



Health Overview and Scrutiny Committee

Report of the Health in All Policies and Planning Task and Finish Group

10th June 2026

Acknowledgments

The Task and Finish Group would like to thank the officers, members, partners, developers, service users, carers and other contributors who provided evidence and practical examples to support this review. The Group appreciated the constructive engagement across Planning, Public Health, Adult Social Care, Children's Services and housing delivery partners, and for the lived experience contributions which grounded the recommendations in the realities experienced by residents and families in Shropshire.

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1. Context

Health outcomes are shaped not only by healthcare services but also by the wider determinants of health, including housing quality and affordability, neighbourhood safety, social cohesion, access to services and green space, connectivity and transport.¹

The Health Overview and Scrutiny Committee therefore commissioned this Task and Finish Group to examine how health and wellbeing are embedded within planning policy and practice in Shropshire, and to identify opportunities to strengthen planning's contribution to prevention. Recognising the significant influence of planning policy on health outcomes, particularly for residents supported by Adult Social Care and Children's Social Care.

Shropshire's predominantly rural geography, dispersed settlements and reliance on small scale development mean that national, "urban centric" planning assumptions can unintentionally exacerbate health inequalities. Evidence heard by the Group highlighted that planning decisions in villages and hamlets directly affect people's ability to remain close to family, access services and sustain independence, with long term consequences for Adult Social Care and Children's Services demand.

The Task and Finish Group heard evidence that, in a rural county such as Shropshire, sustainability must be understood in a broader and more nuanced way than is often reflected in national planning frameworks. The Task and Finish Group and Administration witnesses emphasised that sustainability should not be assessed solely through urban-focused indicators such as frequency of public transport or density thresholds but must also reflect the social sustainability of rural communities.

For the purposes of this review, the Group understands social sustainability to mean the ability of communities to remain viable over time by retaining families, carers and support networks; sustaining essential local services such as schools, shops and community facilities; and enabling people to live close to those who provide informal care and support. The Group heard evidence that socially sustainable communities are associated with better mental wellbeing, reduced isolation, and lower long-term demand for Adult Social Care and Children's Services.²

The Group concluded that planning approaches which do not adequately recognise social sustainability risk undermining prevention objectives by unintentionally displacing families and support networks, particularly in rural areas.

Evidence received by the Group highlights rising and changing demand for specialist and supported accommodation. Local projections indicate significant growth in the older population and increasing needs across cohorts including adults with learning disabilities/autism, adults with mental health needs, young people leaving care and key workers.³

Evidence heard from the Portfolio Holder for Health highlighted that unmet housing need is itself a significant and current public health issue in Shropshire. It was emphasised that prolonged housing insecurity and lack of access to suitable, affordable homes contribute directly to deteriorating mental health, delayed hospital discharge, increased demand for Adult Social Care and poorer outcomes for children and families. The Group therefore considers the availability of social and affordable housing to be an important factor influencing health and wellbeing, rather than solely a housing or planning issue.

The Group's work has taken place alongside significant national and local planning reform, at a point of transition and uncertainty within the planning system. Shropshire Council formally commenced preparation of the next Local Plan⁴ in January 2026, following the introduction of a new national plan-making framework and associated reforms⁵. Evidence heard by the Group highlighted that, while the direction of travel nationally places increased emphasis on outcomes such as health, inclusion and sustainability, important aspects of the new system including the status of Supplementary Planning Documents, the scope for locally specific policy, and the degree of flexibility available to reflect rural circumstances are still being confirmed and clarified.

As described by the Service Director for Place Shaping in her evidence to the Group, local authorities are currently required to progress plan-making in advance of full national guidance being issued, creating a degree of ambiguity around how health-related objectives will ultimately be expressed, weighted and examined within Local Plans. In particular, uncertainty remains regarding how far local plans will be able to go beyond the National Planning Policy Framework without repetition, how qualitative and place-based evidence will be assessed, and what mechanisms will replace existing forms of supplementary guidance. The Group heard that this has resulted in a "watch-this-space" environment for plan-making, requiring councils to interpret emerging policy intent while retaining flexibility to respond to further national clarification.

The Group therefore recognised that its work sits within an evolving policy context, where opportunities to embed Health in All Policies more firmly within planning policy exist, but where the precise tools, weight and form of future policy interventions are not yet fully settled. This uncertainty reinforces the importance of early engagement, strong evidence-bases and cross-service collaboration in the interim, while ensuring that the emerging Local Plan is sufficiently adaptable to respond to further national direction as it becomes clearer.

The Group therefore distinguishes throughout this report between measures that can be strengthened immediately through planning practice and engagement, and those that require clear articulation and policy weight within the emerging Local Plan to achieve consistency and longevity.

