

## **HEALTH & WELLBEING BOARD**

### **Minutes of a meeting of the Health & Wellbeing Board held on Thursday 19 March 2026 at 2.00 pm in the Council Chamber, Third Floor, Southwater One, Telford, TF3 4JG**

**Present:** Councillors A J Burford (Co-Chair), K Middleton, S J Reynolds, P Watling, N Lee, N Pay, C Parker, H Onions and J Suckling

**In Attendance:** L Gordon (Member Support Officer)

**Apologies for Absence:** Councillors S Whitehouse, K L Tomlinson, J Britton, E Hancox, F Mercer and J Williams

#### **HWB43 Declarations of Interest**

None.

#### **HWB44 Minutes of the Previous Meeting**

**RESOLVED** – that the minutes of the previous meeting held on 27 November 2025 be confirmed as a correct record and signed by the Chair.

#### **HWB45 Public Speaking**

None.

#### **HWB46 HWB Quarterly Strategy Progress Report**

The Service Delivery Manager Health Improvement & Prevention provided the Board with an update on partnership priorities and areas of work aligned to the Health and Wellbeing Board's strategic objectives.

Members were advised that significant work was underway to refresh the domestic abuse partnership strategy, incorporating learning and actions emerging from recent Board discussions. It was noted that referral levels have increased and that associated funding risks have been identified and escalated as part of the review process.

An update was provided on drugs and alcohol services, with a particular focus on work with young people. Members were informed that extensive engagement activity was taking place. The development of a recovery charter was highlighted as a key element of this work, with partners actively being supported to sign up. However, ongoing challenges were noted in securing engagement from the business community.

The Committee was advised of the progress of healthy weight initiatives across the borough, with a strong emphasis on peer support and a holistic

approach. Close working with schools was highlighted, alongside efforts to improve engagement with families, particularly those who can be hard to reach. Positive progress was reported in work supporting individuals with learning disabilities.

An update was also provided on the TWIPP programme, which was reported to be strongly aligned with the Health and Wellbeing Board's priorities. Members heard that a well-attended workshop involving over fifty participants had recently taken place, demonstrating strong partnership engagement and collaboration. This work is focused on developing a shared vision and identifying realistic priorities for the next six to nine months.

Members were informed that new national neighbourhood health guidance had been released during the week. It was noted that this will require consideration of future changes and an assessment of forthcoming national expectations and policy direction.

The Committee was advised that a summary of the new neighbourhood health framework had been prepared and could be circulated to members, recognising the length and complexity of the full guidance. It was emphasised that the Health and Wellbeing Board will have a critical role in driving implementation of this agenda. The importance of funding mechanisms was highlighted, including a shift of £2.9 million in recurring funding, which presents opportunities for longer-term planning and transformational change. It was suggested that this could be explored further through a dedicated Health and Wellbeing Board workshop.

Discussion followed regarding the importance of using available funding to reduce barriers to progress and to enable meaningful system change. Concerns were raised about current capacity constraints and the need for the Board to remain accountable for supporting necessary reframing and transformation of services.

Members reflected on the importance of tracking outcomes effectively, particularly in relation to the shift towards prevention and the impact on primary care, acute services, and emergency care. It was also noted that further collaboration will be required as local provider organisations come together under a new community and hospital trust arrangement.

The Committee welcomed the alignment between the neighbourhood health approach and wider system priorities, including the emphasis on community-based, bottom-up change. Members highlighted the need to understand budgets more clearly in order to support the reallocation of resources and to drive delivery at a local level. Clarification was provided that the voluntary and community sector has been involved in the development of the recovery charter and had made a valuable contribution.

The strengthening of the Health and Wellbeing Board's role through the neighbourhood framework was welcomed, with members emphasising the importance of partnership working at neighbourhood level. Updates were also

noted regarding ongoing structural changes within the Integrated Care Board, with further clarity expected over the coming months.

Members reflected on the importance of understanding the limitations imposed by short-term funding arrangements and the benefits that additional capacity and sustained investment could bring. It was emphasised that recognising the context in which services operate, alongside building on examples of good practice such as healthy weight initiatives, will be essential in supporting future delivery and enabling continued progress.

