Shropshire Council

Committee and Date

Health and Wellbeing Board

21 May 2026

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

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

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

48 **Apologies for Absence and Substitutions**

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

49 **Disclosable Interests**

No interests were declared.

50 **Minutes of the previous meeting**

RESOLVED:

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

51 **Public Question Time**

No public questions were received.

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

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

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

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

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

RESOLVED:

To note the contents of the report.

53 **Domestic Abuse**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED:

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

54 Drug & Alcohol Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED:

To note the contents of the report.

55 Mental Health – Suicide Prevention

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

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

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

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

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

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

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

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

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

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

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

RESOLVED:

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

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

56 **SEND JSNA**

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

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

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

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

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

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

RESOLVED:

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

57 BCF – Q3 template

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

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

RESOLVED:

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

58 Cardiovascular, Renal, and Metabolic (CVRM)

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

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

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

RESOLVED:

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

59 **ShIPP Update**

Members noted the ShIPP update.

60 **Pharmacy updates – for information**

Members noted the Pharmacy updates.

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

Noted.

AOB

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

<TRAILER_SECTION>

Signed …… (Chair)

Date: