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

Date: 11 November 2026

**Committee:**
**Health and Wellbeing Board**

**Date:** **Thursday 19 November 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
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
Chris Atherton - Director of Adult Service (DASS), Shropshire Council
Wendi Shepherd – Deputy Director of Public Health, 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
Lynn Millar – Director of Place, STW NHS, STW ICB and Staffordshire & Stoke-on-Trent ICB
Phil Smith - Chief Officer, System Development & Integration, NHS STW, Stoke & Staffs
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
Stacey Keegan – CEO, Robert Jones & Agnus Hunt Orthopaedic Hospital NHS Foundation Trust
Lynn Cawley - Chief Officer, Healthwatch Shropshire
Jackie Jeffrey – Lead Officer, VCSA
Claire Smout - Chief Officer, Partners in Care

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 Apologies for Absence and Substitutions**

**2 Disclosable Interests**

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

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

To confirm as a correct record the minutes of the meeting held on 17 September 2026 (attached).

**4 Public Question Time**

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. The deadline for this meeting is 12 noon on Friday 13 November 2026.

**5 Director of Public Health - 2026 Annual Report** (Pages 9 - 64)

Rachel Robinson, Corporate Director Population, Wellbeing and Neighbourhoods, Director of Public Health / Deputy Chief Executive, Shropshire Council

**6 National Neighbourhood Health Implementation Programme (NNHIP): Shropshire Summary of Achievement and next phase** (Pages 65 - 82)

Naomi Roche, Head of Place for Shropshire, NHS Shropshire, Telford & Wrekin

**7 Placed Based JSNA - Action Plans** (Pages 83 - 90)

Hannah Thomas, Community Wellbeing Team Manager, Shropshire Council

**8 Housing - A National Plan for Homelessness** (Pages 91 - 108)

Laura Fisher, Head of Housing, Resettlement and Independent Living,

Shropshire Council

Fiona Whittaker-Stranks, Homelessness Operations Manager, Shropshire Council

**9** **Better Care Fund 2026-27 Quarter One Reporting Template** (Pages 109 - 114)

Deborah Webster, Service Manager, Commissioning, Quality Assurance, and Business Development, Shropshire Council

If you would like a copy of Appendix A. Shropshire's BCF 26-27 Q1 Reporting Template to be emailed to you, please contact Michelle Dulson on 01743 257719

**10** **Terms of Reference - approval needed** (Pages 115 - 120)

Rachel Robinson, Corporate Director Population, Wellbeing and Neighbourhoods, Director of Public Health / Deputy Chief Executive, Shropshire Council

**11** **Chair's Report**

**12** **Severn Diabetes & Obesity Conference 2026** (Pages 121 - 130)

Cllr Bernie Bentick, Liberal Democrat Councillor for Meole Electoral Ward, Shropshire Council

Dr Probal Moulik Convener Severn Diabetes & Obesity Conference, President Diabetes UK Shrewsbury, Consultant Endocrinologist

**13** **Shropshire Integrated Place Partnership - update** (Pages 131 - 132)

Rachel Robinson, Corporate Director Population, Wellbeing and Neighbourhoods, Director of Public Health / Deputy Chief Executive, Shropshire Council

**14** **Date of next meeting**

Thursday 21st January 2026

Shropshire Council

**Committee and Date**

Health and Wellbeing Board

19 November 2026

**MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 17 SEPTEMBER 2026**
**9.30 - 11.40 AM**

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

**Present**

| | |
|---|---|
| Rachel Robinson | Executive Director of Public Health, Shropshire Council / NHS Shropshire, Telford & Wrekin and NHS Staffordshire & Stoke-on-Trent (ICB) |
| Wendi Shepherd | Deputy Director of Public Health, Shropshire Council (remote) |
| David Shaw | Director of Children's Services, Shropshire Council |
| Vanessa Whatley | Chief Nursing Officer, NHS Shropshire, Telford & Wrekin and NHS Staffordshire & Stoke-on-Trent (ICB) |
| Lynn Millar | Director of Place, Shropshire Telford & Wrekin, NHS Shropshire, Telford & Wrekin and NHS Staffordshire & Stoke-on-Trent (ICB) |
| Phil Smith | Chief Officer, System Development & Integration, NHS Shropshire, Telford & Wrekin and NHS Staffordshire & Stoke-on-Trent (ICB) |
| Ben Hollands | Health and Wellbeing Strategy Implementation Manager, Midlands Partnership Foundation Trust (MPFT) (remote) |
| Nigel Lee | Group Chief Strategy and Integration Officer, STW Community and Hospitals NHS Group |
| Jackie Jeffrey | Lead Officer, Shropshire Voluntary & Community Sector Assembly (VCSA) |
| Claire Smout | Chief Officer, Partners in Care |
| Mike Carr | Chief Operating Officer & Deputy CEO, Robert Jones & Agnes Hunt Orthopaedic Hospital |
| Mark O'Brien | Deputy for Director of Adult Social Services, Shropshire Council |

Also present: Gareth Wright, Damilola Agbato, Naomi Roche, Mish Irvine (remote)

18 **Election of New Co-Chair**

It was proposed, seconded and duly **RESOLVED**:

That Vanessa Whatley (Chief Nursing Officer, NHS Shropshire, Telford and Wrekin ICB) be elected Co-Chair of the Health and Wellbeing Board.

19 **Apologies for Absence and Substitutions**

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 |
| Natalie McFall | Director of Adult Social Services, Shropshire Council |
| Lynn Cawley | Chief Officer, Healthwatch Shropshire |
| Edward Hancox | Superintendent, West Mercia Police |

## 20 Disclosable Interests

No interests were declared.

## 21 Minutes of the previous meeting

**RESOLVED:**

That the Minutes of the meeting held on the 9 July 2026 be approved and signed as a correct record.

## 22 Public Question Time

A public question was received from Mr David Sandbach. Mr Sandbach read his question and the Chair read the response. It was confirmed that questions 3 and 4 would be addressed during discussion on the Winter Planning agenda item.

A copy of the questions and responses are available on the web page for the meeting.

## 23 System Winter Planning

The ICB Director, System Improvement and Emergency Preparedness presented the System Winter Plan and outlined the lessons learned from the previous winter. It was reported that those lessons had informed the development of a revised cluster-wide plan covering Shropshire, Telford and Wrekin, and Staffordshire. The Board was advised that the approach was supported by a unified system command and control structure and a single system coordination centre, which would oversee and coordinate the response to pressures affecting urgent and emergency care.

The ICB Director, System Improvement and Emergency Preparedness confirmed that the plan was structured around four key phases: ensuring winter readiness; reducing rising pressure; sustaining the system response; and exiting the winter period in a stable position. It was explained that the plan was underpinned by the continuation of system-wide interventions, including measures to improve patient flow, the reconfiguration of services, and communications activity intended to support self-care and increase vaccination uptake.

The Board was advised that the system operated under a cluster ICB model with Staffordshire, while continuing to recognise and respond to local needs. Interventions introduced during the previous winter, including modular ward capacity and assessment spaces at acute sites, remained in place and continued to support improvements in patient flow. It was noted that early January was a recurring period of heightened demand and increased system vulnerability. The winter planning arrangements therefore included a

specific focus on known pressure points, including bank holiday periods and the early Easter period.

The preparedness measures included the continued use of modular wards and enhanced assessment spaces to improve patient flow and reduce unnecessary admissions. The Board was informed that work was continuing to expand same-day emergency care and frailty-focused services, subject to their ongoing development. A system-wide communications campaign would promote self-care, encourage the appropriate use of services and support increased vaccination uptake. Collaboration would also continue across NHS providers, local authorities and voluntary, community and social enterprise partners to support the management of demand throughout the winter period.

During the discussion, Board members emphasised the importance of vaccination uptake and preventative activity, together with the need to align the winter plan with the wider work relating to public health and inequalities. They sought assurance regarding changes to capacity and the effect of those changes on winter readiness. In response, it was clarified that the additional bed capacity formed part of a wider service reconfiguration strategy and did not represent a straightforward expansion of capacity. Concerns were also raised regarding the reliability of forecasting and the system's preparedness to respond to variable levels of demand. It was acknowledged that national modelling remained under development. Board members further emphasised the importance of targeted planning for vulnerable populations and of recognising geographic variations in demand across the county. Particular attention was given to discharge planning, and it was agreed that discharge processes should commence at the point of admission and be supported through coordinated multi-agency working.

**RESOLVED:**

to note the System Winter Plan and to support the winter communications strategy, particularly the promotion of vaccination against seasonal illnesses.

that system partners continue to work collaboratively to deliver winter preparedness measures across health and care settings.

## 24 Health Protection Annual Report

The Health Protection Annual Report was presented to the Board. The report provided a comprehensive update on vaccination uptake, communicable disease prevention and control, screening programmes and wider health protection activity across Shropshire. Particular emphasis was placed on the work being undertaken to reduce health inequalities, improve access to preventative services and ensure that vaccination and screening opportunities were available to communities experiencing barriers to access.

The Board was advised that work had continued to improve uptake across the HPV, MMR, influenza, COVID-19 and RSV vaccination programmes, supported by targeted outreach to underserved groups. HPV vaccination uptake was reported at 74.8%. Although this represented a reduction compared with the previous year, performance remained above both regional and national averages. MMR uptake had remained stable at 94.2%, and overall childhood vaccination performance continued to exceed regional and national benchmarks. Seasonal vaccination performance across eligible cohorts was also reported to be strong, with uptake above the corresponding regional and England averages.

Participation in the breast, bowel and cervical screening programmes had remained above regional and national averages, with sustained levels of engagement. The report also described continuing communicable disease activity across the county, including gastrointestinal infections and seasonal respiratory outbreaks, with the greatest pressure arising during the winter period.

Targeted interventions had been implemented to address inequalities in access and uptake. These included engagement through schools, outreach within local communities and the use of pop-up vaccination clinics to bring services closer to residents who might otherwise experience difficulty accessing routine provision.

Board members welcomed the report and drew attention to the strength of partnership working and the positive performance achieved across Shropshire. It was emphasised that targeted work to address inequalities should continue, particularly in relation to vulnerable and underserved populations. The need to strengthen public communications was also highlighted so that residents and communities were aware of the services, vaccination opportunities and wider support available to them.

Concern was raised that cost-of-living pressures were contributing to widening health inequalities and could affect residents' ability to access vaccination and other preventative health services. It was emphasised that prevention planning should take account of the wider circumstances affecting health and wellbeing, including poor nutrition, cold homes and poverty, as these factors could compound existing barriers to engagement with services.

Clarification was sought regarding variations in vaccination uptake among younger people and between different communities. In particular, whether the barriers affecting HPV vaccination uptake could be better understood, including the operation of consent processes, difficulties in accessing vaccination opportunities and the effect of misinformation on the decisions made by young people and their families.

The Chair emphasised the importance of integrated partnership working across health, education and public health services and noted that vaccination, screening and wider prevention activity should be aligned as complementary elements of the system-wide approach to improving population health outcomes.

**RESOLVED:**

To promote childhood vaccination uptake, uptake of seasonal vaccines and to promote sexual health prevention services.

## 25 HWBB Strategy 2028- 33 - proposals

The Board received a report setting out the proposed approach to refreshing the Joint Health and Wellbeing Strategy for the period 2028–2033. It was noted that the current strategy would expire at the end of 2027 and that work was therefore required to develop and agree its successor. The report outlined the proposed development process and timetable, including the principal milestones through which the refreshed strategy would be prepared, consulted upon and progressed.

In considering the strategic approach and proposed engagement arrangements, Board members supported the direction of travel and emphasised the importance of adopting a Marmot approach, embedding co-production and securing meaningful engagement throughout the development of the strategy, particularly in the context of continuing changes across the wider system. It was recognised that the refreshed strategy would establish a key strategic direction for all system partners and should therefore reflect a broad range of priorities, supported by appropriate engagement and genuine co-production.

In relation to scope and policy alignment, it was proposed that the strategy should take account of wider national policy drivers, including children's reform programmes, reforms relating to special educational needs and disabilities, adult social care reform and safeguarding priorities. It was further suggested that the strategy should align with relevant national indicators and make effective use of available system levers, thereby strengthening strategic coherence across partner organisations. The importance of maintaining a system-wide understanding of shared responsibilities across health, social care and safeguarding was also highlighted.

Turning to integration with wider system planning, the need to ensure appropriate alignment between the Health and Wellbeing Strategy, Better Care Fund arrangements and emerging approaches to neighbourhood health planning was emphasised. The principal enablers required to support delivery of the strategy were considered along with the need for workforce transformation, digital development and estates optimisation to be incorporated as key system enablers, alongside effective collaboration across sectors.

The potential to develop more shared and integrated workforce models across public sector partners was noted, together with the important role of digital transformation in shaping and improving service delivery. This approach was supported and opportunities to improve the alignment of resources were identified, including activity relating to health-related worklessness and the wider prevention agenda.

In relation to data, place and system alignment, it was stressed that the Joint Strategic Needs Assessment and wider sources of data intelligence should inform the development of the refreshed strategy. The need to triangulate evidence across relevant datasets and ensure strong alignment with place-based intelligence was emphasised. It was also considered important that the strategy retain sufficient neighbourhood-level detail and that prevention and the reduction of inequalities remain central and consistent themes throughout. Board members noted that workforce and digital transformation were areas in which stronger progress remained necessary and agreed that both should be given greater prominence within the refreshed strategy.

**RESOLVED:**

to note the proposed timetable, milestones and consultation arrangements for the refresh of the Joint Health and Wellbeing Strategy.

to endorse the proposed approach to engagement and co-production as the basis for developing the refreshed strategy.

to confirm agreement to the proposed governance and engagement arrangements and

to note the dates of future meetings at which the work would be considered and progressed.

## 26 **Healthy Neighbourhoods**

The Board received an update on the Healthy Neighbourhoods programme, which would implement the neighbourhood health framework and NHS 10-year plan through existing partnerships and strategies. The programme aimed to deliver more proactive, integrated, community-based care based on local needs.

Integrated Neighbourhood Teams would provide proactive, coordinated community care. Year one would focus on older adults with frailty and complex needs, and patients with cardiovascular, renal or metabolic conditions at risk of admission. Around £2.9 million of NHS funding had been allocated. Five neighbourhoods were proposed across Shropshire and four across Telford and Wrekin, subject to confirmation. Population health and risk-stratification tools would support earlier intervention and multidisciplinary case reviews. Shropshire was identified as the initial integrator, coordinating delivery and devolved funding.

The outcomes framework covered five national goals: better health outcomes; same-day access to urgent general practice; more planned care in community settings; improved urgent care performance; and better patient and staff experience. Measures would include hospital admissions, patient flow, activity, and patient-reported outcomes and experience.

Board members supported the programme's alignment with prevention and ageing well strategies but cautioned that NHS-focused measures might not capture impacts on adult social care and voluntary and community partners. They called for greater focus on early frailty and upstream prevention, explicit alignment with the Better Care Fund and wider transformation programmes, and full involvement of carers, social care and community partners. Existing data capability was welcomed, although better integration and governance were needed. Workforce, digital transformation and effective use of the public estate were identified as key enablers.

Board members sought clearer governance roles for Integrated Neighbourhood Teams, place-based partnerships, the Board and ICB system leadership. A collaborative partner workshop would refine the neighbourhood footprints. Governance should provide clear accountability and aligned decision-making, while allowing flexibility to reflect local needs, relationships and place-based structures.

**RESOLVED**

to note the key messages as set out in the report.

## 27 **Chair's Report**

The Chair provided an update on national and local developments affecting Healthwatch arrangements, noting proposed legislative changes which would see Healthwatch England and local Healthwatch functions abolished, with responsibilities transferring to Integrated Care Boards, local authorities, and NHS services. It was confirmed that current duties, funding, and contractual arrangements remain unchanged pending enactment of

legislation. The Board acknowledged the continued contribution of Healthwatch Shropshire during this transitional period, and work is ongoing across the system to assess implications and future commissioning and governance arrangements.

The Chair also reported that Shropshire has been selected to participate in the national Better Care Fund Support Programme, receiving targeted support for Health and Wellbeing Boards, neighbourhood health, and integration. This was noted as an opportunity to strengthen system learning, with associated task and finish groups to support development, including updates to Board terms of reference.

28 **Pharmacy updates**

Board members noted the pharmacy updates.

29 **Date of Next Meeting**

The next meeting would be held on 19 November 2026 at 9.30am.

Signed …… (Chair)

Date:

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# SHROPSHIRE HEALTH AND WELLBEING BOARD
## Report

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|---|---|---|---|---|---|---|
| **Meeting Date** | **19th November, 2026** | | | | | |
| **Title of report** | **Director of Public Health – 2026 Annual Report**<br>**"More Than Money: *How Poverty Shapes Lives, Places and Health*"** | | | | | |
| **This report is for**<br>(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 - *Corporate Director – Population, Wellbeing and Neighbourhoods (DPH) / Deputy Chief Executive*<br>Rachel.Robinson@shropshire.gov.uk | | | | | |
| **Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply** | Children & Young People | **X** | Joined up working | **X** | | |
| | Mental Health | **X** | Improving Population Health | **X** | | |
| | Healthy Weight & Physical Activity | | Working with and building strong and vibrant communities | **X** | | |
| | Workforce | | Reduce inequalities (see below) | **X** | | |
| **What inequalities does this report address?** | Poverty impacts across a wide range of wider determinants. The support schemes outlined within the report and delivered by partners, direct payments and advice services can reduce poor housing conditions, increase financial resilience, and reduce debts. | | | | | |

### 1. Executive Summary

- The Director of Public Health Annual Report 2026, *"**More Than Money**: How Poverty Shapes Lives, Places and Health",* examines poverty, hardship and deprivation in Shropshire and their relationship with health inequalities. The report particularly considers the often-hidden nature of rural poverty and the additional pressures associated with transport, energy, housing, access to services and lower earnings.
- Although Shropshire performs relatively well on some traditional measures of deprivation, the report identifies significant inequalities within the county. For example, 12.8% of households are estimated to be in fuel poverty; 23.4% of children are identified as being in relative poverty after housing costs; around 16,000 households are described as being in a negative budget; and 57.4% of Shropshire's population live in rural locations. The report also highlights the challenges Shropshire experiences in relation to barriers to housing and services.
- The report describes current activity across Shropshire to address both the immediate consequences and underlying causes of poverty. This includes the Crisis & Resilience Fund, investment in advice and resilience services, support for fuel poverty and energy costs, community-based support, work on employment and skills, Best Start in Life (BSIL), the Family First Partnership Programme (FFPP) and the development of a Health in All Policies (HiAP) approach. Partnership working with the voluntary and community sector is a significant priority and represented throughout the report.
- The report concludes that reducing poverty and health inequalities requires a continued shift towards prevention and early intervention alongside crisis support. Seven recommendations are proposed covering the best start in life, household financial resilience, a "No Wrong Door" approach, reducing fuel poverty, good-quality employment and skills, rural inequalities and improved identification of hidden poverty.

## 2. Recommendations

The Health and Wellbeing Board is asked to:

1. Note the findings of the Director of Public Health Annual Report 2026 and its assessment of poverty, hardship and health inequalities in Shropshire.

2. Endorse the seven recommendations set out within the report:

    - Give every child the best start in life.
    - Improve household financial resilience.
    - Strengthen a "No Wrong Door" approach.
    - Reduce fuel poverty.
    - Improve access to good-quality employment and skills.
    - Address rural inequalities.
    - Improve identification of hidden poverty.

3. Support continued partnership working across the Council, NHS, VCSE sector, education partners and communities to address the wider determinants of poverty and health inequalities.

4. Support a continued focus on prevention and early intervention, alongside appropriate crisis support, through the emerging Health and Wellbeing Strategy and wider partnership activity.

## 3. Report

Directors of Public Health (DPH) produce annual reports providing an independent assessment of the health of their local population. This 2026 report focuses on poverty, hardship and deprivation, building an understanding of how these issues affect health and wellbeing within Shropshire and how the challenges associated with rurality can make poverty less visible.

The report brings together local and national evidence and describes activity being undertaken by Shropshire Council and partners to address both immediate financial hardship and its wider causes.

The report identifies several interconnected challenges:

- **Rurality:** 57.4% of Shropshire's population live in rural locations.
- **Fuel poverty:** around 18,500 households, or 12.8%, are estimated to be in fuel poverty.
- **Child poverty:** 23.4% of children are identified as being in relative poverty after housing costs in 2025.
- **Financial resilience:** approximately 16,000 households are described as being in a negative budget.
- **Employment and earnings:** median gross weekly pay for full-time workers in Shropshire was £727 in 2025, compared with £769.50 for England.
- **Access to services:** the report highlights transport and access to housing and services as particularly important dimensions of rural inequality.

Taken together, the findings demonstrate why poverty in Shropshire cannot be understood through income or geographically concentrated deprivation alone. The report highlights the importance of recognising hidden poverty and the additional costs and access barriers experienced by rural communities.

Significant activity is already underway. The Crisis & Resilience Fund provides a major component of the local response, with Shropshire's annual allocation being £3.7 million. Its four strands comprise Crisis Payments, Housing Payments, Community Coordination and Resilience Services, with an emphasis on linking immediate financial assistance to advice and longer-term support.

Wider activity includes Best Start in Life and the Family First Partnership Programme, affordable warmth and energy-efficiency activity schemes, employment and skills programmes, local food resilience initiatives, financial skills support, community-based provision and the development of Health in All Policies across the organisation.

The overall direction is towards earlier intervention, simpler referral pathways, reduced stigma, improved access and stronger coordination between the Council, VCSE organisations and wider system partners.

The annual report proposes seven areas for continued action, with delivery extending across both Council services and partners. These focus on giving children the best start in life, improving financial resilience, strengthening "No Wrong Door", reducing fuel poverty, improving employment and skills, addressing rural inequalities and improving the identification of hidden poverty.

These priorities provide an opportunity to connect poverty reduction more clearly to the wider prevention and health inequalities agenda and to the development of Shropshire's future Health and Wellbeing Strategy.

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| **Risk assessment and opportunities appraisal** | **Risk:** Poverty and financial hardship are associated with poorer physical and mental health outcomes and wider inequalities. Rurality can make need less visible and create additional barriers in relation to transport, housing, energy and access to services. Failure to identify and support households' early risks problems escalating and increasing demand for crisis and statutory services.<br><br>**Opportunity:** The report provides an evidence base for strengthening preventative and partnership approaches to poverty and health inequalities. Opportunities exist through improved referral pathways, "No Wrong Door", community-based provision, better identification of hidden poverty and action on wider determinants through Health in All Policies.<br><br>**Equalities and community:** Poverty affects a wide range of groups and places and can intersect with age, disability, childhood disadvantage, rurality and other circumstances. The report emphasises accessible routes to support, reducing stigma and reaching residents whose needs may otherwise remain hidden. |
| **Financial implications** | There are no direct financial decisions arising from publication of the Director of Public Health Annual Report. The report describes a range of existing programmes and interventions, including activity supported through external grant funding such as the Crisis & Resilience Fund (CRF). Shropshire's CRF allocation is identified within the annual report as £3.7 million per year for 2026-29.<br><br>Any future financial implications arising from implementation of specific programmes or recommendations would be considered through the appropriate governance and decision-making arrangements. |
| **Climate Change Appraisal as applicable** | The report recognises the relationship between poverty, climate change, housing quality and energy costs. Lower-income households can have less capacity to adapt to extreme temperatures, flooding and increased energy costs, while Shropshire's older housing stock and reliance on off-grid heating contribute to fuel-poverty risks.<br><br>Existing activity highlighted in the report includes energy advice, affordable warmth and energy-efficiency programmes, boiler upgrades and retrofit activity. Improving household energy efficiency can therefore |

| | | |
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| | contribute both to reducing financial hardship and supporting environmental objectives. | |
| **Where else has the paper been presented?** | System Partnership Boards | |
| | Voluntary Sector | |
| | Other | Health Overview & Scrutiny Committee, Cabinet, ICB (after HWBB) |

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

- Crisis & Resilience Fund (CRF) – Delivery Plan Proposals - Date

**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 Public Health*
- *Rachel Robinson - Corporate Director – Population, Wellbeing and Neighbourhoods (DPH) /Deputy Chief Executive*

**Appendices**

- **Appendix A:** Shropshire Director of Public Health Annual Report 2026: *"**More Than Money**: How Poverty Shapes Lives, Places and Health"*
- **Appendix B:** DPH Annual Report – presentation
- **Appendix C:** "Worrying about Money?" leaflet – Digital version

Shropshire Council



# Shropshire's Director of Public Health Annual Report 2026

## More Than Money: *How Poverty Shapes Lives, Places and Health*

*A review of rural poverty, hardship, and the normalisation of deprivation*

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# Acknowledgements and thanks:


Acknowledgements to the fantastic team who have led and supported the development of this report, in particular: **Phil Northfield, Mark Trenfield, Wendi Shepherd and Ellen Tracey**

With Special Thanks to: **Jackie Jeffrey, Catherine Devaney and Citizens Advice Shropshire**

Designed by: **Phil Northfield and Mark Trenfield**


**Data sources:** *This report utilises the most recently available published information from a variety of data sources, these are available on the council's website. References are listed at the back of this report.*

**www.shropshire.gov.uk** - If you would like this information in a different format, please contact **0345 678 9000**



citizens advice Shropshire

# Introduction & Foreword

***Foreword from Rachel Robinson (DPH)***

Hello and welcome to Shropshire's Director of Public Health Annual Report for 2026.

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

While this report again describes current patterns of health and wellbeing across Shropshire, its main focus is **poverty**: an issue that is too often overlooked, particularly in rural areas such as Shropshire, but one that is vitally important to our health and wellbeing and very close to my own heart.

*"Growing up in poverty in one of the most deprived areas of North-East England, I witnessed first-hand the profound impact that deprivation can have on us as individuals, our families and communities. I experienced daily the pressures poverty places on relationships, on our mental wellbeing and physical health, from the constant worry about making ends meet, to not always having access to the right food, not having the basics for your healthcare needs, the list goes on. Although those experiences are part of my past, their influence remains very real and continue to shape who I am today and similarly for the lives of many 1,000s across Shropshire living with poverty daily.*

*Despite these challenges, I feel incredibly fortunate. My mam often told me that while she had very little to give, she would ensure I received an education. That commitment changed the course of my life. Through education, I was able to move beyond poverty and create different opportunities for my own children. For that, I will always be grateful.*

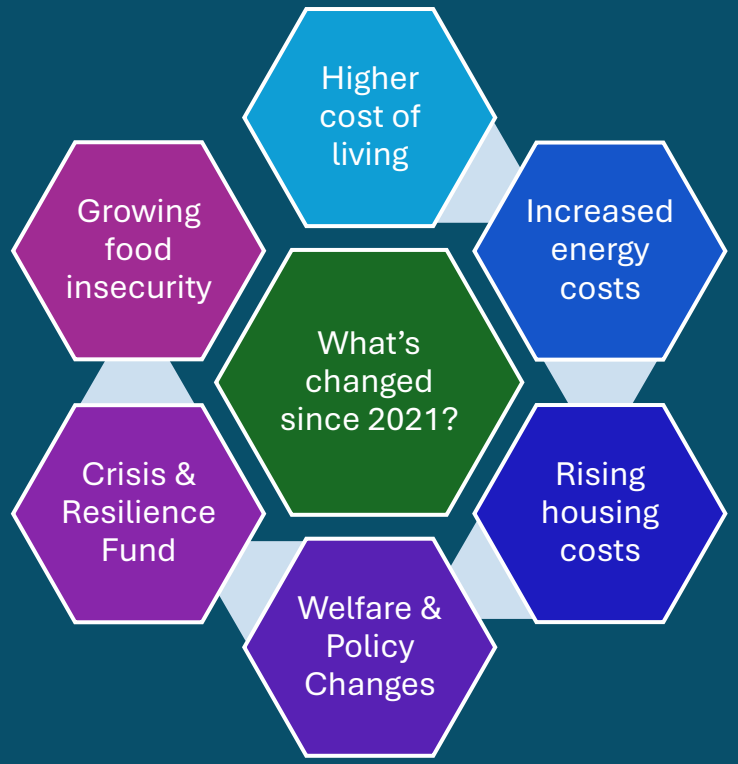
*Those early experiences taught me valuable lessons about resilience, inequality, opportunity and the importance of giving people the support they need to succeed and the importance of the wider determinants of health in influencing outcomes at all stages of life. They also inspired my commitment to public service and led me to a career that I continue to love and feel deeply passionate about today."*

As the Director of Public Health, my colleagues and I are dedicated to improving and enriching the lives of everyone living in Shropshire. Poverty or the absence of it, is an essential aspect of our overall health and wellbeing. In my previous report, I once again highlighted that as little as 10-20% of our health is determined by access to health services. The majority of our health and wellbeing is shaped by our economic, social and environmental conditions as our income, the education we receive, our housing and transport. **Poverty has severe consequences for individuals, communities, our Council, care system, and the wider economy.**

Rachel Robinson

*(Director of Public Health)*








# Introduction/Foreword continued




## Introduction from Cllr Ruth Houghton and Wendi Shepherd (DDPH)

Poverty affects every aspect of life. It influences our health, our opportunities, our relationships and our ability to plan for the future. While Shropshire is often seen as a prosperous county, this report highlights an important reality: poverty and hardship exist in every community, including those where they may be less visible.

The challenges faced by people experiencing poverty in rural areas can often be hidden. Higher transport costs, rising energy bills, limited access to services and the increasing cost of everyday essentials can place significant pressure on individuals and families. Many people experiencing these challenges are working, caring for loved ones, or contributing to their communities, yet still struggle to make ends meet. In this report it is therefore critical to understand that poverty is a major public health issue, particularly in rural areas where the costs of everyday life increases, food insecurity is a particular concern and rising housing prices, transport and energy are major challenges.

This report aims to improve our understanding of poverty in Shropshire, shining a light on the experiences behind the data and exploring the factors that contribute to financial hardship. It also highlights the fantastic work already taking place across the county, with local organisations, communities and partners working together to support residents and build resilience.

In addition, in rural areas poverty is often hidden because of small numbers, stigma and bias. In this report we seek to understand the patterns and types of poverty within our County to identify who is most impacted, determine how levels have changed over time and understand what future trends are likely to be. We also acknowledge demographic trends in Shropshire and how we avoid digitally excluding older residents or those without internet access by offering in-person or phone routes to support where possible, particularly a risk in more rural areas of the county.

Since the publication of the previous Director of Public Health Annual Report, we have continued to strengthen our partnership approach through programmes such as **Healthy Neighbourhoods, Family Hubs**, the **Family First Partnership Programme** and the **Crisis and Resilience Fund**. These initiatives recognise that improving health and reducing inequalities requires action on the wider factors that shape people's lives.

We also recognise the important work done to date with communities and partners to tackle this issue and make recommendations around what more can be done to make a difference together through our partnerships to quite literally transform lives and improve outcomes for individuals.

There is no single solution to poverty, and no organisation can tackle it alone. However, by listening to our communities, working collaboratively and focusing on prevention and early intervention, we can make a meaningful difference. We hope this report helps to inform future action and encourages all of us to play our part in creating a healthier, fairer and more inclusive Shropshire.



Cllr. Ruth Houghton

*(Portfolio Holder: Public Health & Adult Social Care)*

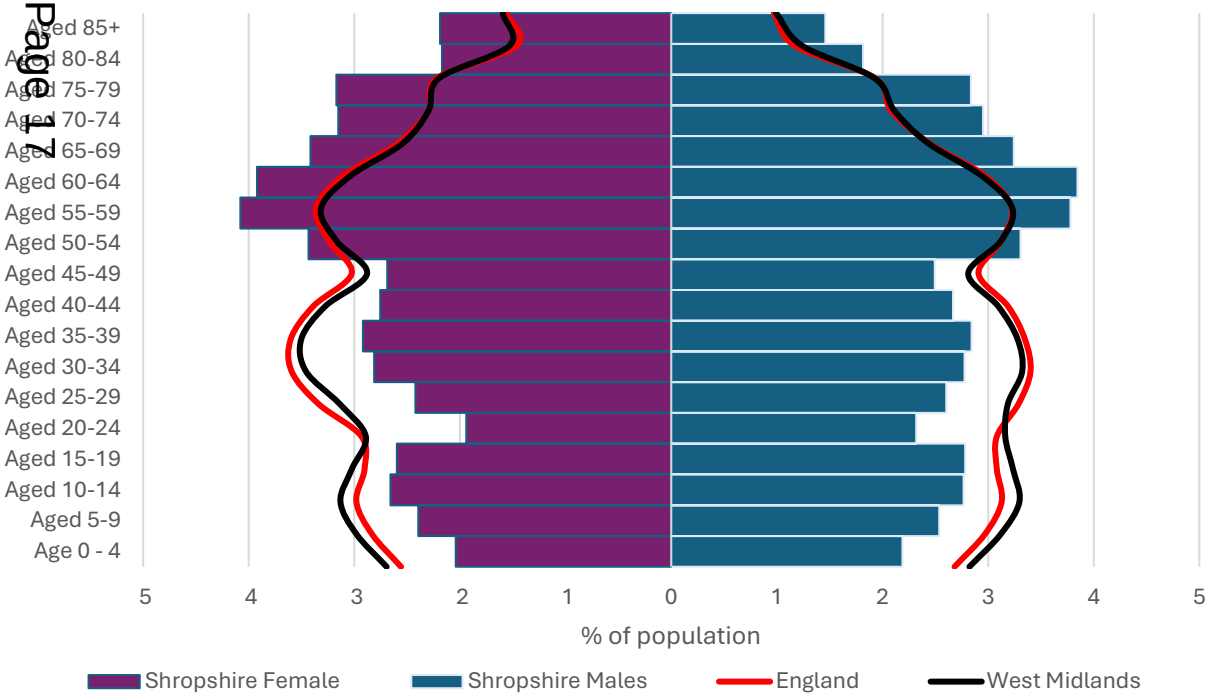


Wendi Shepherd

*(Deputy Director of Public Health)*

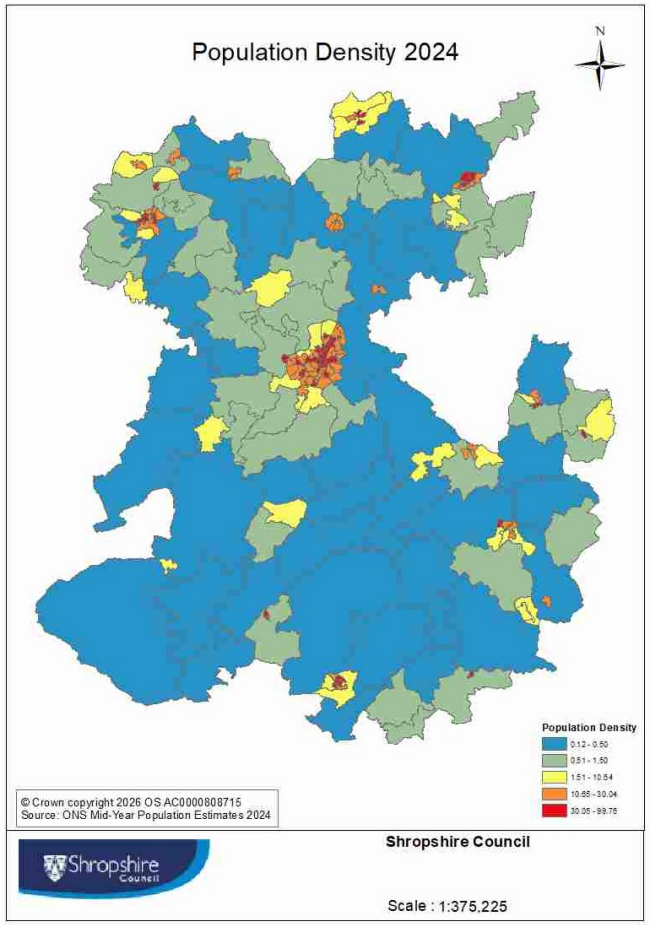
# A profile of Shropshire

- Shropshire is a diverse, large, predominantly rural inland county with a wide range of land use, economic activities, employment and social conditions.
- The total population in Shropshire stood at **332,500** in 2024 having risen by an average of 0.7% per annum over the last decade.
- **Over half (57.4%) of Shropshire's population live in rural locations**. Therefore, Shropshire is classified as "Rural: Majority nearer to a major town or city". Given the rural nature of Shropshire, the ease with which people can access services such as work, healthcare, education and shopping is an important and challenging issue.
- Shropshire's population has a relatively high concentration of people in the older age groups. In 2024, 54.0% of the County's residents were aged 45 or over, compared to only 43.7% nationally (ONS 2024 Mid-year Estimates). 26.4% were aged 65 and above (18.7% in England), while 3.6% were 85+ (2.5% in England). **The median age of the population in Shropshire is 48 compared with 40 in England**
- Shropshire, like many parts of the country, has an ageing population. **The 65+ population has risen by 23.6% since 2014, while the 85+ population has grown by 31.2%**. In contrast, the 40-54 age band has declined, and there has also been a reduction in the number of people aged 0-4 and 15-29.