2. Scope of the work

The Group focused on the intersection of HiAP and planning policy, with a particular lens on:

- the impact of planning decisions on Adult Social Care and Children's Social Care needs.
- how Local Plan development can promote and sustain healthier living environments.
- the role of planning in ensuring the longevity and suitability of housing for vulnerable populations including consideration of multigenerational living, small scale rural development and the importance of enabling families and support networks to remain together.
- healthier and adaptable living environments that enable people to stay in their own homes for longer, including consideration of multi-generational living and innovative housing models.
- as part of its agreed Terms of Reference, the Task and Finish Group undertook benchmarking with comparator councils to understand how Health in All Policies principles can be embedded through planning, housing delivery and place shaping. The review considered planning policy and guidance, development management practice, delivery constraints (including viability and infrastructure), and lived experience evidence from carers and service users.

3. Objectives

In line with the agreed Terms of Reference, the Group's objectives were to:

1. Review how current and proposed planning policies address (or could better address) the health and wellbeing needs of adults and children requiring social care.
2. Identify opportunities to embed HiAP principles in planning policy to support healthier living at home, including design standards (accessibility and adaptability), location and connectivity, and the longevity and sustainability of housing stock.
3. Produce practical recommendations for strengthening the health impact of planning policy, with a focus on prevention, early intervention and reducing inequalities.

4. What the Task and Finish Group have done?

To conduct this review, the Group:

- completed a desktop review of current planning policies, planning guidance and national best practice on embedding health into planning;
- heard evidence from Planning and Public Health officers on current and emerging local guidance, including development of a Health Impact Assessment (HIA) approach;
- heard evidence from Adult Social Care, Children's Services and council housing delivery leads on current demand, gaps and the prevention case for adaptable housing;
- the Group examined how STAR Housing and Cornovii deliver accessible and adaptable homes, scrutinising costs, policy levers and viability for M4(2) and M4(3) standards⁶, and complemented this evidence by making a site visit to view a STAR/Cornovii-built M4(3) home;
- gathered evidence from developers on deliverability, viability and infrastructure constraints;
- heard evidence from Portfolio Holders for Health and Planning to understand how health considerations and inequalities could be embedded more systematically into planning policy, exploring issues such as neighbourhood planning, community empowerment and viability, and the application of Marmot principles⁷, early intervention, social housing, transport and health hubs⁸;
- reviewed case studies and gathered resident and carer lived experience evidence, including a targeted survey on Housing, Health and Independence in Shropshire (31 responses);
- visited Telford and Wrekin Council's Station Quarter regeneration scheme to examine how planning, housing delivery, regeneration, education, transport and public realm investment are coordinated through a whole council approach, and how this supports health, independence, accessibility, digital inclusion and long-term prevention outcomes ([Appendix 2](#)) and
- heard evidence from the Leader of the Council on how planning policy and local plan development can better support rural and social sustainability, drawing on practical examples of exception sites, mixed tenure housing, local lettings policies and community led approaches to keeping rural communities viable and reducing downstream health and care impacts.

5. Who the Task and Finish Group Heard From?

The Task and Finish Group heard from a wide range of people and organisations via written submissions, questionnaires and through attending their meetings, providing the opportunity to share their knowledge and experience of Health and Planning. Please see [Appendix 1](#) for the full list of whom the group heard from during their considerations and meetings.

6. Key Findings

The significance of planning as a determinant of health and wellbeing

The evidence gathered by the Task and Finish Group demonstrates that planning policy and planning decisions can act as an upstream public health intervention, shaping health and wellbeing outcomes for residents in Shropshire⁹. Across all evidence sessions, witnesses consistently emphasised that planning is not merely a neutral or technical process, but one that directly influences people's ability to live healthy, independent lives, particularly those supported by Adult and Children's Social Care.

Officers and partners highlighted that housing quality, location, accessibility, connectivity and proximity to services all affect physical health, mental wellbeing, independence, public safety, safeguarding, and demand for statutory services. Poorly designed or poorly located housing can lead to avoidable health deterioration, increased isolation, family stress, and higher long-term demand for social care and health services. Conversely, well-planned development can support prevention, early intervention, and healthier living environments that enable people to remain independent for longer¹⁰.

The Group identified a consistent theme across its discussions and evidence sessions that while planning policy necessarily contains mandated and technical requirements, planning practice can focus on compliance with these requirements rather than on the people who will ultimately live in the homes being approved. As summarised by the Chair, "the Group has heard planning decisions described as about the boxes, not the people in the boxes, and that this mindset needs to change."

The Group recognised that policy frameworks and national requirements set important parameters for decision-making. However, Members were concerned that an over-emphasis on meeting minimum standards or policy tests can result in housing that technically complies with planning policy but does not adequately support independence, family life, care needs or long-term wellbeing. The Group emphasised that planning decisions should start from an understanding of who homes are for, how people live, and the support networks they rely on, particularly in rural communities. Embedding this people-centred perspective was seen by the Group as fundamental to delivering Health in All Policies through planning.

The Group heard clear evidence that the costs associated with reactive responses to poor housing and place based decisions (such as emergency placements, residential care, or family breakdown) can be reduced by embedding health considerations at the planning stage. This reinforces the principle that planning functions can act as an upstream public health intervention rather than a purely downstream technical control ¹¹. User experience case studies demonstrated the personal impact when suitable, well located housing is not available, with one carer describing how prolonged uncertainty and inappropriate housing options had left their daughter "scared where she is living,

desperate to be near her family,” and had contributed to a “deterioration in her mental health”.

