Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 9 November 2022

Committee:
Health and Wellbeing Board

Date: **Thursday, 17 November 2022**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting. The Agenda is attached

There will be some access to the meeting room for members of the press and public, but this will be limited. If you wish to attend the meeting please email democracy@shropshire.gov.uk to check that a seat will be available for you.

Please click here to view the livestream of the meeting on the date and time stated on the agenda

The recording of the event will also be made available shortly after the meeting on the Shropshire Council Youtube Channel Here

Tim Collard
Assistant Director - Legal and Governance

Members of Health and Wellbeing Board

Simon P Jones – PFH Adult Social Care and Public Health (Chair)
Kirstie Hurst-Knight – PFH Children & Education
Cecelia Motley – PFH Health (integrated Care System – ICS) & Communities

Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Tyler – Assistant Director - Joint Commissioning
Laura Fisher – Housing Services Manager, Shropshire Council

Simon Whitehouse – Accountable Officer / Executive Lead Shropshire, Telford and Wrekin Integrated Care System
Claire Parker – Director of Partnerships

Patricia Davies - Chief Executive, Shropshire Community Health Trust
Zafar Iqbal - Non-Executive Director, Midlands Partnership NHS Foundation Trust
Nigel Lee - Interim Director of Strategy and Partnerships, Shrewsbury & Telford Hospital Trust
Sara Ellis - Robert Jones & Agnes Hunt Orthopedic Hospital NHS Foundation Trust

Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Shropshire Partners in Care
Stuart Bills - Superintendent, West Mercia Police
Mark Docherty - Executive Director of Nursing and Clinical Commissioning WMAS

Your Committee Officer is Michelle Dulson
Tel: 01743 257719 Email: michelle.dulson@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosable Interests

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

3 Minutes of the previous meeting (Pages 1 - 10)

To confirm as a correct record the minutes of the meeting held on 8 September 2022 (attached).
Contact: Michelle Dulson Tel 01743 257719

4 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. The deadline for this meeting is 5.00pm on Friday 11 November 2022.

5 System Update (Pages 11 - 70)

ICS updates
Nicola Dymond, ICB Director of Strategy and Integration

Shropshire Integrated Place Partnership (ShIPP) update
Penny Bason, Head of Joint Partnerships, Shropshire Council and NHS Shropshire, Telford and Wrekin

Joint Commissioning Board/Better Care Fund (BCF)
Laura Tyler, Assistant Director, Joint Commissioning, Shropshire Council and NHS Shropshire, Telford & Wrekin
Penny Bason, Head of Joint Partnerships, Shropshire Council and NHS Shropshire, Telford and Wrekin

Healthy Lives Update
Val Cross, Health and Wellbeing Strategic Manager, Shropshire Council

6 **Inequalities Plan** (Pages 71 - 312)

Berni Lee, Consultant in Public Health, Shropshire Council

7 **Cost of Living Crisis** (Pages 313 - 340)

Emily Fay, Programme Manager (Shaping Places for Healthier Lives: Food Insecurity), Shropshire Council

8 **JSNA update** (Pages 341 - 360)

Rachel Robinson, Director of Public Health, Shropshire Council
Alex McLellan, Public Health Intelligence Manager, Shropshire Council

9 **Health Protection update** (Pages 361 - 366)

Rachel Robinson, Director of Public Health, Shropshire Council

10 **Air Quality update Paper for information** (Pages 367 - 370)

Toby Pierce, PPO – Professional, Environmental Protection, Shropshire Council

11 **Chairman's Updates**

Shropshire Council

Committee and Date

Health and Wellbeing Board

17 November 2022

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 8 SEPTEMBER 2022
9.30 - 11.35 AM