Demographic change will be one of the defining challenges for Shropshire in the coming decades. A growing older population, combined with a relatively smaller working-age population, may increase demand for affordable housing, social care and financial support, while also creating workforce shortages that could affect local economic resilience and inequalities.

## Where do people live in Shropshire?



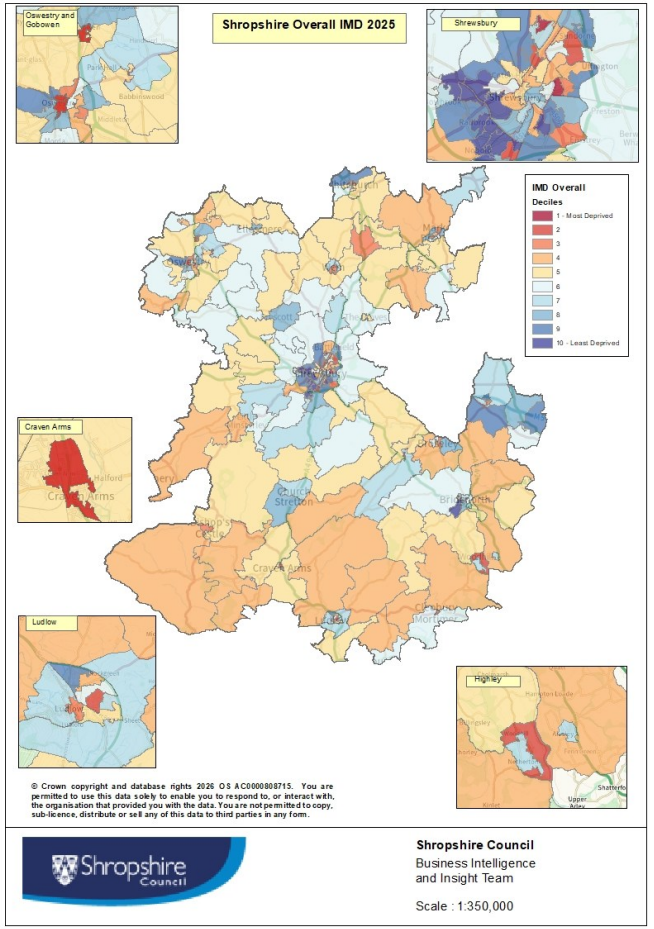

## Populations of largest place plan areas *(as of 2024)*

| Town | Average Age | Population |
|---|---|---|
| Shrewsbury | 44 | 108,093 |
| Oswestry | 48 | 43,482 |
| Bridgnorth | 52 | 24,361 |
| Market Drayton | 46 | 24,005 |
| Wem | 48 | 16,758 |
| Ludlow | 54 | 16,340 |

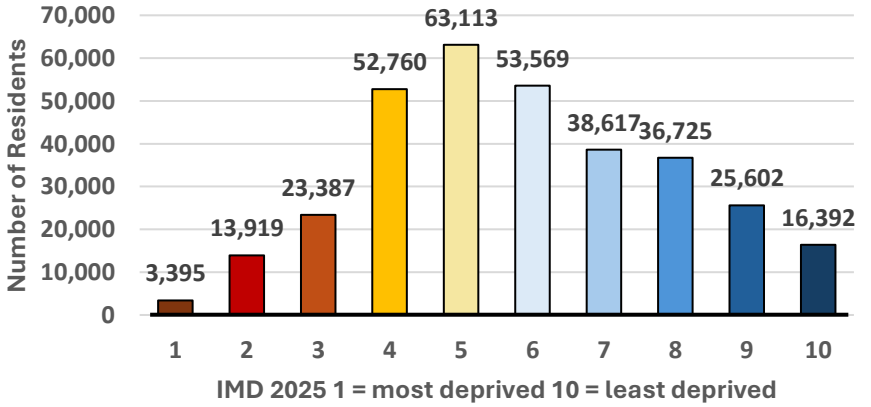
# A profile of Shropshire continued

## Index of Multiple Deprivation (IMD) 2025 for Shropshire

- The IMD was published on 31 October 2025 by the Ministry of Housing Communities and Local Government (MHCLG). The previous IMD was published in 2019. The IMD is the official measure of deprivation in England.
- Each of the 33,755 Lower- Layer Super Output Areas (LSOA) in England are scored against various indicators. LSOAs are non-political geographies that typically have around 1,700 residents in them. Once the scores of these LSOAs have been collected, the areas are ranked, with the bottom 10% considered the most deprived LSOAs in England and the top 10% are the least deprived 10%.
- Overall, **Shropshire ranks as the 154th out of 296** lower tier local authority in overall deprivation. However, there are areas of the county that are more deprived – two LSOAs in Shropshire are in the most deprived 10% in England (dark red on the map on the right) and nine areas are in the most deprived 20%
- In total, **1% or (3,395) people live in the most deprived 10% of LSOAs** nationally compared to 10.2% people in England. 5.3% or 17,314 people live in the 20% most deprived nationally (10.4%) in England.
- The various indicators are grouped into 'domains' that added together make up the overall score, The table below shows how Shropshire ranks against the other lower tier local authorities in each of these domains. The lower the score, the more deprivation.
- While Shropshire is towards the third least deprived of local authorities for income deprivation, Shropshire is in the lowest quarter of local authorities for the 'barriers to services' domain (which includes the physical proximity of local services and amenities as well as issues relating to access to housing i.e. affordability) and the 'Living environment' domain (includes measures about the quality of housing). These are important as it means Shropshire residents need to spend more time and money getting to places, find it harder to buy houses, and are more likely to be living in poor quality housing which might mean higher bills or more expenditure on repairs.
- In my last report, we also highlighted the challenges of using the IMD in a rural County such as Shropshire and other measures of deprivation, where smaller numbers can mask inequalities and issues such as poverty and more broadly deprivation.




| 2025 IMD Domain | Shropshire's Rank (out of 296) – Lower = more deprived |
|---|---|
| **Overall** | 154 |
| **Income** | 193 |
| ***- Income sub-domain: Children in Income Deprivation (IDACI)*** | 173 |
| ***- Income sub-domain: Older People in Income Deprivation (IDAOPI)*** | 190 |
| **Employment** | 189 |
| **Education** | 165 |
| **Health** | 169 |
| **Crime** | 255 |
| **Barriers to Services** | 37 |
| **Living Environment** | 75 |



# Poverty in Shropshire at a glance...

## INFLATION

27.6% between Jan 2021 and Jun 2026

57.4%

live in rural areas in 2022 – 187,931 people. Rural areas account for 97.3% of Shropshire's land mass

12.8%

of households are in fuel poverty (18,500 homes)

16,000

households are in a negative budget

30%

households without a broadband connection *(22)*

36%

of households are in Transport Poverty

68%

of children (1,865) achieved a good level of development before starting school in 24/25.

For children on FSM this is only 43.7% (135 children)

23.4%

of children (12,249) in relative poverty after housing costs in 2025

£2,210 lower gross average earnings per year than England average

14%

of households are in food poverty/food insecurity

*(2021 UoS Study)*

Only 63% of residents can access a GP practice within 15 minutes using public transport. Over 88,993 can't

£113.90 average weekly transport spend in rural Shropshire Vs £76.20 in Urban areas

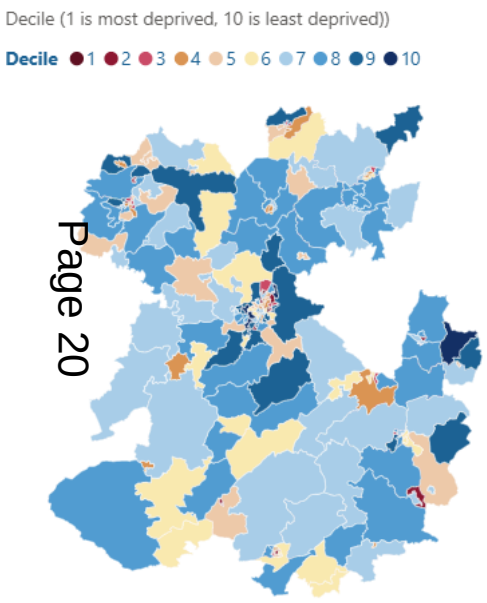
# A profile of Shropshire + Infographics

*A "decile" refers to a 10% group, with 1 being the lowest 10%, and 10 being the top 10%*

*These are calculated the same way nationally, allowing comparison between different areas across England*

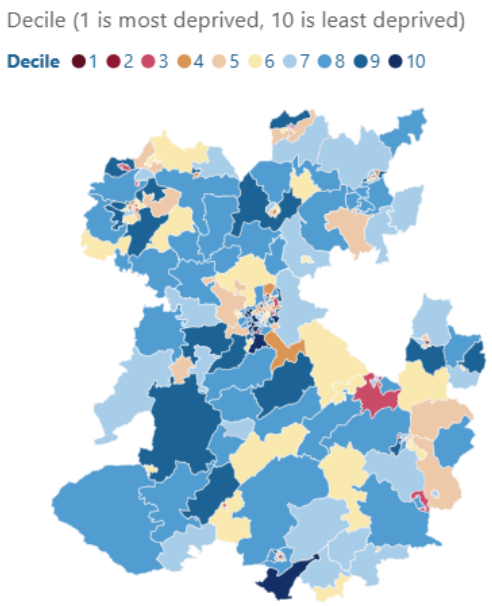
## Index of Multiple Deprivation (IMD) 2025 for Shropshire

### Income Deprivation



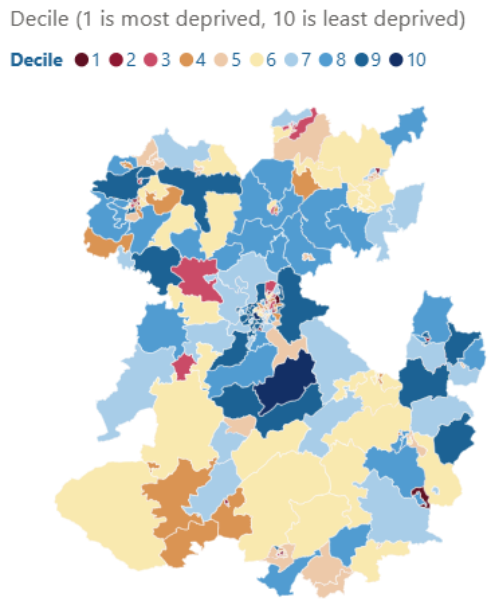

Income deprivation measures the proportion of people living with low incomes or receiving income-related benefits. This map shows how levels of income deprivation vary across Shropshire, helping us understand where financial hardship is most concentrated.

### Income Deprivation affecting older people (IDAOPI)



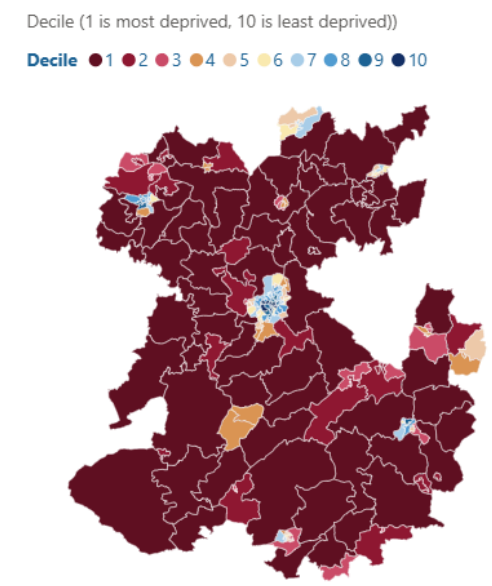

The Income Deprivation Affecting Older People Index (IDAOPI) highlights areas where older residents are more likely to be living on low incomes or relying on income-related benefits. It helps identify communities where older people may be at greater risk of financial hardship.

### Income Deprivation affecting children (IDACI)



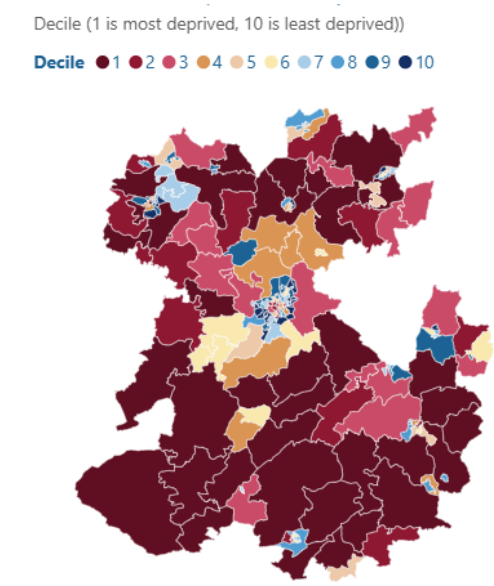

IDACI measures the proportion of children aged 0 to 15 living in income-deprived families. This map shows how child income deprivation varies across Shropshire, helping to identify areas where children may be at greater risk of poorer outcomes linked to poverty.

### Barriers to Housing and Services




The Barriers to Housing and Services map highlights communities where finding affordable housing or accessing everyday services is more difficult. In rural areas, this can reflect the extra time, cost and distance involved in reaching key services.

### Living Environment




This measure looks at the quality of people's homes and local surroundings. It helps identify areas where housing conditions or environmental factors may create additional challenges for residents and contribute to poorer health outcomes.

# Chapter 1: What is poverty and what causes it?

### What is poverty?

The Joseph Rowntree Foundation defines poverty as a person's resources being insufficient to meet their minimum needs. It is a complex, multifactorial, national problem that is difficult to define, especially as much of the poverty in the UK is hidden *(1)*. This is especially true in rural, affluent appearing areas, such as Shropshire.

*"People may be living in poverty if they lack the financial resources to meet their needs, whereas people can be regarded as deprived if they lack any kind of resources, not just income. In the IoD [Index of Deprivation], '**deprivation**' refers to people's unmet needs, whereas '**poverty**' refers to the lack of resources required to meet those needs or socially perceived necessities. These needs and necessities may change and evolve over time, but relative deprivation remains" (2)*

### What is Hardship?

Hardship is the day-to-day experience of going without essentials or struggling to make ends meet. It can be a result of poverty, low income, debt, high living costs, or a sudden financial shock. It is **not** restricted to those who are not in work, have disabilities, or are retired.

### What is Deprivation?

When we talk about deprivation, we mean more than a lack of money. It describes the range of challenges that can make life harder for people and communities, including poor health, limited job opportunities, lower educational attainment, difficulties accessing housing or services, and the quality of the local environment. The Index of Multiple Deprivation (**IMD**) combines these factors to show where disadvantage is most concentrated and where additional support may be needed.

### What causes it?

Poverty, hardship and deprivation are caused by a wide range of social, economic and political factors, including low incomes, rising costs, poor housing, limited access to services, and unexpected life events. These pressures can build up over time, making it difficult for people and families to afford essentials and maintain their health and wellbeing. This report looks at these causes that are particularly prevalent within Shropshire, such as rurality, access to services, lower average wages, fuel poverty, food insecurity, and what work is being undertaken to address them.

*Poverty is not always obvious. In Shropshire, many people experiencing hardship may be working, living in rural communities, or appear financially secure from the outside. Understanding and addressing hidden poverty is critical to improving health and wellbeing across the county.*

**Relative Poverty**

Relative poverty occurs when a household's income is significantly below the average income of the society in which they live, limiting their ability to participate fully in everyday life.

**Absolute Poverty**

Absolute poverty occurs when a household does not have enough income to afford necessities such as food, clothing, heating and shelter, regardless of how wealthy the rest of society is.

**Poverty is not <u>one</u> thing.** It can be experienced in different ways.

**In-work Poverty**

In-work poverty occurs when people are employed but their earnings are still insufficient to meet their basic living costs.

**Rural Poverty**

Rural poverty describes poverty experienced in countryside and sparsely populated areas, where additional costs and reduced access to services create challenges.

**Hidden Poverty**

Hidden poverty occurs when people experience financial hardship, deprivation or poor living conditions that are not immediately visible to others and may not be reflected in traditional measures of deprivation.

### How does poverty manifest/how is this report structured?

- **Fuel Poverty & Energy Costs**
- **Transport and Rurality**
- **Food Insecurity and Cost of Essentials**
- **Housing & Population Inequalities**
- **Employment & Earnings**
- **Welfare and Policy changes**
- **Demographic & Environmental change**

# Health & Wellbeing Strategy 2027-2030 – Marmot Approach

Almost everything in our lives affects our health and how long we live. This includes our jobs, living conditions, access to education and transport, and whether we face poverty or discrimination. Health is influenced by lots of influences, not just visits to the hospital or a GP or any medical ailments we may suffer from.

For example, having a secure and well-paid job, living in a warm and safe home, having good schools nearby, being able to access reliable public transport, and living in a community where people feel safe and included can all improve health. On the other hand, unemployment, poor housing, low income, limited access to services, and experiences of discrimination can harm health.

Together, these influences are known as the wider determinants of health and can **influence as much as 90% of our health outcomes**.

Poverty has a significant impact on health and wellbeing, often leading to significantly worse outcomes in a range of wider determinants. Improving rates of poverty and supporting people to become more financially stable directly improves both physical and mental health and wellbeing.

Tackling inequalities, both health and otherwise, will directly support to reduce some of the influences and drivers of poverty as well as improve health and wellbeing.

As part of the Health & Wellbeing Board (HWBB) priority setting workshop, moving towards making Shropshire a **"Marmot Place"** was agreed and will be part of the next Health & Wellbeing Strategy informing all Public Health and wider strategies across the organisation. This strategy is currently under development, but is due to launch in 2027, and cover the next 5 years of policy within Shropshire.

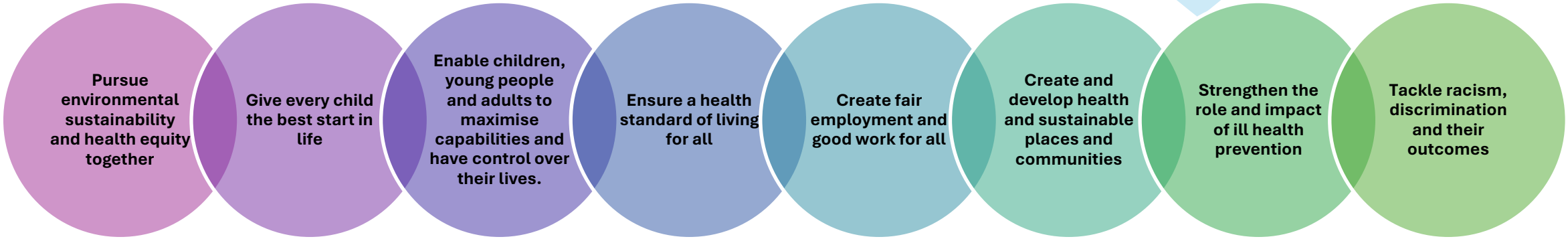
The Marmot Review (2010) *(3)* – sets out key ideas to improve health and reduce inequalities. These 8 "principles" are below and will be embedded within this new strategy.

A key mechanism for embedding these principles across the Local Authority will be through implementing a **Health in All Policies (HiAP)** approach across the council, considering health impacts (positive and negative) in all council policies and strategies, and mitigating negatives, or enhancing positives where appropriate. This moves from a reactive style, into a preventative, and early intervention approach. The rollout of this policy is a key priority for the Council moving forward.

Ultimately, dealing with health issues before they escalate is better for residents, the health & care sector, and the local authority, freeing up capacity and finance to provide more specialised and targeted support.

**Good health is everyone's responsibility.**

## The 8 Marmot Principles



# Fuel Poverty and Energy Costs

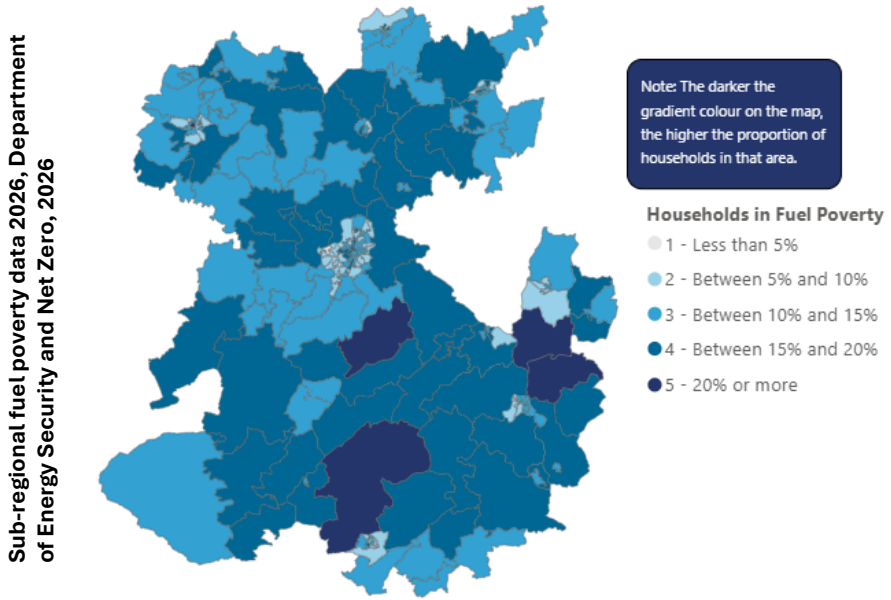
## What is fuel poverty?

Fuel poverty occurs when a household cannot afford to keep its home warm, safe and healthy at a reasonable cost. Shropshire faces specific additional challenges increasing rates of fuel poverty due to:

- A high number of households fuelled by heating oil or otherwise off-grid (LPG etc) combined this is around 21,400 properties. Recent price-spikes in the cost of oil due to geopolitical issues has seen the price of an average fill increase by around **£350**. A support programme has been implemented to assist the most vulnerable with financial support.
- Older housing stock, which is less energy efficient and insulated. EPC data held by the Council shows that almost 108,000 dwellings (75%) have an EPC with a Band D, E, F or G. The average Standard Assessment Procedure (SAP) score across Shropshire is just under 58, which equates to an EPC Band D *(4)*
- Lower average earnings due to a lower-wage economy (see **Employment & Earnings**)

The sub-regional fuel poverty data 2026, based on 2024 data shows that around **18,500** (12.8%) of households within Shropshire *(4)* are believed to be in fuel poverty, this is worse than the England average of 9.9%, and one of Shropshire's most pressing concerns. These are predominantly focused in the south, and more rural parts of the county.

### Households in Fuel Poverty by LSOA




Fuel poverty has a direct and devastating impact on public health and causes thousands of hospital admissions. In a Fuel Poverty Action UK *(5)* survey of UK healthcare workers:

**7 in 10** health workers surveyed said that they regularly see patients going without energy in their homes because they are unable to afford bills.

**68%** of UK health workers say high energy bills contribute to avoidable hospital admissions.

**45%** have sent patients home knowing that their housing situation would make them ill again.

Homes in the UK are generally older and less energy efficient than most of Europe, losing more heat over a shorter time when compared to other European countries after heating is switched off. When combined with expensive energy costs this becomes a significant driver of poverty.

To compensate, UK households may elect to disconnect from supplies, fail to pay bills, or risk not using heating during colder months, leading to:

## Impacts on health:

Fuel poverty can lead to or worsen several health issues.

- **Respiratory illness**: Cold, damp homes are associated with increased rates of asthma, bronchitis, chest infections, and pneumonia.
- **Cardiovascular disease** (CVD): Exposure to low indoor temperatures can increase blood pressure and the risk of heart attacks and strokes.
- **Mental health impacts**: Financial stress, anxiety about bills, and living in an inadequately heated home can contribute to poor mental wellbeing, anxiety, and depression
- **Worsening existing health conditions**: Cold homes can aggravate long-term conditions, including musculoskeletal (MSK) disorders and respiratory diseases
- **Impacts on children**: Children in cold homes may experience poorer physical health, increased school absence, and reduced educational attainment. Poverty and poor housing conditions can affect health throughout life
- **Impacts on older people**: Older adults are more vulnerable to cold-related illness, falls, and excess winter deaths. Shropshire's older population makes this a particularly important issue locally

# Transport and Rurality

## Why does transport matter?

Transport is a crucial **determinant** (or influence) on health. In a county as rural, large, and as sparsely populated as Shropshire, transport, whether private or public allows access to work, education, healthcare, shopping, and more.

The cost of driving can often be prohibitive (particularly for younger people), as well as older people or those on low-incomes or in poverty. Lack of affordable, reliable and timely public transport can lead to people becoming more isolated, developing mobility, or mental health issues, and a feeling of being 'trapped' within their homes or local communities.

**29%**
Of Shropshire is within a 30-minute walk of a train station
*West Midlands average = 48%*

**81.8%**
Households within Shropshire have access to gigabit broadband *(FTTH/FTTP)**

**37%**
Of Shropshire cannot access a GP within a 15-minute public transport journey

**57.4%** of people in Shropshire live in Rural Areas

**Average broadband speeds by place plan area are included on page 14.*
*30% of homes do not have a broadband connection as of 2024 (22).*

## Why does rurality matter?

Rurality leads to what is often called a "rural premium" *(6)*. Residents may face additional costs worsened by being rural because of: Longer commutes, higher fuel spending, limited public transport, higher energy costs, digital connectivity challenges and more.

Access to in-person support services is also amplified by the rural nature of Shropshire. This also extends to younger and working-age residents struggling to get to employment opportunities if they do not have access to private transport, limiting their earning capacity, and increasing the chance of being in poverty. Digital services can mitigate this to some extent, and ensuring a strong digital front door and skills training for residents is a key council plan moving forward whilst balancing against the need to avoid digital exclusion.

Within Shropshire, placement of new services or facilities is informed by this access data amongst other information on need, ensuring an evidence-based approach. A key example of this being the Highley Health & Wellbeing centre opened in April 2024.

*Data & map: Bus Service Improvement Plan (2024) (7)*

**36%**
**Households in Transport Poverty**

**£113.90**
**Average weekly transport spend (Rural)**

**£76.20**
**Average weekly transport spend (Urban)**

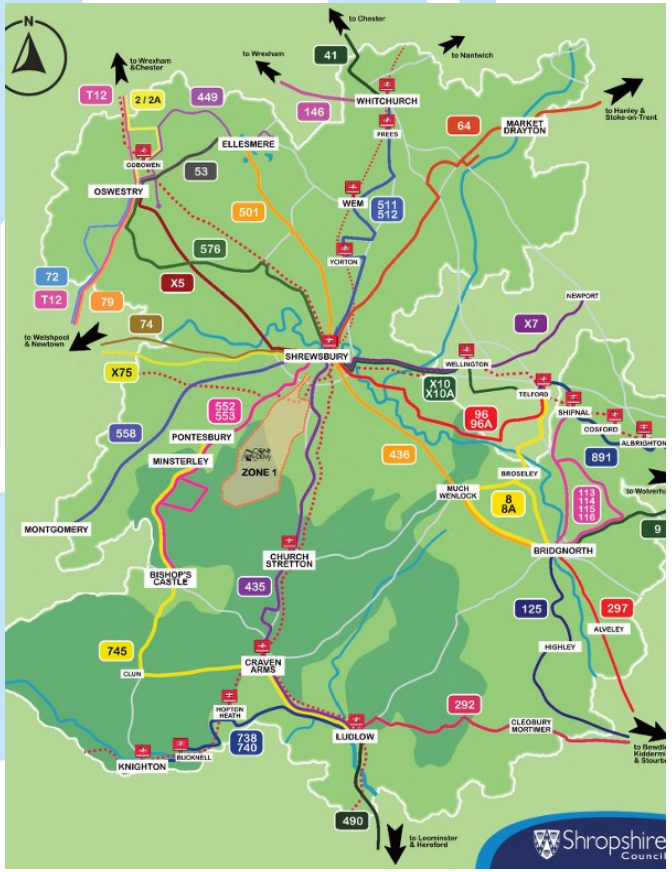
**12%**
**Lower wages than urban areas**

***Transport poverty** means not being able to get where you need to go safely, affordably and when you need to.*

### England Rural Buses

Nationally, across England, in hamlets and isolated dwellings, **buses account for less than 1% of journeys**. Bus usage in rural areas is seen to be at a historic low in terms of service use and coverage as of 2025.

Findings show that only **50%** of eligible pensioners in the most rural areas now use concessionary bus passes (nearly 70% in Urban Conurbations). They have faced reductions in the concessions being provided, as well as declines in overall bus service provision.




*Map (right) – Shropshire Public Transport map, as of 2024 – gaps in provision, particularly in the south of the county are noticeable. Shropshire's next Local Transport Plan (LTP4) is currently in development.*

# Food Insecurity and Cost of Essentials

## What is food poverty?

Food poverty is the inability of individuals or households to access enough healthy and nutritious food because of a lack of financial resources or access to affordable grocery stores. It may occur as a short-term crisis or persist over longer periods as a chronic issue.

There are currently **14** foodbanks located within Shropshire. With demand primarily focused on Shrewsbury, Bridgnorth, and Oswestry. The map to the right showss areas at risk of food poverty across the county, however it can (and does) occur anywhere within Shropshire.

## What causes food poverty?

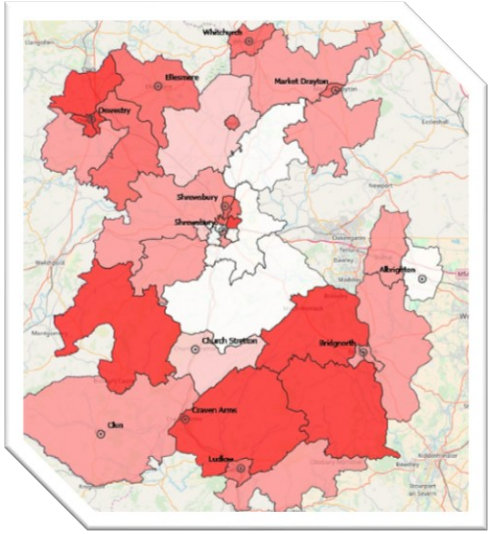
The causes of food poverty are complex and often interconnected. For people with limited financial resilience, an unexpected life event such as illness, job loss, or a household emergency can quickly lead to financial hardship and difficulty accessing food. In many cases, food poverty results from a combination of factors, including low income, rising living costs, barriers to accessing food, and wider economic pressures.

The cost of essentials is not static, and changing or dynamic prices mean that household costs can rise overall over relatively short periods. The figures in this report therefore provide a snapshot in time, while recognising that the financial pressures experienced by households may continue to change.



## Agriculture and food production – impact on nutrition

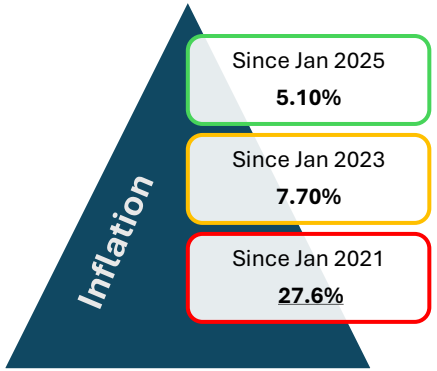
- In 2023/24, **11% of the UK population were living in food insecure households** (defined as a household which cannot "...acquire an adequate quality or sufficient quantity of food in socially acceptable ways" *(10)*
- According to a University of Sheffield study *(21)* conducted in 2021, in Shropshire, this figure was **14%, or around 19,500 households.**
- We know there is a negative relationship between income and access to cooking facilities **" 8% of households with an income below £10,000 per year have no cooker and 16% have no freezer"** and a positive relationship between low income and availability of fast-food, "nearly one in three food outlets in the most deprived areas are fast food, compared to one in five in the least deprived areas". The relationship between deprivation and poor diet is propagated in this way, which we know leads onto diet related health problems such as heart disease and diabetes *(11)*.
- Given the food chain instability globally at present, the forecast for food insecurity in the UK looks set to rise. The BBC report that it can take 7-13 months for the increased food supply chain costs to be reflected supermarket pricing *(13)*.