Applying the Marmot Principles to Health in Planning

The Group heard evidence from the Portfolio Holder for Health that the Marmot Principles provide a robust, evidence-based framework for integrating health and wellbeing into planning policy and practice. The importance was emphasised of adopting the six original Marmot Principles set out in *Fair Society, Healthy Lives* (2010) ⁷, alongside the two additional principles introduced in *The Marmot Review: 10 Years On* (2020) ¹² which place greater emphasis on addressing structural drivers of inequality and strengthening prevention across the life course.

The Portfolio Holder highlighted that these principles are relevant to planning decisions, particularly in shaping access to suitable housing, social and affordable homes, connectivity, safety, and community infrastructure. He shared that more recent policy thinking has further reinforced the importance of parks, green and open spaces as fundamental determinants of physical health, mental wellbeing, social connection and resilience. The Group heard that such spaces should be treated as integral components of healthy place-making rather than discretionary design features ¹³.

The Group also considered that while the Marmot Principles provide a comprehensive framework for embedding health and wellbeing across all local authority functions, the scope of this review was deliberately limited to planning policy and practice, in line with its agreed Terms of Reference. The Group therefore did not undertake a wider assessment of how the Marmot Principles are applied across all council strategies or partnership arrangements.

The Group notes that Shropshire’s Health and Wellbeing Board has committed to working towards becoming a ‘Marmot Place’. The findings of this review are therefore intended to complement that wider programme of work by demonstrating how planning, as a key upstream lever, can make a practical and measurable contribution to prevention, reduced inequalities and improved health outcomes for residents.

However, the Group also recognised concerns raised by some members and witnesses regarding the practicality and interpretation of these ambitions. As while the Marmot Principles are widely respected for their focus on reducing health inequalities, the Group noted that their application should be balanced and carefully interpreted, as highlighted in Marmot’s own work, many of the principles draw upon broader arguments for systemic change. The Group therefore emphasised the importance of tailoring these principles pragmatically to local circumstances.

Limitations of the current policy framework in embedding Health in All Policies

Officers explained that, although there is strong organisational commitment to embedding health and wellbeing within planning, the ability to require health-related considerations is constrained by national planning policy, the current status of local policy documents, and an evolving national reform context. Recent reforms and emerging guidance were described as creating uncertainty and potentially tightening parameters around the extent to which local authorities can introduce or mandate local validation requirements unless these are clearly provided for through an adopted Local Plan.

In particular, the Group heard that Health Impact Assessment approaches cannot currently be relied upon as a consistent tool through the validation process unless clearly embedded within Local Plan policy. Supplementary Planning Documents¹⁴ can encourage and guide developers but cannot introduce policy, and their future status (or successor mechanisms) under the new system remains unclear. As a result, health-supportive design and placemaking principles are often dependent on early engagement, individual negotiation, and professional judgement rather than enforceable requirements.

Public Health and Planning officers stressed that, given capacity constraints, any future use of Health Impact Assessment approaches must be proportionate and clearly targeted. Evidence cautioned against checklist-driven or universal application models, which risk diluting impact and placing unsustainable demands on limited specialist resources. Instead, officers emphasised the greatest value lies in strategic application through plan-making and higher-impact schemes.

Accessible, adaptable and sustainable housing as a foundation for independent living

There was strong consensus across evidence sessions that accessible and adaptable housing is essential to supporting independent living, reducing demand for care, and improving quality of life for residents with disabilities, long-term conditions, or changing needs over time.

Adult Social Care, housing providers and Public Health officers provided evidence of growing unmet demand for homes that can be adapted as people age or experience changes in health with the Shropshire Supported Specialist Housing and Accommodation Needs Assessment affirming this. Retrofitting existing housing stock poses challenges such as cost, technical challenges, and viability, particularly in older or rural properties. Witnesses emphasised that designing adaptability into new homes from the outset represents best value for money and better outcomes for residents.

The Group heard that accessible and adaptable housing standards can only be applied consistently where they are explicitly set out in Local Plan policy. In the absence of such

policy, development defaults to minimum Building Regulations, which do not adequately support independent living over the life course. Planning officers advised that if the Council wishes to secure M4(2) and M4(3) standards at scale, this must be clearly evidenced, viability-tested and incorporated within Local Plan policy.

At the same time, witnesses cautioned against overly prescriptive or blanket application of standards. Evidence from developers, housing providers and lived experience highlighted that adaptability and flexibility are crucial. In many cases, better outcomes are achieved through early engagement and off-plan adaptation to meet specific needs, rather than rigid numerical targets which can increase costs, reduce choice and undermine viability.

The Group therefore concluded that policy approaches which prioritise flexibility, enabling accessibility and adaptability to be tailored to site context, local needs, and viability are most likely to deliver both preventative health benefits and viable development.

Further comparator learning from Telford and Wrekin Council demonstrated how a local authority acting as both planner and housing provider can accelerate delivery of accessible and adaptable homes. Through its wholly owned housing company, Nuplace, Telford and Wrekin Council have delivered M4(2) and M4(3) homes at scale, with adaptations designed in from the outset and allocations linked to demonstrable need. This approach was evidenced as supporting independent living, reducing reliance on crisis adaptations, and enabling residents to remain in their homes or access appropriate new homes as needs change.

