU was reported for discharge by the Care Transfer Hub. This resulted in an increase in patients with no criteria to reside, thereby impacting the discharge ready date to discharge length of stay. This is now in recovery and provides confidence for Shropshire to achieve the metric plans for 2026-27.

Planning for 2026-27 reflects all the above, with continued investment in reablement, rapid response and equipment services to support timely discharge and maximise independence. Capacity planning is informed by historic trends, seasonal variation, improvement plans and system learning, with partners working collectively to flex provision in response to demand.

BCF planning also reflects wider national framework priorities. Investment in home adaptations and equipment supports people to remain safely at home, reducing avoidable admissions. Support to unpaid carers is recognised as a key preventative intervention, with carers embedded in discharge pathways and neighbourhood teams. The voluntary and community sector (VCS) plays a critical role in tackling isolation, providing low level preventative support and strengthening community resilience, particularly in rural areas.

2. **Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

HWB goals for non-elective admissions and delayed discharges are aligned with ICB and provider planning trajectories, ensuring consistency between BCF ambitions and wider NHS operational planning. Where local expectations differ, these reflect specific local circumstances such as rural geography, service configuration and social care capacity. Any divergence is understood and agreed through joint planning forums.

Goals for non-elective admissions of adults aged 65+ and delayed discharges are informed by comparisons with peer areas, local trend analysis, recent performance, system learning from winter pressures, and anticipated impacts of service changes funded through the BCF. Assumptions reflect continued pressure from demographic change alongside improved community capacity, discharge processes and admission avoidance pathways. A 3% population growth has been applied, which is consistent with the Operational Plan for non-elective activity.

2025-26 performance data shows some month-to-month volatility regarding emergency admissions. It also shows a notable change in discharge ready date delay during November 2025, a position that continued into December (from local insights). This was caused by the decommissioning of Rehabilitation and Recovery Unit (RRU) beds from the acute provider that were being utilised for intermediate step-down capacity. As a result of closure, the activity being supported by the RRU was reported for discharge by the Care Transfer Hub. This resulted in an increase in patients with no criteria to reside, thereby impacting the discharge ready date to discharge length of stay. This is now in recovery and provides confidence for Shropshire to achieve the metric plans for 2026-27.

All the above has been used to set realistic but stretching goals that align with system capability and planned investment. They reflect the need for a steady state that supports a year of transition during which there are ambitious plans for the left shift towards prevention and neighbourhoods.

HWB places strong emphasis on high quality data to support BCF metrics. Partners are working to interrogate data further to improve accurate and consistent recording of

Discharge Ready Date, with routine validation and review. Identified data quality issues are addressed through shared protocols, training and system oversight. The next generation of data will have greater granularity that more accurately reflects system and provider performance.

Development of a system Complex discharge data environment will provide further insight into population need and opportunities for improvement during this year of transition.

Shropshire's goals for reducing long term admissions to residential and nursing care are underpinned by investment in prevention, reablement, carers support and homebased provision. Planned activity is expected to contribute to stabilising demand and improving outcomes by supporting people to remain independent for longer.

Regarding reablement, planned activity is expected to improve outcomes through timely access to reablement services, trusted assessment, integrated therapy input and improved pathway management. Focus is placed on supporting people to regain skills and confidence following illness or hospital discharge, increasing the proportion of people who remain at home 12 weeks after discharge.

The Shropshire Wellbeing and Navigation Network (SWANN) is a jointly commissioned new service underpinned by a preventative service contract. The service is delivered by partners British Red Cross, Shropshire Mental Health Support, Community Resource and Live Well Shropshire. It provides interventions including early support, opportunities to build confidence, reduce isolation and connect with local communities, assistance after hospital discharge, peer support for mental health and support for unpaid carers, which all reduce the need for crisis or statutory services and support the achievement of all three metric plans.

3. **Please provide a short explanation of the planned impact of BCF funding on achievement of goals.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

BCF funded services in Shropshire contribute to metric achievement by focusing on admission avoidance, timely discharge and recovery at home. Integrated neighbourhood teams, social prescribing, carers support, reablement, equipment and adaptations all play complementary roles in reducing pressure on acute services.

Recent reviews and improvement activity have shaped funding decisions, with increasing emphasis on services that support pathway 1, reduce reliance on bed-based care and demonstrate positive outcomes. While not all impacts can be quantified, triangulation of activity, outcomes and system feedback informs ongoing investment decisions.

In 2025-26, System partners jointly redesigned and recommissioned preventative services. The new SWANN facilitates early support, admission avoidance, opportunities to build confidence, reduce isolation and connect with local communities, assistance after hospital discharge, peer support for mental health and support for unpaid carers. In terms of metric performance, it's aims are to reduce emergency admissions and delayed discharges and to support pathway flow and pathway profile change.

Recent delivery evidence from SWANN demonstrates the service is actively diverting demand from statutory pathways, with a single front door enabling timely preventative interventions that reduce escalation, support hospital discharge, and mitigate pressure on adult social care and wider system demand.

Social prescribing is strong across Shropshire. Located with neighbourhood teams, multi-disciplinary teams are working together to avoid crisis points being reached. The family hubs model is being developed across the county, promoting a culture of 'how can we help' and sign posting people to access the right information, advice and support where they need it. A key area of focus for 2026-27 is embedding dementia support and developing the carers offer at a neighbourhood level.

The Council continues to develop its technology offer and the joint contract for the 2 Carers in a Car service to support more people at home by providing nighttime support at home and reduce the need for short term bedded provision.

Population Health Management (PHM) is a newly launched approach in STW, using linked health data to better understand local needs and design services that make the greatest difference to communities, as outlined in the NHS 10-Year Plan and the national neighbourhood programme. GP data, collected from local practices, and linked to data from hospitals, community and mental health providers and local authorities, will provide robust evidence to better understand the needs of local populations, now and in the future.

Funding decisions are also informed by JSNAs and the ISNA, enabling resources to be targeted towards population groups that benefit most from preventative and community-based interventions. Priority cohorts include older people with frailty, people with dementia, unpaid carers, people with long term conditions, and children and young people with additional needs.

Engagement with communities, VCE partners and service users informs service design, ensuring that provision is responsive to local need and accessible across Shropshire's diverse and rural communities.

4. **Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.**

Please provide a concise statement of around one page (e.g. around 500 words) please provide your response below:

Aligned with NHS England's Model ICB Blueprint and the 10 Year Health Plan for England, the ICB's Cluster Operating Model sets out five big shifts, one of which is value and productivity. It is a cluster priority to create a single evaluation and assurance framework that measures outcomes, reduces inequalities, and improves access, quality, productivity and system shift to ensure optimal, value-based use of resources and improved outcomes.

To meet its duty to operate within finite budgetary constraints, STW ICB has a Value Based Commissioning and Evidence Based Interventions Policy to provide a structured approach to prioritising resources and providing interventions with the greatest proven health gain for the population.

The BCF Operational Delivery Group is responsible for monitoring efficiency, effectiveness, resource allocation and improvement of BCF schemes, with oversight from HWB. The Group has undertaken a line-by-line review of schemes. This considered outputs, map to BCF priority and expenditure for example. It shows that all schemes support delivery of BCF objectives and metrics.

That said, BCF partners are currently identifying areas in which to improve value for money over the next 12 months as part of preparations for alignment with neighbourhood health planning. Areas already identified for further work include preventative services such as those addressing High Intensity Use and services that are used/could be used to support a shift from pathway 3 to pathway 1.

An example of how this structured approach has been applied is the jointly commissioned new and redesigned Children and Young People's Mental Health Services (CAMHS) model. The model provides a clear, evidence- based framework that assures the ICB and local authorities that the service offers strong value for money, aligning directly with the BCF vision for integrated, preventive and outcome- driven services. Through joint governance, integrated pathways, a strong early help and prevention offer, a shared digital infrastructure, and robust productivity and performance measures, the model delivers a sustainable, high- quality service that supports better outcomes while reducing system- wide costs.

Benchmarking against comparable authorities will be undertaken in quarters two and three of 2026–27, with findings reported by quarter 4 2026–27 as part of work on the market

position statement to inform service improvement, challenge outliers and strengthen value for money decisions.

As part of service review, the opportunities that are considered to improve productivity include longer-term contracting, service redesign, digitisation, improved use of technology and changes to workforce deployment and skill mix. These approaches support sustainability and contribute to systemwide productivity expectations.

Local healthcare Trusts continue to make use of enhanced digital clinical information sharing technology. As a group, digital teams are reviewing further cases for its application and focusing on the portability of devices between settings to enhance access to digital information at the point of need.

The newly redesigned and jointly commissioned CAMHS model is an example of the action taken to improve productivity. Robust productivity and performance measures, with monthly reporting, are in place to improve this key service.