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

Present

Simon Whitehouse – Accountable Officer / Executive Lead Shropshire, Telford and Wrekin Integrated Care System – Acting Chair for this meeting
Simon P Jones – PFH Adult Social Care and Public Health (Chair) present for part of meeting
Kirstie Hurst-Knight – PFH Children & Education
Cecilia Motley – PFH Communities, Culture, Leisure, Tourism & Transport
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Fisher – Housing Services Manager, Shropshire Council (virtual)
Angie Wallace - Shropshire Community Health Trust (substitute) (virtual)
Shirley-Ann Cavill – SaTH (substitute) (virtual)
Lynn Cawley - Chief Officer, Shropshire Healthwatch (virtual)
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Shropshire Partners in Care
Ben Hollands – Health and Wellbeing Strategy Implementation Manager, Midlands Partnership NHS Foundation Trust (virtual)

25 **Election of Chairman**

In the absence of the Chairman for part of the meeting, it was moved, seconded and

RESOLVED: That Simon Whitehead be elected Chairman for this meeting.

26 **Apologies for Absence and Substitutions**

Patricia Davies - Chief Executive, Shropshire Community Health Trust
Nigel Lee - Interim Director of Strategy and Partnerships, SaTH
Stuart Bills - Superintendent, West Mercia Police

Substitutes:

Angie Wallace - Shropshire Community Health Trust (substitute) (virtual)
Shirley-Ann Cavill – SaTH (substitute) (virtual)

27 **Disclosable Interests**

None received.

28 **Minutes of the previous meeting**

RESOLVED: that the Minutes of the previous meetings held on 19 May 2022 and 14 July 2022 be agreed and signed by the Chairman as a correct record.

29 **Public Question Time**

No public questions were received.

30 **System Update**

Urgent and Emergency Care Plan update – Winter plan

This item was deferred to the next meeting.

ICS Update

The Board received the report of the ICB Director of Strategy and Integration – copy attached to signed Minutes – which provided an update to the summary of the Integrated Care System (ICS) development programme across Shropshire, Telford and Wrekin presented at the last meeting of the Board and gave an update on the establishment of statutory functions of the ICS, specifically the creation of the Integrated Care Partnership (ICP) and the development of the integration strategy for Shropshire, Telford and Wrekin.

The Director of Strategy and Integration introduced and expanded on the report and provided more information around where they were with the establishment of the statutory functions within the ICS and particularly that of the ICP. She drew attention to the diagram on page 3 of the report which set out a breakdown of the key points to know around the ICP. The ICPs would play a critical role in bringing together health leaders and local authorities to start to think 'out of the box' around some of the solutions for Health and Wellbeing whilst addressing any inequalities. She went on to describe the next steps including development of the Interim Integrated Care Strategy. She explained that the ICB would have an ongoing role in shaping that interim plan and the longer-term five-year view of what those priorities were and how to take them forward.

It was hoped that the first ICP meeting would be chaired by Telford and Wrekin Council on the 6 October 2022. The Terms of Reference for both Health and Wellbeing Boards were being considered in shaping the Terms of Reference for the ICP and it was hoped to publish those draft Terms of Reference shortly. The first meeting of the ICP would be discussed at the next meeting of the HWBB.

The Executive Director of Health, Wellbeing and Public Health reassured the Board that it would have sight of the draft Strategy at its next meeting in November as it would be a priority for the Board. The Director of Strategy and Integration stressed the importance of not seeing the Strategy as the final point and that it was interim and a blueprint process with many more opportunities between now and March for the partnership to put the meat on the bones of those initial priorities and plans.

RESOLVED: That the Board note:

1) the detail contained in the report;
2) the statutory requirements for ICBs and LA's, as core members of the system wide ICP, to develop an Integrated Care Strategy;
3) that this strategy must be informed by the work of the HWBBs and through engagement with local partners and communities;
4) the proposed Terms of Reference of the Shropshire, Telford, and Wrekin ICP (attached
as an appendix to the report).

Shaping Places

The Board had received a paper, for information, on Shaping Places for Healthier Lives which was a three-year programme funded by the Health Foundation in partnership with the Local Government Association, for which Shropshire was one of five council areas in England to win the funding after a three-stage application process.