*Areas at risk of food poverty:*
*For more info, click here (10)*

## General inflation in the last 5 years...

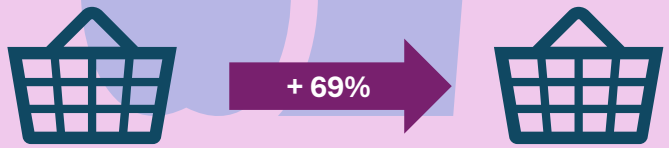
Inflation is when the price of things goes up over time, so the same amount of money buys less than it used to. For example, if a chocolate bar costs £1 today and £1.10 next year, that price increase is inflation.




**Inflation figures provided by the Bank of England, calculated between Jan of each year and Jun 2026 (9)*

Citizens Advice Shropshire compared the cost of the same basket of basic food in rural shops in south Shropshire in 2022 and then again in 2026. This shows how local prices have changed and the extra challenge faced by residents who have limited choice about where they shop. **69% average price increase for local South Shropshire grocery store** *(Appendix 1.)*

- 37% **average price increase** for ASDA online
- Ludlow Tesco experienced the **highest price increase since 2022 of 87%**, closely **followed by Craven Arms Tuffins at 83%**
- Clun Spar again is the costliest grocery store assessed with a food basket total of £68.18




**2022 Cost = £35.43** **2026 Cost = £59.81**

***Citizens Advice Shropshire updated what was formerly a Shaping Places research project evaluating the cost of a basic shopping basket for Shropshire households. The results of this analysis are included at the back of this report as Appendix 1.***

# Housing and Population Inequalities

*Housing Data: Office for National Statistics (8)*

Averages in Shropshire:



### House price - £281,000

The average (median) house price in Shropshire was **£281,000** in May 2026 (provisional), up 3.1% from May 2025. This was higher than the rise in the West Midlands (2.7%) over the same period where the average price was £248,000.

### Monthly rent - £817

Private rents rose to an average of **£817** in June 2026, an annual increase of 3.9% from £786 in June 2025. This was lower than the rise in the West Midlands (4.4%) over the year.

**Average rent by number of bedrooms:**

- One bedroom: **£603**
- Two bedrooms: **£763**
- Three bedrooms: **£946**
- Four or more bedrooms: **£1,390**

### First-time buyers - £227,000

The average price paid by first-time buyers was **£227,000** in May 2026 (provisional). This was 3.2% higher than the national average of £220,000 in May 2025 (revised).

### Housing Affordability Ratio

Ratio of median house price to median gross annual residence-based earnings, April 2025. How many years average salary are required to buy a house outright.

- Shropshire – **7.4**
- West Midlands Average – **6.8**

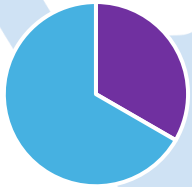
### Number of Social Properties in Shropshire at start of 25/26

- **16,668** properties considered rental stock for general needs
- **280** properties considered rental stock for supported housing
- **2,421** properties for older people
    - Total of **19,369** rental stock
- **1,233** homes low-cost home ownership
- **A total of 20,602** social houses in Shropshire owned by registered providers

## Housing & Health

Housing is a **major** determinant of health. When housing is too expensive, overcrowded, or in poor condition it can increase the risk of physical illness, poor mental health, financial stress, and wider inequalities. Poor quality, badly located housing or having insufficient nearby support services can also make it harder for people to access employment, education and essential services, leading to a cycle that contributes to, and is worsened by poverty. Local Authorities can influence several of these factors for the better, including better planning policy, greater transport connectivity, better access to facilities and more. Public Health aims to influence the wider council on their plans & strategies through a process known as "**Health in All Policies**"

The Marmot- '10 years on executive summary' reports on the risks of air pollution, and that its impacts are worse for: *"...deprived communities and places, showing these places had 'a higher exposure to air pollution and a greater burden of poor health increasing susceptibility to the impact of pollution."*



**1 in 3 households in the private rental sector fall into poverty because of their housing costs.**

Unaffordable housing also damages health: "**21 percent of adults in England said a housing issue had negatively impacted their mental health, even when they had no previous mental health issues, and housing affordability was most frequently stated as the reason**. The stress levels resulting from falling into arrears with housing payments are comparable to unemployment.....**one-third of households in the private rental sector fall into poverty as a result of their housing costs**" *(14)*

At present, **England's most deprived populations can expect to live almost one decade less, than if they had been born into England's least deprived communities** (3) . This is further exacerbated when the systems that support our communities are stretched ; The King's fund reported that in 2022,Covid-19 mortality "...was 2.6 times higher in the most deprived than the least deprived tenth of areas" *(14)*

# Housing and Population Inequalities

*A "place plan" is one of 18 places used to differentiate the various areas across Shropshire, allowing for greater analysis than if data were collected and averaged county-wide.* "Median House Affordability" refers to how many years average wages (in that area) are required to buy an average house (in that area) outright.

**Red = higher than England affordability average (2025) of 7.6.**

**Orange = higher than West Midlands affordability average (2025) of 6.8**

| Place Plan | Median House price sales 2024 | Median Gross household income 2024 | Median House affordability 2024 | Average Broadband Speed (Mbit/s) |
|---|---|---|---|---|
| Albrighton | £306,500 | £43,910 | 7.0 | *433.2* |
| Bishop's Castle | £304,500 | £40,843 | 7.5 | *113.0* |
| Bridgnorth | £278,975 | £45,382 | 6.1 | *326.3* |
| Broseley | £225,000 | £40,015 | 5.6 | *387.0* |
| Church Stretton | £442,500 | £45,443 | 9.7 | *187.0* |
| Cleobury Mortimer | £295,000 | £46,228 | 6.4 | *128.4* |
| Craven Arms | £317,500 | £41,221 | 7.7 | *165.2* |
| Ellesmere | £257,748 | £40,479 | 6.4 | *361.5* |
| Highley | £212,500 | £36,646 | 5.8 | *447.5* |
| Ludlow | £230,000 | £39,216 | 5.9 | *385.7* |
| Market Drayton | £251,250 | £41,485 | 6.1 | *368.8* |
| Much Wenlock | £270,500 | £45,540 | 5.9 | *154.2* |
| Oswestry | £387,500 | £42,470 | 9.1 | *211.5* |
| Pontesbury and Minsterley | £221,250 | £40,464 | 5.5 | *406.6* |
| Shifnal | £262,250 | £44,815 | 5.9 | *414.9* |
| Shrewsbury | £255,000 | £43,005 | 5.9 | *439.2* |
| Wem | £247,500 | £43,047 | 5.7 | *317.6* |
| Whitchurch | £240,000 | £38,483 | 6.2 | *405.2* |
| **Shropshire Average (2024)** | **£265,000** | **£42,238** | **6.3** | ***209.5*** |

*Data as of August 2024, apart from Average Broadband Speed from 2025*



## Population Inequalities – *graphic data correct as of 31st August 2026*

Housing is often a household's largest expense. When housing costs consume a significant proportion of income, families have less money available for food, energy, transport and other essentials. High housing costs can therefore increase the risk of financial hardship, even among people in employment. Housing costs across Shropshire vary dramatically within the county.

Demand for affordable housing continues to exceed supply in many areas. While **Shropshire has over 20,000 registered provider homes**, access to affordable housing remains challenging for many residents, particularly in rural communities where new housing delivery can be limited.

**Shropshire's population is projected to age significantly, increasing demand for suitable, accessible and affordable housing.** Without sufficient housing options, older residents may face higher costs, difficulties maintaining their homes, fuel poverty and social isolation.

| | |
|---|---|
| Households in temporary accommodation | **246** (of which 172 are single-person households) |
| Houses of Multiple Occupancy | **78** Registered HMO's, PRS registration not active until 2027/8 |
| Households owed a duty | **521** (of which, 306 are single-person households) |

Hidden homelessness is often overlooked in rural areas because it is less visible than rough sleeping. Rough sleeping levels in Shropshire are relatively low, and primarily focused in the larger towns (particularly Shrewsbury). Many people may be staying temporarily with friends or family ("sofa surfing"), living in overcrowded homes, remaining in unsuitable accommodation, or delaying leaving unsafe living situations because there are few affordable alternatives. In rural counties such as Shropshire, homelessness can be dispersed across villages and market towns, making it harder to identify and support those affected.

HMOs can provide an important source of lower-cost accommodation for people on low incomes, younger adults, and those experiencing housing insecurity. However, some HMOs can be associated with overcrowding, limited privacy, poorer housing conditions and increased pressure on physical and mental wellbeing if standards are not maintained.

**A shortage of suitable housing can force families to live in homes that do not meet their needs.** This may include children sharing bedrooms for longer than intended, multi-generational households, or families living in properties that are too small for household size.

# Employment and Earnings

*Income & Employment*

Poverty and hardship are not limited to those who are on benefits, unemployed or retired. A household may be in work but still struggle due to: Low wages, part-time hours or underemployment, rising living costs, childcare costs, transport and housing costs or caring responsibilities.

These factors also lead to a lot of hidden poverty and deprivation within the county. Shropshire is a relatively low-wage economy, lower incomes, insecure employment and lower benefit uptake can leave households financially vulnerable, even where communities appear relatively affluent.

Additionally, stigma (from friends, family, colleagues and wider community) around needing to rely on support leads to a lot of support going unclaimed, or unreported.

**78.8%**
of 16 -64-year-olds are in employment
*West Midlands = 75.2%*

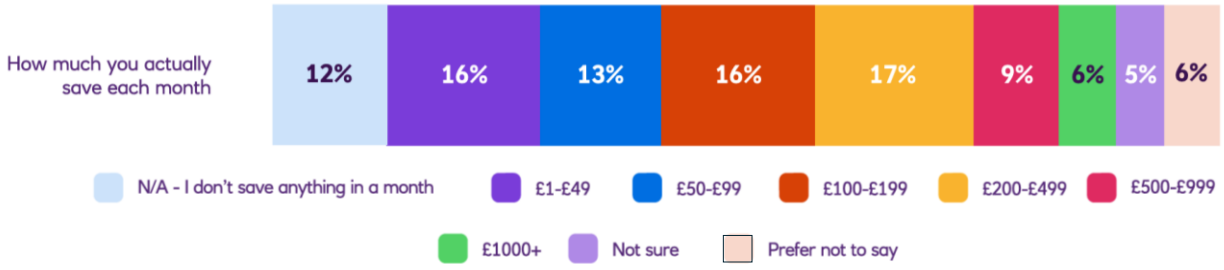
**18%**
Economically inactive
*West Midlands = 21.2%*

**2.4%**
16- to 64-year-olds who are claiming unemployment-related benefits
*West Midlands = 5.3%*



## Savings

**NatWest Saving Index 2026 (*16*) – National Survey of 2000 people**




**Average people save per month: £288**

**Average people think they should save per month: £384.70**

*43% said that rising food costs were behind their inability to save, with 35% blaming high energy costs*

**Employment and working conditions**; Employment not only predicts life expectancy and quality of life; it also has knock-on effects for the next generation. Children growing up in workless households are *"almost twice as likely to fail at all stages of education compared with children growing up in working families" (10)*

We can see this effect persisting and influencing the rest of a child's life;

- being from lower working-class background is associated with the highest rate of young people Not in Education, Employment or Training (NEETs), at 22%, which is a big discrepancy when compared to the 9% rate seen with those from higher professional backgrounds. This clear social gradient in unemployment extends into adulthood and has implications for social mobility *(12)*.
- Shropshire is significantly better in this area than the national average, with a NEET (including "not-knowns") rate of approximately **3.2%** as of June 2026. *(15)*
- This has a direct impact on an individual's income; The proportion of the population in England not reaching the minimum income standard has risen from 25.7 (2008 - 2009) to 30.2% (2014 – 2015), and the figure rises to 45.7% among children. For children in lone parent families in Britain, the figure is 74.5%. *(10)*

## Self Employment:

Self-employment levels within Shropshire are relatively high at 12.9%, above the national average of 9.4%. This is likely due to the large number of agricultural businesses and workers present within the county. Self-employment can potentially lead to less job security, reduced pensions, sick pay and more.

## Shropshire Average Earnings

**Median Hourly Pay for full-time Workers – excluding overtime (2025) - £18.41**
This was in comparison to West Midlands (£18.47) and England (£19.78). **The hourly rate in Shropshire was £1.37 lower than the England average in 2025**

**Gross Median Weekly pay for full-time Workers (2025) - £727**
This was in comparison to West Midlands average *(£731)* and England average *(£769.50)*. **Shropshire full-time workers earn £42.50 a week less than England average, equivalent of £2,210 a year (£37,804 vs. £40,014)**

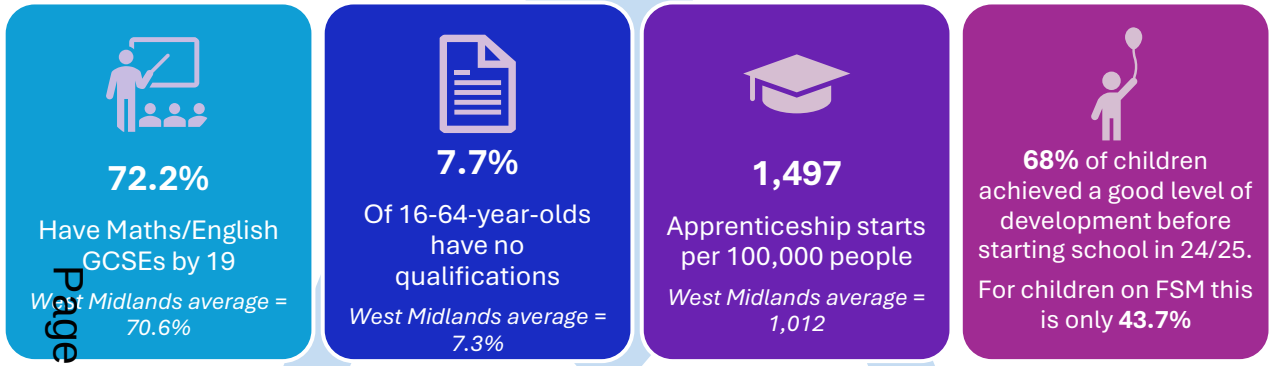
*Data: NOMIS, 2025*

# Employment and Earnings

*Education & Qualifications*

Education can help people develop and build the skills and qualifications needed to access stable and well-paid employment. Lower levels of educational attainment are associated with lower incomes (though not the sole cause), higher unemployment, and an increased risk of poverty and financial hardship.

Lack of financial skills (often not taught in education) can directly lead to people taking on high-interest loans (such as buy-now, pay later **BNPL**), failing to understand debts, or mismanaging their budgeting. Where unavoidable expenditure outstrips income, this is referred to as a **negative budget, impacting around 16,000 households in Shropshire.**




Strong foundations of good health, wellbeing and future prospects are established early in life. Children who start school with strong communication, language, social and emotional skills are more likely to achieve well in education, gain qualifications, access employment and experience better health throughout adulthood. Conversely, children experiencing poverty are less likely to be school-ready, increasing the risk of poorer outcomes across the life course.

Good quality employment is one of the strongest protections against poverty, improving income, health, wellbeing and future opportunities for families. Through the Get Marches Working programme and wider employment support services, local partners are helping residents overcome barriers to work by providing careers advice, skills development, training opportunities and personalised support into employment. Recent national reforms are also placing greater emphasis on joined-up employment, health and skills support, recognising that many people face multiple challenges when seeking work.

In a rural county such as Shropshire, accessible employment support is particularly important, helping residents overcome barriers linked to transport, caring responsibilities, digital exclusion and limited local job opportunities.

## Education + employment

A higher educational attainment correlates with a decreased incidence of chronic health conditions and self-reported poor health. UK Government figures demonstrate that, of the 14% of children eligible for free school meals across the UK, only a third achieved 5 good GCSEs. When compared with 60.9% of children not eligible for free school meals attaining this level, we can see the pattern of poverty and worse health outcomes repeating. This can be traced back to 'school readiness', which is the assessment for a 'good level of development' (**GLD**) at age 5. This involves the ability to pay attention, do simple sums and toilet and dress with a degree of independence. This poverty and low educational attainment can negatively reinforce one another across generations, making social mobility more difficult.

*"From 2015 to 2016, 14.0% of children in England were eligible to receive free school meals (a proxy for low household income). Of these children, 45.6% did not reach a good level of development compared with 28.3% of children not eligible for free school meals" (11)* ***Figures for Shropshire GLD are in the graphic to the left.***

## Best Start in Life (BSIL) / Family First Partnership Programme (FFPP)

The Best Start in Life Programme **(BSIL)** aims to improve child development, strengthen support for families and increase the proportion of children reaching a Good Level of Development **(GLD)** before they leave nursery. The programme recognises that supporting children and families during the earliest years offers one of the greatest opportunities to reduce health inequalities and poverty over the longer term.

Investment in early years support can help improve speech and language development, parental confidence, school readiness and educational outcomes. These benefits extend beyond childhood, supporting future employment opportunities, financial resilience and health throughout adulthood.

The Family First Partnership Programme **(FFPP)** focuses on working with families earlier to address challenges before they escalate into crisis. By improving coordination between services and strengthening support for children and parents, the programme aims to improve child development, educational attainment, family wellbeing and long-term life chances, helping to tackle some of the underlying causes of poverty and inequality.

# Welfare & Policy Changes

*Since 2021*

Many of the levers to address poverty are implemented at a national level by central government.

The removal of the two-child limit in Universal Credit means that eligible families can now receive support for all children in the household. The UK Government estimates this change **could lift around 450,000 children out of poverty** and provide additional financial support to families. As poverty is a key driver of poor health outcomes, this policy change has the potential to improve health and wellbeing for many children.

The UK Government's **Pathways to Work** programme includes significant reforms to disability and health-related benefits, alongside increased employment support for people with health conditions and disabilities. The reforms aim to help more people move into work, but concerns have also been raised about the potential impact on income and financial security for some disabled households. Given the strong links between disability, poverty and health inequalities, the effects of these changes will be important to monitor locally.

From September 2026, eligibility criteria for access to Free School Meals (FSM), has been expanded to all families on Universal Credit. This is an increase in coverage. At the time of writing, the exact numbers affected are unknown, however, this is a positive change in terms of support. Free School Meals during school terms are funded by the Department for Education (DfE).

From 1st October 2026, VAT on electricity bills *(currently 5%)* will be removed from household bills until 31st March 2027. For households on the price-cap, this is expected to save approximately **£45** a year. **This does not cover non-electricity energy bills, such as LPG and heating oil, which is commonly used in Shropshire.**

From 1st January 2027, the £2 bus fare cap will be reintroduced nationally across England, through to the end of the calendar year. For residents making a bus trip twice daily, 5 days per week, working 48 weeks per year, this represents a saving of **£480** over a working year

As of April 1st, 2026, a new cost-of-living support package, titled the Crisis & Resilience Fund (**CRF**) was launched by UK Government, providing Local Authorities funding to provide targeted financial support and resilience schemes to at-risk groups, working closely with external partners. Details on this fund, including the plans within Shropshire are outlined on following pages.

**Shropshire Council** was one of a small handful of authorities across England selected to participate in the co-design and development of this fund.

**Minimum & National Living Wage Changes 2021 to 2026**

| April 2021 | April 2026 | % Increase |
|---|---|---|
| 23 and over = **£8.91** | 21 and over = **£12.71** | 21 and over = **42.7%** |
| 21 to 22 = **£8.36** | 18 to 20 = **£10.85** | 18 to 20 = **65.4%** |
| 18 to 20 = **£6.56** | Under 18 = **£8** | Under 18 = **73.2%** |
| Under 18 = **£4.62** | Apprentice = **£8** | Apprentice = **86%** |
| Apprentice = **£4.30** | | |

Inflation 2021 – 2026 = 27.6%

*Between 1 April 2021 and 31 March 2024 the National Living Wage was for those aged 23 and over. Since 1 April 2024, the National Living Wage has been for those aged 21 and over. (17)*

Rising National Living Wage rates have increased incomes for many lower-paid workers and may help reduce the risk of in-work poverty. However, **wage growth alone does not guarantee improved living standards**. For some households, increases in earnings have been outweighed by rising essential costs (not necessarily reflected in inflation figures), while fiscal drag resulting from frozen tax thresholds has reduced the amount of additional income retained by workers. Some people may have potentially suffered redundancies or a reduction in hours because of these rises in smaller businesses.

**This highlights the importance of considering disposable/discretionary income, rather than earnings alone, when assessing financial wellbeing.**

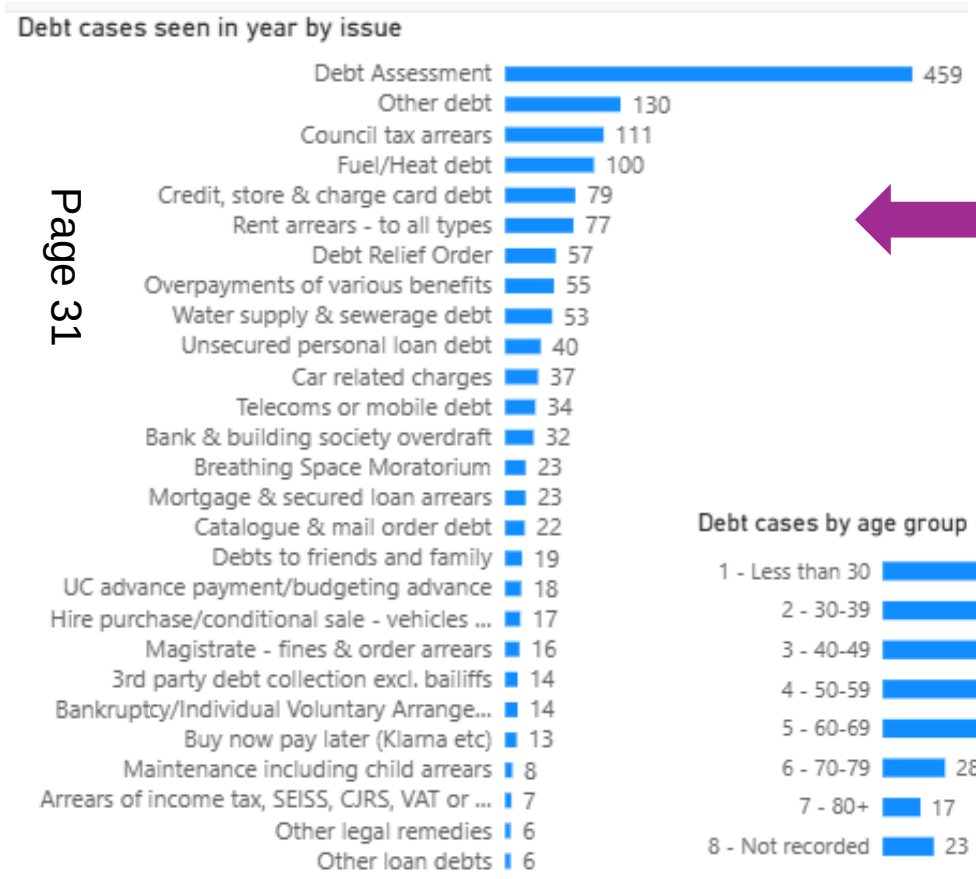
# Citizens Advice Data

*What are people struggling with?*

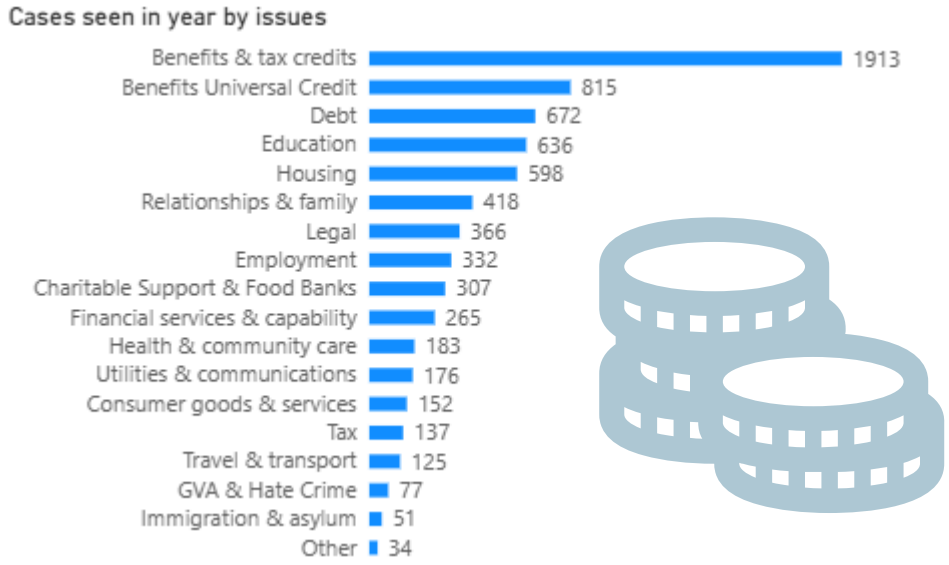
Between 6th August 2025 and 5th August 2026, Citizens Advice Shropshire had contact with **3,678 unique clients**, and a total of 4,783 cases – one client had 7 different cases in this period, with some of these cases resulting in more than one contact.

Within most of these cases, multiple issues were bought up and of the 4,783 cases, there were:

- **1,913 (40%) that were about benefits & tax credits**
- **815 (17%) about benefits, particularly Universal Credit**
- **672 (14%) that were about debt.**



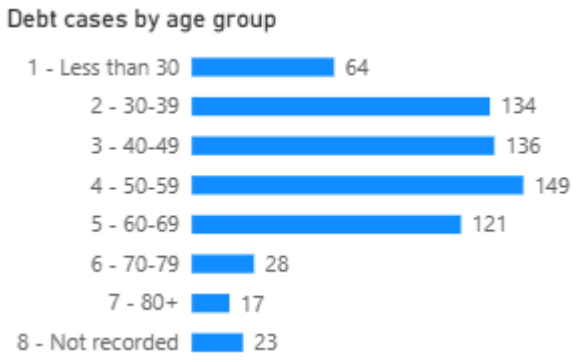


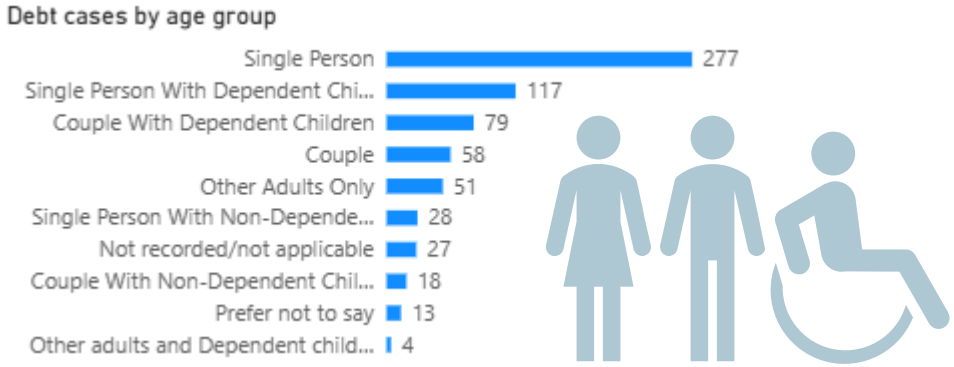



Of the 672 cases where debt was an issue, the graph on the **left** shows which aspect of debt came up during the contact – once again multiple aspects may have been bought up during each case. A debt assessment was carried out in just over two thirds of cases (459 out of 672). Other debts included, debts to gyms, vets, NHS, insurance, TV licence, student loans, gambling and social fund debts.

Of the people coming to Citizens Advice Shropshire about debt, around 50% were women and 46% men. **The average age was 48 years old**, with people ranging between 20 and 97 years old. **Most cases were single people**, be it without children, with dependent children or with non-dependent children.





# Community Insights: *"the faces behind the data"*

*All cases included are representative of true client stories that Citizens Advice Shropshire have supported. Client information has been anonymised for their privacy.*

## Case Study 1

**Stan and Marie**, a retired couple living on a low fixed income, sought advice after Stan's long-term health conditions and dental problems created significant financial strain. A **Citizens Advice Shropshire** Community Adviser helped them successfully claim Attendance Allowance and supported subsequent applications for Pension Credit and Council Tax Reduction. When their Pension Credit claim was wrongly closed, the adviser continued to advocate on their behalf, challenging decisions and escalating the case.

After almost two years of persistence, their complaint was upheld, resulting in a backdated Pension Credit payment of £14,086.14 and a Council Tax refund of £1,900. The financial support enabled Stan to access essential dental treatment and brought much-needed stability to the couple's finances, demonstrating the life-changing impact of dedicated advice trained organisations in assisting Shropshire residents to acquire all eligible benefit support.



## Case Study 2

**Henry**, a single man of working-age with long-term health conditions and depression, was struggling on a low-income earning a standard allowance from Universal Credit while managing priority debts such as utility arrears and parking fines totalling £1,887.00. He felt unable to afford the existing repayment arrangements and sought support from **Citizens Advice Shropshire** Debt Caseworker team.

Through specialist debt advice and partner collaboration, Henry received local foodbank support, guidance on accessing pension entitlements with **AgeUK Shropshire, Telford and Wrekin**, and following a referral by **Citizens Advice Shropshire**, was awarded a £900 contribution towards his energy debt from **Marches Energy Advice. Citizens Advice Shropshire** Debt Caseworker team also helped Henry organise his debts, negotiate with debtors, and supported him towards an affordable repayment plan, improving his financial stability and reducing the pressure of Henry's accrued debt.

## Case Study 3

**Kai**, a nonbinary, working-aged person is a council tenant living with multiple long-term health conditions including Autism, ADHD, Dyslexia, OCD and chronic back pain, was struggling with a monthly budget deficit of £215.60. Living on a low-income of Personal Independence Payment and Universal Credit, rising energy costs and benefit deductions left them unable to manage their arrears, accruing utility debts of over £2,872.

**Citizens Advice Shropshire (CAS)** provided Kai with debt advice and practical support, including referrals to a local foodbank, **Marches Energy Advice (MEA)** and **Community Resource.** With support from CAS Debt Caseworkers, Kai secured a £500 Essential Support Fund grant from Community Resource towards energy arrears, in addition to securing a "Breathing Space" period to prevent an escalation of enforcement action while CAS Debt Caseworkers continued to negotiate with Scottish Power on Kai's behalf. As a result of consultation with MEA, CAS Debt Caseworkers were also directed to available energy debt funds with utility providers to help reduce Kai's arrears as well as being informed of MEA debt support of arrears below £2,000.

The intervention helped reduce financial pressure and protected Kai from further debt escalation while their case is ongoing. Kai's story demonstrates the significant impact of available collaborative voluntary sector partner support in Shropshire.

# Demographic & Environmental change

**Currently:**






**By 2050, current data and trends suggest that:**

*(Data, Shropshire 2050)* *(18)*

- Shropshire's population will increase by more than **61,000** people
- The size of the 80+ population will more than double to **48,000** people
- There will be an additional **11,800** people of working age
- There will be an additional **3,700** children between 0-15, and **44,500** people aged 65+
- Almost **40,000** extra homes will need to be built

These changes to the demographics (population categories) of the county will have several potentially significant risks on poverty across Shropshire.

As Shropshire's population ages, and the number of 65+ residents increases, more people will be living on fixed incomes. Whilst a lot of older people are financially secure (with lower poverty rates than working-age households), others may become more vulnerable to fuel poverty, rising living costs and unexpected financial shocks, with less, or no ability to increase their income. Where these residents live alone or have long-term health conditions these problems will be worsened.

An ageing population can also magnify existing rural inequalities, unless strong plans are implemented around transport, digital inclusion and localised services. Additionally, families may need to reduce working hours to care for elderly relatives, potentially lowering their income.

The projected increase in single-person households (18,000 more between 2021 and 2050) is highly likely to increase the number of residents facing financial pressure as housing, energy, food and other costs cannot be shared across multiple earners.

## Environmental & Climate Change

Climate change doesn't affect everyone equally. Households that have lower incomes are less able to adapt to rising temperatures, flooding, increased energy costs and other environmental changes.

The interdependence of planetary health with human health is becoming increasingly apparent; given the UKs ageing population and the changes to our weather patterns associated with global warming, it is likely we will see an increase in deaths associated with extremes in temperatures among the most vulnerable. (Murage et al. "... the annual UK heat-related mortality could rise from 2.5 per 100,000 people to 6 per 100,000 in the 2030s, 15.1 per 100,000 in the 2050s and 29.4 per 100,000 in the 2070s." *(23)*

**High temperatures** where air conditioning or suitable cooling is not available (or affordable) can lead to severe heatstroke, dehydration or other health issues including loss of life. During the May and June 2026 heat events there were an estimated total of **2,877** heat-associated deaths in England.

Increased temperatures also exacerbate the issue of food insecurity through reduced crop yields and drive up the price of supermarket products.

2025 was the worst year for wildfires on record in the UK and is the most recent data from a worsening trend since 2019 *(24),* with nearly 48,000 hectares burning - this is concerning for a rural county such as Shropshire with many arable farms and woodlands.

Due to its geography, Shropshire is particularly susceptible to flooding. Flooding has several negative health impacts, including mental and physical stress, potential exposure to contaminants in floodwater, and potential loss of life. Flooding can cause financial shocks that worsen financial resilience, increase insurance premiums, and costs related to repairs or relocation.

# Poverty & Health

*Direct impacts*

Smoking is **directly** correlated with areas of poverty and deprivation. Nationally:

Increase 2017 - 2021

Approximately one-third (33.1%) of all smoking adults in England lived in the two most deprived deciles in 2021, up from 29.5% in 2017

Just over one-tenth (10.9%) of all smoking adults in England lived in the two least deprived deciles in 2021, down from 12.1% in 2017

Decrease 2017 -2021

**284**
Shropshire residents reached 4 weeks quit in 25/26

Using ONS data, an average smoker can be expected to spend **£265** per month on cigarettes, or about **15% of a national minimum wage take home salary**.

Where finances are a challenge, people may trend towards cheaper and more dangerous alternatives such as counterfeits, or cigarettes or cigars that have been mixed with items hazardous to health.