A second example is SWANN, which is commissioned through a single Preventative Services Contract covering hospital discharge, mental health outreach and wellbeing support, reducing duplication and enabling more efficient use of resources across providers. The joint commissioning approach prioritises early intervention, admission avoidance and timely discharge, thus reducing escalation into crisis, acute and statutory services. It also enables aligned investment, shared priorities and better value for money through coordinated planning and delivery. Longer-term contracting supports provider stability, workforce planning and continuity of support, contributing to more efficient and sustainable service delivery over time. Delivery through voluntary and community sector organisations makes effective use of community-based staff, volunteers and peer support, ensuring support is provided at the most appropriate and cost-effective level. A single, simplified referral route, including online referral, reduces administrative burden for referrers and improves productivity across health and care partners, and allows for data to be captured more efficiently. The contract allows flexibility in delivery, enabling providers to respond to local need and individual circumstances while making effective use of available resources.

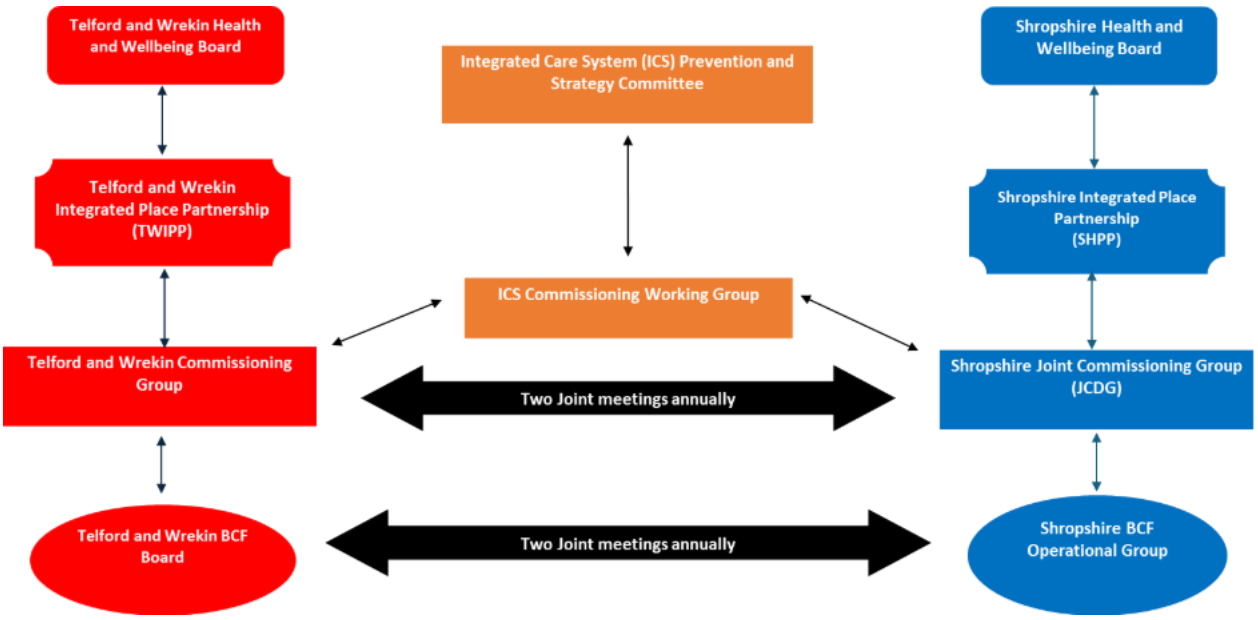
5. Please outline your robust joint governance for managing the expenditure of BCFS funding, including assessing impact of funding, value for money and continuous improvement.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Following a 360-degree audit of governance arrangements in 2024, changes have now embedded, strengthening governance to support delivery of the BCF including managing expenditure.

The ICB's BCF Commissioner provides a first point of contact for BCF oversight and support process and uses established escalation routes to ensure the right level of involvement is engaged.

Clear joint governance arrangements are in place between the ICB, local authority and HWB. The BCF Operational Delivery Group oversees planning, expenditure and performance, with HWB providing formal approval and system level scrutiny. Oversight of BCF in Shropshire mirrors that of Telford and Wrekin as shown in the diagram below.



Quarterly reporting enables routine monitoring of expenditure, delivery and outcomes. Issues are escalated through established routes, ensuring timely corrective action where performance is off track.

The Chief Executive of STW ICB jointly chairs both Shropshire and Telford and Wrekin's HWB, giving consistency of approach across the System.

Links between Shropshire and Telford and Wrekin's BCF Boards are in place and used to identify opportunities to jointly commission, maximise impact of BCF funding and ensure value for money.

Governance groups routinely review progress against 2026-27 goals; act where required and consider longer-term impact of BCF funded services to inform future planning. Links are in place with Telford and Wrekin's BCF Board to support a System approach to cross cutting issues and shared services.

Learning from delivery, performance reviews and service evaluations is captured and shared across partners. This supports continuous improvement, refinement of commissioning approaches and informed decisions on future changes to spending plans.

In the coming months, as BCF aligns to neighbourhood health planning and the ICB restructures and merges with Staffordshire and Stoke on Trent, opportunities to strengthen integrated working through joint roles and integrated governance arrangements will be taken.

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9 July 2026**					
Title of report	**Beter Care Fund 2025-26 End of Year Template and 2026-27 Assurance Return**					
This report is for	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Deborah Webster, Service Manager (Contracts, Quality Assurance, and Business) Deborah.Webster@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address?	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

This report provides a summary of:

1.1. Shropshire's 2026-27 Better Care Fund (BCF) Assurance Return, which was submitted to the national BCF team by the deadline of 19 May 2026.
1.2. Shropshire's 2025-26 BCF End of Year Template, which was submitted to the national BCF team by the deadline of 5 June.

In line with national conditions, the approval of the Joint Chairs of Health and Wellbeing Board (HWB) was obtained prior to both submissions. Formal HWB approval is now required.

2. Recommendations

2.1. HWB approves the 2026-27 BCF Assurance Return which can be found in appendices A and B.
2.2. HWB approves the 2025-26 BCF End of Year Template which can be found in appendix C.

3. Shropshire's 2026-27 Better Care Fund (BCF) Assurance Return

3.1. The BCF framework 2026-27 sets out the first step in the reform of the BCF to provide a more consistent and effective approach to funding services that it is essential to deliver them in a fully integrated way. The initial set of changes will help local areas go further in joining up delivery of health and social care services, in line with the government's objectives for neighbourhood health and devolving more responsibilities.

3.2. The aim of BCF in 2026-27 is to support ICBs and local authorities to in designing and delivering more integrated and preventative care, particularly for people with more complex health and social care needs, helping people stay independent for longer. This includes - but is not limited to - developing integrated intermediate care services that help people retain or

recover their independence. It also covers other health and social care services that support independence, prevent avoidable admission to hospital or long-term residential care, and enable timely and effective acute, community and mental health hospital discharge. BCF funding should be deployed in ways that help deliver the three shifts outlined in the 10 Year Health Plan.

3.3. For this initial year of BCF reform, local areas are asked to start to align their plans for pooled funding with their wider approach to development of relevant areas of neighbourhood health plans, such as intermediate care.

3.4. Funding

As for the 2025-26 BCF, the 2026-27 BCF is composed of the following funds:

- the NHS minimum contribution, including the minimum contribution to adult social care.
- Local Authority Better Care Grant.
- Disabled Facilities Grant.

3.5. For 2027-28 onwards, the government will consider whether local areas should be given more flexibility in deciding the level of pooled funding needed to support better integrated services. There will be a consultation on any proposed changes to minimum NHS and local authority contributions. It will also work with the NHS and local government to develop clearer expectations for the types of services that, as a minimum, should be subject to pooled funding. This will build on the success that many local areas have already seen by taking a more strategic approach to pooled funding.

3.6. Metrics

ICBs and local authorities must set specific goals, agreed by HWBs, to reduce avoidable non-elective admissions for people aged 65 and over and reduce discharge delays, for two metrics:

- non-elective hospital admissions for people aged 65 and over.
- the average length of discharge delay for all acute adult patients, derived from:
  - the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD).
  - for those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge.

ICBs and local authorities are also encouraged to set goals, agreed with HWBs, in relation to long-term admissions to residential care homes and nursing homes for people aged 65 and over. Whether or not a specific local goal is set, ICBs, local authorities and health and wellbeing boards should monitor and drive progress in preventing avoidable long-term care home admissions.

It is also expected that ICBs, local authorities and HWBs monitor and drive improvements in the proportion of people aged 65 and over discharged from hospital, with reablement provided partly or solely by local authorities, who remained in the community within 12 weeks of discharge.