#### **HWB47 TWIPP Prevention Projects Update**

The Committee received a report for information providing an update on prevention projects funded through the TWIPP programme over the past year. The Service Delivery Manager Health Improvement & Prevention presented a summary of the work undertaken, outlining that the projects build on the wider TWIPP programme and focus on prevention. Members were advised that £333,000 of Integrated Care Board funding had been allocated through an agreed process to seven separate prevention projects. A key element of the programme has been the development of relationships and collaboration across the funded projects.

The Committee was provided with examples of the funded initiatives, including a Calm Café model designed to support people in crisis, with consideration given to younger age groups. Live Well Community Hubs were highlighted as a mechanism for bringing a range of services together under a single, accessible offer. The Healthy Hearts Bus was described as a highly neighbourhood-focused initiative, linking healthy lifestyle services with NHS outreach teams in order to deliver care directly within communities. Group Lifestyle Clinics were also discussed, with early learning suggesting that individuals can be more successful in adopting healthy behaviour changes when supported through a group-based approach.

Members noted that the programme has a strong emphasis on collaboration and partnership working, with a person-centred and inclusive approach rooted in close working with the voluntary and community sector. A communications and engagement campaign was undertaken to provide consistent messaging across partners, and the Committee was advised that the initial healthy conversations campaign achieved a strong level of reach and engagement.

The Service Delivery Manager Health Improvement & Prevention outlined that innovation continues to be encouraged across the system, with ongoing conversations about the sustainability of prevention initiatives. Challenges were acknowledged, particularly in relation to capacity within voluntary sector organisations, many of which are keen to expand their involvement but lack the resources to do so. It was also noted that targeting specific populations can present difficulties in reaching and engaging communities effectively.

The Committee discussed the importance of funding arrangements and the expectation that investment of this nature demonstrates proof of concept. It

was emphasised that learning from the funded projects, alongside robust measurement of impact, must be captured and progressed through Integrated Care Board processes to support longer-term sustainability. Members were advised that recurrent funding has now been secured for community blood pressure activity, reflecting the impact of earlier commitments.

Discussion followed regarding data and system challenges, particularly the extent to which incompatibility between systems creates barriers to effective service delivery. The Committee was informed that, in areas such as NHS Health Checks and healthy heart programmes, follow-up lifestyle conversations are delivered collaboratively, but information must be recorded on multiple systems. This can result in data not aligning fully between local authority and NHS systems.

Members noted that digital transformation is a key theme within the neighbourhood health framework and that work is underway to streamline data-sharing processes. This activity is progressing in parallel with neighbouring areas and is considered to be relatively advanced. The Committee acknowledged that multidisciplinary data-sharing is inherently complex, but also recognised the importance of using data to inform targeted interventions and trusting partners across the system to share intelligence appropriately.

Live Well Community Hubs were identified as a positive example of integrated working, with members noting the importance of embedding this approach into day-to-day practice rather than relying solely on discrete events. The Committee reflected on the benefits of offering people choice in how they access support, including both digital and face-to-face options, and the value this brings in building relationships between service providers and communities. Opportunities for services to learn from one another through this approach were also highlighted.

Further discussion focused on technological barriers, with members agreeing that greater clarity is needed on the specific issues hindering progress. The need for appropriate access to shared records across NHS services was highlighted, alongside the importance of collecting data in a consistent way across partners to enable meaningful analysis. Potential investment in digital solutions was noted, and members acknowledged the short timescales within which the funding was allocated, commending the work undertaken to develop and deliver successful projects in that context.

The Committee considered the role of the voluntary sector in supporting neighbourhood-based working, recognising both the challenges and areas of emerging best practice. It was suggested that a future update be provided to the Board on progress with the development of a shared single health record, including learning from pilot activity in other areas and an overview of resource and capacity implications.

Members welcomed the proposal for further updates, noting that while local public health data is strong, combining this with NHS data would provide a

more complete and actionable intelligence base. The importance of data in demonstrating impact was emphasised, alongside the recognition that increased community engagement not only improves data quality but also contributes to alleviating pressure on other parts of the system.