**Stopping smoking completely can save around £3,000 per year**

**If you need help to quit, Shropshire Council run a stop smoking service, click here for more information.**

### Nationally (Data from Action on Smoking & Health, ASH) *(19)*

- When spending on tobacco is taken into account, tobacco forces **417,000** households, who wouldn't otherwise be, below the poverty line
- In addition, it pushes **955,000** households already living below the poverty line into even deeper financial hardship
- In total, **1.37** million households are living in poverty once smoking costs are factored in
- One in four people who smoke (**24%**) went hungry last year after skipping meals, compared to one in ten (**10%**) of those who have never smoked
- **Those who smoke are nearly three times as likely to use food banks as non-smokers (20% vs 7%)**

### Alcohol & Poverty

Alcohol-related harm remains a major public health issue, but it does not affect everyone equally. People living in the most deprived areas often experience much higher levels of alcohol-related harm than those in the least deprived areas, even though they may drink the same amount of alcohol or less. This is known as the alcohol harm paradox.

In 2023, people living in the most deprived areas of England were far more likely to experience alcohol-related harm, including hospital admissions and deaths. The alcohol-specific mortality rate was more than twice as high in the most deprived areas than in the least deprived areas (20.9 deaths per 100,000 population compared with 9.8 per 100,000). These inequalities are seen not only in physical health outcomes, but also in people's experiences of alcohol-related problems and harms.

*The inverse care law was coined in 1971, by* , Julian Tudor Hart

***"The availability of good medical care tends to vary with the need for it in the population served."***

In other words, as a community's deprivation and poverty increase, so too do their health needs; however, they inversely receive less health care than less deprived populations. Inequity in healthcare provision is an enduring phenomenon, despite efforts to tackle its fundamental drivers *(14)*.

### For example;

- The fall in childhood vaccination rates across England has seen the resurgence of previously eradicated diseases, such as measles and pertussis. The Royal College of Paediatrics and Child Health published a report on 2025, which demonstrated that the core challenges lay with access, hidden costs (such as transport and time off work), difficulty in booking appointments and a lack of continuity of care. The populations most at risk of missing out on their childhood vaccinations are those from ethnic minority groups.
- The King's Fund has observed a worrying trend , which is that the prevalence of certain health conditions, such as dementia and heart conditions, is lower in the most deprived areas; yet deaths contributed to these conditions is higher. This suggests that delayed diagnosis and lack of early intervention leaves these populations susceptible to more advanced disease, with associated increased mortality rates *(12)*.
- "**30% of people living in the most deprived areas have turned to 999, 111, A&E or a walk-in centre because they were unable to access a GP appointment, compared to just 10% of people in the least deprived areas**."*(12)*

# Chapter 2: How are we tackling poverty in Shropshire - Current activity



## Financial investment in resilience services

- We have invested approximately £1,000,000 into the VCSE sector to improve their capacity to provide support. Referrals will be made to appropriate services at the earliest opportunity to avoid escalation into crisis across the entire CRF network of partners.

## Localised, evidence-driven proposals from communities

- Listening to proposals for localised plans, understanding that need changes based on area.
- Funding community organisations to deliver this support independently.

## Strengthening and simplification of referral pathways

- Providing uniform referral pathways that are shared across the wider CRF network. Ensuring accurate, up to date information on council webpages and communications.
- Rollout of a single point of access email for referring into council support services.

## Refreshed, simplified and easier to use access routes

- We have developed multi-access routes for residents, including online, in-person, and via phone or email to ensure support is available.
- Webpages will be simplified, use easier language, and have been made more accessible. Offline routes will avoid digital exclusion.

## Reducing stigma

- Provision of multiple access routes enabling residents to choose the one that is easier, and most beneficial for them. Whether online, over the phone/email, in person or through a trusted community partner.
- Clear communications on support available, with careful and considered language.

## Cost-of-Living communications campaign

- We have merged all available cost-of-living support (blue badges, council tax relief, bus passes etc) into a single council resource for simplicity.
- Promotion of available support through the press, our social media and through partners, members and MPs.

## Coproduction with the VCSE sector

- Our CRF delivery plan was co-developed with partners through workshops and regular meetings, taking on board the voice of the community and providing the resources required to support.
- We meet regularly to identify and address problems, and opportunities for improvement.

## Embedding of No Wrong Door approach

- Planned rollout of training to appropriate public-facing council staff, VCSE partners and community venue volunteers on how to have conversations that delve deeper to identify underlying issues.
- Uniform referral routes, that all appropriate parties are aware of, so any route to accessing support is correct.

*In addition to the above, through CRF funded partners, we work closely with other organisations who provide a wide range of support, ranging from gambling and substance misuse to training providers. The council would like to extend its gratitude and appreciation for all organisations who accept referrals across the wider resilience landscape to support the people of Shropshire.*

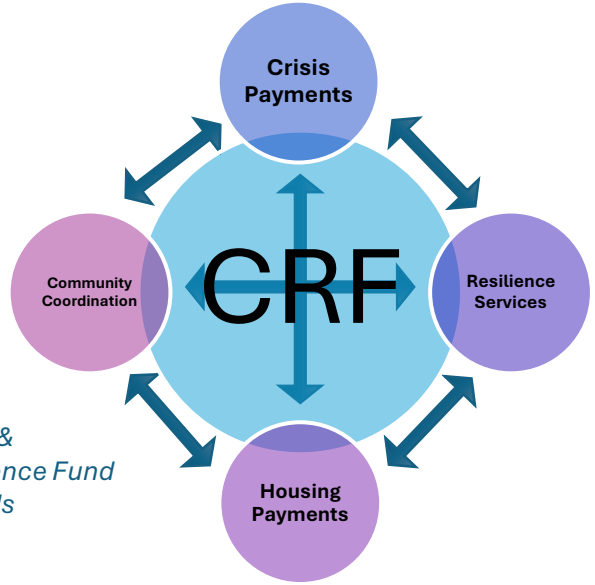
# Crisis & Resilience Fund [CRF] (2026 – 2029)

Funded by UK Government

On 1st April 2026, the UK Government launched the Crisis & Resilience Fund [**CRF**], a three-year grant to local authorities in England, designed to tackle poverty, and the underlying causes through both direct, cash-first payments, and targeted advice and support referrals.

The allocation for Shropshire is **£3.7m** per year. These plans need to cover four areas, each connected and able to refer across to each other for support.

- **Crisis Payments:** Financial (cash-first where possible) support for a wide range of cost-of-living related issues or financial shocks.
- **Housing Payments:** Support with housing costs, such as rent arrears, or deposits to secure accommodation in crises.
- **Community Coordination:** Funding to community initiatives, based on local need.
- **Resilience Services:** Investment in advice and support services




*Crisis & Resilience Fund Strands*

*Outcomes drive the strand programmes, and the strands support the outcomes.*

The CRF will tackle poverty and inequality through ensuring that support programmes support one or more of the 7 outcomes outlined below.

The CRF aims to move away from direct, blanket payments, to targeted support. This support will by default come with a warm referral into appropriate advice services, delivered by partners. These partners have been funded through investment in their staffing, providing such advice as debt management, income maximisation, tariff support and much more.

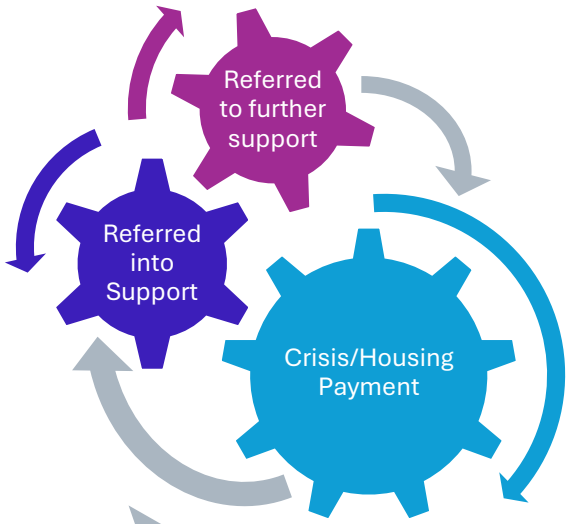
Local Authorities are required to produce a delivery plan for this funding, which, in Shropshire, was developed alongside partners in the VCSE sector. In 2026, an additional £758,558 was awarded to support households reliant on heating oil, of which over 21,000 exist within Shropshire due to its rurality.

As already identified, fuel poverty is a crucial problem within the county, which various schemes are aiming to address.

| | | |
|---|---|---|
| Reduced experiences of material deprivation | Reduced need for emergency food parcels | Increased access to appropriate and quality advice services |
| Increased savings | Reduction in priority debt | Maximisation of individuals' incomes |
| | Decreased need for crisis and housing payments | |

*Crisis & Resilience Fund Outcomes*

*Crisis & Resilience Fund: Referrals & Partners*




Marches Energy Advice

citizens advice Shropshire

SFPA Shropshire Food Poverty Alliance

RADFORD COMMUNITY RESOURCE

Shropshire Telford & Wrekin age UK

# Root causes being addressed

## Fuel Poverty & Energy Costs

- Application based, cash-first financial support for heating oil price rises.
- Energy Debt, advice and grant support/signposting programmes.
- Energy Advice Phoneline – delivered by Marches Energy Advice
- Sustainable Warmth Programme
- Home retrofitting and boiler upgrade scheme (BUS)

## Housing & Population Inequalities

- Housing & Health Action Plan
- Local Plan, reviewing how to embed health into planning policy.
- High-Quality Design and Design of New Dwellings Supplementary Planning Documents (SPDs)
- National Neighbourhood Health Implementation Programme (NNHIP)
- Place Universal Offer, improving physical activity within 3 “places”

## Transport and Rurality

- Full Health Impact Assessment completed for the next Local Transport Plan
- Rurality impacts have been incorporated into Equality, Social Inclusion and Health Impact Assessments (ESHIAs) since 2014, in social inclusion impact assessments and socio-economic and environmental considerations.
- Continued evidence and advocacy for fairer funding to rural Local Authorities, emphasising equality and equity.
- Digital-first transition(not digital-only) methods for reaching rural communities.

## Employment & Earnings

- Digital Skills Programme
- Financial skills courses run through Shropshire Libraries.
- Apprenticeships & Upskill Shropshire
- Shropshire Economic Growth Strategy
- Get Marches Working
- Enable Employment Support

## Food Insecurity and Cost of Essentials

- Locally led, evidence-based foodbank resilience programmes funded by CRF
- Increased funding for Holiday Activities & Food (HAF) Programme over the 2026 summer holidays
- Exploring rollout of Free School Meal (FSM) autoenrollment system for all eligible pupils in Shropshire.

## Welfare and Policy changes

- Crisis and Resilience Fund [CRF] (2026 – 2029)
- Launch of new Council Tax support schemes
- Families First Partnership Programme – Community Hubs
- Embedding of Inequalities through the next Health & Wellbeing Strategy and Health in All Policies (HiAP)

***and much, much more...***

# What are we doing?

*Shropshire Council*

*The three "Cash-first"* schemes administered by Shropshire Council*




**Schemes are cash-first, not cash-only. Where cash is not appropriate, e.g. in cases of substance misuse, or gambling, vouchers or in-kind support may be provided instead.*

Continuing from the **Household Support Fund** [HSF] (2021-2026), our successful Crisis payments scheme provides person-centred, cash-first (where appropriate) support to people at risk of financial shock.

We continue to provide support on housing costs for at-risk individuals through our Housing Payments scheme (formerly DHPs)

To ensure continuity and support, these schemes were implemented by the same, experienced teams who previously delivered the HSF. Additionally, any applications that were in train before the launch of the replacement fund (01.04.26), were carried forward onto the new programme, avoiding the need for residents to reapply.

A one-year top-up to the **Crisis & Resilience Fund** was awarded to Shropshire Council to support in the increase in the price of heating oil caused by global instability. Working collaboratively with partners **Community Resource**, a means-tested scheme was launched in June 2026, with online, phone, and in-person access routes to support people currently on heating oil supplies.

Communications around these schemes, including other council support on the cost-of-living continue to be shared across the wider council, as well as partners and in the media. Additionally, VCSE partners can refer any residents into these direct payment schemes for support, and in the opposite direction, residents may be referred to VCSE partners for advice, guidance, training and any other support that they specialise in such as budgeting, applying for benefits, or dealing with debts.

## Other programmes

### Libraries Financial Skills Workshops

Lack of financial skills and understanding is a key driver of poverty. Being able to budget, manage debts, and handle personal finances are crucial to becoming more financially resilient and lowering the risk of falling into debt or needing crisis support. Working closely with Libraries in Shropshire, training sessions will be offered to teach these skills to the public.

### Targeted support for Care Leavers

In alignment with Shropshire Council's decision to identify care leavers as a local grouping, alongside compliance with support for national groupings through Equality Act 2010 and the Armed Forces legislation, various schemes will be launched to support care leavers to access training, support them against financial shocks, and more. This will be handled with a dedicated budget to our in-house care leaving team.

### Affordable Warmth & Energy Efficiency (AWEE) Schemes

Using investment from CRF, and other grant-funded schemes, alongside advice and support through Marches Energy Advice, our in-house AWEE team provide retrofitting, hazard removal, and support with boiler upgrades, heat pumps and more.

### Economic Abuse Workshops

Financial control is one of the key mechanisms by which people can abuse their partners. The council's domestic abuse prevention team will run workshops on economic abuse across the county and continue to support those who are at-risk.

### Direct Council Tax Award

Based on evidence from Citizens Advice Shropshire identifying council tax arrears as the primary priority debt of residents within Shropshire, a direct award of up to £80 was paid to working-age residents in Shropshire at risk of failing to meet the 20% minimum payment required by law. This was paid in April 2026 for the 2026/27 FY.

# What are we doing?

*Partners – Resilience Services & Community Coordination*

## Citizens Advice Shropshire

Working closely with the Shropshire Food Poverty Alliance (SFPA) – funding was provided to foodbanks across Shropshire to run local, needs-driven resilience programmes. Grants were administered and managed by Citizens Advice, with decisions made by a cross-organisation panel. These schemes are expected to launch from **September 2026**.

Capacity within the local Citizens Advice team was identified as an issue during a collaborative workshop, and so funding of posts was provided to increase the workforce and enable extra advice and support, as well as accept referrals from both Shropshire Council and other CRF partners.

## Marches Energy Advice

Continuing from our successful "Warm Welcome" – programme from the last few years, a new CRF focused programme is being managed by Marches Energy Advice to create community-led initiatives aimed at increasing resilience and supporting around a wide range of cost-of-living issues. These sites will be focused on local need, and proposals will be put forward by charities, community interest groups and others. Details on these venues and their offers will be publicised once the programme is fully launched in **Winter 2026**.

Additionally, Marches Energy Advice provide advice, support and guidance around debts, grant schemes, tariffs and more. Working closely with the council's Affordable Warmth & Energy Efficiency (AWEE) team to provide support to residents struggling with fuel poverty.

## Community Resource

Rollout and delivery of Ask, Assist, Act training. A conversational framework for partners and charities to maximise opportunities to identify underlying issues and refer to appropriate support. Reduces the risk of future crisis by connecting with resilience services as soon as possible.

Co-delivered and co-produced Heating Oil scheme for vulnerable, at-risk households. Providing cash, direct oil deliveries and subsidised memberships to a community oil buying scheme, embedding resilience and cheaper prices in the long term.

Delivery of hardship grant awards where appropriate, upon referral, to enable support to those in need who might not wish to engage with the Local Authority for various reasons.

## Age UK Shropshire, Telford & Wrekin (STW)

Rurality, digital exclusion and complicated financial documentation can make moving into care or handling social care support residents may receive difficult. Working closely with both Age UK STW and the Council's Financial Assessment Team (FAT) – a new developmental post has been created to help residents with this potentially difficult process.

Alongside Citizens Advice, at the same development workshop, Age UK STW also identified lack of capacity as a serious issue for their organisation. A year's funding was initially agreed and provided to increase their capacity to replace loss of previous funding, and to accept warm referrals from both the Council and other CRF partners.

## Community Wellbeing Outreach Team

The **Community Wellbeing Outreach Team** (CWOT) supports the Crisis Resilience Fund (CRF) and helps to reduce the risk of further hardship by working with foodbanks, community organisations and local partners to identify gaps in support, particularly in rural and remote communities. The team helps people access the right services through signposting and referrals, connecting residents to health, wellbeing, social care and community support. CWOT also strengthens partnership working between foodbanks, Citizens Advice, health services and VCSE organisations, ensuring support is better coordinated and informed by local need to build longer-term community resilience.

# Tackling stigma

Many individuals and families feel a sense of shame or embarrassment when seeking help, often viewing it as a personal failure rather than a response to wider economic pressures. This can be particularly true in communities where there is a strong culture of self-reliance, or where negative narratives around welfare and debt have become embedded over time. As a result, people may delay seeking support until their situation becomes more severe, leading to increased financial hardship, stress, and negative impacts on health and wellbeing.

Concerns about being judged, not believed, or treated differently can act as powerful barriers, especially for those who have not previously engaged with support services. Importantly, this stigma does not reflect the reality that many factors contributing to financial difficulty—such as rising living costs, insecure employment, and unexpected life events—are outside an individual's control. Global and national issues have caused significant impacts on people from all walks of life.

Normalising conversations around financial support, promoting dignity-based services, and ensuring access routes are simple and discreet are crucial steps in reducing these barriers. Addressing stigma requires a compassionate, system-wide approach that reframes support as a positive and proactive step, helping people to maintain independence, stability, and resilience.

## Shropshire Approach




*Reducing stigma in Shropshire*

# Promoting Support

Many people in Shropshire are worried about rising costs. Across the county, a strong, well-connected network of partners can support on a wide range of issues in a safe, confidential and judgment free space.

**You are not alone, and there is no shame in accessing help.**




If you cannot view this video, click here



## Key messages

- If you or someone you know is worried about money or is struggling right now, you're not alone
- There may be simple steps you can take to cut costs or maximise your income
- If you're getting into debt or your mental health is suffering, don't wait to get help
- Support is confidential, non-judgmental and free
- With your permission, partners may also refer you on to other, additional support

# Chapter 3
# Summary and recommendations

This annual report highlights that poverty continues to be one of the most significant public health and socio-economic challenges affecting residents across Shropshire. Poverty is well known to be closely linked to both poorer physical and mental health outcomes, while financial insecurity increases stress, anxiety and social isolation while reducing opportunities to live healthy lives. As a result, many of the health inequalities seen across the population are rooted in deprivation and wider social and economic disadvantage.

## What England Can Learn from Shropshire: Tackling Hidden Poverty in Rural Communities

Shropshire's work on poverty highlights an issue often overlooked in national policy discussions: **poverty in rural areas looks different, but it is no less severe**. While urban deprivation is often concentrated and visible, rural poverty can be dispersed, hidden behind employment, home ownership and attractive landscapes.

A key lesson is that poverty cannot be measured through income alone. Rural residents often face a "**rural premium**" of lower earnings alongside higher essential costs. Transport, heating, housing maintenance and access to services typically cost more, yet these pressures are poorly reflected in national funding formulas and poverty measures. As a result, hidden poverty can remain invisible until households reach crisis point. Many people may be employed, own their homes, or live in desirable villages, yet still struggle to afford food, energy, transport or participation in community life/access services.

## Key Takeaways for England

- **Rural areas within England contain millions of people. This is not a niche issue.**
- **Poverty exists across all communities, including affluent appearing rural areas.**
- **Rural poverty is often hidden from traditional measures and under-recognised.**
- **Living costs are frequently higher due to transport, energy and housing pressures. This is on top of lower incomes on average.**
- **Prevention and early intervention deliver better outcomes and value than crisis responses.**
- **Improving health requires coordinated action across housing, transport, employment, education and planning.**
- **Rural demographic change requires long-term investment and planning. Local authorities need flexibility to develop solutions that reflect local circumstances.**

### Key Issues/Changes

- **Higher cost of living**
- **Increased energy costs**
- **Rising housing costs**
- **Welfare & policy changes**
- **Crisis & Resilience Fund launched**
- **Growing food insecurity**

Shropshire's experience also demonstrates the continued importance of addressing **the wider determinants of health**. We know that health outcomes are shaped not only by healthcare services but also by housing, transport, employment, education, fuel costs, access to healthy food and community infrastructure and other wider determinants of health (as much as 90%). Poverty policy must therefore be integrated across government rather than viewed solely as a welfare issue. This aligns with the council's **Health in All Policies** approach, embedding health and inequality considerations across decision-making.

Another important lesson is the need to recognise demographic change. Rural counties such as Shropshire face an ageing population, increasing demand for services, workforce shortages and growing pressure on unpaid carers.

**National approaches focused primarily on urban deprivation risk overlooking the interaction between ageing, rurality and poverty.**

# The way forward...

Many of the actions needed to tackle poverty and reduce inequalities are already underway across Shropshire. However, there remains more to do.

We will continue to work with valued partners to intervene earlier, prevent problems from escalating into crisis, and address the wider determinants of health such as housing, employment, education, transport and financial resilience through **Health in All Policies.**

1

### Start Earlier

Poverty can affect outcomes before a child has even started school. Improving early childhood development, supporting families and giving every child the best start in life offers one of the greatest opportunities to reduce poverty and health inequalities across future generations. Continued investment in programmes such as **Best Start in Life** and the **Family First Partnership Programme** will be key to improving life chances.

2

### Prevent Problems Escalating

Financial hardship often develops gradually before reaching crisis point. By identifying concerns earlier and improving access to advice, income maximisation, debt support and practical assistance, more residents can be supported **before** problems become entrenched. **Prevention should remain at the heart of future activity.**

3

### Tackle the Drivers of Poverty

Long-term progress will depend on addressing the factors that contribute to poverty, including low income, insecure employment, poor housing, fuel poverty, transport barriers and limited access to opportunities. A stronger focus on financial resilience, good quality employment, affordable housing and healthy places will help improve outcomes across the county.

4

### Recognise Rural Poverty

Rural poverty is often less visible than deprivation in urban areas, but the additional costs associated with transport, energy, housing and access to services can create significant hardship for residents, leading to inequities. **Future policy and service design should continue to recognise the unique challenges faced by rural communities and ensure support reaches those who need it most.**

5

### Continue Working Together

No single organisation can tackle poverty alone. The progress made in recent years has been achieved through strong partnerships between Shropshire Council, the NHS, schools, community organisations, employers and residents. Continued collaboration, shared learning and collective action will be essential if we are to reduce inequalities and improve outcomes for future generations.

6

### Make Support Easier to Access

Residents should not need to navigate complex systems to get help. Strengthening **"No Wrong Door"** approaches, improving referral pathways and increasing awareness of available support can help ensure people receive timely assistance regardless of where they first seek help.

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Reducing poverty is **not** solely about increasing income. It is about creating the conditions that enable people to live healthy, secure and fulfilling lives. By focusing on **prevention and early intervention, partnership working and tackling the wider determinants of health**, Shropshire has an opportunity to reduce inequalities, strengthen community resilience and enable all residents to live healthy, secure and fulfilling lives.



## A Vision by 2029

*"What Success Looks Like"*

- Fewer households in crisis
- Reduced food insecurity
- Reduced fuel poverty
- Better access to support
- Improved health outcomes
- Stronger communities

Draft

# Next Steps & Recommendations

| Who? | What? | When? |
|---|---|---|
| • ***Shropshire Council (Early Help)***<br>• ***System Partners***<br>• ***Education Partners***<br>• ***National Government*** | **1. Give Every Child the Best Start in Life**<br>*Poverty in childhood influences educational attainment, future employment opportunities and health throughout life.*<br>• Continue implementation of Best Start in Life (BSIL).<br>• Support delivery of the Family First Partnership Programme (FFPP).<br>• Improve school readiness and GLD outcomes.<br>• Target support towards children eligible for Free School Meals.<br>• Strengthen Family Hub and community-based provision. | FFPP – **launches 2027**<br><br>Best Start in Life – **Ongoing**<br><br>Public Health Nursing Service Refresh – **2027 – 2032.** |
| • ***VCSE Partners*** | **2. Improve Household Financial Resilience**<br>*Many households are one unexpected expense away from crisis.*<br>• Expand income maximisation support.<br>• Improve access to welfare and benefits advice.<br>• Support residents not claiming their full entitlement.<br>• Increase awareness of available support. | Rollout of referral scheme **April 2026 onwards.** |
| • ***Residents***<br>• ***Shropshire Council***<br>• ***VCSE Partners***<br>• ***System Partners*** | **3. Strengthen a "No Wrong Door" Approach**<br>*People experiencing poverty often require support from multiple organisations.*<br>• Improve referral pathways between the council and VCSE.<br>• Improve appropriate information sharing between partners, in line with data protection requirements.<br>• Improve signposting and warm referrals to appropriate support.<br>• Develop more integrated support services. | Over course of CRF delivery, **now through to 2029 and beyond.** |

| Who? | What? | When? |
|---|---|---|
| • ***Shropshire Council (Affordable Warmth, Housing)***<br>• ***VCSE Partners*** | **4. Reduce Fuel Poverty**<br>*Fuel poverty is one of the most significant poverty-related challenges facing Shropshire.*<br>• Continue delivery of the Sustainable Affordable Warmth Strategy.<br>• Expand retrofit and energy-efficiency measures.<br>• Improve access to heating oil and energy support schemes.<br>• Enhance affordable warmth advice services. | Sustainable Warmth Strategy – **now through to 2030**<br><br>Heating Oil Scheme – **Winter 2026.** |
| • ***Shropshire Council (Economic Growth)***<br>• ***System Partners*** | **5. Improve Access to Good Quality Employment and Skills**<br>*Secure employment remains one of the strongest protections against poverty.*<br>• Support Get Marches Working.<br>• Strengthen skills and training programmes.<br>• Improve opportunities for disadvantaged groups.<br>• Support progression into higher-paid employment. | Get Marches Working – **ongoing.** |
| • ***Shropshire Council***<br>• ***System Partners***<br>• ***National Government*** | **6. Address Rural Inequalities *(and Inequities)***<br>*Poverty can be less visible in rural areas but may be intensified by transport costs, housing costs and limited-service access.*<br>• Design services that reflect rural challenges.<br>• Improve access through community hubs and outreach.<br>• Continue to develop rural transport (Local Transport Plan - LTP4) and digital inclusion initiatives.<br>• Continue to advocate for fairer rural funding settlements. | LTP4 - **2026 – 2036**<br>Digital Skills Programme – **till March 27**<br>Local Plan – **2027 onwards.** |
| • ***Shropshire Council***<br>• ***System Partners***<br>• ***VCSE Partners***<br>• ***Residents*** | **7. Improve Identification of Hidden Poverty**<br>*Many residents do not recognise themselves as being in poverty or may not seek support.*<br>• Use data to identify vulnerable households earlier.<br>• Improve understanding of hidden poverty.<br>• Reduce stigma associated with asking for help.<br>• Increase community awareness of support services. | Over course of CRF delivery, **now through to 2029 and beyond.** |

# Conclusion/ Closing Summary

This report has shown that poverty remains one of the greatest challenges to health and wellbeing in Shropshire. It affects people of all ages and backgrounds, influences outcomes across the life course and contributes significantly to health inequalities.

Whilst Shropshire is often viewed as an affluent county, this report has highlighted the hidden nature of hardship and deprivation that exists within our communities. Rurality, housing costs, transport barriers, fuel poverty and rising living costs can combine to create significant challenges for residents and families.

There is no single solution, but there is a clear direction. By giving every child the best start in life, improving financial resilience, tackling fuel poverty, supporting good quality employment and strengthening our communities, we can reduce the impact of poverty and create opportunities for people to thrive.

Our challenge now is not simply to respond to poverty when it becomes visible, but to prevent it wherever possible, identify it earlier and work collectively to address the wider conditions that allow it to persist.

Together, we can help ensure that **everyone** in Shropshire can achieve better outcomes.



Rachel Robinson
*(Director of Public Health)*

Wendi Shepherd
*(Deputy Director of Public Health)*

Cllr. Ruth Houghton
*(Portfolio Holder, Adult Social Care & Public Health)*

*Poverty is preventable and not inevitable. While no single organisation can solve poverty alone, every organisation has a role to play in reducing its causes and consequences.*

*Over the coming years, partners across Shropshire will continue working together to tackle both the symptoms and root causes of poverty, reducing health inequalities and supporting residents to live healthy, independent and fulfilling lives.*

## What are the next steps?

- Give Every Child the Best Start in Life
- Improve Household Financial Resilience
- Strengthen a "No Wrong Door" Approach
- Reduce Fuel Poverty
- Improve Access to Good Quality Employment and Skills
- Address Rural Inequalities
- Improve Identification of Hidden Poverty

# What support is available?

*Where do I get help?*

| Where? | What? |
|---|---|
| Click here | **Cost of Living Support** including:<br>• Crisis & Resilience Fund<br>• Council Tax Support<br>• Blue Badges<br>• Free School Meals<br>• Holiday Activities & Food<br>• Library Cards<br>• Bus Passes<br>• & more... |
| Click here | **Citizens Advice Shropshire**<br>Advice, guidance and support:<br>• Debt advice<br>• Budgeting<br>• Advocacy<br>• Income Maximisation<br>• Consumer rights<br>• & more... |

| Where? | What? |
|---|---|
| Click here | **AgeUK Shropshire, Telford & Wrekin**<br>Advice, guidance and support for older people:<br>• Income maximisation<br>• Benefit advice<br>• Social care<br>• Financial Assessments<br>• & more... |
| Click here | **Marches Energy Advice**<br>Advice, guidance and support:<br>• Debt arrears<br>• Grant schemes<br>• Tariffs<br>• Home upgrades & EPC<br>• & more... |

Or call Shropshire Local on **0345 678 9000** or visit in person at one of their many locations.

## Can't get online?

## Shropshire Local

**Shrewsbury:**
Guildhall, Frankwell Quay, Shrewsbury, England SY3 8HQ
**Mon to Fri:**
**09:30 – 17:00**

**Ludlow:**
Ludlow Library, 7-9 Parkway Lane, Ludlow SY8 2PG
**Mon to Fri (no Weds):**
**09:30 – 17:00**

**Oswestry:**
Free public phone access, regular library opening times apply.

# Resources

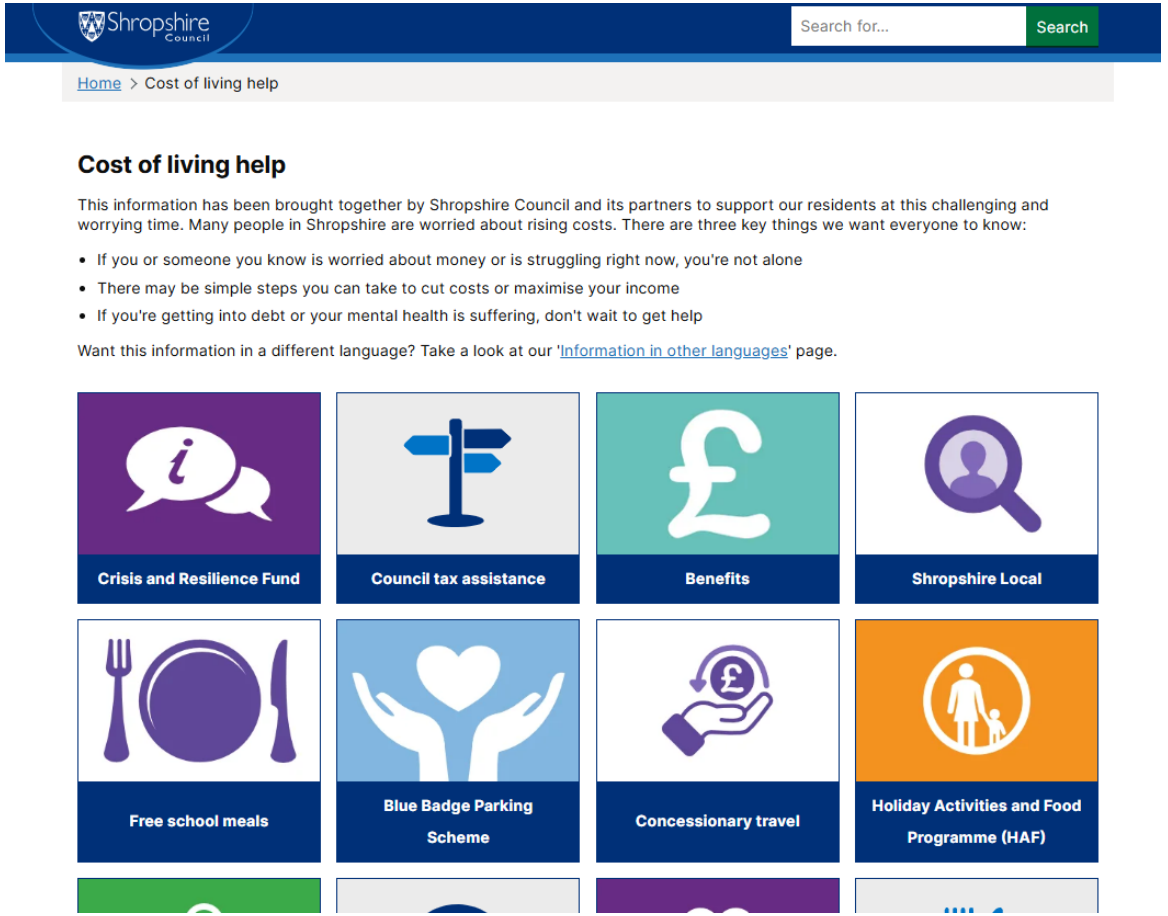



*Produced by the Independent Food Aid Network (IFAN) – and informed by Shropshire Council, Citizens Advice Shropshire and CRF Partners. Leaflets were produced on available support and shared in key locations across the county.*

**https://worryingaboutmoney.co.uk/shropshire**

## Cost of living help | Shropshire Council

*Refresh and rebranding of cost-of-living support available through Shropshire Council, simplifying access and promoting all opportunities including, but not limited to the Crisis & Resilience Fund.*



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Marches Energy Advice

Shropshire Telford & Wrekin age UK

RAFO SDCIW COMMUNITY RESOURCE

citizens advice Shropshire

SFPA Shropshire Food Poverty Alliance

## Appendix 1: Citizens Advice Shropshire - Shopping Basket Data

**Summary**

Citizens Advice Shropshire updated what was formerly a Shaping Places research project evaluating the cost of a basic shopping basket for Shropshire households. Following the previous research design, prices were collected from 5 local stores in the South of Shropshire and contrasted with previous years findings. As a new addition to the project, online shopping prices were obtained from the leading 5 supermarket companies: Sainsburys, Tesco, Morrisons, Aldi and ASDA to capture alternative cost implications for households utilising online ordering platforms. While prices were substantially cheaper when ordering from leading retailer's online platforms, there are several barriers that may prevent access to these options for Shropshire residents.