3.7. Assurance Return

3.8. ICBs and local authorities, working with HWBs, must submit an assurance return to demonstrate compliance with the national funding conditions and planning requirements for 2026-27. BCF Assurance Returns must include:

- A Narrative Return – an assurance statement showing how national BCF conditions are met (appendix 1).
- A Numerical Return – a breakdown of planned BCF expenditure by category of spend and funding source (appendix 2).

3.9. National conditions

The national condition requirements are outlined in the table below.

National condition	Planning requirement
National Condition 1: ICBs and local authorities must develop joint plans, agreed by HWBs, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the wider development of neighbourhood health and social care services.	**ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.**
	ICBs and local authorities must set out plans for reasonable progress in the national priority metrics of emergency admissions (for those 65 years old and over) and delayed discharges and how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement. **These must include the specific contribution of BCF-funded services.**
	ICBs and local authorities must demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity.
National Condition 2: ICBs and local authorities must comply with BCF national grant and funding conditions, and deliver in accordance with their approved return, including, for ICBs, maintaining the NHS minimum contribution to adult social care and the pooling of NHS BCF contributions into a section 75 pooled fund.	**ICBs and local authorities must pool their designated minimum contribution (in the case of ICB Partners) and the Local Authority Better Care Grant and Disabled Facilities Grant (in the case of local authority Partners). Partners are able to voluntarily pool additional funding through the BCF where they are assured that this represents value for money.**
	The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each HWB area. **Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the Disabled Facilities Grant, including the pooling of funding.**
National Condition 3: ICBs and local authorities must comply and engage with BCF planning and reporting requirements including adherence to any assurance and oversight processes.	**ICBs and local authorities must ensure that effective joint governance is in place to ensure local accountability for delivery, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track.**
	ICBs, local areas and HWBs are required to engage with BCF reporting, oversight and support processes.

3.10. Monitoring and reporting

Once assurance returns are approved, regional better care managers may provide oversight and support to the most challenged local areas, focusing on improvement and managing risk. Escalation may be triggered if national conditions are not met or there is a material risk that they will not be met. In such a situation, regional BCF leads and national partners (NHS England, DHSC and MHCLG) will follow a clear escalation process

3.11. Further information will be published about how assurance and oversight, including regular monitoring of performance against the metrics, will work for 2026-27, both in relation to BCF spending plans and to local goals for non-elective hospital admissions and delayed discharges.

3.12. Summary of the Assurance Return

The Assurance Return sets out how Shropshire partners will use the Better Care Fund in 2026–27 to deliver integrated, preventative health and care services. It aligns with national policy (including the NHS 10 Year Health Plan) and local strategic frameworks, with a strong emphasis on system integration, community-based care, and improved outcomes.

Key takeaways are:

- Strong strategic alignment with national and local priorities.
- A clear shift towards prevention, community care, and neighbourhood delivery.
- Evidence-based planning with ambitious but realistic metric plans that reflect the period of transition now underway to support the shift from sickness towards prevention and a neighbourhood model.
- An emphasis on integration, data-driven decision-making, and system learning.
- Robust governance and a clear focus on value, productivity, and sustainability.

Overall, the plan reflects a transition year, maintaining essential services while accelerating transformation towards a more preventative, integrated care system.

4. Shropshire's 2025-26 BCF End of Year Template

4.1. As for 2026-27, ICBs and local authorities were required to set specific goals, agreed by HWBs. For 2025-26 these were:

- Emergency admissions to hospital for people aged 65 and over.
- Average length of discharge delay for all acute adult patients, derived from:
  - the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD).
  - for those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge.
- Long term support needs of older people aged 65 and over met by admission to residential and nursing care homes.

4.2. Performance

2025-26 metric plans for emergency admissions and residential admissions were achieved.

The metric plan for discharge delays was not achieved. The performance dashboard shows a notable change in discharge ready date delay during November 2025, a position that continued into December. This was caused by the decommissioning of Rehabilitation and Recovery Unit (RRU) beds from the acute provider that were being utilised for intermediate step-down capacity. As a result of closure, the activity being supported by the RRU was reported for discharge by the Care Transfer Hub. This resulted in an increase in patients with no criteria to reside, thereby impacting the discharge ready date to discharge length of stay. This is now in recovery and provides confidence for Shropshire to achieve the metric plans for 2026-27.

4.3. End of year impact summary

HWB areas were asked to provide narrative about two key successes observed towards driving the enablers for integration. For Shropshire these are:

- Data and shared information - changing the local acute provider's data system posed significant challenge due to data loss during 2024-25 and the start of 2025-26. The new data system is now embedded, data flow has been restored, and the data is supporting the rapid maturity of population health management capabilities.

- Integrated working continues to develop through for example integrated teams at neighbourhood level, all age social prescribing, the proactive care multi-disciplinary team, a care hub that works effectively through the joint teams and effective reablement via the Short Term Assessment and Reablement Team supporting people to remain and return home.

HWB areas were also asked to provide narrative about two key challenges observed towards driving the enablers for integration. For Shropshire these are:

- Challenges are posed by the limited financial resources available and difficulty in reallocating resources to enable the left shift.
- Providing services across a rural county remains a challenge. There may be opportunities to develop innovative ways of addressing this challenge with the clustering and longer-term merging of Shropshire, Telford and Wrekin with Staffordshire and Stoke on Trent.

5. The future of the BCF

The BCF is undergoing significant reforms. These reforms aim to ensure consistent and joint funding for services that require fully integrated delivery, such as hospital discharge, intermediate care, rehabilitation, and reablement. The BCF will be incorporated into Neighbourhood Health Plans, developed jointly by the NHS, local government, and partners, as all BCF Plans have been to date.

The reforms will focus on supporting local areas to achieve better outcomes in line with the priorities of the NHS 10 Year Health Plan. An announcement detailing the scope of these reforms will be made in due course. New financial systems will encourage innovation, shift funding from hospitals to community care, and reward best practices in the NHS.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	For this initial year of BCF reform, local areas are asked to start to align plans for pooled funding with wider their approach to development of relevant areas of neighbourhood health plans, such as intermediate care. There will be no changes to the current system of minimum funding contributions. For 2027-28 onwards, the government intends to consider whether local areas should be given more flexibility in deciding the level of pooled funding needed to support better integrated services. There will be a consultation on any proposed changes to minimum NHS and local authority contributions. The government will work with the NHS and local government to develop clearer expectations for the types of services that, as a minimum, should be subject to pooled funding. This will build on the success that many local areas have already seen by taking a more strategic approach to pooled funding. Indicative ICB allocations for 2027-28 and 2028-29 have been provided. If consultation results in giving local areas more flexibility and a lower minimum required level of pooling (from 2027-28 at the earliest), the relevant funding will remain in NHS and local authority budgets and will continue to be spent on health and social care services respectively. No changes will be introduced to the NHS and local authority minimum contributions to the BCF before financial year 2027-28. The government is increasing the NHS minimum contribution to adult social care between 2026-27 and 2028-29 in line with the Spending Review 2025 settlement - and this will be preserved in any new arrangements for 2027 to 2028 onwards. Local Authority Better Care Grant allocations remain the same in 2026-27 as they were in 2025-26. The government will confirm the distribution and allocations of the Local Authority Better Care Grant from 2027-28 onwards, as well as how places undergoing local government re-organisation can transition to new funding arrangements, in due course. Work on reviewing Shropshire's BCF schemes will continue in 2026-27 to identify how partners can further collaborate and identify efficiency savings.

Financial implications (Any financial implications of note)	Financial details are included in appendices B and C.	
Climate Change Appraisal as applicable	All commissioned activity considers climate change.	
Where else has the paper been presented?	System Partnership Boards	Not applicable
	Voluntary Sector	Not applicable
	Other	Not applicable

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

Better Care Fund 2026/27 to 2028/29: minimum NHS contributions from integrated care boards

Local government finance policy statement 2026-27 to 2028-29

List of local authority DFG allocations 2026-27

Better Care Fund framework 2026 to 2027

BCF Metrics Handbook

BCF Planning Principles document

Cabinet Member

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

Appendices

Appendix A 2026-27 Narrative Return
Appendix B 2026-27 Numerical Return
Appendix C 2025-26 End of Year Template

NB: Members: Appendix B & C will be provided as a separate attachment due to format Public: through website, Appendix B& C can be provided on application to louisa.jones@shropshire.gov.uk

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**						
Title of report	**Shropshire, Telford and Wrekin 5 Year Strategic Commissioning Plan**						
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	Dr Lorna Clarson Lorna.clarson1@nhs.net						
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	x	Reduce inequalities (see below)	x			
What inequalities does this report address?	Individual elements will be worked through at a programme delivery level but in summary, the Five-Year Strategic Commissioning Plan has been developed in line with the ICB's statutory duties under the Health and Care Act 2022, including responsibilities to improve quality, reduce health inequalities, involve patients and the public in decision-making, ensure safeguarding, and secure continuous improvement in outcomes and efficiency. The plan aligns with the regulatory expectations set out by NHS England, including requirements for Integrated Impact Assessments (IIAs), Equality Impact Assessments (EQIAs), Core20PLUS5 inequalities duties, compliance with national patient safety and quality frameworks, and adherence to the Gunning Principles for consultation. The plan also strengthens regulatory assurance through improved data quality, contract compliance, provider oversight, and structured quality and inequalities governance, ensuring that statutory obligations are embedded throughout transformation and service redesign.						