Lived experience evidence reinforced the preventative value of accessible and adaptable housing designed around individual needs. A Shropshire Council tenant who lives in an M4(3) wheelchair-accessible home, described the impact of purpose-built accommodation on independence and the ability to live their life the way they want to:

“I have lived in different types of accommodation, both shared and private rented. This property has been designed around me, and it lets me live without interruption.”

When asked what could be improved, he highlighted ongoing supply and choice issues, stating:

“There is a shortage of accessible housing, with not much choice currently. I’d love to see a portfolio of accessible housing so there’s more choice.”

The Group heard from Housing Officers that demand for homes requiring adaptations is recorded by household across a range of indicators, including wheelchair-accessible or level-access accommodation, level-access showers, sheltered housing and medical priority. At the writing of this report, 993 households had been assessed as requiring level-access accommodation, 772 as requiring a level-access shower, and 56 as

requiring wheelchair-accessible accommodation, alongside households with urgent, serious or moderate medical need¹⁵.

The Group considered this combined qualitative and quantitative evidence to demonstrate that, while accessible and adaptable homes can significantly support independence and reduce reliance on services, current supply and limited choice remain a constraint, reinforcing the importance of embedding adaptability and accessibility within planning policy to prevent avoidable escalation into care.

Affordability and security of tenure as a determinant of health and independence

Alongside physical accessibility and adaptability, the Group heard that affordability and security of tenure are important for independent living. Prolonged housing insecurity and lack of access to suitable, affordable homes were evidenced as contributing to deteriorating mental health, delayed hospital discharge, increased demand for Adult Social Care and poorer outcomes for children and families. The Group therefore considers access to social and affordable housing to be a health and wellbeing issue, as well as a housing and planning issue.

The Group heard evidence from the Portfolio Holder for Health that the Administration has articulated an ambition for up to 40% of new homes to be delivered as social and affordable housing, reflecting the scale of unmet need locally. Comparator examples were referenced, including Bath and North East Somerset Council¹⁶, which has adopted a similar strategic ambition within its planning policy framework. Evidence presented to the Group indicated that such approaches are increasingly framed as health-led interventions, with social and affordable housing recognised as a core mechanism for addressing health inequalities and supporting prevention.

However, the Group also recognised concerns regarding deliverability within a market-led housing context, reflecting challenges being experienced nationally as well as locally in Shropshire. Evidence indicates that delivery of social and affordable housing through Section 106 agreements has become increasingly constrained, with developers reporting difficulties securing registered provider partners, delays in agreeing contracts, and schemes being stalled as a result of affordability pressures within the wider housing market.

The Group acknowledged that under current conditions, ambitions for higher proportions of social or affordable homes may not be achievable on all sites without significant intervention, and that rigid or undeliverable requirements risk slowing build-out, discouraging smaller and medium-sized developers and worsening overall housing supply. The Group therefore emphasised the importance of a pragmatic, evidence-led approach which aligns ambition with local viability evidence, applies policies flexibly where justified, and monitors outcomes to ensure that planning requirements translate

into homes being delivered, supporting improved health outcomes rather than contributing to stalled sites or land being held without development¹⁷.

The evidence suggests that policy approaches which prioritise flexibility, early engagement with delivery partners, adaptability in tenure mix, and collaborative working between local authorities, developers and registered providers are more likely to secure both affordable housing delivery and viable development. National evidence highlights that overly rigid quota-based approaches, particularly on smaller or marginal sites, can unintentionally suppress delivery, while proportionate and negotiated solutions are more effective in bringing forward both market and affordable homes. The Group considers that such an approach is essential to balancing the health benefits associated with affordable housing provision with the practical realities of delivery, particularly in rural and mixed-viability contexts¹⁸.

Multigenerational living and adaptability as preventative planning

The Group heard consistent evidence that planning barriers to multigenerational living, including restrictions on extensions, annexes and adaptable layouts, can have unintended consequences for health and social care demand. Witnesses described how families are sometimes prevented from adapting homes to accommodate changing needs, resulting in people being separated from support networks or placed in more intensive and costly care settings.

Evidence from councillors and lived experience highlighted the benefits of mixed and inclusive communities, where people with different needs and at different life stages live alongside one another. This approach was described as supporting wellbeing, reducing isolation and avoiding the risks associated with clustering people with similar needs in isolated settings.

The Group concluded that planning policy needs to be an enabler of adaptable homes and multigenerational living. This approach would support prevention, independence and resilience, and would align closely with the objectives of Health in All Policies.

Rurality, place and health inequalities

The Group heard extensive evidence that rurality significantly shapes health outcomes and can amplify existing inequalities¹⁹. In a county such as Shropshire, dispersed settlements and reliance on informal support networks mean that the relationship between place, health and wellbeing differs from urban contexts and is not always well reflected in national, urban-centric planning assumptions.