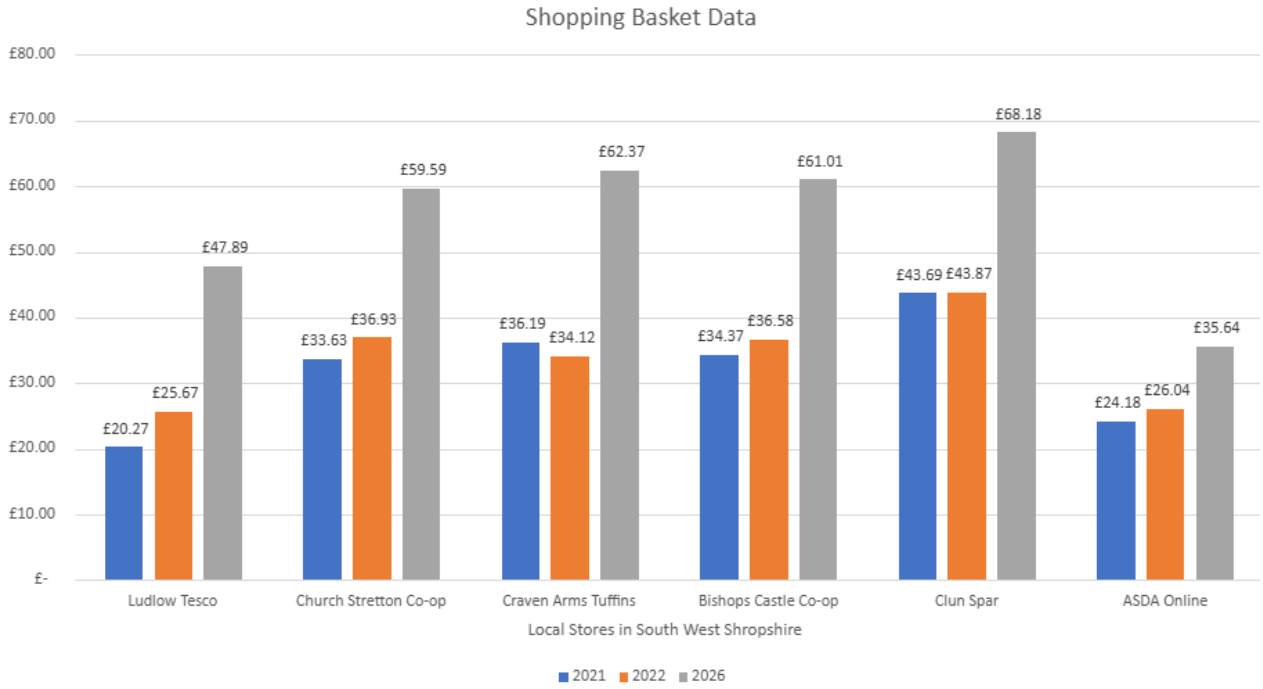
In 2026, Aldi was found to be the cheapest major food retailer for this shopping basket but does not offer online ordering and therefore delivery to rural locations. Other major providers often have a minimum purchase of **£40** for delivery, alongside charging additional delivery fees that can be up to **£7** depending on the time slot selected, which are often more expensive for times when working adults would be available. As a result, households are often better off travelling to do their grocery shopping in-person which presents further barriers for households in rural areas, especially when combined with the transport issues previously identified. For many households across Shropshire, local grocery stores are the only manageable option, but the privilege of proximity does then come at a **price premium**.

The results of this research demonstrated substantial increases in prices from 2022 to 2026, both for online retailers and localised grocery stores. **Keeping ASDA online as the control variable, food basket prices from 2022 to 2026 increased by just under 37%. Yet at the local level for South Shropshire stores, the average price increase was just under 69%, an enormous inflation from 2022.** Rising food prices place a massive pressure on household budgets across Shropshire, coupled with sometimes complex access barriers to affordable grocery retailers -- keeping food on the table for many, comes at a premium.

**Summary Findings**

- **69% average price increase** for local South Shropshire grocery store
- **37% average price increase** for ASDA online
- Ludlow Tesco experienced the **highest price increase since 2022 of 87%**, closely **followed by Craven Arms Tuffins at 83%**
- Clun Spar again is the costliest grocery store assessed with a food basket total of **£68.18**
- Average food basket price in South Shropshire in 2026 is **£59.81** an increase of **£24.38** from 2022

While prices have starkly increased, a reduction in quantity within products (called shrinkage) also means households are paying more for products they are getting less of.




As shown, **the most rural locations in South Shropshire face the highest price implications**. Alongside increasing food prices, households in these areas face multiple cost penalties: living further from major retailer options that often require travel by car or if utilising online options, are met with additional costs to their basket purchases to both meet the minimum order requirements and added delivery costs.

While Ludlow residents benefit from having the lowest **actual** price increase **(£22.22)** for their shopping basket between 2022 and 2026, when compared with other rural locations across South Shropshire, this was the highest **percentage** price increase across these retailers since 2022 at almost **87%**. Consequently, this significant increase places an enormous cost implication to household budgets in Ludlow that many would have been unprepared to financially plan for.

While not perhaps exceeding Ludlow's basket percentage increase, household's budgets across South Shropshire will undoubtedly have felt the financial burden of price inflation over the last 4 years. **Each rural grocery store researched experienced a percentage price increase on this sample food basket of at least 55% since 2022**. For working households since 2022, wages have only increased by around 33.8% and for residents receiving welfare support, benefits have increased by approximately 30.3% in large part due to high inflation. As indicated, wage and welfare increases are not matching the inflation levels of food prices across South Shropshire, consequently presenting persisting budgetary constraints for this necessity.

Shropshire Council

Appendix 2: Glossary of terms/acronyms



| Acronym | Meaning |
|---|---|
| ASH | Action on Smoking and Health |
| AWEE | Affordable Warmth & Energy Efficiency |
| BSIL | Best Start in Life |
| BUS | Boiler Upgrade Scheme |
| CAS | Citizens Advice Shropshire |
| CRF | Crisis & Resilience Fund |
| CWOT | Community Wellbeing Outreach Team |
| DfE | Department for Education |
| DHP | Discretionary Housing Payment |
| DPH | Director of Public Health |
| EPC | Energy Performance Certificate |
| ESHIA | Equality, Social Inclusion and Health Impact Assessment |
| FAT | Financial Assessment Team |
| FFPP | Family First Partnership Programme |
| FSM | Free School Meals |
| GCSE | General Certificate of Secondary Education |
| GLD | Good Level of Development |
| HAF | Holiday Activities and Food Programme |
| HiAP | Health in All Policies |
| HMO | House of Multiple Occupancy |
| HSF | Household Support Fund |
| IFAN | Independent Food Aid Network |
| IMD | Index of Multiple Deprivation |
| MEA | Marches Energy Advice |
| NEET | Not in Education, Employment or Training |
| NNHIP | National Neighbourhood Health Implementation Programme |
| NOMIS | National Online Manpower Information System |
| ONS | Office for National Statistics |
| SAP | Standard Assessment Procedure |
| SFPA | Shropshire Food Poverty Alliance |
| SPD | Supplementary Planning Document |
| UC | Universal Credit |
| VCSE | Voluntary, Community and Social Enterprise |

| Term | Plain-English explanation |
|---|---|
| Absolute poverty | Not having enough income to afford basic necessities such as food, clothing, heating and housing. |
| Cash-first support | Providing money directly where appropriate, rather than only providing vouchers or goods. |
| Decile | One of ten equal groups used to compare areas. In the IMD, decile 1 represents the most deprived 10% of areas. |
| Deprivation | A wider lack of resources and opportunities, which can include income, employment, education, health, housing and access to services. |
| Food insecurity | Not always having reliable access to enough affordable, nutritious food. |
| Fuel poverty | When a household struggles to afford the energy needed to keep its home warm, safe and healthy. |
| Health inequalities | Unfair and avoidable differences in health between different groups of people. |
| Hidden poverty | Financial hardship or deprivation that may not be obvious to others or captured well by conventional measures. |
| In-work poverty | Experiencing poverty despite someone in the household being in employment. |
| Income maximisation | Helping someone make sure they receive all the income, benefits and financial support they are entitled to. |
| Negative budget | Where essential household spending is greater than the household's income. |
| No Wrong Door | An approach where someone seeking help should be connected to appropriate support regardless of which service they approach first. |
| Place Plan area | One of the local geographical areas used within Shropshire for planning and analysis. |
| Relative poverty | Having an income substantially below typical household incomes, limiting participation in everyday life. |
| Rural poverty | Poverty experienced in rural areas, where costs and access barriers can create additional pressures. |
| Rural premium | The additional costs people may face because they live rurally, including transport, energy and accessing services. |
| Wider determinants of health | The social, economic and environmental circumstances that shape health, such as income, housing, education, employment and transport. |

Shropshire Council

Health & Wellbeing Board
19th November 2026



# Shropshire's Director of Public Health Annual Report 2026

**More Than Money:** *How Poverty Shapes Lives, Places and Health*

*A review of rural poverty, hardship, and the normalisation of deprivation*

- Introduction & foreword
- A profile of Shropshire
- Chapter 1 – What is Poverty & what causes it?
- Chapter 2 – How are we tackling poverty in Shropshire - Current Activity
- Chapter 3 – Summary & Recommendations
- What support is available?
- References
- Appendix 1. Citizens Advice Shropshire – Food Basket Research
- Appendix 2. Glossary




# Acknowledgements and thanks:

Acknowledgements to the fantastic team who have led and supported the development of this report, in particular: **Phil Northfield, Mark Trenfield, Wendi Shepherd and Ellen Tracey**

With Special Thanks to: **Jackie Jeffrey, Catherine Devaney and Citizens Advice Shropshire**

Designed by: **Phil Northfield and Mark Trenfield**

**Data sources:** *This report utilises the most recently available published information from a variety of data sources, these are available on the council's website. References are listed at the back of this report.*

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**www.shropshire.gov.uk** - If you would like this information in a different format, please contact **0345 678 9000**



citizens advice Shropshire

# Poverty in Shropshire at a glance...

## INFLATION

27.6% between Jan 2021 and Jun 2026

57.4%

live in rural areas in 2022 – 187,931 people. Rural areas account for 97.3% of Shropshire's land mass

12.8%

of households are in fuel poverty (18,500 homes)

16,000

households are in a negative budget

30%

households without a broadband connection *(22)*

36%

of households are in Transport Poverty

£2,210 lower gross average earnings per year than England average

14%

of households are in food poverty/food insecurity

*(2021 UoS Study)*

Only 63% of residents can access a GP practice within 15 minutes using public transport. Over 88,993 can't

68%

of children (1,865) achieved a good level of development before starting school in 24/25.

For children on FSM this is only 43.7% (135 children)

23.4%

of children (12,249) in relative poverty after housing costs in 2025

£113.90 average weekly transport spend in rural Shropshire Vs £76.20 in Urban areas

# Hidden hardship affects health

- Poverty can affect both working and non-working or retired households and remain hidden in apparently prosperous communities.
- **57.4%** of residents in Shropshire live in rural areas.
  - Travel costs, limited and harder to access services and lower than average wages can make everyday life harder. This is referred to as a **"Rural Premium"**
- **12.8%** of households in Shropshire face fuel poverty, around **18,500** homes, compared with 9.9% across England (*2024 data*).
  - Around 24,000 properties are off-grid. The average EPC rating in Shropshire is a grade D.
- Approximately **14%** of households are in food poverty/food insecurity.
  - The county has 14 foodbanks.
- Around **16,000** households are in a negative budget *(their costs exceed their income)*
- Cold homes, food insecurity and money worries can damage physical and mental health.

# How Shropshire is responding

## Immediate help

- The Crisis & Resilience Fund allocates £3.7m a year to Shropshire for 2026–2029.
- It combines crisis and housing payments with community support and advice.
- Heating Oil support payments to those on low-incomes.
- Localised, needs-based proposals from foodbanks and community venues & organisations across the county.
- Training for VCSE partners on what support is available and how to refer.

## Longer-term support

- Citizens Advice Shropshire, Marches Energy Advice, Age UK Shropshire, Telford & Wrekin, Community Resource and other local partners help with benefits, debt, energy costs and applying for other support or entitlements.
- Internal family-based programmes, skills support and energy schemes can help to address underlying pressures.
- Coproduced delivery plans will listen to the voice of resilience partners and deliver a Shropshire-specific programme.

# Earlier help and easier access

- The report calls for earlier support for families, stronger referral pathways, fuel poverty and food insecurity support programmes and better access to good work.
- A **“No Wrong Door”** approach aims to connect people to appropriate help, wherever they first ask.
- Community Hubs, Welcome Spaces, Foodbanks, outreach and phone options can help people facing rural or digital barriers.
- For help with money worries: Shropshire Council’s Cost of Living Help or **worryingaboutmoney.co.uk/shropshire**.
- In-person advice can be found at Shropshire Local.

# Conclusion/ Closing Summary

This report has shown that poverty remains one of the greatest challenges to health and wellbeing in Shropshire. It affects people of all ages and backgrounds, influences outcomes across the life course and contributes significantly to health inequalities.

Whilst Shropshire is often viewed as an affluent county, this report has highlighted the hidden nature of hardship and deprivation that exists within our communities. Rurality, housing costs, transport barriers, fuel poverty and rising living costs can combine to create significant challenges for residents and families.

There is no single solution, but there is a clear direction. By giving every child the best start in life, improving financial resilience, tackling fuel poverty, supporting good quality employment and strengthening our communities, we can reduce the impact of poverty and create opportunities for people to thrive.

Our challenge now is not simply to respond to poverty when it becomes visible, but to prevent it wherever possible, identify it earlier and work collectively to address the wider conditions that allow it to persist.

Together, we can help ensure that **everyone** in Shropshire can achieve better outcomes.

*Poverty is preventable and not inevitable. While no single organisation can solve poverty alone, every organisation has a role to play in reducing its causes and consequences.*

*Over the coming years, partners across Shropshire will continue working together to tackle both the symptoms and root causes of poverty, reducing health inequalities and supporting residents to live healthy, independent and fulfilling lives.*

## What are the next steps?

- Give Every Child the Best Start in Life
- Improve Household Financial Resilience
- Strengthen a "No Wrong Door" Approach
- Reduce Fuel Poverty
- Improve Access to Good Quality Employment and Skills
- Address Rural Inequalities
- Improve Identification of Hidden Poverty

# What support is available?

*Where do I get help?*

| Where? | What? |
|---|---|
| Click here | **Cost of Living Support** including:<br>• Crisis & Resilience Fund<br>• Council Tax Support<br>• Blue Badges<br>• Free School Meals<br>• Holiday Activities & Food<br>• Library Cards<br>• Bus Passes<br>• & more... |
| Click here | **Citizens Advice Shropshire**<br>Advice, guidance and support:<br>• Debt advice<br>• Budgeting<br>• Advocacy<br>• Income Maximisation<br>• Consumer rights<br>• & more... |

| Where? | What? |
|---|---|
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# Resources

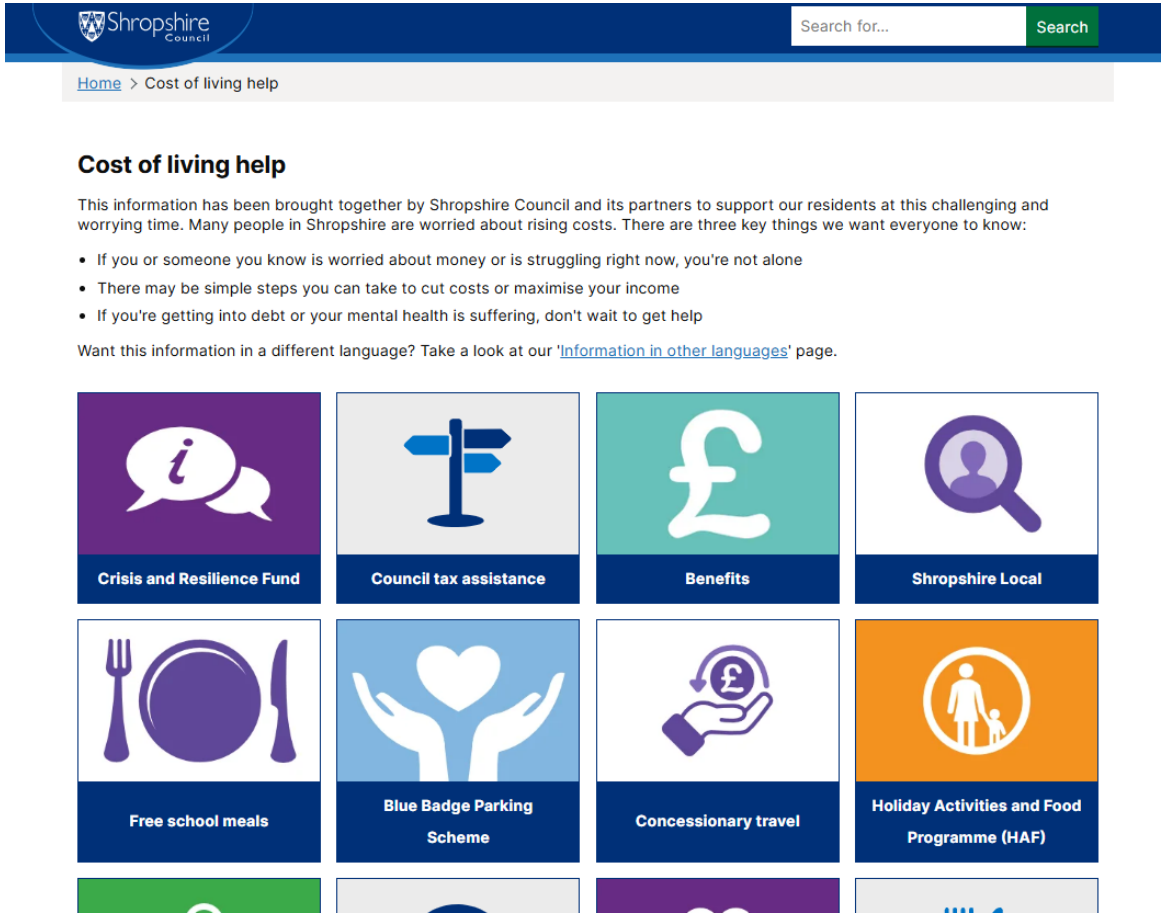



*Produced by the Independent Food Aid Network (IFAN) – and informed by Shropshire Council, Citizens Advice Shropshire and CRF Partners. Leaflets were produced on available support and shared in key locations across the county.*

**https://worryingaboutmoney.co.uk/shropshire**

## Cost of living help | Shropshire Council

*Refresh and rebranding of cost-of-living support available through Shropshire Council, simplifying access and promoting all opportunities including, but not limited to the Crisis & Resilience Fund.*



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# Worrying about money?

## Free, confidential help is available in Shropshire




## Three steps to find options and places to get help

Page 61

## Step 1: What's the problem?

### I suddenly have no money

- Lost job or reduced hours
- Money stopped
- Lost money
- Unexpected expense
- Disaster (e.g. flood or fire)
- Relationship breakdown
- Sanctioned (see option: 5)

**See options: 1 2 6**

### I am waiting on a benefit payment or advance

- New claim for benefit
- Payment delayed
- Waiting for decision

**See options: 1 4**

### My money doesn't stretch far enough

- Deciding between food, fuel, and mobile credit
- Low income
- Zero hours contract
- Statutory Sick Pay too low to cover costs
- Facing redundancy
- Not sure if eligible for support
- Change of circumstance

**See options: 1 2**

### I have debt

- Rent or Council Tax
- Gas and electricity
- Payday loans
- Owe friends and/or family
- Benefit repayments

**See option: 3**

## Step 2: What are some options?

### 1 Council Support Schemes

If you're struggling to meet your most essential living costs or are facing an unexpected crisis you may be able to access a Crisis Payment through Shropshire Council from the Crisis and Resilience Fund (CRF).

You may also be eligible for Housing Benefit and Council Tax Support as well as the Crisis and Resilience Housing Payment scheme.

If you apply, we may, with your permission, refer you onto partners who can help you with further advice and support.

Find out more: next.shropshire.gov.uk/cost-of-living-help/crisis-and-resilience-fund

### 2 Maximise Your Income

Anyone who is struggling financially can get a benefit check and speak to an advisor for free and confidential advice. A benefit check can ensure that you are receiving all the money you're entitled to, especially if your circumstances have changed recently. Advisors can also provide support to access any discounts you may be entitled to, help with managing gas and electricity bills, and make sure you're not missing out on things like school clothing grants or free school meals.

### 3 Debt Advice

Debt can happen to anyone. Free advice and support can help you find ways to manage your debts and reduce how much you pay each month.

### 4 Benefit Advance

If you have made a new claim for benefit and are in financial hardship while you wait for your first payment, you may be able to get an advance to afford things like rent or food. It's important to get advice before taking out an advance. Benefit advances must be paid back, and the money will be taken from your future benefit payments (a loan).

### 5 Hardship Payment

If you have been sanctioned and you are on Universal Credit, you may be able to access a Hardship Payment. Hardship payments are not always paid immediately and usually need to be paid back.

### 6 Challenge a Decision

You can challenge a benefit decision if your benefit has been stopped / sanctioned / reduced / refused or you have been overpaid. Most benefit decisions need to be challenged within one month.

## Step 3: Where can I get help? For free and confidential advice



### SHROPSHIRE COUNCIL

**Advice on Housing Benefit, Council Tax Support and the CRF Housing Cost scheme**
0345 678 9002 (Benefit Service)
www.shropshire.gov.uk/benefits
**Help with option:** 1

**Advice on crisis payments**
0345 678 9078 (Welfare Support Team)
next.shropshire.gov.uk/cost-of-living-help/crisis-and-resilience-fund
**Help with option:** 1

**Cost of living help**
next.shropshire.gov.uk/cost-of-living-help

**Scan for full, up-to-date list of support**
**Drop-in support is available via – Shropshire Local**

### CITIZENS ADVICE SHROPSHIRE

Advice on benefits, debt, housing and more
0808 278 7894 (Freephone)
Text: 0800 144 8884 (Freephone)
01743 280 019 (Debt advice)
www.cabshropshire.org.uk
**Help with options:** 1 2 3 4 5 6

### MARCHES ENERGY ADVICE

Energy advice and support with energy tariffs, bills, emergency grants and more
0800 677 1307 (Freephone)
shropshire@mea.org.uk | www.mea.org.uk
**Help with option:** 2

### AGE UK SHROPSHIRE TELFORD & WREKIN

Support and advice for older people, their families and carers
01743 233 123
www.ageuk.org.uk/shropshireandtelford
**Help with options:** 1 2 6

### COMMUNITY RESOURCE

Grants and energy advice for people struggling with fuel and energy bills
01743 360 641
grants@community-resource.org.uk
www.community-resource.org.uk/essential-support-fund
**Help with options:** 1 2

## Other Support

**Christians Against Poverty**
Advice and ongoing support for people struggling with debt
0800 328 0006
07943 669 727 (Debt Centre Manager, Bridgnorth) | marktriggs@capuk.org
www.capuk.org/get-help

**Just Credit Union**
Provide safe home for savings with access to affordable low cost loans
01743 252 325
info@justcreditunion.org
www.justcreditunion.org

**Shropshire Larder**
Advice on income maximisation, budgeting, debt and more
www.shropshirelarder.org.uk

**The Shrewsbury Ark**
Advice, support and signposting for people experiencing homelessness or at risk of homelessness
01743 363 305
info@shrewsburyark.co.uk
www.shrewsburyark.co.uk

**The Samaritans**
24/7 telephone support, non-judgemental and confidential
116 123
www.samaritans.org/branches/shrewsbury

**Shropshire Council – Mental Health and Wellbeing**
Resources to support your mental health
www.shropshire.gov.uk/healthy-shropshire/mental-health-and-wellbeing

**Shropshire Mental Health Support**
Support and services for people affected by mental health difficulties
01743 368 647 | www.shropshiremhs.com

# Other Support

**Shropshire Domestic Abuse Services**
Supporting for anyone affected by domestic abuse or sexual violence
0300 303 1191
(Shropshire – Freephone)
sdas@shropsdas.org.uk
www.shropsdas.org.uk

**StepChange**
Debt advice and money management
0808 138 1111
www.stepchange.org

**MoneyHelper**
Debt advice and guidance on money and pensions
0800 011 3797
07701 342 744 (WhatsApp)
www.moneyhelper.org.uk

**Turn2us**
Information on benefits and grants
www.turn2us.org.uk
benefits-calculator.turn2us.org.uk

**Shelter**
Advice and information for people with a housing problem or who are homeless
Emergency helpline: 0808 800 444
england.shelter.org.uk

**Healthy Start**
Help to buy fruit, vegetables and milk if you're on a low income and pregnant or have a child under 4
(Also available for people with NRPF)
0300 330 7010
healthy.start@nhsbsa.nhs.uk
www.healthystart.nhs.uk

# For Migrants with No Recourse to Public Funds (NRPF)

**This means you may not be able to claim benefits**

**Shropshire Supports Refugees**
Support with issues around housing, benefits, work, medical support and more
01743 216 758 (Freephone)
info@shropshiresupportsrefugees.co.uk
www.shropshiresupportsrefugees.org

**The Unity Project**
Support to have NRPF condition removed if applicable and other support
www.unity-project.org.uk

**Project 17**
Advice on housing and financial options for families with children facing severe poverty or homelessness because they have NRPF
07963 509 044 | www.project17.org.uk

**Migrant Help**
Independent advice and guidance to assist asylum seekers in the UK
0808 801 0503 (Freephone)
www.migranthelpuk.org

Shropshire Council | citizens advice Shropshire | Marches Energy Advice | Shropshire Telford & Wrekin age UK

Oxfordshire Community Resource | Independent Food Aid Network

**Interactive version:**

Funded by UK Government

**www.worryingaboutmoney.co.uk/shropshire**

Feedback? Share your experience of using this guide by visiting www.bit.ly/worryingfeedback



Updated: 21/08/26

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**SHROPSHIRE HEALTH AND WELLBEING BOARD**
**Report**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Meeting Date** | **19th November 2026** | | | | | |
| **Title of report** | National Neighbourhood Health Implementation Programme (NNHIP): Shropshire Summary of Achievement and next phase | | | | | |
| **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** | Naomi Roche – Head of Place, Shropshire<br>naomi.roche1@nhs.net<br><br>Susan Blakey - National NNHIP Coach<br>susan.blakey@nhs.net | | | | | |
| **Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply** | Children & Young People | | Joined up working | x | | |
| | Mental Health | | 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?** | The neighbourhood approach aims to address inequalities associated with rurality, travel and access to services, deprivation in rural and urban communities, age and frailty, multimorbidity, and unequal access to prevention and coordinated care. | | | | | |

## 1. Executive Summary

Shropshire has taken part in Wave One of the National Neighbourhood Health Implementation Programme (NNHIP). The programme has provided structured support, challenge, coaching and shared learning to help partners test and develop the foundations for neighbourhood health. It was not intended to create a single new service. Its value has been in helping Shropshire strengthen relationships, connect existing work and build the conditions for more proactive, coordinated and person-centred care.

NNHIP has supported Integrated Neighbourhood Team development across neighbourhoods, with an emerging focus on frailty and ageing well, cardiovascular, renal and metabolic conditions, prevention and inequalities.

The next stage of development is being shaped through the Neighbourhood Outcomes Framework. Each of Shropshire's five current working neighbourhoods has been asked to develop two locally tailored proposals: one for frailty and one for cardiovascular, renal and metabolic conditions (CVRM). While each will reflect local population need and existing services, the intention is not to create disconnected approaches. The proposals need to be connected through a shared vision, agreed principles, common outcomes and the core capabilities expected of an Integrated Neighbourhood Team (INT).

The Neighbourhood Outcomes Framework provides a mechanism for linking investment to the development of core INT infrastructure, multidisciplinary team maturity, population health management and improved outcomes for the agreed priority cohorts. The accompanying funding is therefore intended to accelerate neighbourhood development, rather than fund a collection of separate projects.

**Progress is encouraging across Shropshire, within the wider Shropshire, Telford and Wrekin (STW) Healthy Neighbourhoods approach.**

- Three of the five current working neighbourhoods are operating active frailty-focused multidisciplinary team test phases. Local learning includes Shrewsbury Ageing Well, South East Shropshire care-home, dementia and diabetes work, and wider rural neighbourhood development.
- Partners have also developed a shared STW Healthy Neighbourhoods vision, principles and delivery approach, developed initial governance principles and emerging Place-based arrangements and begun to align the Outcomes Funding Framework, prevention investment and shared enablers.
- Early evidence from Shrewsbury Ageing Well shows 109 people seen at the point of reporting, 32 inappropriate medicines stopped, 84% describing the assessment as helpful or very helpful, and 66% feeling more confident about managing their health as they get older. These are local service findings. They are encouraging but should not be attributed to NNHIP alone and do not yet demonstrate population-level impact.
- The next phase is therefore not about creating more separate initiatives. It is about connecting and strengthening what already exists, agreeing what should be consistent across Shropshire and the wider STW system and where neighbourhoods need local flexibility, and moving from promising activity to measurable and sustainable delivery.

**Three messages for the Board**

- There is something real to build on. Shropshire is not starting from scratch - neighbourhood relationships, multidisciplinary tests and practical local learning are already in place.
- The next phase is about joining things up, not adding another layer. Shropshire now needs to bring the work across its neighbourhoods into a locally owned Shropshire Neighbourhood Health Plan, with a shared direction, common outcomes and clearer governance and decision-making. This should align with the wider STW Healthy Neighbourhoods approach while retaining appropriate flexibility for Shropshire and its individual neighbourhoods.
- The next test is demonstrable impact. Partners need agreed cohorts, baselines, outcome measures and routine learning so that the system can show who is benefiting, what is changing and whether inequalities are reducing.

The NNHIP learning and current frailty and CVRM work should therefore be treated as important building blocks for the locally owned Shropshire Neighbourhood Health Plan and roadmap previously requested by the Board, rather than as a separate programme of work

## 2. Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress and learning from Shropshire's participation in Wave One of NNHIP, including the development of neighbourhood foundations and active local tests.
- Endorse the direction of travel towards a locally owned Shropshire Neighbourhood Health Plan and roadmap, bringing together the work across the current neighbourhoods within one shared approach, with common expectations and outcomes alongside appropriate local flexibility. The Shropshire plan should align with, and contribute to, the wider STW Healthy Neighbourhoods approach.
- Support the development of the Frailty and CVRM proposals as part of a connected neighbourhood approach, aligned with the shared vision and principles, Neighbourhood Outcomes Framework, and NNHIP maturity framework.
- Support confirmation of neighbourhood footprints, governance, decision-making and accountability through the relevant Place arrangements, including the Health and Wellbeing Board (HWBB) and Shropshire Integrated Place Partnership (ShIPP), using existing structures wherever possible and ensuring meaningful community, voluntary, community and social enterprise (VCSE) sector and unpaid carer influence.
- Request that a further decision report returns through existing assurance arrangements, setting out the developing Shropshire Neighbourhood Health Plan and roadmap, confirmed

neighbourhood footprints, governance and decision-making arrangements, the frailty and CVRM proposals, common outcomes and baselines, funding alignment, shared enablers and evidence of community influence.

**3. Report**

**1. Purpose and strategic fit**

The purpose of this paper is to provide a concise account of what NNHIP has enabled in Shropshire, what has been learnt, the main risks to continued progress and the priorities for the next phase. The immediate focus of this paper is the developing Integrated Neighbourhood Teams (INT) activity within the wider STW Healthy Neighbourhoods vision and system approach

The work directly supports the Health and Wellbeing Board's aims to improve population health and wellbeing, reduce avoidable health inequalities, place prevention at the heart of health and care, strengthen joined up working and work with communities. It also aligns with the Joint Health and Wellbeing Strategy priorities of joined-up working, improving population health, strong and vibrant communities, workforce and reducing inequalities.

Healthy Neighbourhoods provides the wider approach within which Integrated Neighbourhood Teams are developing. It connects neighbourhood health delivery with Community and Family Hubs, prevention and outreach, children's and adult social care transformation, VCSE partners and local community assets. Frailty and cardiovascular, renal and metabolic conditions (CVRM) are initial delivery priorities within this broader ambition, rather than its full scope.

The executive visioning exercise helped partners develop a shared understanding of the purpose, principles and ways of working needed for neighbourhood health. This builds on the themes identified in the May and July 2026 HWBB papers: a shared vision and roadmap, clearer leadership and accountability, agreed neighbourhood footprints and stronger alignment of existing programmes. Strategic development and practical delivery now need to progress in parallel.

**2. Progress made during the NNHIP period**

- A structured space for partners to test, learn and develop the foundations for neighbourhood health.
- Integrated Neighbourhood Team development across Shropshire neighbourhoods, recognising different starting points and local circumstances, with active frailty-focused multidisciplinary testing currently taking place in three neighbourhoods.
- Stronger cross-partner relationships spanning primary care, community services, social care, mental health, acute care, public health and voluntary, community and social enterprise partners.
- Growing use of quality improvement methods, including driver diagrams, pathway mapping and Plan-Do-Study-Act cycles, to refine local approaches.
- A clearer shared direction through Healthy Neighbourhoods work, emerging governance arrangements, the Outcomes and Funding Framework and alignment with prevention and investment discussions.
- Work with each neighbourhood to develop locally appropriate frailty and CVRM activity, creating ten locally tailored proposals within a shared neighbourhood approach and common expectations.
- Development of a system-wide communications and engagement approach to create a clearer shared narrative, support meaningful involvement and explain what neighbourhood working means for residents, carers, staff and partners.

Local learning demonstrates how the shared approach can respond to different neighbourhood needs. Examples include North Shropshire's developing governance arrangements; South West and Rural work on community hubs, multidisciplinary coordination and integrated pathways; Shrewsbury's links with the Community Independence Pathway; and the extension of the South East dementia multidisciplinary approach into Shrewsbury. These provide opportunities to share learning and adapt effective practice without requiring every neighbourhood to adopt an identical model.

## 4. What the evidence currently tells us

The evidence is strongest on readiness, relationships, process, experience and local service learning. Shrewsbury Ageing Well provides encouraging service-level findings and demonstrates how clinical assessment, medication review, therapy, prevention and community support can be brought together around a person. South East Shropshire work provides further practical learning about proactive care, dementia coordination, care-home support and diabetes outreach.

There are important limitations. Common definitions, starting values, GP data extraction and information-sharing arrangements still need to be agreed. Evidence should therefore be presented with clear cohorts, time periods, comparators and attribution limits. The current position is promising, but it does not yet provide consistent evidence of population-level impact across all five current working neighbourhoods.

The NNHIP maturity framework provides a useful baseline for the next phase. It should not be treated as a performance score or league table. Used as a structured conversation, it can help each neighbourhood and the wider system understand its current position across population health, model of care, community-led solutions, person-centred coordination and system integration, alongside enabling areas such as leadership, digital, estates, strategic commissioning, workforce and evaluation.

The value of the NNHIP maturity framework will be in identifying what is already sufficiently mature to build on, where neighbourhoods require tailored development support, and which barriers need action at Place or system level rather than being left to individual neighbourhoods to resolve. It can then be revisited periodically to demonstrate progress and inform future support and investment.

The completion status, date and findings of Shropshire's endpoint NNHIP maturity assessment remain to be confirmed for this paper. Once available, the findings should inform neighbourhood development support and identify barriers requiring action at Place or system level.

## 5. Priorities for the next phase

- **One shared Shropshire approach** – embed the shared vision and principles and use them to guide decisions, behaviours and ways of working while allowing for local flexibility.
- **Turn priorities into delivery** – develop the frailty and CVRM proposals around existing services, teams and community assets. Assess proposals against shared criteria covering strategic alignment, deliverability, prevention impact, inequalities, VCSE contribution and accountability, with a clear connection to agreed neighbourhood outcomes.
- **Strengthen neighbourhood working** – build multidisciplinary working, shared caseloads, care coordination and community involvement.
- **Make community involvement meaningful** – ensure residents, VCSE partners and unpaid carers can influence neighbourhood priorities, design and decisions, rather than being engaged only after proposals have been developed. The carers' needs assessment should inform how unpaid carers' needs and contributions are reflected.
- **Be clear about footprints, governance and accountability** – use the Shropshire neighbourhoods as the basis for development, while confirming proposed footprints and governance through the relevant Place arrangements, including HWBB and ShIPP. Arrangements should reflect natural communities and population need, with clear leadership, decision-making, escalation and assurance routes.
- **Clarify governance, decision-making and accountability** – confirm what decisions should be made within neighbourhoods, what requires agreement at Shropshire Place and what needs STW system action. This should include clear leadership and accountability for delivery, delegated authority where appropriate, agreed escalation and assurance routes, and distinct but connected roles for HWBB, ShIPP, provider and system arrangements. Existing structures should be used wherever possible, avoiding new or duplicated groups.
- **Measure progress and impact** – agree common outcomes, baselines and measures, using the Outcomes and Funding Framework and NNHIP maturity framework to identify progress and where further support is needed.

- **Align the support around neighbourhoods** – bring together funding, data, digital, workforce, estates, evaluation and communications to enable delivery. Strengthen the connection with the ShIPP Prevention Funding Framework so that community capacity, early intervention, VCSE infrastructure and outreach support neighbourhood priorities and agreed outcomes.

| | |
|---|---|
| **Risk assessment and opportunities appraisal (***NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation*) | **Risk 1 - Fragmentation.** Integrated Neighbourhood Teams could develop without sufficient connection across the neighbourhoods, leading to duplication, variable offers and unclear accountability. The response is not uniformity. It is to agree a small number of common expectations, outcomes and governance arrangements while retaining local flexibility.<br><br>**Risk 2 - Activity without evidence.**<br>The system may be able to describe substantial activity without being able to demonstrate consistent impact, value or reduction in inequalities. Agreed cohorts, coding, baselines, measures, information-sharing and routine review are needed before scaling.<br><br>**Risk 3 - Neighbourhood health becomes an additional layer.**<br>If governance, workforce, investment and accountability are not aligned, neighbourhood health may become another programme or meeting structure rather than a different way of organising existing resources around populations. This could add pressure to teams and reduce long-term sustainability. |
| **Financial implications** (*Any financial implications of note)* | No new financial decision is requested through this paper. Progressing the next phase will, however, require alignment of existing and future prevention and neighbourhood investment, clarity about the contribution of partner organisations, and attention to workforce and delivery sustainability.<br><br>The ShIPP Prevention Funding Framework offers an opportunity to align prevention investment with neighbourhood population need and agreed outcomes. Its contribution should be considered alongside the Neighbourhood Outcomes Framework, with clarity about the purpose, conditions and accountability for each funding source. Alignment should support a connected approach to delivery without assuming that funding streams are interchangeable or that additional resources have been agreed. |
| **Climate Change Appraisal as applicable** | No formal climate impact assessment has been completed. As neighbourhood models develop, their potential effect on travel, local service access and the appropriate use of digital approaches should be considered. |
| **Where else has the paper been presented?** | System Partnership Boards: N/A<br>Voluntary Sector: N/A<br>Other: NNHIP core programme arrangements and local neighbourhood development sessions |

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

- Shropshire NNHIP Wave One Summary of Achievement Report, October 2026.
- Shropshire Health and Wellbeing Strategy 2022-2027
- Shropshire, Telford and Wrekin Healthy Neighbourhoods vision, outcomes and related governance work.
- Local evidence from Shrewsbury Ageing Well, South East Shropshire and rural neighbourhood development.

- Health and Wellbeing Board neighbourhood health paper, May 2026.
- Health and Wellbeing Board neighbourhood health paper, July 2026.
- ShIPP Draft report: National Neighbourhood Health Implementation Programme (NNHIP) – Shropshire Progress Update, October 2026.

(reports above can be supplied upon request)

**Appendices**

Appendix A: Shropshire NNHIP Wave One Summary of Achievement Report, October 2026 - presentation

Department of Health & Social Care

NHS England

# National Neighbourhood Health Implementation Programme (NNHIP) - Wave One Summary of Achievement Report: October



Shropshire

16 October 2026

| Place | NNHIP Focus |
|---|---|
| Shropshire is a large, predominantly rural county with five neighbourhoods at different stages of development. Rurality, travel, access to services and an older population shape local need. Partnership working spans primary care, community services, social care, mental health, acute care, public health and VCSE organisations. | NNHIP has supported the development of Integrated Neighbourhood Teams and the conditions needed for proactive, coordinated and person-centred neighbourhood care. The emerging focus is frailty and ageing well, CVRM, prevention and inequalities, supported by the Neighbourhood Outcomes Framework and shared system enablers. |

| Delivery | |
|---|---|
| Interventions / initiatives implemented | • INT development across Shropshire's five neighbourhoods, recognising different starting points<br>• Shrewsbury Ageing Well and proactive frailty development<br>• South East Shropshire care-home CGA, dementia coordination and diabetes outreach<br>• South West and rural development focused on access, community assets and integrated pathways<br>• Executive visioning and development of the STW Healthy Neighbourhoods approach<br>• Governance, funding, outcomes, data, digital, workforce and learning work across the system |
| Anticipated outputs and outcomes | • A clearer Shropshire neighbourhood story; locally relevant INT models; priority frailty and CVRM cohorts; stronger MDTs and care coordination; shared outcomes and baselines; meaningful community and VCSE involvement; and clearer governance, accountability, investment and learning arrangements. |
| Actual outputs and outcomes | • NNHIP has strengthened relationships and provided a platform for testing, learning and developing neighbourhood foundations.<br>• Three of five Shropshire neighbourhoods are operating active frailty-focused MDT test phases. Local evidence includes Shrewsbury Ageing Well, South East Shropshire care-home and diabetes pilots, and rural neighbourhood development.<br>• Across STW, partners have developed a shared Healthy Neighbourhood vision, values, principles and delivery approach; progressed governance and Place-based Accelerator Groups; and aligned Year 1 proposals, the Outcomes Framework, prevention investment and shared enablers. • QI learning is beginning to embed in day-to-day neighbourhood work. Shrewsbury used driver diagrams and five PDSA cycles to refine Ageing Well; South East Shropshire applied measurement and driver-diagram methods to care-home and CVRM work.<br>• A digital pathway exercise grew from frailty work into system-wide mapping across acute, community, local authority and primary care, identifying opportunities for more joined-up, digitally enabled pathways rather than simply digitising current processes. |

# Performance against Neighbourhood Health Outcome Measures – Shropshire

**Shrewsbury**

**EARLY LOCAL SERVICE EVIDENCE**

• 109 patients seen through the Shrewsbury Ageing Well service at the point of reporting.
• 77% had a recorded Clinical Frailty Score of 4–6.
• 32 inappropriate medicines were stopped.
• 84% described the assessment as helpful or very helpful.
• 66% felt more confident about managing their health as they get older.
• Patients were connected to a broad range of prevention, therapy and community support.

**OUTCOMES FRAMEWORK BASELINE FOR THE NEXT PHASE**

• Validated high-risk registers and active management of agreed frailty and CVRM cohorts.
• Personalised care plans and medication reviews.
• Measures covering non-elective admissions and emergency bed days, inequalities, resident experience and independence.
• Common definitions, starting values, GP data extraction and information-sharing arrangements still need to be agreed.

**South-East Shropshire early delivery evidence**

**Care homes:**

- 10 residents identified,
- eight MDT reviews,
- four falls referrals,
- five dietetic/nutrition reviews,
- two memory-service referrals ReSPECT plans for all eight reviewed residents.

**Diabetes outreach:**

- 100 people contacted,
- 17 appointments made and three non-attendances.
- Longer-term clinical and hospital-use outcomes still require follow-up.

# Maturity Framework – Progress to Date – Shropshire

| Domain | Mobilising | | | Developing | | | Maturing | | | Optimising | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 30 % | 60 % | 90 % | 30 % | 60 % | 90 % | 30 % | 60 % | 90 % | 30 % | 60 % | 90 % |
| 1. Pop health… | | | | | | | | | | | | |
| 2. New model of care… | | | | | | | | | | | | |
| 3. Community led solutions… | | | | | | | | | | | | |
| 4. Person centred co-man… | | | | | | | | | | | | |
| 5. System integration… | | | | | | | | | | | | |

| Enabler | Mobilising | | | Developing | | | Maturing | | | Optimising | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 30 % | 60 % | 90 % | 30 % | 60 % | 90 % | 30 % | 60 % | 90 % | 30 % | 60 % | 90 % |
| A: Leadership… | | | | | | | | | | | | |
| B: Digital… | | | | | | | | | | | | |
| C: Estates… | | | | | | | | | | | | |
| D: Strategic Commissioning… | | | | | | | | | | | | |
| E: Workforce… | | | | | | | | | | | | |
| F: Evaluation… | | | | | | | | | | | | |

Sept 25 Feb 25 Mar 26 Oct 26

# NbH Readiness - self-assessment scores - only to be completed by sites smaller than their places

NNHIP sites smaller than the Places they are in should note any divergence from their Place scores, providing narrative in the comments section. No action needed otherwise – this will be updated nationally based on place self-assessment scores.

| Stage 1 requirement | Site stage 1 total | Comments |
|---|---|---|
| S1 – Urgent rehabilitation and reablement capacity | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |
| S3 – Neighbourhood footprints | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |
| S4 - INTs for priority cohorts and devolved budgets | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |
| S5 – Neighbourhood approach to elective pathways | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |
| S8 – Primary and secondary care interface | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |
| S9 – Organisational ownership | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |
| S10 – Data sharing | | To be updated nationally from the Place self-assessment. No separate site-level score entered in this draft. |

# Delivery plan - Shropshire

| Based on learning from NbH readiness visits, self assessments and work on NNHIP over the past year, please summarise your: | |
|---|---|
| Key priorities | • Confirm one Shropshire story, five neighbourhood footprints and priority cohorts<br>• Move frailty and CVRM into measurable Year 1 delivery<br>• Strengthen MDTs, shared caseloads, care coordination and community participation<br>• Clarify governance, decision rights, integrator and partner accountability<br>• Align the Outcomes Framework, prevention funding and other investment<br>• Strengthen PHM, digital, data, workforce, estates and evaluation enablers |
| Next steps | • Finalise neighbourhood proposals, baselines and routine outcome reporting<br>• Map and spread learning from Shrewsbury, South East Shropshire, rural and other neighbourhood work to support development of INT<br>• Confirm governance links between neighbourhood, Place and STW arrangements<br>• Progress shared data, coding, digital and information-governance solutions<br>• Maintain meaningful VCSE, community and carer involvement<br>• Turn the foundations into routine delivery while retaining flexibility for local population need<br>• Use coaching and QI methods to support further testing, including driver diagrams, PDSA cycles, pathway mapping and run-chart measures. |
| Methods to measure progress | • Priority cohort reach, MDT review and active management<br>• Care plans, medication reviews, referrals and coordinated actions<br>• Experience, independence, confidence and inequalities measures<br>• Non-elective admissions and emergency bed days using clear comparators<br>• Workforce, capacity, implementation and financial measures<br>• Evidence of spread, adaptation and learning across neighbourhoods<br>• Evidence that teams are independently reusing QI tools in new neighbourhood priorities and adapting interventions from learning. |

# Looking ahead – Shropshire

| Reflecting on the programme itself, please provide feedback on what has worked well, current challenges and what could be improved in the future. | |
|---|---|
| What have you achieved as a result of your participation in NNHIP? | NNHIP has created the conditions for neighbourhood working to develop more quickly. It has brought partners together around shared priorities, strengthened Integrated Neighbourhood Team development and increased the focus on population health.Partners understand each other's pressures and priorities better. Relationships have grown, conversations have become more open and mature, and people feel better able to discuss difficult issues in a safe and constructive way. |
| What elements of the programme have you valued the most? | Partners particularly valued the opportunity to work across organisational boundaries, build relationships and learn from other places. This helped people consider different approaches, including how neighbourhood health can better meet the needs of rural communities.Coaching provided a valuable critical-friend role by testing thinking, helping partners make sense of the work and maintaining direction. The programme also created a reason and a space for important conversations and shared visioning that may not otherwise have happened. |
| How could the programme be improved? | The programme could be simpler, with clearer and earlier national expectations, more consistent communication and less duplication between local and national work. Participants would welcome fewer frameworks and clearer guidance about what is required.Future support should be more locally tailored, recognise Shropshire's rural context and place greater emphasis on turning learning into practical changes for residents and frontline teams. Places also need enough time, data and implementation support to test approaches and understand what works. |
| What do you perceive as the current challenges to neighbourhood health? | The most significant challenges are workforce capacity, financial sustainability, data sharing, digital connectivity and demonstrating outcomes and benefits. Different neighbourhoods are also starting from different positions and face competing priorities.<br>Stronger alignment across senior leadership is needed, alongside greater recognition of the importance of organisational development, quality improvement and evaluation. There is also more to do to move from organisations working alongside one another to people genuinely working differently together. |
| What will be needed to successfully implement neighbourhood health in the future? | Successful neighbourhood health will require:<br>• a shared direction, with flexibility to respond to local and rural needs<br>• strong collective leadership and clear decision-making<br>• sustainable workforce, funding and estates support<br>• greater emphasis on prevention and earlier intervention<br>• shared data, agreed outcomes and clear evidence of the difference being made<br>• meaningful involvement of communities, carers and the VCSE sector<br>• continued learning about what is changing, what is working and what needs to improve. |

# Case study- Shrewsbury Aging Well

| Initiative | | |
|---|---|---|
| *Problem statement* | Interventions | *Expected impact* |
| Older people with frailty or emerging complexity can experience fragmented support and may not receive enough time for preventative conversations before needs escalate. Shrewsbury needed a more proactive, person-centred approach that connected clinical review with therapy, prevention and community support. | An Ageing Well approach provided fuller assessment, medication review and onward connections to social prescribing, falls prevention, bone health, occupational therapy, audiology, physiotherapy, continence, speech and language therapy and bereavement support. The developing INT work is connecting this service evidence with frailty MDTs, risk stratification and the Community Independence Pathway. | Earlier identification and support; safer medication; improved confidence and experience; better connection to local services; maintained independence; and fewer avoidable escalations. Future evaluation should use defined cohorts, baselines, service-use measures and patient-reported outcomes. |
| Results and next steps | | |
| Actual impact | At the point reported, 109 patients had been seen; 77% had a Clinical Frailty Score of 4–6; 32 inappropriate medicines had been stopped; 84% rated the assessment helpful or very helpful; and 66% felt more confident managing their health as they get older. These are descriptive local service findings and do not demonstrate direct NNHIP attribution. | |
| Relevant learning | People valued unhurried conversations, being listened to, preventative checks and help that bridged the gap between routine care and crisis. The case also shows why an INT is more than an MDT meeting: impact depends on connecting assessment, coordination, therapy, prevention and community support. | |
| Plans to scale | Use the learning to strengthen the shared frailty pathway across Shrewsbury, align with the Community Independence Pathway and agree a common evidence template. Spread should follow evidence of cohort reach, outcomes, inequalities and sustainability, rather than activity alone. | |

Integrated Care System
Shropshire, Telford and Wrekin

# Neighbourhood Health in Shropshire

## Happy, healthy, connected communities

The National Neighbourhood Health Implementation Programme (NNHIP) in Shropshire is a partnership between NHS STW, Shropshire Council, local GPs, NHS Trusts, and the Voluntary and Community Sector, working together to lay the groundwork for Neighbourhood Health.

The aims of the programme are:

- o Bringing health services, resources and support closer to the communities where people live
- o Promoting preventative healthcare, health education and tailored support
- o Targeting health inequalities and improving access to care
- o Empowering neighbourhoods and individuals to take charge of their own physical and mental health
- o Facilitating partnerships among health services and community groups
- o Developing the broad framework required to provide health provision and services in local communities.



## Introduction to case study

**South-East Shropshire Integrated Neighbourhood Team – Dementia (August 2024 - August 2026)**

In August 2024, health and care colleagues in South-East Shropshire established an Integrated Neighbourhood Team (INT) to support individual cases of patients with dementia – a priority for health and care services for this population and an opportunity to work differently, and beyond organisational boundaries.

Patient referrals into the INT were made directly to the Dementia Care Co-ordinator. Patient needs were discussed, background detail, demographics and known support in place, and then a plan agreed.

The team met fortnightly, a

- Admiral Nurse
- Link Worker
- Adult Social Care
- Memory Team
- Care and Community Co-ordinators
- PCN Care Co-ordinators



## What did the neighbourhood team do?

Meeting remotely, a total of 51 patients have been discussed at the DMDT since it started in Aug 2024 through to Aug 2026
. Actions from the INT included:

- Exploring befriending opportunities
- Raising referrals for medication review
- Raising a psychological referral for a carer
- Acted on safeguarding concerns; supporting a carer with respite options in community
- Patient admitted for respite and family referred to ICS carer support for discharge into an appropriate setting

In the period since the pilot ended, up until January 2026, **25 more patients have been supported by the INT.** The team has now introduced a face-to-face meeting every quarter to better support partnership working.

## What was the outcome?

- Partners worked well together to better support patients living with dementia.
- New ways of working were adopted, such as making immediate contact with the patient rather than waiting the usual 7-14 days for the referral processing, due to the nature of the case.
- Actions were taken by the most appropriate partner, preventing health and care needs escalating to crisis. Examples include arranging blood tests, joint agency visits and Best Interests Meetings.
- **The patients were supported by the INT to remain healthy and connected in their community, with needs met by the right service, at the right time**.
- In one practice, during the pilot stage, Emergency Department use reduced by 50% following intervention (18 > 9).
- Assuming an average length of stay, over a six-month period this equates to a saving of £64,980. This represents a saving of £16,245 per 1,000 patients.

Integrated Care System
Shropshire, Telford and Wrekin

# Neighbourhood Health in Shropshire

## Happy, healthy, connected communities



A carer contacted the Dementia Care Co-ordinator for support with their spouse, whose dementia-related behaviours were escalating. The situation had reached crisis point, with police involvement following an incident of physical aggression. The carer was struggling to manage the increasing complexity of care and required urgent support.

### What did the neighbourhood team do?

The case was discussed at the Dementia INT, bringing together health, social care and the voluntary sector. Risks were reviewed and a co-ordinated support plan agreed. An immediate referral to the Admiral Nurse service was made due to the severity of the situation. Support was prioritised and delivered without waiting for the standard referral timescale.

During the INT discussion, partners identified that this was one of two cases from the same community where carers were struggling to manage dementia-related behaviours.

The INT enabled partners to:

- Identify common themes across multiple cases.
- Share specialist expertise and knowledge.
- Escalate support quickly when risks were identified.
- Develop solutions that benefited the wider community, not just individual patients.
- Strengthen collaboration across health, social care and voluntary sector services.
- The INT was not just a referral route - it acted as a forum for shared learning, proactive problem-solving and early intervention.

### What was the outcome?

The INT recognised that carers would benefit from greater understanding and support to help manage dementia-related behaviours.

A "Let's Talk About Dementia" education session was developed and delivered locally.

The session:

- Achieved full attendance.
- Included both carers discussed at the INT.
- Provided practical advice and support.
- Raised awareness of available services and support networks.

The impact:

- Improved understanding of dementia and behavioural symptoms.
- Increased confidence amongst carers.
- Better awareness of local support services.
- Preventative support delivered before further crises developed.

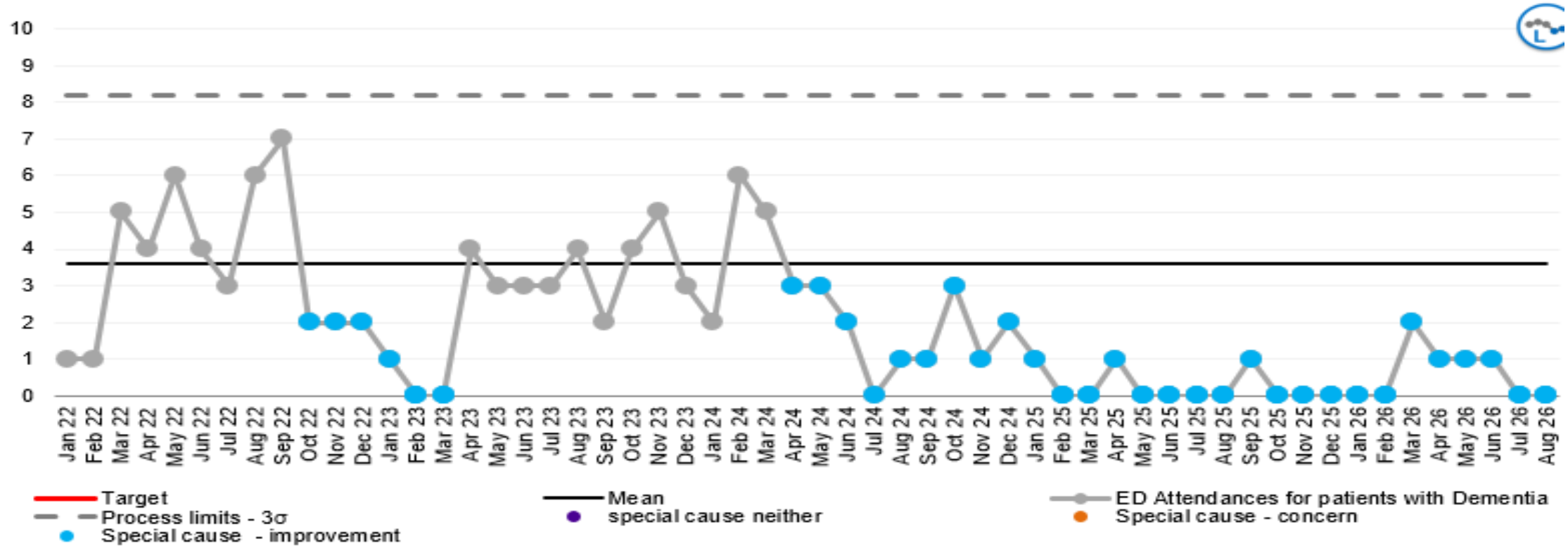
> *"What started as support for one family led to a community-wide intervention that improved knowledge, confidence and support for carers across the neighbourhood."*

Integrated Care System
Shropshire, Telford and Wrekin

# Neighbourhood Health in Shropshire

Happy, healthy, connected communities

Since the Dementia Integrated Neighbourhood Team (INT) was introduced at Much Wenlock and Cressage Medical Practice in August 2024, monthly Emergency Department attendances among patients with dementia have remained below the baseline average of 3.6, with many months recording no attendances between May 2025 and Jan 2026. These sustained low levels are encouraging and align with the INT's aim of reducing reliance on emergency care.



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| SHROPSHIRE HEALTH AND WELLBEING BOARD<br>Report | | | | | | |
|---|---|---|---|---|---|---|
| **Meeting Date** | **19th November 2026** | | | | | |
| **Title of report** | **Place Based Joint Strategic Needs Assessment (JSNA) – Action plans update** | | | | | |
| **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** | Hannah Thomas<br>hannah.thomas@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 | | Reduce inequalities (see below) | | | x |
| **What inequalities does this report address?** | The place–based JSNA address unique geographic barriers and optimize local service placement | | | | | |

## 1. Executive Summary

The Joint Strategic Needs Assessment (JSNA) has never had a more central role in English health and care. The policy changes of 2025 and 2026 have created a formal requirement for JSNA evidence to inform NHS commissioning decisions at the neighbourhood level.

The current place based JSNA's for Shropshire show that the area has strong communities and generally good outcomes, but important and avoidable inequalities remain between towns, villages and neighbourhoods.

We propose to update the action plans for each of the 18 place plan areas with current activity, to provide a more accurate reflection of partnership working throughout Shropshire.

The current Place Based JSNA for Shropshire can be found here, including a map of areas [Place-based Joint Strategic Needs Assessment | Shropshire Council]

## 2. Recommendations

The Board is asked:

- To complete a full review of all 18 action plans, to confirm delivery, impact, ownership, outstanding actions and opportunities to sustain or scale good practice
- To receive an update on the actions at a later meeting in Spring 2027.

## 3. Report

Shropshire is a large and diverse county, which, for the purposes of the JSNA is split into 18 place plan areas. These are mostly focused on market towns and surrounding rural communities. Since COVID-19 we have been working with each community in turn to understand the health and wellbeing needs and the determinants of health in these communities.

Collecting information at a local level lets us know more about the local health and wellbeing of each area. This includes things that are working well, things that need improving and where services and resources should and can be placed, now and in the future.

We aim to support our residents at a local level with local issues that affect and matter most to them. This includes working together with local organisations such as voluntary and community groups, schools and colleges, GP practices, local businesses, and Town and Parish Councils to gain local knowledge, insight, and connections.

This has helped us to connect with communities, especially those who are often unrepresented and with the most areas of unmet need at the highest risk of the worst outcomes. We can then work together to highlight and best use the strengths, capacity, and knowledge of all the partners involved to look at actions and possible solutions. This is referred to as an asset-based approach.

Currently, the data highlights several **key themes** across the County:

- **Access to Health Services** (mentioned in 17 areas): focusing on improving access to NHS dentists, community healthcare, GP services and addressing issues related to hospital and emergency services.
- **Children & Young People** (mentioned in 15 areas): including improving youth services, activities, and future opportunities, also providing support for children and young people to be present and safe in communities.
- **Mental Health** (mentioned in 15 areas)**:** affecting health and wellbeing, identifying the need for better and earlier mental health support and services across all age ranges.
- **Transport & Infrastructure** (mentioned in 12 areas): better transport links and infrastructure are seen as essential for accessing services and overall community wellbeing.
- **Cost of Living** (mentioned in 12 areas): the rising cost of living is a common concern, highlighting the need for information on support available and early intervention to prevent crisis.
- **Crime and Safety** (mentioned in 11 areas): improving community safety, the perception of safety and reducing crime rates which impact community cohesion and wellbeing.
- **Housing** (mentioned in 10 areas): there was a focus is on affordable housing, improving housing suitability and quality and addressing housing-related challenges.

**What the 18 JSNA's tell us:**

- Overall life expectancy is higher than the England average, but there is significant variation within Shropshire.
- Some communities experience poorer access to services, mental-health concerns, gaps in support for children and young people, poor housing and greater cost-of-living vulnerability.
- These differences affect life expectancy and healthy life expectancy and are unfair and avoidable.
- The action plans capture work already under way, good practice and further action needed.

**Next steps**

The Public Health Team aims to complete a full review of all 18 action plans in 2027, which will confirm delivery, impact, ownership, outstanding actions and opportunities to sustain or scale good practice. We aspire to:

- Renew commitment to local neighbourhood working, recognise the essential role of communities and continue shifting investment into community and voluntary-sector support.
- Use neighbourhood guidance, community hubs and JSNA intelligence to align future services in distinct local areas and build existing programmes at scale.
- Improve the evidence base for rural outcomes and inequalities. Continue involving communities in developing and delivering action plans with collective ownership.
- Work as one community of partners, asking "How can we help?", and enable communities and the voluntary and community sector to play a more central role in service development.

The current action plans demonstrate progress and good practice. The next phase is to understand delivery consistently across all 18 areas and determine what should be sustained, scaled or refreshed.

| | | |
|---|---|---|
| **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**
Public Health Annual Report 2024-25
dph-annual-report-2024-25.pdf

**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, Corporate Director – Population, Wellbeing and Neighbourhoods (DPH), Shropshire Council

**Appendices**
Appendix A. Place Based JSNA update – presentation

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# From 18 JSNAs to action

The JSNAs show that Shropshire has strong communities and generally good outcomes, but important and avoidable inequalities remain between towns, villages and neighbourhoods.

## What the 18 JSNAs tell us

- Overall life expectancy is higher than the England average, but there is significant variation within Shropshire.
- Some communities experience poorer access to services, mental-health concerns, gaps in support for children and young people, poor housing and greater cost-of-living vulnerability.
- These differences affect life expectancy and healthy life expectancy and are unfair and avoidable.
- The action plans capture work already under way, good practice and the further action needed.

### R1. Place-based, neighbourhood and community working

Renew commitment to local neighbourhood working, recognise the essential role of communities and continue shifting investment into community and voluntary-sector support.

### R2. Alignment

Use neighbourhood guidance, community hubs and JSNA intelligence to align future services in distinct local areas and build existing programmes at scale.

### R3. Intelligence-led action

Improve the evidence base for rural outcomes and inequalities. Continue involving communities in developing and delivering action plans with collective ownership.

### R4. One Shropshire

Work as one community of partners, asking “How can we help?”, and enable communities and the voluntary and community sector to play a more central role in service development.

# key themes across the County:

**Access to Health Services**: A recurrent theme across the majority of our communities (17), focusing on improving access to NHS dentists, community healthcare, GP services and addressing issues related to hospital and emergency services.

**Children & Young People (CYP):** Another recurrent theme across the majority of our communities (15), including improving youth services, activities, and future opportunities, also providing support for children and young people to be present and safe in communities.

**Mental Health:** A key theme across the majority of our communities (15) affecting health and wellbeing, identifying the need for better and earlier mental health support and services across all age ranges.

**Transport & Infrastructure:** A key theme to improve accessibility, as better transport links and infrastructure are seen as essential for accessing services and overall community wellbeing. This is a theme in 12 of our communities, including Market Drayton, Cleobury Mortimer and Ellesmere

**Crime and Safety:** Improving community safety, the perception of safety and reducing crime rates which impact community cohesion and wellbeing is a key theme in 11 of our communities including Shrewsbury, Bridgnorth and Ludlow

**Cost of Living:** The rising cost of living is a concern in 12 of our communities across Shropshire including Highley, Pontesbury & Minsterley and Whitchurch, including the need for information on support available and early intervention to prevent crisis.

**Housing:** A key theme in 10 of our communities including Bishop Castle, Craven Arms, Albrighton and Church Stretton. The focus is on affordable housing, improving housing suitability and quality and addressing housing-related challenges.

# Delivery, learning and next steps

The action plans demonstrate progress and good practice. The next phase is to understand delivery consistently across all 18 areas and determine what should be sustained, scaled or refreshed.

| Area | Themes addressed | Work delivered or developing, including link to recommendations | Further action / next focus |
|---|---|---|---|
| Highley | Access to health services; CYP; Mental health; Transport; Cost of living; Prevention; Physical activity; Healthy ageing | The relocation of the GP practice into the Severn Centre has supported a broader health and wellbeing offer, including Health Visiting, mental-health support, social prescribing, physiotherapy and other wellbeing services. Stop-smoking support and wider prevention activity are being developed alongside work to make better use of outdoor spaces, walking routes, community venues and existing local assets. The Place Universal Offer (PUO) provides an opportunity to test new approaches locally, particularly around physical activity, prevention, active environments and strengthening community capacity. Workplace health checks provide another route to identify health risks earlier and connect people with appropriate support. Work around cardiovascular risk management (CVRM) and frailty provides an opportunity to strengthen prevention and earlier intervention, particularly for residents at greater risk of poor health. A regular community drop-in provides an accessible local point where residents can receive cost-of-living information, advice and wider support, bringing different VCSE and community partners together in one place. This supports earlier intervention, better signposting and connections into wider health, wellbeing and community services. A regular local steering group helps coordinate the different strands of neighbourhood work, bringing partners together across health, the VCSE sector, community organisations and the Parish Council, rather than services working separately. | Join the different strands into a coherent neighbourhood prevention offer. Strengthen referral and signposting pathways, build on the community drop-in, develop physical activity and outdoor-space opportunities, target people experiencing inequalities or at greater health risk, and use the steering group and PUO evaluation to understand impact, identify gaps and scale what works. |

| Area | Themes addressed | Work delivered or developing, including link to recommendations | Further action / next focus |
|---|---|---|---|
| Market Drayton | Access to Health Services; Children & Young People; Mental Health; Transport & Infrastructure; Crime & Safety; Cost of Living; Housing and wider determinants | Market Drayton has a strong foundation for neighbourhood working through the Community Covenant, Community & Family Hub development, Active Market Drayton, local councils, VCSE organisations and wider community partners.. Mental-health and wellbeing pop-ups are taking support into community settings, helping residents access advice and support earlier and linking people with mental-health services, social prescribing, stop-smoking support, physical activity and wider wellbeing support. Community health checks, including outreach at livestock markets, are also helping reach farming and rural communities who may be less likely to access traditional preventative services, providing opportunities to identify health risks earlier and signpost into appropriate support. The Baby Bank, Foodbank and other VCSE/community provision provide practical support to families and residents experiencing financial pressures and create opportunities to connect people with wider health, wellbeing, housing and family support. The Place Universal Offer (PUO) is building on this existing activity, with Market Drayton acting as a test-and-learn neighbourhood to understand barriers to being active and healthy, including transport, access, social isolation, awareness of opportunities and fragmented referral pathways. Existing work around frailty, diabetes and prevention provides another foundation to build on. Work with children and young people is also developing through youth transformation and co-design, with opportunities for young people to influence activities, physical activity, open spaces and wider place shaping. | The next focus is to bring these different strands together into a more coordinated Market Drayton neighbourhood offer, using the Community Covenant to connect Health, VCSE partners, local councils, and community organisations. Build on mental-health pop-ups and livestock-market/community health checks to reach residents who may not traditionally engage with services, while strengthening referral routes into primary care, social prescribing, stop-smoking, mental-health and wider prevention services. Continue developing opportunities for children and young people, including youth voice and access to safe and active spaces. Address barriers such as transport and access to services and connect cost-of-living support more closely with housing, health and wellbeing services. |



| SHROPSHIRE HEALTH AND WELLBEING BOARD<br>Report | | | | | | |
|---|---|---|---|---|---|---|
| **Meeting Date** | 19 November 2026 | | | | | |
| **Title of report** | A National Plan to End Homelessness: Developing a Whole-System Shropshire Response | | | | | |
| **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) | |
| **Reporting Officer & email** | Laura Fisher<br>Head of Housing, Resettlement and Independent Living<br>Laura.Fisher@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) | ☒ | | |
| **What inequalities does this report address?** | Homelessness is closely linked with health inequality and wider disadvantage. People experiencing homelessness, rough sleeping or insecure accommodation may also experience mental and physical ill-health, substance use, self-neglect, safeguarding concerns and multiple disadvantage.<br><br>Effective prevention therefore requires coordinated action across housing, health, social care, public health, safeguarding, criminal justice and the voluntary and community sector.<br><br>The report also considers the experiences of children living in temporary accommodation, people leaving care, prison or hospital, and other groups at particular risk of homelessness.<br><br>The emerging Shropshire approach seeks to identify housing risk earlier, prevent homelessness wherever possible and improve coordination between services where needs cross organisational boundaries.<br><br>The local draft delivery plan specifically identifies prevention, temporary accommodation, rough sleeping, transitions from institutions and service quality as areas for action. | | | | | |

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

**1. Executive Summary**

The Government's A National Plan to End Homelessness establishes a renewed national approach centred on making homelessness rare, brief and non-recurring, supported by a Local Outcomes Framework against which local areas will monitor progress.