Report Content:

1. **Executive Summary**

-

2. **Report Recommendations**

The Health and Wellbeing Board is asked to note the content and implications of the Shropshire, Telford and Wrekin (STW) Five-Year Strategic Commissioning Plan for 2026/27–2030/31, and the direction of travel as the system moves into the delivery phase.

3. **Main Report**

The plan sets out a clear and ambitious roadmap for improving health and care outcomes for local people, based on a strong understanding of population need, including the Integrated Strategic Needs Assessment, Population Health Improvement Plan, and Clinical Strategy. It aligns with national policy and is underpinned by five fundamental shifts that will shape how care is planned and delivered across the system.

The first shift is from hospital-centred care to care delivered within local communities and neighbourhoods. This will be achieved through strengthening integrated neighbourhood teams for both adults and children, enabling more proactive, coordinated and person-centred care closer to home. Key developments include expansion of urgent community response services, increased use of virtual wards, enhanced intermediate care, and bringing more diagnostics and planned care into community settings. Improving access to primary care is central to this shift, supported by strengthened roles for pharmacy, dentistry and optometry, alongside multidisciplinary working and improved care coordination.

The second shift is from analogue to digital ways of working, supporting more accessible, efficient and joined-up care. This includes the development of shared care records, increased use of remote monitoring, and digital access to services through tools such as online triage and the NHS App. A key principle is ensuring digital innovation reduces, rather than exacerbates, health inequalities, with targeted support for inclusion and access across all communities.

The third shift is from treating illness to preventing it and improving population health. The plan prioritises action on the main drivers of poor health, including smoking, obesity, alcohol harm, hypertension and respiratory disease, alongside a strong focus on mental health and wellbeing. Prevention will be embedded across all services, supported by strengthened screening, vaccination, early years support and targeted interventions through Core20PLUS5. A population health management approach will ensure resources are directed to the communities with the greatest need, helping to reduce unwarranted variation and inequalities in outcomes.

The fourth shift focuses upon a clear shift towards improving access which will make it easier for people to get the care they need, when they need it. The plan focuses on removing barriers linked to distance, digital exclusion, disability and deprivation, while expanding timely routes into primary and community services. Efforts will centre on simplifying referrals, increasing capacity where waits are longest, and strengthening early contact points so support is available before problems escalate. By using population health insights to identify groups facing the biggest obstacles, the system will target resources where they will have the greatest impact, reduce variation and ensure access to care is fair, consistent and responsive.

The fifth and final shift will require a sustained shift towards improving productivity to ensure services deliver more effective care with the resources available. The plan focuses on reducing unwarranted variation, streamlining pathways and strengthening operational discipline so staff time is used where it adds the greatest value. Modern digital tools, better data sharing and clearer performance frameworks will support teams to work efficiently and consistently across the system. Targeted action to improve flow, reduce delays and optimise clinical and administrative processes will help tackle backlogs and enhance the quality of

care. By directing improvement support to areas with the greatest opportunity, the system will boost productivity, improve outcomes and build a more sustainable model of delivery.

These strategic shifts are reflected in a set of commissioning priorities across key service areas. Urgent and emergency care will be redesigned to better manage demand, reduce avoidable hospital admissions and improve patient flow. Elective and diagnostic services will be expanded within communities, including through community diagnostic centres and streamlined pathways, whilst cancer services will focus on earlier diagnosis and improved outcomes. Mental health services will be increasingly delivered locally, with strengthened alternatives to hospital care. Services for children and young people will prioritise early intervention, particularly within schools and community settings, and improve pathways for those with additional and neurodevelopmental needs. Women's health, maternity services and long-term condition management will be delivered through integrated neighbourhood models, emphasising continuity, prevention and personalised care.

Delivery of the plan will require a strong and sustainable financial approach. The Board should note that the system continues to operate within a constrained financial envelope, requiring a continued focus on efficiency, productivity and value-based commissioning. Investment will be prioritised towards prevention, community-based care and digital transformation, with an expectation that this will reduce reliance on higher-cost acute services over time. Any transitional investment will need to demonstrate a clear trajectory to medium-term financial benefit and be managed within the system's overall financial framework and control total.

Workforce is a critical enabler of delivery. The plan supports the development of integrated, multidisciplinary neighbourhood teams, alongside expansion of the primary and community workforce and a more coordinated, system-wide approach to workforce planning. There is a continued focus on staff wellbeing, retention, leadership development and organisational culture, recognising that a resilient and supported workforce is essential to delivering sustainable transformation.

A number of system-wide enablers underpin delivery of the plan. These include digital and data capability, estates optimisation, research and innovation, and robust governance and risk management arrangements. There is also a continued emphasis on safeguarding, emergency preparedness and resilience. Reducing health inequalities is a cross-cutting priority, with all partners expected to contribute to addressing variation in access, experience and outcomes.

The Board is also asked to note the wider implications of the plan. In particular, delivery will depend on strong partnership working across health, local authority, voluntary and community sector partners, as well as effective engagement with local communities. The plan also aligns with the system's climate change and sustainability commitments, supporting delivery of the NHS Green Plan through more sustainable models of care, reduced unnecessary travel, and consideration of the environmental impact of service delivery.

Overall, this plan represents a significant shift towards more proactive, preventative and locally-delivered care. The Board is asked to note the scale of transformation required and the importance of continued system leadership and collaboration to ensure successful delivery and improved outcomes for the population of Shropshire, Telford and Wrekin.

Risk assessment and opportunities appraisal	The 5-Year Plan Risk Register outlines the key strategic, operational and financial risks that may impact delivery of the plan. The highest-rated risks relate to financial sustainability, workforce capacity, digital capability, delivery of the left-shift model, performance recovery, and the management of major service changes. Each risk is accompanied by defined mitigations and a target position, with oversight provided through the relevant ICB committees. Across the system, the most significant themes include rising demand and cost pressures, capital constraints, workforce shortages across sectors, variation in digital maturity, and challenges in shifting activity from hospital to community settings. Additional risks relate to health inequalities, screening and prevention performance, digital exclusion, and limitations in data quality and population health management. Engagement-related risks highlight the need for sustained patient, public and stakeholder involvement throughout the development and delivery of the Plan. Mitigations focus on strengthened financial planning, targeted workforce actions, digital investment, enhanced programme governance, population health approaches, and improved community capacity. All risks have clear oversight routes, and the register will be monitored and updated regularly as delivery of the 5-Year Plan progresses.
Financial implications	The Health and Wellbeing Board is asked to note the financial implications of this proposal in the context of the Shropshire, Telford and Wrekin (STW) five-year plan. The system continues to operate within a constrained financial envelope and is required to deliver recurrent efficiencies while improving population outcomes. As set out in the plan, there is a clear strategic shift towards investing in prevention and community-based provision to reduce reliance on higher-cost acute services. Any investment associated with this work is therefore expected to align with these priorities and demonstrate value for money, with a trajectory to deliver medium-term financial benefits through reduced demand and improved productivity. Where pump-priming or transitional funding is required, this will need to be managed within the system's overall financial framework and control total. The Board should also note the importance of partnership working and the maximisation of external funding opportunities to support delivery and ensure that resources are targeted to areas of greatest population impact.
Climate Change Appraisal as applicable	The Health and Wellbeing Board is asked to note the climate change and sustainability implications of the plan. The plan aligns with the NHS Green Plan and commits the system to reducing its environmental impact while improving population health, recognising the interdependencies between climate change,

	health inequalities, and service demand. Delivery of this work is expected to support a shift towards more sustainable models of care, including prevention, community-based provision, and reduced unnecessary travel and resource use. Consideration will also need to be given to the carbon impact of any service changes, procurement decisions, and estate utilisation, ensuring alignment with the system's net zero ambitions. The Board should note that embedding sustainability within service design is a core requirement of the plan, with opportunities to realise co-benefits for health outcomes, system efficiency, and environmental performance over the medium to long term.	
Where else has the paper been presented?	System Partnership Boards	ShIPP
	Voluntary Sector	
	Other	The 5 Year Plan has been presented to the ICB Board in Public.
List of Background Papers Our Strategies - NHS Shropshire, Telford and Wrekin		
Exec lead – Dr Lorna Clarson, Chief Officer: Strategy and Improving Outcomes NHS Shropshire, Telford and Wrekin, NHS Staffordshire and Stoke-on-Trent		
Appendices Appendix A. Appendix A. 5 Year Strategic Commissioning Plan presentation		

This page is intentionally left blank

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Shropshire, Telford and Wrekin 5-Year Commissioning Plan (2026–2031)

Overview and Priorities

Background

National Requirement (NHSE Planning Framework 2026/27–2030/31) linked to the delivery of the 10 Year Plan

The plan moves commissioning from annual cycles to a rolling 5-year plan, enabling:

- The development of clear, stable commissioning intentions.
- Long-term investment decisions.
- A coherent roadmap for transformation across the system.

Our plan brings together:

- Assessment of population need using:
  - The Integrated Strategic Needs Assessment (ISNA).
  - The Population Health Improvement Plan (PHIP).
  - The Clinical Strategy.
  - Neighbourhood-level data and inequalities insights.
  - Long-term ambitions for outcomes, inequalities, access, financial sustainability, digital and workforce.

To deliver our 5 system shifts of:

- Hospital → Community
- Analogue → Digital
- Sickness → Prevention
- Improving Access
- Value & Productivity

Hospital to Community and Analogue to Digital

Hospital to Community	Analogue to Digital
Shift activity, resources, and workforce into community settings.	**Digitally enable the system to improve access, efficiency, and outcomes.**
• Expand neighbourhood multidisciplinary teams for Frailty and Long Term Condition management, Children and Young People and Mental Health. • Increase community urgent response, virtual wards, and home-based care. • Strengthen intermediate care and discharge pathways. • Move diagnostics and outpatient activity into community hubs. • Reduce avoidable admissions and length of stay.	• Implement shared, interoperable digital records. • Expand remote monitoring for frailty, COPD, heart failure, diabetes. • Improve digital access in primary care (online triage, messaging, video). • Use Population Health Management, data and analytics to drive commissioning. • Strengthen digital maturity, infrastructure, and cyber security.

Sickness to Prevention and Improving Access

Sickness to Prevention	Improving Access
Reduce long-term demand by improving population health.	**Ensure timely access to primary, urgent, planned, and mental health care.**
• Targeted prevention for CVD, smoking, obesity, diabetes, mental health. • Expand screening, early detection, and proactive case finding. • Strengthen early years and family support. • Embed population health management in all pathways. • Work with councils on housing, employment, environment.	• Increase primary care capacity and continuity. • Reduce elective waits, focusing on long waiters and diagnostics. • Expand same-day emergency care and alternatives to ED. • Improve mental health access, including crisis alternatives. • Strengthen SEND and CYP pathways

Value and Productivity

Value and Productivity
Deliver better outcomes within available resources.
• Reduce unwarranted variation across providers. • Improve theatre utilisation, outpatient productivity, and flow. • Optimise workforce skill-mix and shared roles. • Strengthen the ICB's intelligent payor capability. • Market Development and Commercial expertise.

Delivery Enablers

A sustainable, flexible workforce aligned to new models of care

- Skill-mix redesign across neighbourhood teams
- New roles: care coordinators, digital navigators, advanced practitioners
- Integrated workforce planning across health and social care
- Leadership development for neighbourhood and community teams
- Recruitment and retention aligned to population need

Modern, accessible spaces that support community-based care

- Development of community hubs and diagnostic centres
- Co-location of primary, community, mental health and VCSE services
- Rationalisation of under-used estate
- Investment in modern, flexible clinical and non-clinical spaces
- Estate strategy aligned to neighbourhood footprints

Turning data into actionable insight

- Population Health Management (PHM) to identify high-need cohorts
- Predictive analytics for demand, risk and outcomes
- Real-time dashboards for flow, performance and quality
- Data-driven commissioning and value-based decision making
- Integrated datasets across health, social care and VCSE

Collective delivery across the whole system

- Strong collaboration with local authorities, PCNs, providers and VCSE
- Joint planning through ICP and neighbourhood alliances
- Shared governance for transformation programmes
- Co-production with communities and people with lived experience
- Clear accountability for delivery across partners

Risks

Workforce Capacity & Capability
- Ongoing shortages across primary care, community, mental health and social care
- High reliance on agency and temporary staffing
- Limited capacity to support transformation alongside operational pressures

Financial Pressures & Productivity Requirements
- Challenging financial position across system partners
- Inability to left shift funding
- Rising demand outpacing available resources
- Delivery of productivity expectations (theatres, outpatients, medicines optimisation)

Digital & Data Readiness
- Variation in digital maturity across providers
- Dependence on timely delivery of shared care records, FDP and digital infrastructure

System Flow & Demand Pressures
- High levels of urgent care demand and delayed discharges
- Risk that acute pressures divert focus from community shift
- Rising demand in mental health, SEND and CYP services

Partnership & Delivery Complexity
- Multi-agency delivery across NHS, councils, VCSE and PCNs
- Variation in readiness and capacity across partners
- Risk of misalignment between organisational priorities

Estates Constraints & Infrastructure Gaps
- Ageing estate and limited capacity in primary and community settings
- Delays to capital investment and approvals
- Insufficient space for co-location of neighbourhood teams

Governance and Assurance

Integrated Care Board (ICB)

- Produces the 5-Year Strategic Commissioning Plan.
- Sets system-wide priorities, outcomes and financial strategy.
- Commissions services and allocates resources.
- Holds providers and Places to account for delivery.
- Ensures delivery of national requirements and system transformation.

Place-Based Partnerships (Place)

- Brings together NHS, councils, PCNs, community services and VCSE.
- Designs and delivers local models of care.
- Oversees neighbourhood teams, prevention and community services.
- Drives local improvement, integration and early intervention.
- Provides local insight to shape commissioning.

Health & Wellbeing Board (HWBB)

- Sets the Joint Strategic Needs Assessment (JSNA) and Health & Wellbeing Strategy.
- Provides democratic oversight of local priorities.
- Ensures NHS, council and partners align to local population needs.
- Holds the system to account for improving outcomes and reducing inequalities.

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**					
Title of report	**Shropshire Council Corporate Plan**					
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	Tom.Dodds@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			
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce		Reduce inequalities (see below)			
What inequalities does this report address?						

Report content:

1. Executive Summary
Please see appendix A. Shropshire Council Corporate Plan – presentation

2. Recommendations
The Board is asked to note the update given on the Shropshire Council Corporate Plan.

3. Report
Please see appendix A. Shropshire Council Corporate Plan – presentation

Risk assessment and opportunities appraisal	- The Corporate Plan sets out the priority ambitions of the Council. There are direct links between these ambitions and the priorities set out in the Health and Wellbeing Strategy, reinforcing opportunities for partners to deliver shared outcomes together.	
Financial implications	- There are no financial implications directly related to this report	
Climate Change Appraisal as applicable	- There are no climate change implications directly related to this report	
Where else has the paper been presented?	System Partnership Boards	ShIPP
	Voluntary Sector	
	Other	Shropshire Council Cabinet (6 May 2026) Shropshire Council – Council (14 May 2026)

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

Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead
Tanya Miles, Chief Executive, Shropshire Council
Cllr Heather Kidd, Leader of Shropshire Council

Appendices
Appendix A. Shropshire Council Corporate Plan – presentation
Appendix B. Shropshire Council Corporate Plan Shropshire Council Corporate Plan 2026-2030

Shropshire Council

Corporate Plan 2026-2030

Rebuilding Shropshire Together

Update to Health and Wellbeing Board
7 July 2026

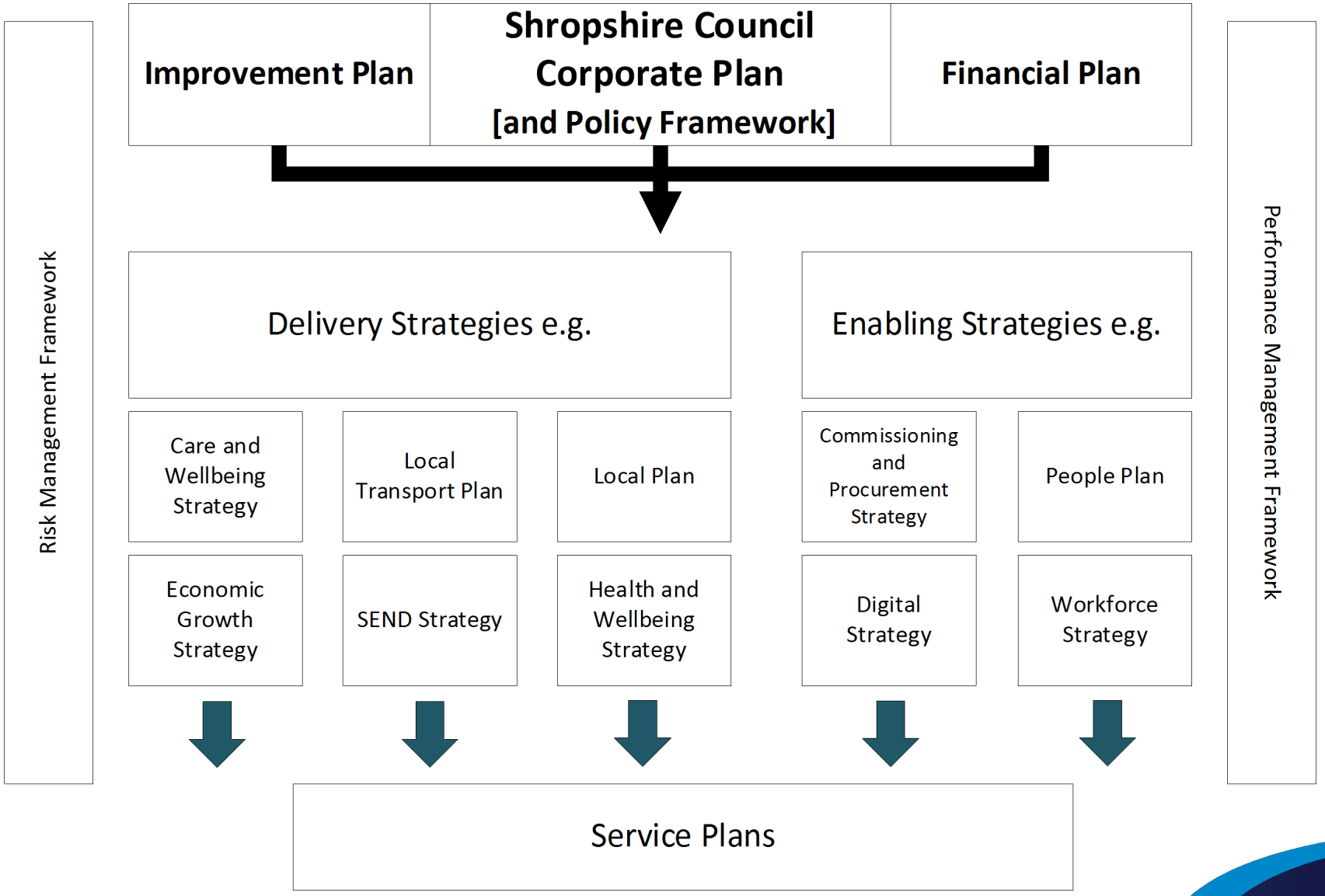
Our vision: Sustainable – Resilient – Together

Sustainable: We need to live within our means, protect our environment and support a strong local economy, so services and opportunities remain sustainable for the long term

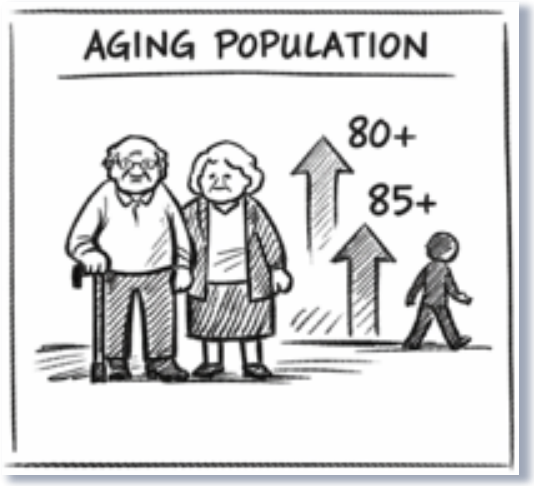
Resilient: We want to build strong communities that can respond to change and future challenges, where people stay healthier and independent for longer, and where council services are there when they are most needed.

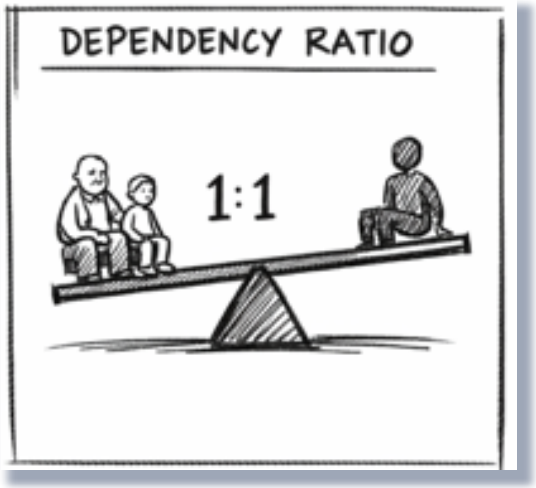
Together: We want to be a council that works closely with its communities and partners, and a county that is well connected, so people can easily access services, opportunities and support they need.

Delivering our ambitions and priorities

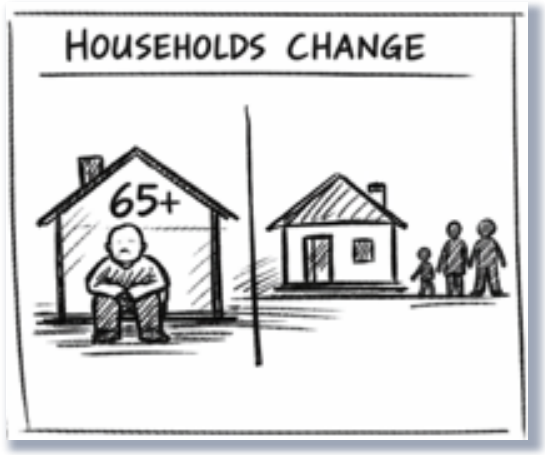



POPULATION GROWTH
+65,400


AGING POPULATION
80+
85+


DEPENDENCY RATIO
1:1


HEALTH & CARE


HOUSEHOLDS CHANGE
65+


EXTREME WEATHER

Working with our partners and communities we want Shropshire to be a place where....

- there is a financially sustainable council, with clear priorities and purpose, and a workforce that is supported to excel
- communities are connected by well-maintained roads, accessible transport and infrastructure
- people live in safe, inclusive places with homes that meet their needs
- everyone has an opportunity to be healthy and thrive at every stage of life
- an environment that harnesses our natural assets and supports wellbeing
- a thriving economy that benefits everyone

Our priority ambitions and the Health and Wellbeing Strategy Priorities

Corporate Plan Priority Ambitions	H&WB Strategy Priorities
•A financially sustainable council	Joined-up working
•Connected communities	Strong and Vibrant communities
•Safe and inclusive places	Reducing inequalities
•Opportunity to be healthy and thrive	Children and Young People
•Environment and wellbeing	Improving population health
A thriving economy	Mental Health
	Healthy weight and physical activity
	Workforce

The Future Council Principles:

- Agility and adaptability
- Early intervention and prevention
- Working with others in partnership
- Digitally enabling and automation
- Resident and customer focus
- Data, insight and demand management

A selection of Corporate Plan Delivery Commitments (1)
A single Children's Transformation Programme (developed by June 2026)
An Adults Social Care transformation programme (developed by Sept 2026)
An agreed approach to working with parish and town councils to deliver services and outcomes (by March 2027)
A proposed approach to a Shropshire Partnership (by November 2026)
A new Adult Social Care Strategy – outlining key priorities and operating model for adult social care (Oct 2026)
Increase the number of households where homelessness is prevented to start to reduce our use of temporary accommodation (ongoing, measured by KPI)
Produce and consult on our draft Local Plan (by June 2027) having: Completed a Green Belt Review (July 2026) Commissioned a Strategic Housing Market Assessment (October 2026) Delivered an Economic Development Needs Assessment (November 2026) Undertaken site assessment / development options ready for consultation/allocation (December 2026)
Deliver 10 new or improved access routes / green space schemes to improve access to green space and support wellbeing (by March 2027)

A selection of Corporate Plan Delivery Commitments (2)
Work with DWP to support families on benefits and reduce the impact of child poverty e.g. by expanding free school meals (by April 2027)
Expand community-based wellbeing and prevention services into library and community hub spaces (March 2027)
Expand integrated neighbourhood working through Community & Family Hubs (Best Start in Life) and VCSE partners for priority areas aligned to statutory requirements (September 2026)
Recommission our mandatory public health service contracts – including: • community drug and alcohol services to provide support, treatment, and recovery options for individuals and their families struggling with substance use issues (from April 2027) • 0-19 Healthy Child Programme to provide support for young people and their families (from April 2027)
Deliver a refreshed Statutory Joint Health and Wellbeing Strategy (JHWBS) focusing on the Marmot principles, incorporating our inequalities and prevention plans and setting out the long-term vision for improving health and wellbeing (April 2027)
Work with partners to develop a system-wide strategic approach to neighbourhoods including neighbourhood health as part of the national mandate (December 2026).