Evidence highlighted factors affecting lived experience in rural areas, including access to public transport, digital connectivity, distance from services and community infrastructure such as GP practices, schools and local hubs. Residents described practical challenges associated with these factors, for example: *“It’s hard to find a personal assistant for my son due to inadequate public transport,”* and *“all the opportunities for SEN are located far away. Public transportation is very poor.”*

The Group stressed that such evidence should not be interpreted as indicating that rural development is inherently unsustainable or inappropriate. Rather, it reinforces the importance of a holistic, place-based approach which considers how housing, connectivity, services and support networks operate together in rural communities.

Public Health officers highlighted that rural deprivation is often masked within aggregate data, making need harder to identify and respond to effectively.

Evidence from Adult Social Care and Children’s Services demonstrated that where planning does not adequately reflect local context and support networks, unintended consequences can arise, including increased isolation and greater reliance on statutory services.

Witnesses emphasised that these issues are most effectively addressed at the plan-making and site-allocation stage, using shared intelligence across the Council to inform settlement strategy, housing mix and infrastructure priorities. The Group was concerned that rigid application of urban-focused assumptions around transport, walkability or density, without scope for justified local discretion, risks undermining rural social sustainability and exacerbating health inequalities rather than reducing them.

Community hubs and clusters as a mechanism for social sustainability

The Group heard evidence from the Leader that the hubs and clusters approach used in previous Local Plans provides a practical and health positive framework for supporting rural sustainability in Shropshire. Under this model, development is focused around a more sustainable settlement acting as a community hub, with surrounding villages and hamlets forming a functional cluster that collectively supports services, facilities and social networks.

Evidence highlighted that this approach enables smaller settlements to remain viable by contributing to the sustainability of shared schools, shops, transport links and community facilities, even where individual settlements would not meet conventional sustainability thresholds in isolation. The Group heard that this collective approach to sustainability helps retain families, carers and informal support networks, which in turn supports wellbeing and reduces isolation.

The Group noted that this approach aligns closely with the operation of Shropshire's Place Plans²⁰, which already organise growth, infrastructure priorities and community investment around hubs, clusters and their wider rural hinterlands. The Group therefore considers that clearer recognition of the hubs and clusters model within planning policy would support more consistent application of Health in All Policies principles across rural areas.

The role of rural exception sites and local needs housing

The Group heard evidence from the Leader of the Council that rural exception sites and local needs housing play an important role in supporting health, independence and social sustainability in Shropshire's villages and hamlets. Describing how exception sites can enable the delivery of affordable housing for local people who would otherwise be unable to remain in their communities, including carers, key workers, younger families and older residents seeking to downsize.

Evidence highlighted that, when appropriately located on the edge of existing settlements and supported by local lettings policies developed with parish councils, exception sites can sustain schools, local services and informal care networks. This approach was described as reducing isolation, supporting multigenerational living and helping to avoid the downstream costs associated with people being forced to relocate away from their communities and support networks²¹.

The Group noted concerns that without clear policy support within the Local Plan, the authority's previous success in utilising rural exception sites may be lost and local needs housing risk being constrained. The Group therefore considers this approach to be an important planning lever for supporting healthier, more resilient rural communities.

Viability, deliverability and unintended health consequences

The Group heard consistent evidence that viability is central to whether planning permissions translate into homes built. Officers and developers emphasised that cumulative policy requirements, if not carefully balanced, risk reducing land values, stalling delivery and encouraging land banking. Witnesses cautioned that aspirational policy targets which are not supported by local market evidence and viability assessment can result in planning approvals without corresponding build-out, ultimately worsening housing shortages and health outcomes.

While the ambition to increase the supply of affordable housing was acknowledged, the Group's evidence did not support a fixed percentage approach where this would undermine delivery. Witnesses emphasised the importance of viability-led, evidence-based policy, supported by ongoing monitoring, to ensure that planning ambition results in homes delivered rather than permissions stalled.

Viability emerged as a central and complex theme throughout the evidence sessions. Developers, planning officers and housing partners all recognised the importance of improving health outcomes through planning but cautioned that cumulative policy and regulatory requirements can undermine the deliverability of development if not carefully balanced.

Developers provided evidence of rising costs associated with Community Infrastructure Levy (particularly in rural areas), affordable housing contributions, building regulations, future standards, environmental requirements and the complexity of Section 106 agreements. They emphasised that while many health-promoting design principles are supported in principle, the cumulative impact of multiple requirements can reduce land values, deter investment, and delay or prevent schemes from being built.

The Group noted the paradox highlighted by several witnesses: if policy ambition results in fewer homes being delivered, the overall impact on health outcomes may be negative, as housing shortages, affordability pressures and unsuitable accommodation persist. Several witnesses warned that an over-reliance on aspirational policy without sufficient regard to viability risks increasing planning approvals without corresponding delivery, particularly in rural areas where infrastructure constraints are greatest.

The Group concluded that the recruitment of a dedicated operational officer to assist the planning team with viability assessments, working collaboratively with developers as part of Shropshire Councils new pre-application model could ensure that more planning approvals get 'built out' in a timely manner. The Group also concluded that active engagement between this person and relevant officers in the areas of public health and social care is vital and would mean that known needs could be identified and form part of the assessment process.