The Executive Director of Health, Wellbeing and Public Health highlighted the two training sessions that had been developed within Shropshire with the voluntary sector, Shropshire Council and all its partners, there was limited capacity and everything people needed to know would be in these sessions which would be recorded. It was for frontline staff, members and volunteers across the whole system. She agreed to bring an update on the social taskforce to the next meeting of the Board.

A brief discussion ensued in relation to rural poverty and the recognition by government of rural deprivation.

31 **Innovative practice - Digital report (deferred from last meeting)**

The Board received the report of the Digital Champion Lead – copy attached to the signed Minutes – which updated members on the Shropshire Council Digital Skills Programme. The Customer Services Manager introduced and amplified the report. He reported that the programme had had some very positive outcomes due wholly to the efforts of the Digital Champion Lead who had set up the initial pilot and had kept it going throughout the pandemic but also managed to expand it and commissioned the providers as well as monitoring the outcomes.

The Customer Service Manager highlighted the significance of the project in helping people to use the internet which had a very unique payback because, more than any other medium, the internet could bring the outside world into somebody's home, turning their four walls into four windows instead. It was felt that the benefits of this project was the familiarity of having broadband and the technology to access the internet and could help people who were otherwise very isolated and vulnerable to stay safe and independent in their own homes. It was hoped that the work would continue and that the project would be delivered to 500 people by the end of March 2023.

The Board thanked the Customer Service Manager and the Digital Champion Lead

for their report. It was felt that the real-life case studies really brought the paper to life, especially the impact that it had had on them. In response to a query about how this project would be upscaled, the Customer Service Manager expressed his hope that the project would be rolled out more widely and that investment in the region of £80,000 would be required for salaries and equipment etc in order to reach twice as many people. It was hoped that this project would assist older people to manage their health care differently, for example booking GP appointments on-line and ordering prescriptions etc.

Concern was raised in relation to deprivation, access to Wi-Fi, mobile phones with data etc. In response, the Customer Service Manager explained that it was a concern however there were some good broadband deals around and that some customers did have their own IT equipment but didn't know how to use it, whilst some equipment had been provided via grants and that going forward it would be a mix of the same. The Customer Services Manager would update members around the level of uptake and the level of skills increase. The Executive Director of Health, Wellbeing and Public Health felt the report highlighted how a small amount of investment could offset a huge amount of health and wellbeing costs further down the line.

RESOLVED:

The Board noted the contents of the report and the innovative work taking place.

32 **Severe Mental Illness and Complex need. A Qualitative review of service user experience.**

The Population Health Fellow for Shropshire Council gave a presentation following a qualitative review of patient experiences of services in the Shropshire, Telford and Wrekin area – copy of slides attached the signed Minutes – and which covered the following areas:

- Definitions of severe mental illness and complex need
- Project roll out
- Survey Results and emerging themes
- Semi structured interview results and emerging themes
- Overview
- Key recommendations and questions

The Population Health Fellow drew attention to the survey results. When asked how easy or difficult it was to get help, 48% felt it was difficult or extremely difficult to get help due to a number of reasons, including a poor understanding of the help that was available, long waiting lists, lack of trust and poor communication. It was felt that unless someone was very sick, they would be bounced around a lot of different services and would not get the help needed.

Other themes that emerged from the project included the inappropriate use of services that did not meet the needs of service users, connections between services whereby voluntary organisations and GP services had slightly more positive feedback, whereas the feedback for mental health services ranged from very positive

to less positive and the crisis emergency services flagged up more negative experiences. The same trend emerged when asked to consider how their treatment had been tailored to their individual needs.

It was felt that people's negative experiences were in part due to service delivery concerns and that the system was over capacity with long waiting lists and inappropriate services for their needs. Staff concerns were also picked up and it was felt that if these concerns were addressed this would naturally translate to better patient experiences. The Population Health Fellow then drew attention to the real-life stories set out in the slides, in particular the respondent who needed help with managing their finances and taking public transport which highlighted a theme around gaps in life and/or social skills.