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**					
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?	All protected characteristics					

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. ShIPP is a formal subcommittee of the ICB Board.

ShIPP meets Bi-monthly, with the last meeting on the 18th June 2026. The meeting was quorate and well attended and the minutes of the last meeting were accepted without amendment. No declarations of pecuniary interest were made.

2. Recommendations

(not needed - information only report)

3. Report

1b. Past actions

Completed actions included establishment of the ShIPP risk register, escalation of key ShIPP Accelerator Group issues to the ICB, CAMHS updates being taken through the Accelerator Group, and escalation of NNHIP matters relating to strategic direction, leadership, governance, neighbourhood footprints and funding.

Action: Items escalated in the ShIPP key issues report to the ICB to be raised and reported back to ShIPP by Lynn Millar.

2. Shropshire Drug and Alcohol Joint Strategic Needs Assessment
The Board received the Shropshire Drug and Alcohol JSNA, which highlighted local needs, service strengths, gaps and recommendations. The update covered rural access barriers, unmet drug treatment need, service performance, mental health and safeguarding links, young people's treatment, housing support, family safeguarding, prevention, recommissioning, co-location, neighbourhood delivery and engagement with people who may not currently access treatment. The group agreed that progress should be tracked and revisited in 12 months.

Actions:

- The Drug and Alcohol Task and Finish and commissioning group to report back to ShIPP in one year on progress.
- Sharon Fletcher to link the Steering Group with the Burdett Trust preconception care pilot.

3. Five-Year Strategic Commissioning Plan and HealthHero update
The Board received an update on the HealthHero out of hours and care coordination service, which was reported to be performing strongly, with high patient satisfaction and a reduction in category 3 ambulance admissions. A one-year review is expected to be shared in September.

The Five Year Strategic Commissioning Plan was also presented. It set out priorities around neighbourhood multidisciplinary services, community urgent response, virtual wards, intermediate care, discharge, diagnostics, digital transformation, prevention, access, productivity, risk management and governance. Discussion focused on ensuring alcohol and drugs prevention is visible within the plan, developing Shropshire-specific models of care, clarifying routes for funding and ICB governance, and strengthening neighbourhood-level estates planning. Members agreed that estates planning should be developed locally and then brought together into an overall Shropshire view.

Action: Gemma Smith to pick up estates planning with Tanya Miles, Lynn Millar and Angela and return with a proposal for next steps.

4. Renters Rights Act 2025 and Housing Enforcement update
The Board received an overview of the Renters Rights Act 2025 and associated housing enforcement reforms. The update covered tenancy reform, new enforcement powers, landlord registration, the private rented sector database, civil penalties, the private sector ombudsman, extension of the decent homes standard and future supported housing requirements. The Chair expressed strong support for the reforms and their importance in protecting vulnerable residents.

Action: A future agenda item to be scheduled for further discussion due to time constraints.

5. Place Universal Offer update
The Board considered the next stage of Place Universal Offer development. Three geographical areas were proposed following work with the Shropshire PUO Steering

Group: North Shrewsbury, Market Drayton and Highley. These areas were selected to support wider system change and learning, reflecting identified need and inequality, existing community and partnership capacity, alignment with wider transformation, opportunities for prevention and neighbourhood working, and a mix of urban and rural contexts.

Approvals: The Committee approved the work of the PUO Steering Group to date and approved the focus on the three identified geographical locations for targeted investment, including the rationale for their selection.

6. ShIPP Accelerator Group

The item was received for information only.

7. NNHIP update

The item was received for information only.

8. Any Other Business

- The Chair informed members of the forthcoming CQC inspection of adult social care, including data submission, self-assessment and stakeholder engagement. Members were asked to look out for engagement sessions and contact the Chair if they required further information.
- The Board was also updated on the Home Office commissioning of Serco to manage properties in the Hodnet area for asylum dispersal. Significant media interest and limited prior engagement with the local authority were noted. A steering group involving health and local authority representatives has been established, with further information to be shared when available.

Actions:

- Members to look out for CQC stakeholder engagement sessions and contact the Chair if further information is required.
- Further information on the Home Office property update to be shared when available.

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	
	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

Cllr Ruth Houghton, Portfolio Holder for Adult Social Care & Health, Shropshire Council
Rachel Robinson, Executive Director – Public Health (DPH), Shropshire Council

Appendices

N/A

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**9th July 2026**					
Title of report	**Health and Wellbeing Board Performance against measures of success**					
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	Mark Trenfield, Public Health Intelligence Analyst, mark.trenfield@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			
	Workforce	X	Reduce inequalities (see below)	X		
What inequalities does this report address?	Gender and Shropshire comparison to England.					

Report content - *Please expand content under these headings or attach your report ensuring the three headings are included.*

1. Executive Summary

Areas the have changed since the previous Health and Wellbeing Board update

1. Health life expectancy in males has dropped since last update from 64.7 years to 63.0 years – dropping from significantly higher than England to being statistically similar to England (60.9 years)
2. Health life expectancy for females has dropped from 64.8 years to 62.4 years, however it is still statistically similar to England (61.3 years).
3. Healthy life expectancy at 65 for males has dropped from 11.3 years to 11.0 years, however this is statistically similar to England which remains at 10.1 years.
4. Healthy life expectancy at 65 for females has dropped from 12.1 years to 11.4 years, remaining statistically similar to England (11.1 years).
5. Emergency hospital admissions for pneumonia have increased from 470.1 per 100,000 to 501.6 per 100,000, which means that Shropshire's rate continues to be significantly higher than England's rate, which has dropped to 426.6 per 100,000.
6. 16- to 17-year-olds not in education, employment or training (NEET) or whose activity is not known has dropped significantly in the last year from 6.3% to 3.0% for 2024/25, moving from being significantly higher than England (5.4%), to being significantly lower than England (5.6%).

Overall ratings compared to national for the 27 indicators

Rating against National in chosen 26 indicators	Rating at Baseline		Latest Rating	
	Number	Percentage	Number	Percentage
Green	3	12%	3	12%
Amber	6	23%	9	35%
Red	13	50%	10	38%
Data no longer available	1	4%	1	4%
No metric decided yet	2	8%	2	8%
No rating	1	4%	1	4%