The value of early, collaborative engagement

One of the most consistent findings across all evidence sessions was the value of early, collaborative engagement between planning, Public Health, Adult Social Care, Children's Services, housing providers and developers. Witnesses described examples where early, round-table discussions enabled better design outcomes, improved understanding of health and care needs, and reduced conflict later in the planning process. Developers in particular contrasted these collaborative approaches adopted by Shropshire Council with

checklist-driven or late-stage requirements, which were seen as less effective and more adversarial.

Public Health officers emphasised the importance of clarity regarding expectations and capacity. While early Public Health input was evidenced as adding significant value to planning outcomes, witnesses highlighted that this must be proportionate and targeted. Evidence suggested that Public Health involvement should prioritise strategic policy development, plan making and higher impact or complex schemes, rather than routine review of all planning applications, to ensure that limited specialist capacity is used effectively. Furthermore, the Group recognised that officer capacity is a key consideration not just for Public Health, but across all council services involved in the planning process. It was agreed that resources should be deployed where they can add the most value, ensuring that specialist input is focused on areas of greatest need and impact, and avoiding unnecessary duplication or overextension of limited staff.

The Group heard that where health considerations are discussed early, they are more likely to be embedded meaningfully into site layout, housing mix and design, rather than treated as add-ons. This approach was seen as particularly important given the current limitations of policy weight.

The Group observed at Telford and Wrekin Council how early, cross-departmental engagement is embedded structurally rather than relying on informal relationships. Evidence from the Station Quarter development illustrated how Planning, Housing, Regeneration, Adult Social Care and Education work collaboratively from project inception, enabling health, accessibility, connectivity and prevention outcomes to be designed into the master planning stage rather than mitigated later. This whole-council approach was seen to reduce downstream costs, support deliverability and provide greater certainty for developers.

Drawing on this learning, the Group recognises that developing strong cross-service communication and a shared whole-council mindset is a key part of Shropshire Council's ongoing improvement journey, supported by both the Administration and senior officers. The Group considers this approach essential to achieving improved health outcomes and more effective, deliverable planning decisions in Shropshire.

Measuring impact

The Group found that, although there is a strong shared understanding of the relationship between planning, place and health, this is not yet matched by a clear or consistent approach to measuring the health impacts of planning decisions in practice.

Public Health officers advised that high-level population measures, such as life expectancy, are too blunt to reflect the contribution of planning policy over the short to

medium term. Instead, the Group heard that a more meaningful assessment of impact would focus on place-based and intermediate indicators that sit closer to planning decisions and the lived experience of residents. These include measures such as housing quality and energy efficiency, fuel poverty, accessibility and adaptability of homes, digital connectivity, access to services, green space and transport, and the stability and affordability of housing.

The Group heard that relevant data already exists across the Council, Public Health and NHS systems, including national Public Health Outcomes Framework indicators and local datasets relating to cost of living pressures, fuel poverty and housing need. However, this information is not routinely linked to planning decisions, site allocations or development outcomes, nor is it consistently monitored in a way that enables trends over time to be assessed or lessons to be drawn about which planning approaches are having the greatest preventative impact.

The Group heard that data sharing barriers, fragmented systems and the use of health data aggregated at wider geographies remain significant challenges, limiting the ability to draw direct causal links between specific planning interventions and health outcomes. However, the Group concluded that this should not preclude a more systematic approach to monitoring. Without clearer expectations, agreed indicators and baseline data, it remains difficult to assess whether Health in All Policies is being embedded consistently through planning practice, to understand where policies are working well, or to identify where targeted adjustments are needed to strengthen prevention and reduce future demand on health and care services.

7. Conclusions and Recommendations

Conclusion

Taken together, the evidence demonstrates strong support for embedding Health in All Policies (HiAP) within planning. Planning is clearly a critical lever for improving health, independence and equity in Shropshire, particularly for adults and children supported by social care. However, the Group found that current arrangements rely heavily on goodwill, early engagement and individual practice, rather than being underpinned by consistent and enforceable policy.

The interaction between health objectives, rural realities and development viability remains complex and, at times, unresolved. Without stronger alignment between planning policy, health outcomes and deliverability, there is a risk that planning decisions will continue to generate avoidable demand for health and care services rather than preventing it. The evidence highlights the importance of early, collaborative engagement to support better design outcomes, but also demonstrates the limitations of relying on process rather than policy to secure health benefits.

Whilst Shropshire's draft design guidance provides a strong foundation for healthier, inclusive and multigenerational communities, including proposals to increase the provision of accessible and adaptable homes through Building Regulations Part M standards. The Group heard that clear and explicit intent within the Local Plan is critical to ensuring that Health in All Policies principles are consistently applied in practice. Witnesses emphasised that a strong statement of purpose at the outset of the Plan can help articulate what the Council is seeking to achieve for Shropshire residents, including prevention, independence and reduced health inequalities, and can provide officers with the confidence to apply appropriate discretion within national policy parameters.

Evidence suggested that, in the absence of clear intent, planning decisions risk defaulting to narrow interpretations of national policy that may not reflect Shropshire's rural character or the Council's health and wellbeing objectives. The Group therefore considers that explicit articulation of health, social sustainability and local needs within the Local Plan is essential to embedding Health in All Policies in planning decision making.

Comparator evidence from Telford and Wrekin Council demonstrates that where Health in All Policies principles are embedded as part of whole council place shaping, housing delivery and planning alignment, it is possible to achieve both improved health outcomes and delivery at pace. The Group concludes that Shropshire can draw on this learning to inform its own approach, adapted appropriately to rural context and governance arrangements.

Lived experience evidence reinforces the urgency of increasing the supply of suitable, safe and adaptable homes, particularly for younger disabled adults and families with complex needs. Evidence from carers and residents demonstrates the direct harms that arise when appropriate housing is unavailable, including safety risks, loss of independence and disconnection from family and support networks. This evidence underlines the preventative value of designing adaptability into homes from the outset.

The Group concludes that clearer articulation of the hubs and clusters approach, alongside a stronger emphasis on social sustainability and the role of Place Plans, would strengthen the Local Plan's ability to embed Health in All Policies in rural planning decisions. This would support prevention, independence and reduced demand for health and care services, while reflecting Shropshire's rural character and community structures.

The Group concludes that Health Impact Assessment approaches can add value by supporting consistency, transparency and early consideration of health impacts. However, evidence from Public Health and Planning officers highlighted that recent national planning policy changes now limit the ability to mandate such assessments through local validation requirements.

The effectiveness and enforceability of any HIA approach is therefore dependent on it being clearly embedded within Local Plan policy, rather than applied through standalone guidance or checklist based processes. Any future HIA approach should be proportionate, clearly defined and aligned with national planning requirements to ensure clarity for applicants, decisionmakers and service areas involved.

The Group therefore supports a phased approach which focuses on strengthening existing design guidance in the short term, while considering whether additional health related policy provisions could add value through the emerging Local Plan once national requirements are clearer.

Overall, the Group concludes that embedding HiAP within planning policy supported by clear standards, proportionate assessment tools and deliverable requirements offers a significant opportunity to improve health outcomes, reduce inequalities and support independent living, while ensuring that planning decisions contribute to prevention rather than avoidable demand on health and care services.

Any recommendations arising from the Task and Finish Group report would need to be considered and, where appropriate, taken forward in a way that is consistent with the statutory planning framework, national policy, the Council's evidence base, viability and deliverability. Not all recommendations will necessarily be capable of being translated into enforceable planning policy and some may be more appropriately addressed through guidance, operational practice or wider corporate action.

The Group concludes that planning can only deliver Health in All Policies outcomes consistently where it is informed by timely intelligence, aligned strategies and shared ownership across the Council and its partners. Evidence demonstrated that without structured collaboration and clear policy intent, opportunities to embed prevention, social sustainability and inclusive design risk remaining fragmented and reactive, rather than systematic and preventative.

Recommendations

1. Formalise Strategic, Early, Cross-Service Engagement as Part of the Planning Process

Cabinet is recommended to support the formalisation of early, structured cross-service engagement between Planning, Public Health, Adult Social Care, Children's Services and Housing as a standard part of plan-making, through agreed governance, roles and trigger points, taking a coordinated whole-Council approach. Ensuring that whole-Council intelligence informs plan-making and site allocation at the earliest possible stage.

This should ensure that:

- people, families and communities are considered in the round, rather than through service silos;
- planning decisions reflect health, care, housing and economic impacts collectively; and
- collaboration moves beyond informal goodwill to a consistent, expected process.

2. Embed Health in All Policies as a Core Purpose of Planning

Cabinet is recommended to confirm that Health in All Policies (HiAP) is a core objective and guiding principle of planning policy and practice in Shropshire, recognising planning as an upstream public health intervention that supports prevention, independence and reduced demand on Adult Social Care and Children's Services. Taking the opportunity to clearly articulate this intent within the emerging Local Plan and reflected consistently in planning decision-making.

3. Improve Information and Early Advice for Foster Carers and Adopting Parents

Cabinet is recommended to ensure that clear, accessible information on pre-application planning advice is proactively provided to foster carers and adopting parents. This action supports placement stability, prevention and better outcomes for children and families.

4. Strengthen Policy Weight for Accessible and Adaptable Housing within the Local Plan

Cabinet is recommended to support the inclusion of clearer Local Plan policies on accessible and adaptable housing, including clear Local Plan expectations for Building Regulations Part M standards (M4(2) and M4(3)), justified by evidence and viability, and applied flexibly to reflect site context and local need, as opposed to a fixed percentage of adaptable homes.

Policy should:

- prioritise designing adaptability into homes from the outset;
- allow flexibility based on site context, local need and viability; and
- be supported by clear guidance to give confidence to decision-makers and applicants.

5. Reflect Rural Social Sustainability Explicitly within Planning Policy

Cabinet is recommended to ensure that the Local Plan explicitly reflects rural social sustainability, recognising Shropshire's geography and community structures.