Turning to the semi-structured interview results, a lot of similar themes arose including long waiting lists, lack of support in between treatments, which was where the voluntary sector came in with more positive feedback. Some of the things that it was felt would improve patient experience of care for their particular needs included more patience, more professional and more access.

As a whole it was felt that there was generally a lot of good work happening, but they were not as connected or as streamlined as maybe the physical health services were. The Population Health Fellow drew attention to the recommendations set out in the slides.

The Chairman thanked the Population Health Fellow for her presentation which really brought the slides to life and highlighted the need for integration and better connectivity of services. He felt there was a role here for the NHS around integration and how to bring physical health services and mental health services together in a more equitable way, along with a role for the NHS and its broader partners e.g. social care, local authorities, voluntary/community sector in order to get a better outcome for the population that was served.

A brief discussion ensued in relation to the work currently ongoing in relation to the issues raised. It was agreed for the work that has been done to be fed through into the structures already in place and have conversations around the transformation programme that was in place across the mental health services and connect those parts of the conversation. The Head of Joint Partnerships drew attention to social prescribers who were available in all GP practices and had a wealth of knowledge around what was happening in those communities along with care coordinators whom GPs could refer patients. She informed the Board of an awareness raising event on 10 October in Shrewsbury Abbey, which would have all kinds of voluntary sector organisations as a marketplace for all staff across all services, to see what all those organisations were doing and the connections between those organisations.

The Head of Joint Partnerships thanked the Population Health Fellow for her work which was part of a national programme funded by Health Education England, part of which involved taking part in workshops around population health and what that means and how to analyse population health. The work undertaken would be a good launch pad to really do something about improving work around integration and the work that was already being done.

33 The Khan review: making smoking obsolete

The Board received the report of the Consultant in Public Health and the Public Health trainee – copy attached to the signed Minutes – which provided a brief summary of the Khan review into making smoking obsolete which concluded that the government target for smokefree 2030 would be missed by at least 7 years. The report also outlined the burden of smoking and smoking-related ill health and health inequalities in Shropshire. It summarised the current tobacco control efforts in Shropshire and highlighted the recommendations contained in the Khan report.

The Public Health trainee gave a presentation – copy of slides attached to the signed Minutes – and highlighted the implications of the Khan Review for Shropshire. She reported that smoking was the biggest single cause of illness and death nationally and that although the numbers of people smoking in the UK (14%) had come down since the 1970s and 1980s due in part to tobacco control, the numbers were still significant.

The Public Health trainee drew attention to the smoking burden in Shropshire and how that compared to the national average and to the Council's 15 nearest neighbours. Smoking prevalence in Shropshire was similar to the national picture, however hospital admissions were higher in Shropshire than the national average and higher than other local authorities and perhaps not performing as well as it might.

Whereas smoking in Shropshire was similar to what it was nationally, it could be seen that for some particular groups it was a health inequality issue and that the smoking prevalence in those particular groups was high in Shropshire and higher than the national average. This suggested that there were some particularly at-risk groups in Shropshire who were really affected by the health inequalities related to smoking.

The Public Health trainee looked at what smoking really costs us as a society not just in terms of health and social care, but in terms of productivity and loss of earnings. Shropshire were currently spending around £14-16m so this was a significant issue for Shropshire. She then went into more detail around the Khan review of the smoke free 2030 ambition set out by government in 2019 that had been published earlier in the year. The main headline from the report was that the target was going to be missed by at least seven years and for those who were most deprived in society, that target would not be met until 2044.

The Public Health trainee drew attention to the main recommendations of the review which focussed on strengthening tobacco control and the critical recommendations contained within the pictorial illustration of what the review was all about. The critical recommendations were 'must do now' recommendations that would have the most impact.