#### **HWB48 JSNA Update: Pharmacy Needs Assessment**

The Director of Public Health informed Members that the Pharmaceutical Needs Assessment (PNA) was a statutory requirement of the Board and an essential tool for planning pharmaceutical services. It was noted that while some services were provided by the Local Authority, the majority were commissioned by the NHS. This was the fourth PNA undertaken locally, following three previous assessments. The Board was advised that the target was for the document to be published by the end of March.

It was reported that a statutory consultation had taken place between 9 January and 10 March, involving statutory consultees as well as the wider public, with four formal responses received. The current PNA had been informed by a review of progress against recommendations from the previous three years. It was also noted that Power BI dashboards had been used for the first time to support analysis and presentation.

The Insight Partner outlined the methodology used in developing the PNA, explaining that the borough had been divided into four localities based on population demographics, rural and urban characteristics, and transport and infrastructure. These geographies aligned with Census data and Office for National Statistics datasets, enabling robust and consistent analysis.

The key health needs identified through the assessment showed that the borough's population was both growing and ageing at a rate above the national average. The population was also becoming more diverse, with 17 percent of residents identified as being from diverse backgrounds, compared to 11 percent in the 2011 Census. Despite these changes, significant health inequalities remained, with some neighbourhoods continuing to experience levels of deprivation below national benchmarks.

Members heard that Power BI dashboards had been used to undertake detailed data analysis, bringing together multiple datasets to support the PNA. The dashboards would be publicly available, improving transparency and accessibility, and would allow users to filter information interactively down to locality level.

In terms of access to pharmacy services, it was noted that almost all households within the borough were located within a six-mile radius of a community pharmacy, with the exception of approximately 30 households. All areas were within a 20-minute travel time by car, based on varying travel conditions. Overall, pharmacy provision across Telford and Wrekin was assessed as good. However, it was highlighted that provision on Sunday evenings was more limited, with travel times increasing up to 30 minutes in some areas, presenting a challenge for access.

The Board was also informed of a recent notification that Donnington Pharmacy would cease provision, resulting in the loss of 89 hours of service. It was acknowledged that this development would impact the PNA and that the document would need to be updated to reflect this change.

The discussion emphasised the importance of ensuring that the PNA provided a robust and defensible assessment of pharmaceutical provision across the borough in order to give assurance to the NHS, the Health and Wellbeing Board and the Local Authority. It was recognised that while the document currently set out a detailed assessment, further recommendations would strengthen its position, particularly in response to consultation feedback.

Members noted that current regulatory frameworks and commissioning arrangements meant that the Board's position needed to be clearly articulated within the PNA. Concerns were raised regarding the national pharmacy contract, which was considered to remain heavily focused on dispensing volume rather than broader service provision and health outcomes. Particular attention was drawn to the ongoing challenge of Sunday evening access and the need to consider neighbourhood-level impacts when planning services. It was suggested that there may be value in advocating to national government for reforms to the pharmacy contract to better reflect local needs and population health outcomes.

The discussion also highlighted the important role of pharmacy services in supporting wider health outcomes, including the development of the "Pharmacy First" approach. It was noted that this area had already been subject to scrutiny and remained a key area of focus for improving access to care and supporting preventative health work.

Board members agreed that the PNA was an important and critical piece of work and that it was necessary to agree a clear recommendation.

**RESOLVED** – that the Telford & Wrekin Pharmaceutical Needs Assessment for 2026/27-2028/29 be approved for publication.

#### **HWB49 Best Start in Life Delivery Plan**

The Board received an update on the development of the plan to deliver the Good Level of Development (GLD) targets. The Board was informed that work on the GLD plan had been progressing through a dedicated working group over the past year. It was noted that GLD formed part of the Government's Opportunity Mission and was measured by the Department for Education through 12 early learning goals across five key areas of development.

An overview of local performance was provided, with confirmation that 67.3 percent of children had achieved GLD in 2024/25. This figure was approximately one percent below the national average. It was noted that the local target had not been formally challenged with the Department for

Education. The plan included a narrative ambition that children who had not reached GLD by age five would achieve this by the age of five and a half.

Further performance data was presented, indicating that 50.6 percent of five-year-olds had met GLD in the previous year, with an ambition to increase this to 64.6 percent. The Board was advised that the approach was strongly intelligence-led, with detailed profiling used to understand performance variations, including those linked to deprivation, gender, and the readiness of summer-born boys for school.