This should include:

- clear articulation of the hubs and clusters approach;
- stronger alignment with Place Plans; and
- recognition of the role of local services, informal care networks and digital connectivity in supporting health and independence.

6. Reinforce Policy Support for Rural Exception Sites and Local Needs Housing

Cabinet is recommended to ensure that the Local Plan provides clear and supportive policy for rural exception sites and local needs housing, recognising their role in:

- enabling people to remain within their communities;
- supporting multigenerational living;
- sustaining local services and support networks; and
- preventing avoidable escalation into health and care services.

7. Deliverability and Transparency

Cabinet is recommended to ensure that Shropshire Council improves transparency and timeliness around CIL/S106 and related processes, addressing identified delays and improving understanding of local benefit and reducing barriers that risk undermining timely delivery of housing and infrastructure critical to health, independence and social sustainability, to support the delivery of healthy communities.

8. Ensure Specialist Viability Expertise within the Planning Process

Cabinet is recommended to ensure access to a dedicated specialist viability function to enable consistent and transparent assessment of development viability, particularly where health, accessibility and social sustainability objectives are relevant. This will:

- enhance early and constructive engagement with developers;
- provide decision-makers with greater confidence to balance policy ambition with deliverability; and

- address viability challenges on smaller and rural sites, supporting both housing delivery and positive health outcomes.

9. Measure and Monitor the Health Impacts of Planning

Cabinet is recommended to support the development of a proportionate approach to monitoring the health and wellbeing impacts of planning policy and planning decisions, using place-based and intermediate indicators (such as housing accessibility and adaptability, affordability, connectivity, access to services and community infrastructure), drawing on existing Council and Public Health data, to support transparency, learning and continuous improvement in embedding Health in All Policies through planning.

In developing its recommendations, the Task and Finish Group has deliberately focused on planning policy, guidance and governance arrangements, in line with its agreed Terms of Reference. While the Group heard wider evidence relating to housing allocation and lettings systems, housing delivery models and the operation of housing- and care-related processes, these matters sit outside the formal scope of this review and have therefore not been developed into recommendations.

The Group notes, however, that evidence in these areas raised substantive and recurring issues with clear implications for health, independence and prevention. These included the interaction between housing delivery and care needs, the practical operation of viability and delivery mechanisms, and the important role of parish-level engagement in shaping locally appropriate housing outcomes.

In particular, the Group heard evidence regarding the contribution of locally-based housing delivery partners, including STAR Housing and Cornovii Developments Ltd, in delivering accessible, adaptable and specialist homes aligned to local need. While housing delivery, ownership and allocation mechanisms fall outside the scope of this review, the Group considers that there would be value in further examining how such partners might play a more strategic role in supporting the future supply of specialist and supported housing.

This could include consideration of how planning policy, land identification, funding models and partnership arrangements might better enable locally-led delivery of homes that support independence, prevention and reduced demand for health and care services, particularly in rural areas. The Group therefore considers that this is an

appropriate area for further exploration through relevant scrutiny committees or other governance routes with responsibility for housing delivery and investment.

Appendices

Appendix 1

Below is a list of the witnesses that the Group heard from over the course of their work:

Cllr David Walker-Portfolio Holder for Planning (in person)

Amanda Allcock- Service Manager- Mental Health, Learning Disability, Preparation for Adulthood, Emergency Social Work Team (in person)

Louise Forbes- Service Manager, All Age Commissioning (in person)

Natasha Moody- Families First Partnership (FFP) Strategic Lead (in person)

Cllr Bernie Bentick-Portfolio Holder Health (in person)

Philip Northfield-Public Health Integration & Inequalities Officer (in person)

Tabitha Lythe-Planning and Development Services Manager (in person)

Edward West -Planned Policy & Strategy Manager (in person)

Andy Wigley-Policy and Environment Service Manager (in person)

Harpreet Rayet-Managing Director of Cornovii Developments Ltd (in person)

Jeremy Shingler-Managing Director Shingler Group (in person)

Adam Turnell-Shingler Group Architect and Landscape Architect (in person)

Richard McEvelly-Shingler Group Head of Land and Planning (in person)

James Dunn - Director - Prosperity & Investment, Telford and Wrekin Council (in person)

Kate Callis - Head of Service - Housing Investment Programme Telford and Wrekin Council (in person)

Joanne Cornwell - Housing Strategy and Commissioning Programme Manager Telford and Wrekin Council (in person)

Cllr Heather Kidd-Shropshire Council Leader (in person)

Richard Amos- STAR Trustee (in person)

Mark Feeney-Senior Development Manager for STAR (in person)

Kassandra Polyzoides- Service Director - Place Shaping (in person)

Appendix 2

Comparator Learning: Telford and Wrekin Council

As part of its evidence gathering, the Task and Finish Group visited Telford and Wrekin Council to examine how Health in All Policies principles are applied through planning, regeneration and housing delivery. The visit focused on the Station Quarter regeneration scheme and the role of the Council as project sponsor, planner and housing provider, including the delivery of accessible and adaptable homes through its wholly owned

housing company. The learning from this visit informed the Group's findings on early engagement, place shaping, deliverability and prevention.



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