The Public Health trainee informed that Board of the work currently being undertaken within Shropshire to tackle smoking and smoking related inequalities which fell into four main areas, the first being tobacco control led by trading standards including enforcement activities which disrupted the supply chain of illegal tobacco and

particularly identifying, detecting and preventing the sale to minors. The second area was the tobacco dependency treatment programme, which was part of the NHS long-term plan, the third point was the new national scheme for community pharmacies to provide follow-up post-discharge community support. The final area was local authority level support, including the social prescribing service. There were also plans in place to operate a new service looking at behavioural support for those discharged from mental health inpatient treatment.

Concern was raised about the recommendation of offering vaping as an alternative as it was felt that the impact and consequences of vaping were not yet know and that schools were reporting a significant rise in the number of quite young children now vaping rather than smoking. In response, the Public Health trainee reported that Public Health England were very clear that vaping was not risk free and that research was emerging about the potential risks of vaping and research that she had seen had shown that vaping was about a third as dangerous as smoking as there weren't as many chemicals and toxins present in vaping smoke compared to cigarette smoke. Vaping was considered as a very good quit tool and not a 'cool' tool and concern was expressed about how vaping was being made to look attractive to children. More work was therefore needed around this messaging.

RESOLVED:

To note the contents of the report and to receive updates going forward.

34 **JSNA update**

The Board received the report of the Executive Director of Health, Wellbeing and Public Health – copy attached to the signed Minutes – which provided an update on Shropshire's JSNA including progress to date, future direction and timescales.

The Executive Director of Health, Wellbeing and Public Health highlighted a number of key points. She updated the Board in relation to the Place-based JSNA work which was moving forward, and drew attention to the screenshots of the web-based tool which were attached to the report, and which was the baseline information that would be pulled into a web-based profile that the public would be able to access. It was hoped to launch this later in the year. The screenshots were contained in the report just to share with the Board the progress that was being made and she explained that data would be added to the web-based tool as the thematic JSNAs were progressed. It would also be an important tool for the population health management going forward.

The next part of that would be the place-based JSNAs which would take the information from the web-based tool plus the additional information held from research and from various needs assessments. It would also bring in stakeholder and patients voices, asking them about the big issues around health and wellbeing that mattered to them and listening to those realities that were coming from those communities. This work had started in Highley and will be undertaken in Oswestry and St Martins before being rolled out across the other areas to capture that data. There was a stakeholder event taking place the following Monday in Highley in order to develop the recommendations based on that information going forward. The

Executive Director of Health, Wellbeing and Public Health agreed to update the Board at its next meeting.

Turning to the Pharmaceutical Needs Assessment, the Population Health Manager gave a brief summary and drew out a few salient points. He reported that there were 47 pharmacies within Shropshire local authority area. 421 resident questionnaires were received which was smaller than they would have wished and was slightly skewed towards women and more affluent socio-economic groups. He then took members through the results and key messages of both the patient and the pharmacist surveys and he summarised the recommendations (set out on page 52). In conclusion, it was considered that the current pharmaceutical service provision in Shropshire was insufficient and that in areas of development and population growth, additional pharmacy provision would be required.

Concern was raised about the shortage of pharmacists seen in recent months in the South of the County and people were needing to travel to access a pharmacy. A query was raised as to whether there was a shortage of pharmacists nationally and whether there was any way to encourage people to become pharmacists. In response the Accountable Officer/Executive Lead for Shropshire, Telford and Wrekin ICS explained that the workforce issue was similar to other NHS workforce challenges nationally, around how many staff were needed, how many could be trained, over what time period, how to retain current staff, how to develop staff from the local area and how to make the area an attractive place to work etc. He informed the Board that from April 2023 community pharmacies would be the responsibility of the ICB, so there was an opportunity going forward to think about how we want to work locally with existing pharmacies and what the future provision would look like.

RESOLVED:

To note the contents of the report and to receive updates going forward.

