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 • Shrewsbury Ageing Well and proactive frailty development • South East Shropshire care-home CGA, dementia coordination and diabetes outreach • South West and rural development focused on access, community assets and integrated pathways • Executive visioning and development of the STW Healthy Neighbourhoods approach • 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. • 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. • 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. • 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		
1. Pop health…	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %
2. New model of care…	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %
3. Community led solutions…	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %
4. Person centred co-man…	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %
5. System integration…	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %	30 %	60 %	90 %

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

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 • Move frailty and CVRM into measurable Year 1 delivery • Strengthen MDTs, shared caseloads, care coordination and community participation • Clarify governance, decision rights, integrator and partner accountability • Align the Outcomes Framework, prevention funding and other investment • Strengthen PHM, digital, data, workforce, estates and evaluation enablers
Next steps	• Finalise neighbourhood proposals, baselines and routine outcome reporting • Map and spread learning from Shrewsbury, South East Shropshire, rural and other neighbourhood work to support development of INT • Confirm governance links between neighbourhood, Place and STW arrangements • Progress shared data, coding, digital and information-governance solutions • Maintain meaningful VCSE, community and carer involvement • Turn the foundations into routine delivery while retaining flexibility for local population need • 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 • Care plans, medication reviews, referrals and coordinated actions • Experience, independence, confidence and inequalities measures • Non-elective admissions and emergency bed days using clear comparators • Workforce, capacity, implementation and financial measures • Evidence of spread, adaptation and learning across neighbourhoods • 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. 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: • a shared direction, with flexibility to respond to local and rural needs • strong collective leadership and clear decision-making • sustainable workforce, funding and estates support • greater emphasis on prevention and earlier intervention • shared data, agreed outcomes and clear evidence of the difference being made • meaningful involvement of communities, carers and the VCSE sector • 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.

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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."*

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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.