Shropshire Council already has an established Preventing Homelessness and Rough Sleeping Strategy 2024–2029. Rather than replacing that strategy, an emerging supplementary delivery plan is being developed to align existing local priorities and activity with the National Plan, its Local Outcomes Framework, governance requirements and areas requiring wider partnership action.

The emerging framework includes five principal areas of activity: prevention and early intervention; temporary accommodation, B&B and move-on; rough sleeping and repeat homelessness; people leaving care, prison and hospital; and service quality and continuous improvement.

Initial feedback from the Council's MHCLG Homelessness Adviser has been positive about the alignment between the emerging local delivery plan, the National Plan and Shropshire's existing strategy. The feedback has also identified an important opportunity to strengthen partner ownership, including consideration of actions which could be led or jointly led by partners rather than Housing Options by default. Further detailed refinements have also been identified, including around the Rough Sleeping Programme, prison pathways, care leavers, veterans, development and early intervention.

Latest locally reported H-CLIC information for July to September 2026 also provides some encouraging early indications. Households with children in temporary accommodation stood at 0.39 per 1,000 households, compared with the baseline of 0.50 recorded in the emerging plan; no households with children were reported as remaining in B&B for more than six weeks, compared with a baseline of one; and successful prevention and relief stood at 34.69%, compared with the recorded baseline of 30.26%. The methodology for the Local Outcomes Framework measure relating to households with three or more support needs is still being finalised locally, while updated rough sleeping measures are due at the November checkpoint. The baseline framework is recorded in the emerging delivery plan.

The wider health and safeguarding context is also important. The recently published local Safeguarding Adult Review, SAR Bobby - Overview Report (final), identifies learning relating to multi-agency coordination, hospital discharge, safeguarding and responses to people experiencing homelessness and multiple disadvantage. It includes a recommendation relating to hospital discharge arrangements for adults at risk of rough sleeping and a target of zero discharges to the street.

This local learning is consistent with wider safeguarding evidence around multiple exclusion homelessness and reinforces the importance of moving from fragmented or crisis-led responses towards earlier, coordinated prevention.

The National Plan therefore provides an opportunity not simply to improve the Housing service response to homelessness, but to strengthen the way in which the wider Shropshire system collectively identifies and responds to housing risk.

The Health and Wellbeing Board is asked to consider how health, care, public health, children's services, safeguarding and wider partnership activity can support the emerging local delivery framework and where shared leadership or joint ownership of actions would strengthen delivery.

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

The Health and Wellbeing Board is asked to:

1. Note the implications of A National Plan to End Homelessness for health, wellbeing and inequalities in Shropshire.

2. Note the development of a supplementary Shropshire delivery plan aligning the National Plan with the Council's existing Preventing Homelessness and Rough Sleeping Strategy 2024–2029.
3. Recognise that preventing homelessness and rough sleeping requires a whole-system response across housing, health, social care, public health, children's services, safeguarding, criminal justice and the voluntary and community sector.
4. Support the principle of shared ownership of the emerging delivery plan, including identifying areas where partner organisations should lead or jointly lead relevant actions alongside the Council's Housing service.
5. Support greater alignment of relevant health, care, safeguarding and prevention pathways with the emerging delivery framework, particularly in relation to people experiencing multiple disadvantage and people leaving hospital, care or prison.
6. Identify strategic gaps, dependencies or barriers which require collective action through the Health and Wellbeing partnership.

## 3. Report

### 1. Purpose and background

1.1 The purpose of this report is to update the Health and Wellbeing Board on the implications of A National Plan to End Homelessness for Shropshire and the work underway to translate the national direction into a local delivery framework.

1.2 Shropshire's existing Preventing Homelessness and Rough Sleeping Strategy 2024–2029 remains the Council's overarching strategy. The emerging delivery plan is intended to supplement rather than replace it, providing a clearer link between the existing strategy, national priorities, Local Outcomes Framework measures, local actions and partnership delivery.

1.3 The approach is therefore intended to avoid creating unnecessary parallel structures. The objective is to align existing strategies, services and partnership arrangements wherever possible, while identifying areas where further development, clearer ownership or stronger coordination is required.

### 2. From national direction to local delivery

2.1 The National Plan places increased emphasis on preventing homelessness before crisis, reducing the length of time households remain homeless, preventing prolonged use of B&B accommodation for families, reducing rough sleeping and repeat homelessness, and improving outcomes for people whose needs cross traditional service boundaries.

2.2 The emerging Shropshire delivery framework currently organises work across five principal areas:

- Prevention and early intervention
- Temporary accommodation, B&B and move-on
- Rough sleeping and repeat homelessness
- People leaving care, prison and hospital
- Service quality and continuous improvement

2.3 The framework is intended to provide a practical "golden thread" between national expectations, the existing Shropshire strategy, local performance and delivery activity.

2.4 Initial feedback from the Council's MHCLG Homelessness Adviser has welcomed that alignment and the proposed approach to Local Outcomes Framework metrics and governance.

Importantly, the feedback has also challenged the Council to consider whether sufficient delivery responsibility is currently shared across partner organisations, rather than Housing Options being identified as lead for a significant proportion of activity.

2.5 This is particularly relevant to the Health and Wellbeing Board. Some of the factors which contribute to homelessness, and some of the interventions required to prevent it, sit wholly or partly outside the direct control of Housing. A genuinely preventative delivery plan therefore requires wider system ownership.

## 3. Local Outcomes Framework and latest position

3.1 The National Plan's Local Outcomes Framework provides six measures against which local areas are expected to understand their position and set local ambitions. The MHCLG homelessness strategies and action plans toolkit sets expectations for local action plans to demonstrate alignment with the national framework and partnership delivery.

3.2 The latest locally reported position available for July to September 2026 is:

| Measure | Baseline recorded in emerging delivery plan | Jul–Sep 2026 / latest position |
|---|---|---|
| **Households with children in temporary accommodation per 1,000 households** | 0.50 | 0.39 |
| **Households with children in B&B over six weeks** | 1 | 0 |
| **Successful prevention and relief of homelessness** | 30.26% | 34.69% |
| **Successful prevention and relief for households with three or more support needs** | 9.09% | Methodology being finalised |
| **People sleeping rough on a single night** | 22 | November checkpoint |
| **People sleeping rough long-term** | 8 | November checkpoint |

The recorded baselines appear in the emerging Shropshire delivery plan.

3.3 These early figures show positive movement in each of the three measures for which a July to September update is currently available. They should, however, be interpreted as an emerging performance picture rather than evidence that the longer-term outcomes of the National Plan have already been secured.

3.4 The measure relating to successful prevention and relief for households experiencing three or more support needs is particularly relevant to the Health and Wellbeing Board. The emerging delivery plan identifies that outcomes for this group can depend upon coordinated intervention involving Housing, Adult Social Care, Public Health, mental health, substance misuse, criminal justice and commissioned services.

3.5 Once the methodology has been finalised and validated, this measure will provide an

important indication of whether improved overall homelessness outcomes are also being experienced by households with more complex support needs.

## 4. Homelessness as a health, wellbeing and safeguarding issue

4.1 Homelessness does not sit in isolation from health and wellbeing. Housing instability can intersect with mental and physical health needs, substance use, self-neglect, safeguarding, domestic abuse, poverty and other forms of disadvantage.

4.2 The national Multiple Exclusion Homelessness: A Safeguarding Toolkit for Practitioners emphasises multi-agency support for people experiencing multiple exclusion homelessness who appear to have care and support needs and considers themes including coordination, safeguarding and hospital discharge. "Safeguarding is everyone's business": launch of new Expert Citizens toolkit | Homeless Link

4.3 The recently published Shropshire Safeguarding Adult Review SAR Bobby - Overview Report (final) provides an important local context. The Review identifies learning relating to multi-agency coordination, hospital discharge, safeguarding and responses to people experiencing homelessness and multiple disadvantage. bobby-safeguarding-adult-review-report.pdf

4.4 The Review also identifies subsequent areas of improvement in joint working and includes a recommendation relating to hospital discharge arrangements for adults at risk of rough sleeping, with a target of zero discharges to the street.

4.5 The purpose of referencing this review within the National Plan work is not to revisit the circumstances of the individual case. Rather, the published learning provides important evidence about the need for clear pathways, coordinated planning and earlier intervention where homelessness intersects with health, care and safeguarding.

4.6 The emerging homelessness delivery framework provides an opportunity to incorporate that learning into wider prevention and partnership activity.

## 5. Prevention and earlier intervention

5.1 A central principle of the emerging approach is that homelessness prevention should begin before a household reaches acute housing crisis.

5.2 This requires Housing Options to work effectively with organisations which may become aware of housing instability earlier, including health and care services, children's services, criminal justice partners and commissioned and voluntary-sector services.

5.3 The MHCLG toolkit places emphasis on partnership working, earlier identification, effective referral arrangements and responses to people leaving public institutions.

5.4 For Shropshire, the emerging delivery plan provides the mechanism through which existing pathways can be reviewed and strengthened, gaps identified and responsibilities made clearer.

## 6. Multiple disadvantage

6.1 People experiencing homelessness alongside multiple support needs are particularly important within the local framework.

6.2 The emerging delivery plan recognises that improving outcomes for households with three or more support needs cannot be achieved through Housing activity alone. It identifies the

relevance of coordinated intervention across Housing, Adult Social Care, Public Health, mental health, substance misuse, criminal justice and commissioned services.

6.3 This provides an opportunity to consider whether existing multi-agency structures are sufficiently connected to homelessness prevention and whether escalation and ownership are clear where needs span organisational or professional boundaries.

6.4 The Health and Wellbeing Board has an important strategic interest in ensuring that homelessness prevention is connected to wider work addressing health inequalities and multiple disadvantage.

## 7. Transitions from care, hospital and prison

7.1 Transitions between services or settings represent an important opportunity for early homelessness prevention.

7.2 The emerging delivery plan includes actions relating to people leaving care, prison and hospital.

7.3 Initial MHCLG feedback has suggested that the prison element of the plan is developed further to differentiate between:

- prevention and tenancy retention where appropriate;
- planning and immediate support before and around release; and
- longer-term accommodation sustainment following release, including following the end of time-limited accommodation.

7.4 MHCLG feedback has also identified the need to ensure the local plan appropriately reflects national commitments concerning care leavers under 25, rather than considering homelessness prevention solely at the point a looked-after-child placement ends.

7.5 Hospital discharge is similarly an area where housing, health, care and safeguarding responsibilities intersect. The learning within SAR Bobby - Overview Report (final) makes the continued development of effective discharge arrangements especially relevant locally.

## 8. Rough sleeping

8.1 Reducing rough sleeping and long-term rough sleeping remains a specific element of the Local Outcomes Framework and of Shropshire's emerging delivery arrangements.

8.2 MHCLG has confirmed through adviser feedback that Shropshire is not required to produce a separate Long-term Rough Sleeping Partnership Plan. The emerging delivery plan will therefore continue to address long-term rough sleeping without creating an unnecessary additional plan.

8.3 The revised delivery plan will also make the relationship with the Rough Sleeping Programme clearer and incorporate developing programme activity as this is agreed.

8.4 Shropshire has a Rough Sleeping Programme allocation of £951,168 over three years, comprised of £597,077 revenue and £354,091 capital, as recorded in the supporting National Plan material previously prepared for the Council.

## 9. Shared ownership and partnership leadership

9.1 One of the most useful themes arising from initial MHCLG feedback is the need to ensure that the local delivery plan is genuinely collaborative.

9.2 A significant number of actions within the current draft identify Housing Options as the lead. Some actions will properly remain within Housing, but where delivery depends fundamentally on another service or partnership, there is an opportunity to identify appropriate partner leads or joint leads.

9.3 This does not require the creation of entirely new structures. In many areas the focus can instead be on aligning existing pathways, strategies and programmes and establishing clear responsibility for the contribution they make to preventing homelessness.

9.4 Areas where shared leadership could be particularly important include:

- multiple disadvantage;
- hospital discharge;
- care leavers;
- people leaving prison;
- mental health and substance misuse pathways;
- safeguarding and self-neglect;
- domestic abuse;
- early identification of housing instability; and
- accommodation supply and development.

9.5 The Health and Wellbeing Board is therefore being asked to help shape this aspect of the emerging framework while the delivery plan is still being developed, rather than being asked simply to note a completed Housing action plan.

## 10. Governance and next steps

10.1 The emerging delivery plan is a supplementary action plan supporting Shropshire's existing homelessness and rough sleeping strategy. It remains under development and will continue to be refined to reflect local evidence, performance information, national expectations and partner input.

10.2 The existing draft identifies formal Council governance through Housing Overview and Scrutiny Committee and Cabinet.

10.3 The role proposed for the Health and Wellbeing Board is therefore complementary. The Board is not being asked to substitute for the Council's formal approval arrangements. It is being asked to help shape the whole-system elements of delivery, particularly where successful prevention depends upon health, care, safeguarding and wider partnership activity.

10.4 Following HWBB consideration, the emerging delivery framework can reflect appropriate partner ownership, lead and joint-lead arrangements and any strategic gaps or dependencies identified through the discussion.

10.5 The overall ambition is to move progressively from crisis response towards earlier prevention: not simply improving the response received after somebody becomes homeless, but reducing the number of households reaching homelessness in the first place.

| | |
|---|---|
| **Risk assessment and opportunities appraisal (***NB This will include the following: Risk* | **Risk Management**<br><br>Failure to develop a coordinated local response creates a risk of fragmented pathways, missed opportunities for prevention, avoidable |

| | |
|---|---|
| *Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation*) | homelessness and emergency accommodation use, and poorer outcomes where people's needs cross organisational boundaries.<br><br>Clear governance, defined ownership, appropriate partner leadership and proportionate performance monitoring provide opportunities to identify risks earlier and strengthen accountability.<br><br>**Human Rights and Equalities**<br><br>Homelessness can significantly affect people's dignity, safety, family life and ability to access services. Some households experiencing homelessness may also face additional barriers associated with ill-health, disability, caring responsibilities, domestic abuse or other disadvantage.<br><br>The emerging delivery framework seeks to strengthen prevention and improve coordination where housing needs interact with care, health and safeguarding needs.<br><br>**Community**<br><br>Preventing homelessness and rough sleeping has wider benefits for individuals, families and communities. Earlier prevention can reduce disruption associated with housing crisis and support people to remain connected with existing services and support networks where appropriate.<br><br>**Consultation and partnership**<br><br>Development of the delivery plan is ongoing. Initial feedback has been received from the Council's MHCLG Homelessness Adviser, and the current stage presents an opportunity to strengthen involvement and ownership across partner organisations.<br><br>Further engagement will be required as lead and joint-lead responsibilities are determined and detailed actions are refined. |
| **Financial implications** (*Any financial implications of note)* | This report does not seek approval for additional expenditure.<br><br>Delivery will initially be progressed through existing services, commissioned provision, available funding and partnership arrangements. Where future activity requires additional resources or expenditure, this will be subject to the relevant financial and governance processes.<br><br>Shropshire has received a Rough Sleeping Programme allocation of £951,168 over three years, comprising £597,077 revenue funding and £354,091 capital funding. Programme activity is being developed and will be reflected within the homelessness delivery framework as appropriate. |
| **Climate Change Appraisal as applicable** | There are no direct material climate change implications arising specifically from the recommendations in this report.<br><br>Any future accommodation, capital, commissioning or development |

| | | |
|---|---|---|
| | proposals arising from the delivery plan will be subject to the appropriate decision-making processes and relevant environmental or climate considerations. | |
| **Where else has the paper been presented?** | System Partnership Boards | One Shropshire Board - The National Plan and developing local response have previously been considered through the One Shropshire Board. |
| | Voluntary Sector | Relevant voluntary and community sector partners contribute to existing homelessness and rough sleeping partnership arrangements. Further engagement will form part of the development of shared ownership and delivery arrangements. |
| | Other | Housing Overview and Scrutiny Committee, 23 September 2026<br><br>The emerging delivery plan has also been shared with the Council's MHCLG Homelessness Adviser for initial feedback. |

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

A National Plan to End Homelessness

Shropshire Council, Preventing Homelessness and Rough Sleeping Strategy 2024–2029

DRAFT strategy delivery plan alignment to national plan

OSB - A National Plan for Homelessness

SAR Bobby - Overview Report (final)

Multiple Exclusion Homelessness: A Safeguarding Toolkit for Practitioners

TOOLKIT FOR DEVELOPING HOMELESSNESS STRATEGIES AND ACTION PLANS.pdf

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

Paula Mawson, Service Director – Communities & Customer
James Owen – Portfolio Holder for Housing

**Appendices**

Appendix 1: Health and Wellbeing Board presentation: A National Plan to End Homelessness – From national ambition to a whole-system Shropshire response

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Shropshire Council

# A National Plan to End Homelessness

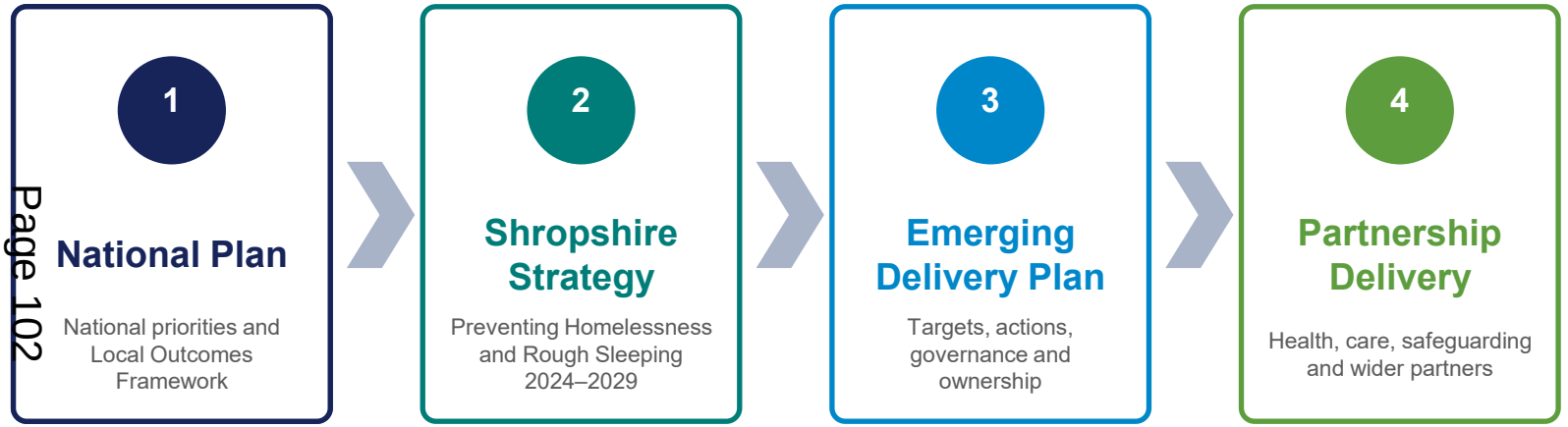
From national ambition to a whole-system Shropshire response

**Health and Wellbeing Board | 19 November 2026**

**Rare • Brief • Non-recurring**

# From national ambition to local delivery

The emerging plan supplements, rather than replaces, Shropshire's existing strategy




**The aim is to create a clear "golden thread" from national expectations to locally owned delivery.**

# Early indications are positive

Latest available H-CLIC information for July to September 2026

**0.39**

**Households with children in temporary accommodation per 1,000**

Baseline: 0.50

**0**

**Households with children in B&B over six weeks**

Baseline: 1

**34.69%**

**Successful prevention and relief**

Baseline: 30.26%

**Still to be finalised**

3+ support-needs methodology

Rough sleeping measures: November checkpoint

**Positive movement, but sustained improvement depends on prevention, housing supply and effective partnership delivery.**

# Housing instability rarely exists in isolation

Homelessness is a health, wellbeing and safeguarding issue




**Local safeguarding learning reinforces the need for clear pathways, early planning and shared ownership.**

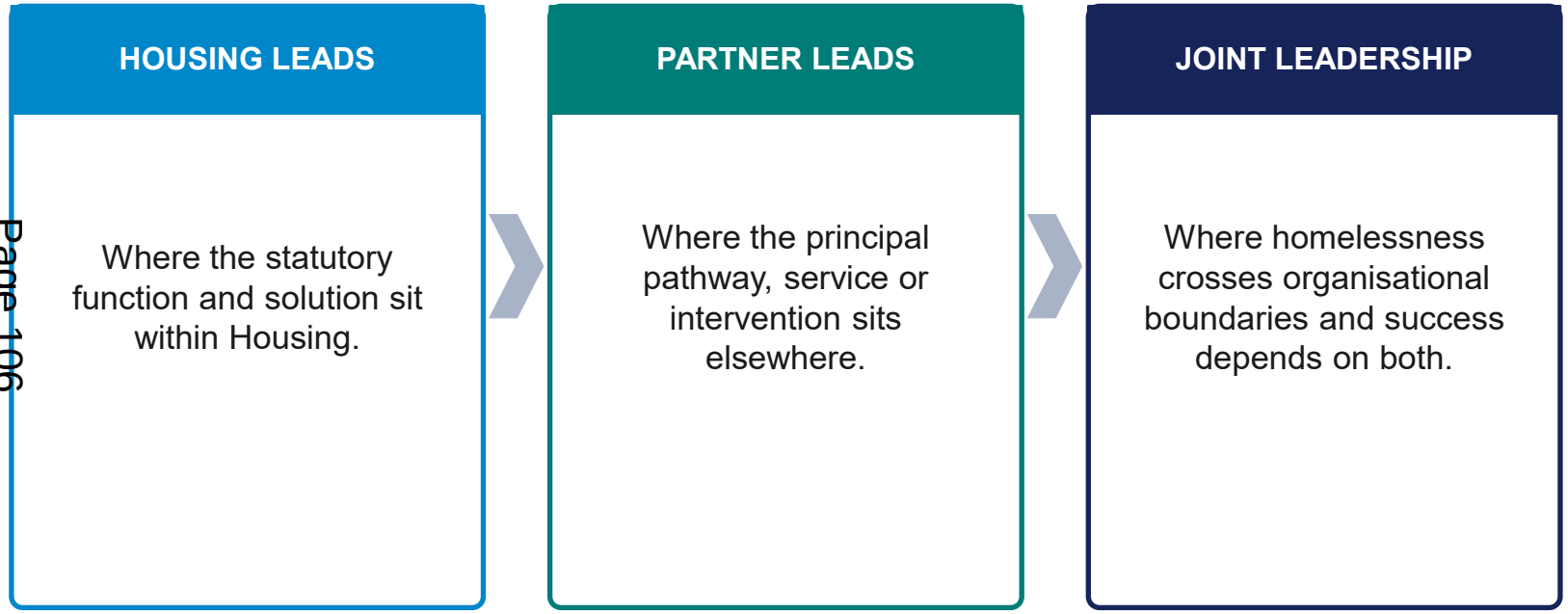
# Where partnership action matters most

Five connected priorities within the emerging Shropshire framework

| | | |
|---|---|---|
| 1 | **PREVENTION** | Earlier identification, timely referral and intervention before crisis |
| 2 | **MULTIPLE DISADVANTAGE** | Coordinated support, escalation and clearer multi-agency ownership |
| 3 | **HOSPITAL DISCHARGE** | Accommodation and contingency planning beginning early |
| 4 | **CARE LEAVERS** | Joint pathway planning, corporate parenting and prevention under 25 |
| 5 | **PRISON PATHWAYS** | Tenancy retention, pre-release planning, immediate support and sustainment |

# From a Housing plan to a partnership plan

Initial MHCLG feedback supports the golden thread and challenges us to strengthen shared leadership




**The plan should record clear lead and joint-lead responsibilities, using existing pathways wherever possible.**

# What we need from the Health and Wellbeing Board

Help shape the partnership response while the local delivery plan is still emerging

| | | |
|---|---|---|
| 1 | **RECOGNISE** | Homelessness prevention as a health, wellbeing and inequalities priority |
| 2 | **OWN** | Identify appropriate partner leads and joint leads for relevant actions |
| 3 | **ALIGN** | Connect existing health, care, safeguarding and prevention pathways |
| 4 | **REMOVE** | Identify strategic gaps, dependencies and barriers requiring collective action |
| 5 | **ACCOUNT** | Support shared accountability for agreed delivery and outcomes |

**Success is not simply a better crisis response. Success is fewer people reaching crisis at all.**

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## SHROPSHIRE HEALTH AND WELLBEING BOARD
## Report

| | | | | | | |
|---|---|---|---|---|---|---|
| **Meeting Date** | **19 November 2026** | | | | | |
| **Title of report** | **2026-27 Better Care Fund Quarter One Template** | | | | | |
| **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)<br><br>Deborah.Webster@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?** | 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

1.1. This report provides a summary of Shropshire's 2026-27 Better Care Fund (BCF) quarter one template, which was submitted to the regional BCF team by the deadline of 16 October. In line with national conditions, the approval of the Joint Chairs of Health and Wellbeing Board (HWB) was obtained prior to submission. Formal HWB approval is now required.

### 2. Recommendations

2.1. HWB approves the 2026-27 BCF quarter one template which can be found in appendix A.

### 3. Shropshire's 2026-27 Better Care Fund (BCF) Quarter One Template

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 have started 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. Shropshire's plan has received a letter of approval. It is acknowledged that it demonstrates:

- 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.

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

**3.6. Funding**

3.7. 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.

3.8. 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.

**3.9. Metrics**

3.10. ICBs and local authorities have set specific goals, agreed by HWBs, to reduce avoidable non-elective admissions for people aged 65 and over and reduce discharge delays, for the following 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.

3.11. ICBs and local authorities were 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. Shropshire has done this.

3.12. 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.

### 3.13. National conditions

3.14. 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.<br><br>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.<br><br>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. |

### 3.15. Monitoring and reporting

3.16. 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.

3.17. Regular monitoring of performance against the metrics will take the same form as for previous years. Quarterly templates for quarters one, two and three that capture progress in

relation to BCF spending plans, local goals for non-elective hospital admissions, delayed discharges and residential admissions and additional insight narrative are required. A more detailed end of year template will be required.

## 4. Summary of quarter one template

### 4.1. Income and expenditure

4.2. Expenditure at quarter end is on track.

### 4.3. Performance

4.4. Shropshire achieved the quarter one metric plans for non-elective admissions for people aged 65and over, discharge delays and long term admissions to residential care homes and nursing homes for people aged 65 and over.

### 4.5. Additional insights

4.6. The following regional intelligence was reported:

- Observed successes towards driving the enablers for integration include data and shared information. A new data system is supporting the rapid maturity of population health management capabilities. In addition, 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.
- Challenges are posed by the limited financial resources available and difficulty in reallocating resources to enable the shift from hospital to home. In addition, 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.
- Forward planning on BCF is difficult without a clear understanding of how funding will be used from 2027.

4.7. The following alignment with related programmes and support requirements were reported:

- HWB and partners would like to further advance progress towards system maturity through tailored support to better understand and translate their statutory leadership role. This would support the refresh of the HWB strategy and co-production of an effective Terms of Reference that clearly articulate and support the role of HWB in a way that is translatable in practice. For this reason, Shropshire is participating in wave one of the National Neighbourhood Health Improvement Programme and has been selected for the BCF Support Programme's Community of Practice for Health and Wellbeing Boards and Targeted Support for Health and Wellbeing Boards.

4.8. The following progress against national conditions should be noted:

- Shropshire's Section 75 Agreement for 2025-26 will be submitted alongside the 2026-27 Section 75 Agreement. Both Agreements are with the ICB's legal partner Mills and Reeve for legal review before being issued for signature.

4.9. The following impact of improvement support was reported:

- Shropshire's expression of interest for participation in the national BCF support offer's Community of Practice for Health and Wellbeing Boards and Targeted Support for Health and Wellbeing Boards was successful. It's too early to assess the impact of these. However, it's hoped the impact will be a strengthened neighbourhood health approach, accelerated delivery of prevention and health inequalities ambitions, and further development of the role of Health and Wellbeing Board as a key system leader in place-based integration. Regarding the Communities of Practice, it's hoped that Health and Wellbeing Board will learn from and contribute to emerging national best practice.

Regarding the targeted support, it's hoped that bespoke improvement and leadership support will help to strengthen governance, shared priorities, partnership working, and delivery arrangements.

**5. BCF Support Programme**

5.1. Following an expression of interest process, Shropshire was selected to receive support from the BCF Support Programme through:

- A Community of Practice for Health and Wellbeing Boards
- Targeted Support for Health and Wellbeing Boards.

5.2. Shropshire already is part of wave one of the National Neighbourhood Health Improvement Programme. This additional support from the BCF Support Programme offers an ideally timed next step to further advance progress towards maturity. It will be integral to the refresh of the HWB strategy, co-production of an effective Terms of Reference that clearly articulate and support the role of HWB in a way that is translatable in practice and the development of Neighbourhood Health Plans that integrate with BCF.

5.3. Through its leadership, governance and partnership role, HWB will use and share learning to help create the conditions for neighbourhood teams and partners to work differently together, enabling more coordinated, preventative and person-centred services that improve outcomes for local people. In this way, learning will collectively strengthen HWB, Scrutiny Committees and the local Integrated Place Partnership and strengthen system leadership.

**6. The future of BCF**

6.1. The national BCF team is working towards publishing the 2027-28 BCF Framework in Autumn 2026, which will set out the expectations for local systems for the forthcoming financial year. No significant changes in scope from the 2026-27 framework are anticipated. The framework will include a requirement to complete all 2027-28 BCF planning and assurance by 31 March 2027. The team is working with colleagues to align BCF assurance more closely with neighbourhood health to reduce duplication and ensure proportionate assurance processes are completed ahead of the start of 2027-28.

6.2. The Government is currently considering the future development of the BCF beyond 2027-28 as part of wider work to strengthen adult social care and integrated health and care services. This remains a live area of policy development and decisions on future arrangements are yet to be finalised.

6.3. Through these quarterly reports, HWB will be kept updated on progress.

| | |
|---|---|
| **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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 appendix A. | |
| **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 Social Care & Health, Shropshire Council

**Appendices**

Appendix A. Shropshire's BCF 26-27 Q1 Reporting Template

# DRAFT SHROPSHIRE HEALTH & WELLBEING BOARD TERMS OF REFERENCE

## 1. Purpose

The Health and Wellbeing Board (HWBB) acts to ensure that key leaders from health, care, and the Voluntary and Community Sector work together to protect people's health, improve the health and wellbeing of Shropshire residents, reduce inequalities and positively influence the wider determinants of health. Health and Wellbeing Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services.

The statutory functions of the Board are set out in the Health and Social Care Act 2012:

- Prepare and publish a Joint Strategic Needs Assessment (JSNA)
- Prepare and publish a Pharmaceutical Needs Assessment every 3 years.
- Prepare and publish a Joint Local Health and Wellbeing Strategy (JLHWS) setting out how the needs identified in the JSNA will be prioritised and addressed
- Ensure effective public engagement and consultation in developing the JSNA and JLHWS.
- Promote the integration of health and social care services, including providing advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006.
- Approve the Better Care Fund arrangements, including section 75 agreement.
- Encourage providers to work closely with the Board and encourage those that provide health, health related or social care services in an area to work "closely together".
- Consider and report on whether ICB Commissioning Plans have taken proper account of the JLHWS. See the local government legislation page for further information. (Health & Wellbeing Boards - guidance)
- The Health and Wellbeing Board (HWBB) will provide strategic leadership, democratic oversight and partnership accountability for the development and delivery of healthy neighbourhoods including neighbourhood health and community-centred models of care within Shropshire. Working in partnership with NHS organisations, local government, the voluntary and community sector, and other stakeholders
- Population Health Improvement Plans

## 2. Health and Wellbeing Board Vision and Aim:

**Our Vision:**

*A healthier Shropshire, where everyone can flourish and achieve their full potential.*

**Our Aim:**

- To improve the health and wellbeing of the residents of Shropshire.
- To reduce health inequalities: the avoidable, unfair and systematic differences in health outcomes across the population and between different groups in society.
- To ensure prevention is at the heart of improving health and wellbeing, reducing ill health and the associated demand on health and care services.
- Provide democratic input into the Integrated Care System
- To empower our residents to take an active role in improving their own health and

wellbeing.