The role of Family Hubs was outlined as a central component in supporting GLD outcomes. It was explained that the Department for Education prescribed a clear delivery framework for Family Hubs, including a set of required services. The local model involved a highly collaborative partnership approach, with hub locations focused within the 30 percent most deprived areas, while also considering both need and demand.

The partnership landscape was also highlighted, with emphasis placed on both current collaboration and future plans. While the primary focus remained on GLD outcomes, equal importance was given to wider early years priorities, including oral health and the broader “best start in life” agenda.

The themes within the delivery plan were presented, including a continued shift toward a more data and intelligence-led approach. Work was underway to map outcomes from Early Years Foundation Stage settings and to strengthen the approach to the two to two-and-a-half-year developmental checks. This work aligned with the “Critical Six” priorities for 2026, with a particular focus on increasing uptake of health visiting checks through targeted thematic work. The model included a universal offer delivered through Family Hubs and partner services, alongside exploration of a more integrated, multi-disciplinary approach to improve pathways from early childhood onwards.

It was reported that speech and language development was currently the lowest-performing area across the five key themes. The ongoing impact of the COVID-19 pandemic was identified as a significant contributing factor, and this area had therefore been prioritised within the plan, including through work linked to the Families First Partnership and Family Hubs.

The Board was advised that the Families First Partnership provided strategic oversight of this work. It was also highlighted that the co-location of health visitors within Family Hubs had been positively received. In addition, the “5 by 5” initiative aimed to promote activity and outdoor experiences for young children and was being promoted universally across the borough.

The discussion recognised the importance of early years development and acknowledged that the partnership approach had delivered positive progress across a number of areas. However, it was noted that achieving the required step change to meet the ambitious GLD targets would require further strengthening of delivery and impact.

It was suggested that a more comprehensive and coordinated approach would be necessary, building on previous pilot programmes while ensuring greater consistency and scale. The importance of working closely with parents and carers to improve understanding of early childhood development was highlighted, alongside the need to continue raising the profile of the agenda among both professionals and families. The role of additional funding in supporting delivery was also acknowledged, as well as the importance of effective partnership working.

Attention was drawn to workforce challenges, particularly in relation to speech and language therapy within the NHS. It was suggested that greater use could be made of wider support roles, including teaching assistants and school-based staff working with children with special educational needs and disabilities, to help address capacity issues.

In response, it was noted that existing programmes aimed at upskilling the wider workforce formed part of the action plan, including activity linked to national initiatives. It was also confirmed that the forthcoming Special Educational Needs and Disabilities (SEND) report would align with this work and would be published at a similar time.

The Board was advised that the plan was scheduled for publication on 31 March, with consideration by Cabinet to follow in April. It was noted that additional time had been built into the process to allow for thorough partnership engagement and detailed review prior to publication. The plan would be brought back to the Board following publication.

#### **HWB50 Cardiovascular, Renal and Metabolism (CVRM) Strategy**

The Board was provided with an overview of the CVRM Strategy, which had expanded the existing cardiovascular prevention strategy to incorporate renal conditions and diabetes. This broader approach reflected the interconnected nature of these conditions and aimed to address multi-morbidity pathways more effectively. It was reported that there were strong clinical links between these conditions, with evidence presented that approximately 50 percent of people with heart failure also had diabetes.

The strategy was described as encompassing the full pathway from prevention through to intervention and specialist services. A key principle of delivery was the provision of care closer to home, supporting a shift toward community-based models of care.

The Board was advised that work was underway to align existing programmes and initiatives within a unified strategic framework. Analytical support from the Business Intelligence team had enabled further exploration of the relationship between preventative interventions, such as smoking cessation, and their impact on hospital bed usage and associated costs.

It was highlighted that the first year of delivery would focus on embedding the strategy and aligning system-wide activity. Future work would consider scalability and long-term sustainability. Particular attention would be given to diabetes management, including reducing the risk of complications such as amputation, and strengthening links to primary care services.

It was suggested that a further report should be brought back to the Board after the first year of implementation to assess progress and outcomes.

The discussion supported the strategic direction of the CVRM approach and emphasised the importance of establishing clear milestones and key performance indicators to measure progress over the first year. It was noted that the integration of services and the focus on prevention aligned with broader system priorities.

The importance of community-led approaches was highlighted, with recognition of the role of primary care, NHS Health Checks and wider prevention programmes in supporting improved cardiovascular health outcomes. It was further noted that this work demonstrated the value of collaboration across the system.

The discussion also acknowledged the increasing complexity of patient needs, particularly within acute hospital settings, where demand for general medicine services had grown. It was recognised that a more integrated, patient-centred approach was required, focusing on planned care and prevention rather than reactive, emergency-based interventions. The shift from acute to community-based care was identified as a key objective of the strategy.

**RESOLVED** – that:

- a) The CVRM Strategy and Delivery Plan be endorsed for system-wide implementation
- b) The governance arrangements and year one milestones be approved
- c) Development of neighbourhoods-level action plans and BI dashboards to monitor KPIs be supported.

**HWB51 Healthwatch Update**

The Board received a briefing note outlining Healthwatch activity over the previous six months and proposed plans for 2026/2027. The Board was advised that some updates had occurred since the briefing note had been prepared. It was reported that Healthwatch had continued to focus on improving patient experience and ensuring that community voices were heard and represented in key decision-making processes.

It was noted that the appointment of a part-time Engagement Officer had increased organisational capacity, enabling broader and more targeted engagement activity. Recent visits had included the hospice and the Community Diagnostic Centre.

The Board was informed that project work had included a focus on veterans, with engagement undertaken through community groups and the completion of a survey. This survey would be made publicly available following Board approval.

A discharge project, which had been ongoing for the past 18 months, was reported to be nearing completion. In addition, Healthwatch had revisited the Emergency Department at Princess Royal Hospital, with the resulting report shared with the Trust. A response had been received in the form of an action plan. A related survey report had also been produced and was currently being reviewed with staff.

At the time of reporting, a total of 976 residents had been engaged. Feedback gathered through this engagement had identified several recurring themes, including access to GP services, long waiting times in Emergency Departments, access to NHS dental services, outpatient waiting times, and more recently, concerns regarding car parking at Princess Royal Hospital. It was also reported that Healthwatch had undertaken 18 formal visits, in addition to four further visits, to hospital sites. In most cases, recommendations arising from Enter and View visits had either been implemented or had received further explanatory context from service providers.

The Board was advised that Healthwatch would continue its work over the next 12 months, with a greater focus on smaller, shorter projects designed to maximise impact. Planned activity included targeted engagement, ongoing Enter and View visits, and evaluation of the impact of previous projects. It was noted that a report on the Pharmacy First initiative had been produced in 2024, and that further work was underway to review pharmacy provision in this area. Healthwatch had also contributed to the Pharmaceutical Needs Assessment consultation and was developing a report highlighting key successes.

Future work would include the development of intelligence reports to support system understanding and decision-making.

The discussion highlighted the value of an independent, intelligence-led approach in gathering community insight and informing health and care services. It was recognised that this role remained essential in ensuring that patient voices continued to influence service planning and delivery. The Board expressed support for the continuation of this work and the increased capacity that had enabled further engagement.

The importance of maintaining an independent perspective was emphasised, alongside recognition of the effectiveness of the work undertaken to date. The contribution of Healthwatch to recent work, including the Pharmaceutical Needs Assessment, was acknowledged. It was noted that while direct engagement for that consultation had been limited, previous Healthwatch findings had informed the process, particularly in relation to issues such as the privacy of consultation rooms within pharmacies.

An update was provided regarding concerns raised around car parking at Princess Royal Hospital, with confirmation that a programme of work was underway and that affected spaces would be reinstated. It was also reported that outpatient waiting times remained an issue, although performance had shown improvement, including within cancer pathways, and continued to improve on a weekly basis.

The Board noted the update for assurance.

**HWB52    Safeguarding Children's Board Annual Report**

This item was for information only.

**HWB53    Chairs Update**

The Chair thanked Co-Chair Simon Whitehouse, who was stepping down from his position on the Board for his contributions to the Board.

The meeting ended at 3.50 pm

**Chairman:** .....

**Date:**            Thursday 18 June 2026