See table on next page for full overview of indicators and performance

Strategic Priority Name	Strategic Priority Name	Baseline Value	Baseline Rating	Latest Value	Latest Rating	Trend since Baseline	Trend Latest value compared to previous y	Baseline Value	Latest Value	KPI in Shropshire Plan Performanc	Baseline Period	Latest Period
Improving population health; Reducing inequalities, Working with and building strong and vibrant communities, Joined-up working	Healthy life expectancy at birth (Male, All ages) - Years	65.3	●	63	●	↓	↓	62.7	60.9	No	2019 - 20	2022 - 24
	Healthy life expectancy at birth (Female, All ages)- Years	66.1	●	62.4	●	↓	↓	63.7	61.3	No	2019 - 20	2022 - 24
	Healthy life expectancy at 65 (Male, 65)- Years	11.5	●	11	●	↓	↓	10.4	10.1	No	2019 - 20	2022 - 24
	Healthy life expectancy at 65 (Female, 65)- Years	12.3	●	11.4	●	↓	↓	11.7	11.1	No	2019 - 20	2022 - 24
	Improving access to health and care services - Barriers to housing and services domain IMD score	24.5	* no rating	29.6	* no rating	↑	↑	no value for England	no value for England	No	2019	2025
	Excess under 75 mortality rate in adults with severe mental illness (SMI) (Persons, 18-74 yrs)	455.1%	●	436.0%	●	↓	↓	385.9%	383.7%	Yes	2019 - 20	2021 - 23
	Personalisation- NHS GP Patient Survey Q44. Have you had a conversation with a healthcare professional from your GP practice to discuss what is important to you when managing your conditions or illnesses?	32%	●	40%	●	↑	↑	35%	42%	No	2022	2025
	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years)- Crude rate per 10,000	106.2	●	56.7	●	↓	↓	93.6	68.5	No	2019 - 21	2024/25
	Emergency hospital admissions for pneumonia (Persons, All ages)- DSR per 100,000	549.7	●	501.6	●	↓	↑	489.7	426.6	No	2019 - 21	2023/24
	Hospital admissions as a result of self-harm (Persons, 10-24 yrs) - DSR per 100,000	368.6	●	129.9	●	↓	↓	426.4	266.6	No	2020 - 2021	2023/24
	Coronary heart disease: hospital admissions (Persons, All ages)- DSR rate per 100,000	453.7	●	374	●	↓	↓	369.4	386.6	No	2020-21	2024/25
Workforce	Average weekly earnings (Persons, 16+ yrs)	£426.60	●	£575.00	●	↑	↑	£475.60	£632.50	No	2020	2025
	16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known (Persons)	7.2%	●	3.0%	●	↓	↓	5.5%	5.6%	Yes	2019 - 2020	2024/25
	Make Every Contact Count (MECC) training. Numbers of staff trained	Metric to be decided	-	-	-	-	-	-	-	No	-	-
	Workforce who works together to improve access to the right services at the right time	Metric to be decided	-	-	-	-	-	-	-	No	-	-
	School pupils with social, emotional and mental health needs (Persons, School age)	2.2%	●	3.9%	●	↑	↑	2.8%	4.0%	No	2020 - 2021	2024/25
	Suicide rate (Persons, 10+ yrs)- DSR per 100,000	10.0	●	13.5	●	↑	↑	10.0	10.9	Yes	2017 - 2019	2022 - 24
Children and Young People	Child development: percentage of children achieving a good level of development at 2 to 2 and a half years (Persons, 2-2.5 yrs)	65.0%	●	65.6%	●	↑	↑	83.3%	81.4%	Yes	2019 - 2020	2024/25
	Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years (Persons, 2-2.5 yrs)	78.2%	●	78.4%	●	↑	↑	88.9%	87.6%	No	2019 - 2020	2024/25
	Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years (Persons, 2-2.5 yrs)	84.0%	●	84.5%	●	↑	↑	92.9%	91.8%	No	2019 - 2020	2024/25
	Children in care (Persons, <18 yrs)- Crude rate per 10,000	86	●	119	●	↑	↓		67	Yes	2020 - 2021	2024/25
Healthy Weight and Physical Activity	Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight) (Persons, 18+ yrs)	65.0%	●	64.0%	●	↓	↓	62.6%	64.6%	Yes	2020 - 2021	2024/25
	Obesity in early pregnancy (Female, All ages)	Data no longer available	Data no longer available	Data not availa	Data not availa	Data not availa	Data not availat	25.40%	26.2%	No	Data no longer available	2023/24
	Diabetes prevalence aged 17+ (QOF)	6.9%	●	7.8%	●	↑	↑	7.1%	7.9%	No	2019-20	2024/25
	Smoking in early pregnancy (Female, All ages)	21.8%	●	18.4%	●	↓	↓	17.2%	13.6%	No	2022 - 2023	2023/24
	Smoking status at time of delivery (Female, All ages)	11.4%	●	7.1%	●	↓	↓	8.8%	6.1%	No	2022 - 2023	2024/25

2. Recommendations (*Not required for 'information only' reports*)

3. Report

Areas showing improvement since baseline:

1. **Excess under 75 mortality rate in adults with severe mental illness (SMI) (Persons, 18-74 yrs)-** reduced but still significantly worse than national rate

2. **Personalisation- NHS GP Patient Survey Q44: Have you had a conversation with a healthcare professional from your GP practice to discuss what is important to you when managing your conditions or illness? –** people answering 'Yes' has increased from 32% to 40%, but still below national figure of 42%
3. **Hospital admissions caused by unintentional and deliberate injuries in children** (aged 0 to 14 years) – this was significantly worse than England at baseline, but rate in Shropshire has reduced and is now statistically lower than England
4. **Emergency hospital admissions for pneumonia** this was significantly higher than England at baseline, and started to fall, however, it has gone back up in the last 2 years, although is not as high as at baseline and has remained significantly worse than England
5. **Hospital admissions as a result of self-harm** (Persons, 10-24 yrs)- from being statistically similar to England at baseline, this rate has reduced and is now significantly better (lower) than national rate
6. **Coronary heart disease: hospital admissions (Persons, All ages)- DSR rate per 100,000 –** rate has decreased since baseline which was significantly above national rate but is now similar but better (lower) than national rate.
7. **Average weekly earnings (aged 16+) -** increased since baseline - £426.60 to £575.00, but still significantly below the national figure (£632.50)
8. **16 to 17 year olds not in education, employment or training** (NEET) or whose activity is not known- reduced since baseline, when it was significantly worse and is now significantly lower than England
9. **Child development: percentage of children achieving a good level of development at 2 to 2 and a half years (Persons, 2-2.5 yrs) –** at baseline, rate (65%) was well below national and while it has increased very slightly to 65.6%, it remains well below national (81.4%).
10. **Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years (Persons, 2-2.5 yrs) –** at baseline rate of 78.2% was well below national and while there has been a very small increase to 78.4%, this continues to be significantly worse than national (87.6%).
11. **Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years (Persons, 2-2.5 yrs) –** was significantly below national at baseline (84%) and despite a slight increase to 84.5%, continues to be significantly below national (91.8%).
12. **Adults Overweight/Obese –** slight decrease from baseline of 65% to 64%, but has fallen from previous few years, remains statistically similar to England (64.6%)
13. **Smoking in early pregnancy-** since baseline of 22/23, Shropshire (21.8%) was well above national and while it reduced in 23/24 to 18.4%) was still well above national (13.6%), however the data source has not been updated since as there were concerns about data quality.
14. **Smoking status at time of delivery –** baseline (11.4%) was significantly above national figure, but most recent figure has dropped to 7.1%, which is now statistically similar to England (6.1%).

Areas worsening since baseline:

1. **Healthy life expectancy for males and females**- reduced for both since baseline – 65.3 years to 63.0 years for males, and 66.1 years to 62.4 years for females. Shropshire was significantly higher than England at baseline but is now statistically similar to it.
2. **Health life expectancy at 65 for males and females –** has slightly dropped for both since baseline – for males has dropped from 11.5 to 11 years, and for females has dropped from 12.3 to 11.4 years – both remain statistically similar to England.
3. **Improving access to health and care services - Barriers to housing and services domain IMD score –** there is no value for England for this sub-domain of the IMD, however Shropshire's score for this domain rose from the 2019 IMD to the 2025 version – a higher number means more deprivation
4. **School pupils with social, emotional and mental health needs**- has risen since baseline from 2.2% (significantly lower than England) to 3.9% and now similar to national rate of 4.0%.
5. **Suicide rate** - risen since baseline from 10.0 to 13.5 per 100,000 and now worse than national rate of 10.9 per 100,000
6. **Children in care –** rise from 86 per 10,000 since baseline to 119 per 10,000 and continues to be significantly above national rate of 67 per 10,000**.**

7. **Diabetes prevalence age 17+ (QOF)** (previously diabetes diagnostic rate which has been discontinued) – this indicator has risen since baseline in 2019/20 from 6.9% to 7.8% but remains statistically similar to the national rate of 7.9%**.**		
Risk assessment and opportunities appraisal		
Financial implications		
Climate Change Appraisal as applicable		
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)		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead: Rachel Robinson, Executive Director of Public Health Shropshire Council & NHS STW Cllr Ruth Houghton, Portfolio Holder for Adult Social Car e& Health, Shropshire Council		
Appendices *N/A*		

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**7th July 2026**					
Title of report	**Pharmacy updates (to the Shropshire PNA)**					
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	louisa.jones@shropshire.gov.uk					
Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working			
	Mental Health		Improving Population Health			
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities			
	Workforce		Reduce inequalities (see below)	x		
What inequalities does this report address?	The Pharmaceutical Needs Assessment and subsequent updates aim to address and monitor inequalities in pharmacy coverage and accessibility in Shropshire					

Report content

1. Executive Summary

The Pharmaceutical Needs Assessment (PNA) is a crucial part of the market entry system and supports commissioning decisions based on patient needs. The Health and Wellbeing Board has a statutory duty to prepare the PNA for Shropshire and communicate subsequent updates to the pharmaceutical list.

2. Recommendations

Not required for information only reports

3. Report

Changes listed since the last meeting are as follows:

1. **30.03.26: Consolidation of pharmacies** at New St, Shrewsbury, SY4 5AF (remaining site) and Unit 1, Morris Central Shopping Parade, Wem, Shropshire, SY4 5NY (closing site)

2. **25.06.26: Change of Ownership**: with effect from 23rd June 2026 the pharmacy at The Former Ticket Office, The Cross Gobowen, Shropshire, SY11 3JS will be operated by Gobowen Cross Pharma Ltd and the pharmaceutical list for the area of Shropshire Health and Wellbeing Board will be amended with effect from that date.

Risk assessment and opportunities appraisal	-
Financial implications	-
Climate Change Appraisal as applicable	-

Where else has the paper been presented?	System Partnership Boards	
	Voluntary Sector	
	Other	
List of Background Papers The current PNA for Shopshire is here shropshire-pna-2025.pdf		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead Rachel Robinson, Executive Director of Public Health (DPH), Shropshire Council & NHS STW Cllr Ruth Houghton, Portfolio Holder for Adult Social Care & Health		
Appendices – N/A		