- The HWBB provides a forum for discussions about setting strategic direction and operational co-ordination in the delivery of services working in partnership to address health inequalities set and deliver strategies across health and care and the wider determinants of health and ensuring a prevention progress, ensuring strategies meet local need
- To support delivery of Healthy Neighbourhoods including the Neighbourhood Health Framework by strengthening integrated, place-based working across health, care, local government, voluntary and community sector partners, and communities, so that services are better coordinated around local needs and help reduce inequalities.

## 3. Principles of Membership and Partnership Working

To support effective partnership working and improve the health and wellbeing of Shropshire residents, members of the Health and Wellbeing Board will:

- Act in the best interests of the people of Shropshire, bringing their expertise, insight and influence while taking a whole-system perspective rather than representing organisational interests alone.
- Work collaboratively, constructively and by consensus wherever possible.
- Contribute actively to the development of the Joint Strategic Needs Assessment (JSNA) and delivery of the Joint Local Health and Wellbeing Strategy (JLHWS).
- Foster a culture of trust, respect, openness and constructive challenge to maximise the effectiveness of the Board.
- Champion the work of the Board within their organisations and support communication, engagement and stakeholder involvement activities.
- Promote transparency, ensuring that decision-making is open, informed by the views of local people, and provides opportunities for public influence and participation.
- Adopt a trauma-informed approach, embedding the principles of safety, trust, choice, collaboration, empowerment and cultural awareness.
- Be accountable for their actions and decisions to their organisations, staff, partners and the residents of Shropshire.
- Focus on delivering added value through partnership working, with a shared commitment to improving outcomes and reducing inequalities for local communities.

The Health and Wellbeing Board (HWBB) will work collaboratively across the health and wellbeing system to deliver the priorities of the Health and Wellbeing Strategy through:

- **Prevention and reducing inequalities** by promoting healthy lifestyles, improving wellbeing across the life course, and addressing the needs of communities experiencing the greatest inequalities, including seldom-heard groups.
- **Influencing the wider determinants of health** by working with partners across areas such as housing, planning, transport, health protection, economic development, and environmental sustainability.
- **Community engagement and co-production** by involving residents, service users, and communities in the development of services and ensuring that engagement informs the JSNA and decision-making processes.
- **Integration and joint commissioning** by supporting joined-up planning, commissioning, and delivery of health and social care services, ensuring quality, value for money, and improved outcomes.
- **Neighbourhood health** by providing strategic oversight of neighbourhood health plans, promoting place-based working, aligning partner priorities and resources, and monitoring



delivery and impact.

- **Partnership working and governance** by overseeing delivery through sub-groups and partner boards, including Shropshire Integrated Place Partnership (ShIPP), statutory partnerships, and other strategic forums.
- **Accountability and assurance** by acting as the principal forum for democratic and public accountability for health and wellbeing, receiving assurance on progress, outcomes, and statutory responsibilities.
- **System leadership** by working with the Integrated Care Board (ICB) and wider system partners to ensure that Shropshire's priorities and statutory responsibilities are reflected within system governance and decision-making.

## 4. Membership

Membership of the Health & Wellbeing Board consists of:

- Cabinet Portfolio Holder, Adult Social Care & Health (co-chair)
- Chief Nurse, NHS Shropshire, Telford and Wrekin and Staffordshire & Stoke-on-Trent (Co-chair)
- Cabinet Portfolio Holder for Children and Education
- Leader of Shropshire Council
- Executive Director (Director of Public Health), Shropshire Council
- Director for Adult Social Services (DASS), Shropshire Council
- Director of Children's Services (DCS), Shropshire Council
- Head of Service - Housing, Resettlement and Independent Living
- Lead Officer, Voluntary and Community Sector
- Chief Officer, Healthwatch Shropshire
- Chief Officer System Development and Integration, NHS STW
- Director Place for Shropshire NHS Shropshire Telford and Wrekin
- Chief Executive, Shropshire Telford and Wrekin Community and Hospital NHS Trust Group
- Group Chief Strategy and Integration Officer, Shropshire Telford & Wrekin Community and Hospitals NHS Group
- Chief Officer, Partners in Care
- CEO Robert Jones and Agnes Hunt Hospital (RJAH)
- Associate Director, Midlands Partnership Foundation Trust (MPFT)
- Co-Chair, GP Board
- Chief Officer, Community Pharmacy Shropshire
- Superintendent, West Mercia Police

## 5. Meetings of the Board

Meeting Frequency – The Board usually meets at least quarterly. Meetings will be held in person; however, provision will be made for online meetings in circumstances such as severe weather or pandemics. This will be agreed with the chair and co-chair.

Election, Roles and Responsibilities of the Co-Chairs

- Election – the Board will operate a co-chair arrangement selected and agreed by the Board; one Portfolio Holder HWBB Member and one Integrated Care System (ICS) HWBB member.
- Responsibilities – Represent views of the Board as required; allow views to be heard fairly and cultivate an atmosphere of true collaboration.

Notice of Meetings – meetings of the Board will be open to the press and public and arranged 5 clear working days in advance by Shropshire Council, who will also provide the clerking and recording of the meeting. Meeting dates, agendas, and minutes will be published on the Council website.

Public questions - Public questions are a standing agenda item and are welcomed, but notice of any question should be received prior to the commencement of the relevant meeting in accordance with the provisions of the Constitution of the Council for questions from the public. The agenda is published on the Council website 5 clear working days before the meeting. A response to the question will be made available on the Council website.

Confidential Items – Members of the public and press may only be excluded either in accordance with the Access to Information Rules as set out in Part 4 of Shropshire Council's Constitution or Rule 26 (Disturbance by the Public).

Substitutes – Nominating groups may appoint a substitute member for each position; notification of the named substitute member must be made prior to the meeting start. Substitute members will have full voting rights.

Disclosable Pecuniary Interests - Members will be required to disclose any pecuniary interest in any matters to be discussed that are not included in the Register of Interests and leave the meeting prior to the matter being discussed.

Agenda items – The Chair or Co-Chairs, in consultation with the Director of Public Health at Shropshire Council, will set the agenda for Health and Wellbeing Board meetings. The Council's Head of Service for Healthy Population will coordinate agenda planning and administration.

Standard items, included at the discretion of the Chair or Co-Chairs, usually include:

- *System updates*: updates from the Shropshire Integrated Place Partnership (ShIPP) including Healthy Neighbourhoods, Joint Commissioning/Better Care Fund (BCF), and Integrated Care System (ICS).
- *Population health:* JSNA updates to support a shared understanding of local community needs, informed by locally collected quantitative and qualitative evidence.
- *Joint Local Health and Wellbeing Strategy (JLHWS) reporting*: regular reports on progress against the agreed strategic priorities and key areas of focus.
- *Health protection*
- *Inequalities*

**Annual reports** will include updates from Healthwatch Shropshire, the Director of Public Health, the Shropshire Community Safety Partnership, the SEND and AP Board and other groups as appropriate. Other agenda items may include strategies, reports, and updates from system partners and other organisations where these are relevant to HWBB priorities and functions. This includes reports from Healthwatch Shropshire, where the Board may be asked to comment on the findings and, where appropriate, report on improvements made in response.

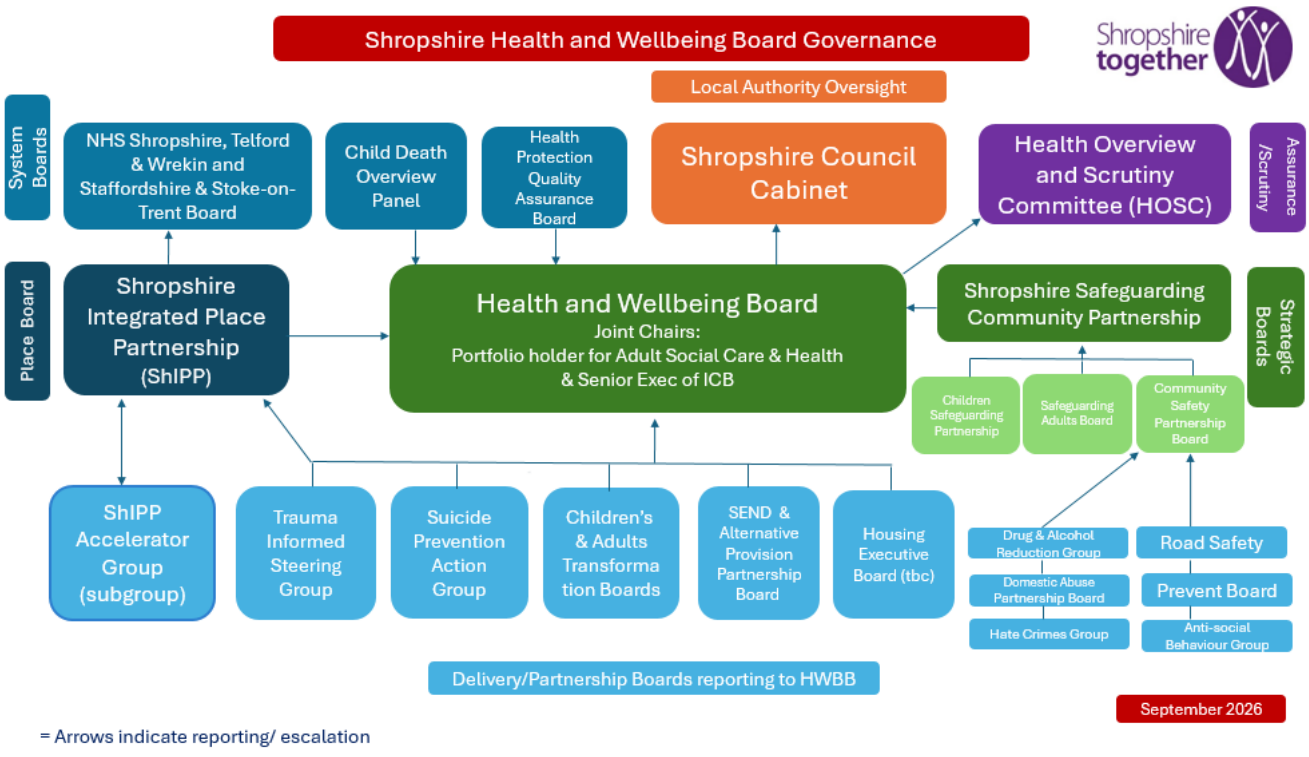
Reports for Board meetings should be submitted to the Council's Head of Service for Healthy Population at least ten working days before the meeting to allow time for preparation and publication on the Council website.

Quorum – The quorum for all Health and Wellbeing Board meetings, whether held in person or online, is one quarter of the whole number of voting members, subject to a minimum of 3. This must include at least two representatives from Shropshire Council, one representative from the Integrated Care Board, and one representative from another organisation. Members must be present in person to count towards quoracy and to vote. On-line attendees are not counted towards quoracy and cannot vote

Decision making – Decisions should be reached by consensus wherever possible. Where a vote is required, decisions will be determined by a simple majority of members present and voting. In the event of an equal vote, the Chair will have a casting vote.

## 6. Reporting Mechanisms/Accountability

- The Health and Wellbeing Board, as a Committee of the Council, will report to Full Council as required.
- The actions of the Health and Wellbeing Board will be subject to independent scrutiny by the relevant members of the Overview and Scrutiny Committee of the Council.
- This Governance structure is subject to change, and if updated, will be reported and added to the Council website.




## 7. Review date

The Terms of Reference will be reviewed annually to ensure that the Board is fit for purpose and able to respond to the changes in the way we work.
***Review date: November 2027***

*Acknowledgement: Some additions to this ToR have been adapted from; Derbyshire County*

| Date | Author | Comments |
|---|---|---|
| November 2026 | R. Robinson | Extensive re-writing including quoracy, membership and addition of healthy neighbourhood principles. |

PUBLIC HEALTH

# Severn Diabetes and Obesity Conference 2026

## Report to the Shropshire Health and Wellbeing Board

Healthy Population and Partnerships

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| **Report date** | 30 October 2026 |
| **Report authors** | Mr Bernie Bentick, Dr Probal Moulik |
| **Report purpose** | Information, assurance and partnership development |
| **Conference date** | 25 September 2026 |
| **Conference attendance** | Approximately 250 delegates |

### Key messages

*Prioritisation and dedicated funding, stronger prevention, earlier action and closer collaboration across services are essential to reduce the growing burden of diabetes and obesity and improve outcomes across our communities.*

# 1. Executive summary

Diabetes and obesity are major and closely connected public health challenges. The figures supplied for this report indicate diabetes prevalence of approximately 7.1% in Shropshire and around 8% in Telford, while approximately 67% of adults, around 180,000 people locally, are living with being overweight or obese. Nearly one in three children in Year 6 is described as overweight or very overweight.

The Severn Diabetes and Obesity Conference (SDOC), held on 25 September 2026, brought together approximately 250 delegates for a full day of education, practical training, patient experience and discussion. Demand exceeded venue capacity. The programme covered prevention, inequalities, modern diabetes treatment, cardiovascular and kidney protection, liver disease, hypertension, neuropathy and foot disease, lipid management, obesity treatment, bariatric surgery, continuous glucose monitoring and insulin therapy.

The central conclusion was that diabetes and obesity cannot be addressed by individual services working in isolation. Prioritisation, dedicated funding, earlier case identification, healthy weight across the life course, integrated physical and mental healthcare, community-based prevention, clear referral pathways and closer working between primary, community and hospital teams are required.

The conference is intended to continue annually. Severn Diabetes Network CIC is also being established to support work between conferences, including community engagement, fundraise and support the proposed Severn Pumpers Financial Hardship Fund for people with type 1 diabetes experiencing financial disadvantage.

## Key Messages and Recommendations

1. Note the scale and interrelationship of diabetes, obesity, cardiovascular disease, kidney disease, liver disease and health inequalities across the local population.
2. Note the successful delivery and strong professional engagement achieved by SDOC 2026.
3. Support closer collaboration between Public Health, primary care, community services, secondary care, patients and voluntary and community partners.
4. Support a stronger emphasis on prevention, earlier identification and healthy weight across the life course.
5. Encourage the development of shared, equity-focused outcome measures covering prevention, access, inequalities and clinical outcomes.
6. Welcome continued professional and community engagement through SDOC and Severn Diabetes Network CIC, while maintaining clear governance and organisational boundaries.

# 2. Purpose of the report

This report provides the Healthy Population and Partnerships meeting of the Health and Wellbeing Board with an overview of the population-health context for diabetes and obesity, the delivery and learning from SDOC 2026, and the opportunities arising for prevention and partnership working.

The report is intended to support discussion about how the momentum generated by the conference can contribute to a coordinated local response across Public Health, primary care, community services, secondary care, the voluntary and community sector, patients and wider partners.

# 3. Population-health background

## 3.1 Scale of diabetes and obesity

Diabetes prevalence is approximately 7.1% in Shropshire and around 8% in Telford. Diabetes is closely associated with obesity, and approximately 67% of adults, representing around 180,000 people locally, are living with overweight or obesity. The cost to NHS services is about 6% of the UK health budget (Diabetes UK), equivalent to £68.5 million of the core revenue allocation to Shropshire, Telford and Wrekin NHS ICB for 2026/27 (NHS England).

The impact on younger people is a particular concern. Nearly one in three children in Year 6 is overweight or very overweight, reinforcing the need for prevention and healthy-weight action throughout the life course.

### 3.2 Cardiovascular risk and undiagnosed diabetes

Diabetes and obesity are strongly associated with cardiovascular disease, including heart attack and stroke. The figures supplied for the conference report indicate that approximately 25% of people presenting locally with acute cardiovascular events have diabetes, and around one in six of those with diabetes are diagnosed for the first time at presentation. This illustrates the continuing burden of undiagnosed disease and the opportunity for earlier identification.

### 3.3 Inequalities and mental health

The burden is not evenly distributed. Obesity is approximately twice as common in the most deprived communities as in the most affluent, making diabetes and obesity important contributors to health inequalities.

There is also a two-way relationship with mental health. The figures presented for this report indicate that people living with obesity have around a 50% increased risk of depression and anxiety, while people living with mental health conditions are approximately three times more likely to experience obesity. Physical health, mental health and the wider determinants of health should therefore be considered together.

## 4. The whole-system case for action

A meaningful response to diabetes and obesity requires coordinated action across the health and care system. Public Health, primary care, secondary care, community services, the voluntary and community sector, patients, local communication channels and the media all have a role in prevention, earlier identification, effective treatment and sustained self-management.

SDOC was developed as a practical contribution to this agenda. The annual conference was started 3 years back by Dr Probal Moulik, Consultant endocrinologist, as the Severn Diabetes Conference and was renamed this year as SDOC (Severn Diabetes and Obesity Conference) to reflect the central importance of obesity in the development and management of type 2 diabetes and related metabolic disease.

Its purpose is not only to raise awareness but also to equip healthcare professionals with current knowledge and practical skills, facilitate exchange of ideas, build relationships and strengthen collaboration across organisational boundaries.

## 5. SDOC 2026: delivery and reach

SDOC 2026 was held on 25 September 2026 at the Wroxeter Hotel, Shropshire, as a full-day event. Approximately 250 delegates attended, and demand exceeded the capacity of the venue. The level of interest demonstrated strong appetite among healthcare professionals for education and collaboration in diabetes and obesity.

As an annual event, SDOC can build cumulative reach across the workforce. Professionals unable to attend in one year may participate in subsequent years, progressively extending learning and relationships across the local health and care system.

## 6. Opening session: inequalities and prevention

The conference opening placed diabetes and obesity within the wider context of population health, inequalities and prevention. Shrewsbury Mayor and former NHS Consultant Bernie Bentick highlighted the Marmot principles and six objectives for a healthier society:

1. Give every child the best start in life.
2. Enable people to maximise their capabilities and have control over their lives.
3. Create fair employment and good work.
4. Ensure a healthy standard of living.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill-health prevention.

The opening discussion emphasised that health inequalities have widened and cannot be addressed by healthcare acting alone. It also emphasized three strategic shifts within the NHS 10 year Plan: care from hospital

to community, analogue to digital systems, and sickness treatment to prevention. These shifts need to operate together rather than in isolation between and within the local Healthcare system and wider partners.

### Proposed Shropshire Prevention Compact

- Prioritisation and dedicated funding to achieve measurable outcomes.
- Earlier identification of risk and clear referral pathways.
- A healthy-weight approach across the life course.
- Place-based support where need is greatest and barriers to access are highest.
- Integrated physical health, mental health and community support.
- A shared, equity-focused outcomes dashboard.

## 7. Clinical education and practical learning

### 7.1 Modern treatment and cardiorenal protection

Professor Vinod Patel discussed updated NICE NG28 guidance for type 2 diabetes and the role of modern glucose-lowering treatment. Particular emphasis was placed on SGLT2 inhibitors and incretin-based therapies, reflecting the need to consider cardiovascular and kidney protection alongside glucose control.

Dr Jayesh Makan, consultant cardiologist, addressed optimal management of hypertension in diabetes. Dr Rob Chand, Consultant Nephrologist, examined the interrelationship between cardiovascular, renal and metabolic disease and described strategies for earlier recognition of kidney disease and reduction of long-term risk.

### 7.2 Liver disease and metabolic complications

Dr Ulrich Thalheimer, Consultant Hepatologist, discussed MAFLD ie fatty liver disease associated with obesity and metabolic dysfunction. Fat deposition in the liver can be associated with inflammation, progressive liver damage and, in some individuals, cirrhosis. The session reinforced the need to address obesity, type 2 diabetes and liver health together.

### 7.3 Complications and prevention of avoidable harm

Dr Dimple Jain, Consultant Dermatologist, presented the dermatological manifestations of diabetes. Dr Prashant Singh, Consultant endocrinologist, provided a practical discussion on diabetic neuropathy and its consequences. Neuropathy may cause pain and disability, but loss of protective sensation also increases the risk of foot ulceration and amputation. Prevention requires a joined-up pathway: community services identifying people at higher risk and providing surveillance, education and preventive care, with timely access to hospital-based multidisciplinary diabetic foot services for active ulceration.

### 7.4 Lipid and obesity management

Dr Helen Ashby, Consultant in metabolic medicine, discussed management of dyslipidaemia and cardiovascular risk in diabetes, including established and newer lipid-lowering therapies.

Dr Probal Moulik presented on the medical management of obesity and current challenges associated in delivering the services. Newer medicines are highly effective but are expensive and should be combined with sustained lifestyle measures. With finite resources, equitable prioritisation of people at greatest risk of obesity-related complications is important. The role of bariatric and metabolic surgery was also explored by Mr Umesh Parampalli, Consultant Upper GI/Bariatric Surgeon.

### 7.5 Practical workshops

Parallel workshops provided hands-on education and practical workshops in continuous glucose monitoring and insulin therapy. These sessions supported the translation of knowledge into practical skills for everyday clinical care.

# 8. Patient voice and primary care perspective

## 8.1 Patient experience

Patient representative Mr John Clark described his experience of fatty liver disease, followed later by diabetes. He explained the substantial changes he made through exercise, weight loss and healthier eating. His diabetes is now well controlled and his liver function tests have normalised.

His account illustrated the close relationship between obesity, liver disease and diabetes, the value of sustained lifestyle change, and the importance of ensuring that people living with long-term conditions have a meaningful voice in service development.

## 8.2 Primary care

Dr Abigail Kinmond, local GP from Newport, discussed the growing complexity of long-term-condition management in primary care. Practices vary in their capacity to deliver expanding and increasingly complex services. Movement towards prevention, earlier intervention and care closer to home must therefore be accompanied by appropriate workforce development, resources and funding.

# 9. Conference conclusions

Dr Probal Moulik emphasised that SDOC is not simply a forum for discussing science. It is also a place to exchange ideas, build relationships and strengthen collaboration between primary care, community services and hospital teams.

The closing discussion identified the following shared priorities:

- Earlier prevention and intervention before diabetes, obesity and complications become established.
- Explicit action on health inequalities and barriers to access.
- Integrated cardiovascular, renal and metabolic risk management rather than glucose control in isolation.
- Recognition of obesity as a chronic health condition requiring lifestyle, medical and, where appropriate, surgical treatment.
- Earlier identification supported by screening and clear referral pathways.
- Closer working between primary, community and specialist services.
- Continuing professional education and practical training.
- Meaningful patient and community involvement.
- Commissioning, resourcing and evaluation that support prevention.

The day closed with shared emphasis on earlier action and closer integrated working across services.

# 10. Developing a sustainable local network

The intention is to continue SDOC as an annual conference, enabling professionals to update their knowledge, exchange ideas and strengthen working relationships. The wider opportunity is to use the conference as a catalyst for collaboration throughout the year.

Severn Diabetes Network CIC is currently being established By Dr Moulik and his team as a community-focused not for profit organisation to support work beyond the annual event. Its proposed activities include prevention, education, community engagement, professional networking and fundraising, arranging annual SDOC conference and other training events and supporting the Severn Pumpers hardship fund. Appropriate governance and clear separation from statutory commissioning and NHS service delivery will be important as the organisation develops.

# 11. Severn Pumpers Financial Hardship Fund

A proposed initiative within Severn Diabetes Network CIC is the Severn Pumpers Financial Hardship Fund, focused particularly on people with type 1 diabetes who are experiencing financial disadvantage.

Although NHS care addresses many direct treatment costs, living with diabetes can generate additional and less visible financial pressures, including:

- Travel to hospital and primary care appointments.
- Parking and other costs associated with attending healthcare.
- Loss of working time to attend appointments.
- Self-funded items used to treat hypoglycaemia.
- Higher costs in areas such as insurance.
- Other day-to-day costs associated with managing a complex lifelong condition.

For people already experiencing hardship, these costs can accumulate and become a barrier to effective self-management. The proposed fund is intended as a community-supported response to this aspect of the wider determinants of health, subject to robust eligibility, governance, confidentiality and financial-control arrangements.

## 12. Opportunities for Healthy Population and Partnerships

SDOC provides a potential platform for linking professional education with wider population-health objectives. Areas for future collaboration include:

- Professional education in diabetes, obesity and prevention.
- Earlier identification and clearer referral pathways.
- Population engagement and education to promote healthy lifestyle including diet, regular exercise and healthy weight across the life course, from pre-schoolers to pensioners.
- Closer links between Public Health, primary care, schools, community and specialist services.
- Place-based approaches for communities experiencing greater need and barriers to care.
- Integration of physical health, mental health and community support.
- Greater patient and community participation.
- Engagement with local media and community communications to support prevention.
- Development of shared measures for prevention, access, equity and clinical outcomes.

## 13. Proposed next steps

| No. | Proposed action | Suggested lead | Status |
|---|---|---|---|
| 1 | Develop a concise shared prevention proposition covering education, nutrition, exercise, mental health and behaviour patterns, earlier identification, healthy weight and referral pathways. | Public Health, schools and system partners | For partnership discussion |
| 2 | Explore an equity-focused outcomes dashboard for diabetes and obesity, particularly in communities and populations at high risk | Public Health, primary care and specialist services | Scoping |
| 3 | Strengthen year-round professional links arising from SDOC. | SDOC leads and partner organisations | Ongoing |
| 4 | Continue annual SDOC planning, including consideration of venue capacity and wider workforce reach. | SDOC organising team | Annual cycle |

| No. | Proposed action | Suggested lead | Status |
|---|---|---|---|
| 5 | Develop Severn Diabetes Network CIC governance, partnerships and fundraising arrangements. | Severn Diabetes Network CIC | In development |
| 6 | Establish robust rules and controls for the Severn Pumpers Financial Hardship Fund. | Severn Diabetes Network CIC | In development |

## 14. Matters for the Board

The Board is invited to:

7. Note the report and the main learning from SDOC 2026.
8. Endorse the principle of earlier action, prevention and integrated working across diabetes and obesity pathways.
9. Support exploration of a shared, equity-focused approach to outcomes and evaluation.
10. Encourage continued engagement between Public Health, primary care, community services, secondary care, patients and voluntary and community partners.
11. Note the development of Severn Diabetes Network CIC and the proposed Severn Pumpers Financial Hardship Fund as independent community initiatives.
12. Prioritise diabetes and obesity with dedicated funding to achieve measurable outcomes.

## Appendix 1. Headline conference themes

| Theme | Board relevance |
|---|---|
| Population engagement and education<br>Prevention and earlier identification | Opportunity to reduce avoidable disease and complications. |
| Health inequalities | Need for place-based action where disease burden and barriers are greatest. |
| Healthy weight across the life course | Requires action from pre-schoolers to pensioners. |
| Cardiovascular, renal and metabolic protection | Supports integrated risk reduction rather than glucose-only care. |
| Community and specialist integration | Clear pathways are required for prevention, escalation and complex care. |
| Professional education | Rapidly changing treatment requires continuing workforce development. |
| Patient voice | Services should be shaped with people living with diabetes and obesity. |
| Shared outcomes | Progress should be measured across prevention, access, equity and clinical outcomes. |

## Appendix 2. Data note

The prevalence, population and risk figures in this report have been reproduced from information supplied for the preparation of the paper. They should be checked against the latest agreed local Public Health, NHS and programme datasets before formal publication or external circulation. Speaker names, professional titles and organisational details should also be checked against the final conference programme.

# SDOC Severn Diabetes & Obesity Conference



## Friday 25 Sept 2026 | The Wroxeter Hotel, Shropshire

**Organised by Dr Probal Moulik** on behalf of SDOC and Diabetes UK

## AGENDA

| | | |
|---|---|---|
| **8.00 onwards** | Registration and breakfast | |
| **8.50 - 9.55 Breakfast session: Main lecture hall** | 8.50 - 9.00 Welcome from SDOC organising committee. Dr Probal Moulik<br>9.00 - 9.15 Inauguration Mayor Bernie Bentick<br>9.15 - 9.55 New NICE Diabetes guidance NG28 Prof Vinod Patel | |
| | **Eyton Suite** | **Wroxeter Suite** |
| **10.00 - 11.30** | 10.00 - 10.30 Cerebrovascular disease in diabetes. Dr Indira Natarajan, UHNS<br>10.30 - 11.00 Hypertension in diabetes. Dr Jayesh Makan<br>11.00 - 11.30 Cardio renal metabolic syndrome. Renal perspective. Dr Rob Chand | **Diabetic Footcare**<br>Ms Kate Merriman and Nichola Beard |
| **11.30 - 11.55** | **Tea and refreshments break** | |
| | **Eyton Suite** | **Wroxeter Suite** |
| **12.00 - 13.30** | 12.00 - 12.30 The liver in metabolic syndrome. Dr Ulrich Thalheimer<br>12.30 - 13.00 Dermatological manifestations of diabetes. Dr Dimple Jain<br>13.00 - 13.30 Painful diabetic neuropathy. Dr Prashant Singh | **Use of CGM in diabetes**<br>Dr Probal Moulik, Marie Jones, Vicky Wilkes, Hayley Brown |
| **13.30 - 14.25** | **Lunch** | |
| | **Eyton Suite** | **Wroxeter Suite** |
| **14.30 - 16.00** | 14.30 - 15.00 Diabetic dyslipidemia. Dr Helen Ashby<br>15.00 - 15.30 Medical management of obesity. Dr Probal Moulik<br>15.30 - 16.00 Bariatric surgery in the age of Incretins. Mr Umesh Parampalli | **Insulin therapy in type 2 diabetes**<br>Dr Navya Basavaraju, Vicky Wilkes, Marie Jones, Hayley Brown |
| **16.00 - 16.10** | **Comfort break and return to main lecture hall – Eyton suite** | |
| **16.10 - 17.00 Concluding session: Main lecture hall** | 16.10 - 16.20 Patient story Mr John Clarke<br>16.20 - 16.40 Primary care perspective. Can we deliver? Dr Abigail Kinmond<br>16.40 - 17.00 Discussion and close. Dr Probal Moulik | |
| | **Repeat breakout session (pre-registered delegates) Wroxeter Suite** | |
| **17.00 - 19.00** | **Insulin therapy in type 2 diabetes (with pizza station dinner)**<br>Dr Probal Moulik, Marie Jones and Hayley Brown | |

### SDOC ORGANISING COMMITTEE

| | | | | | | |
|---|---|---|---|---|---|---|
| **Dr Probal Moulik**<br>Convener SDOC, President DUK Shrewsbury, Consultant Endocrinologist | **Dr Proma Moulik**<br>Secretary SDOC, GP First5 Network Lead | **Dr Christopher Cane**<br>Resident doctor representative and IT lead SDOC, GP Registrar | **Mrs Hayley Brown**<br>Lead DSN SDOC and Diabetes Specialist Nurse | **Ms Nicky Beard**<br>Foot Lead SDOC and Lead Diabetic Specialist Podiatrist | **Mr John Clarke**<br>Patient Representative | **Mr Rodger Briers**<br>Chair DUK Shrewsbury |

### SPONSORS

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*All pharmaceutical companies above have provided sponsorship to SDOC to cover the cost of this meeting. They have had no influence over the meeting, agenda or arrangements.*

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# SHROPSHIRE HEALTH AND WELLBEING BOARD
## Report

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Meeting Date** | 19th November 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@shropshire.gov.uk<br>Corporate Director – Population, Wellbeing and Neighbourhoods, (DPH) and Deputy Chief Executive | | | | | | |
| **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) | | | | |
| **What inequalities does this report address?** | The work of ShIPP focuses on rural and underserved communities, inequalities in children's mental health access and experience, earlier preventative support and support of the VCSE sector. | | | | | | |

### 1. Executive Summary

The Shropshire Integrated Place Partnership (ShIPP) meeting held on 15 October 2026 reviewed neighbourhood health, ShIPP Prevention Funding and Child & Adolescent Mental Health Service (CAMHS) Needs Assessment. Members supported closer integration, stronger prevention and clearer governance, with further work required to align responsibilities, reduce duplication and demonstrate outcomes.

### 2. Report

**ShIPP Accelerator Group**
The Accelerator Group will develop proposals clarifying its purpose, responsibilities and reporting arrangements alongside Healthy Neighbourhoods and the Health and Wellbeing Board.

**Healthy Neighbourhoods**
The neighbourhood implementation programme (NNHIP) has strengthened partnership relationships and generated early evidence of impact. Members supported the shared vision and principles, subject to review. Governance progress will return to the next meeting, with a maturity assessment, evidence and case studies due in December.

**ShIPP Prevention funding**
Funding of £399,999 has been received by the accountable organisation. "Healthy Ageing" delivery began on 1 October, covering falls prevention, musculoskeletal support and physical activity. "Trusted Faces" will mobilise seven organisations in stages as agreements, funding and staffing become ready. Members supported the recommendations, emphasising sustainable voluntary-sector capacity, clear referral pathways and shared outcomes. A delivery and finance update is due at the next meeting, with quarterly reporting initially proposed. An external evaluator is expected to be appointed in early 2027.

**Child & Adolescent Mental Health Service (CAMHS) Needs Assessment - Recommendations**

The needs assessment highlighted increasing demand and inequalities in access and experience. Members agreed to support a partnership workshop to review prevention provision, refresh existing service mapping and identify gaps. A local coordinating lead will be identified, with primary care, children's commissioning and social care involved, and links strengthened with neighbourhood delivery.

**Next steps**

Priority actions are to clarify governance and accountability, receive programme updates at the next meeting in December, convene a system- wide workshop to discuss a prevention offer for children and their families as well as a system-wide estates discussion. The next ShIPP meeting is scheduled for 17 December 2026.

| | | |
|---|---|---|
| **Risk assessment and opportunities appraisal** | Key risks are unclear governance, insufficient voluntary-sector resources and weak connections between children's mental health services and primary care, potentially causing duplication, gaps and excessive demand on services. ShIPP Prevention Funding delivery also faces mobilisation, cash-flow, data-sharing and safeguarding risks. Opportunities include coordinated investment, earlier community support and shared learning to strengthen neighbourhood delivery. | |
| **Financial implications** | The update notes £399,999 in ShIPP Prevention Funding, managed through phased agreements and payments. Sustainable coordination and voluntary-sector capacity remain important delivery considerations | |
| **Climate Change Appraisal** | N/A | |
| **Where else has the paper been presented?** | System Partnership Boards | NHS Shropshire, Telford and Wrekin & NHS Staffordshire and Stoke-on-Trent - Integrated Care Board |
| | Voluntary Sector | |
| | Other | |

**List of Background Papers** N/A

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

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

**Appendices**

N/A