35 **Health Protection update (including COVID-19)**

The Board received the report of the Consultant in Public Health for noting (copy attached to the signed Minutes) which addressed immunisation and screening and provided an overview of communicable, waterborne and foodborne diseases. She explained that there had not been a Health Protection meeting since the last meeting of the HWBB and that a more detailed update would be provided to the next meeting.

The Consultant in Public Health reported that the Health Protection Strategy had been out for consultation. Any member of the Board who wished to comment needed to let her know that day.

36 **Chairman's Updates**

The Chairman updated the Board in relation to the following items:

- The Air Quality report, which had been scheduled for this meeting, had been deferred to the next meeting. This was also the case for the Safeguarding Annual Report which was reported to this Board annually.

- The Shropshire Healthy Weight Strategy consultation had now gone live. It opened on the 5th September and closed on the 31st October. Members should have received an email about this. The public and stakeholder survey could be found on the 'Get involved' section on the front page of the Council website.

- Resilience film – The Health and Wellbeing Strategic Manager would send the link to Board Members.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD Report				
Meeting Date	17 November 2022			
Title of Paper	ICS Update – Developing our ICP and draft Integrated Care Strategy (IC Strategy)			
Reporting Officer and email	Nicola Dymond – Director of Strategy and Integration – NHS STW nicola.dymond@nhs.net			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People		Joined up working	x
	Mental Health		Improving Population Health	x
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	x
	Workforce	X	Reduce inequalities (see below)	
What inequalities does this paper address?				

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

Executive Summary

This report is an update to the summary of the Integrated Care System (ICS) development programme across Shropshire, Telford and Wrekin presented at the last meeting of this board.

This paper is intended to provide an update on progress made on:

- the establishment of the Integrated Care Partnership (ICP)
- the development of the Integrated Care Strategy (IC Strategy) for Shropshire, Telford and Wrekin.

Recommendations

The Board is asked:

- to note the detail contained in the report
- to note the statutory requirements for ICBs and Local Authorities (LA), as core members of the system wide ICP, to develop an Integrated Care Strategy.
- to note that this strategy must be informed by the work of the HWBs and through engagement with local partners and communities.
- to note approval of the Terms of Reference of the Shropshire, Telford, and Wrekin ICP

Report

ICP development

On 5 October 2022 the first statutory meeting of the Shropshire, Telford and Wrekin Integrated Care Partnership (STW ICP) took place, hosted by Telford Council. Agenda items discussed

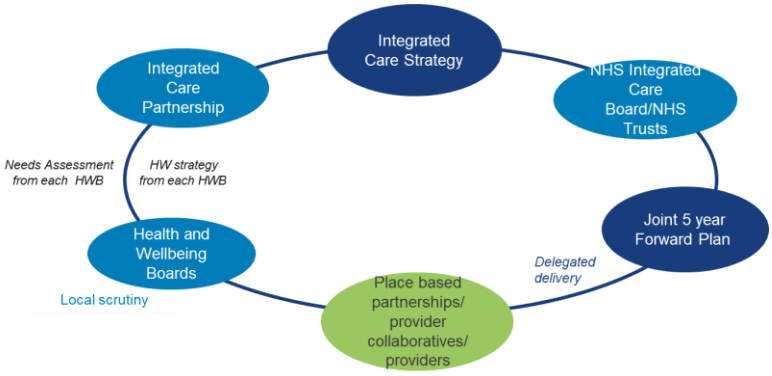
were Ways of Working, Guidance on Development of Integrated Care Strategy, Headlines of the JSNA for Shropshire and Telford & Wrekin, Health & Wellbeing Strategies and ICS Priorities. The Terms of Reference of the ICP were signed off in this meeting.

A date for an extraordinary meeting of the ICP in mid-December to sign off the draft IC Strategy is currently being coordinated. The ICP will meet three times in its first year of operation and then decide on the frequency of meetings in subsequent years.

Integrated Care Strategy (IC Strategy)

An IC Strategy development working group, comprised of ICB, Local Authority and local Health Watch members has been meeting regularly to progress the development if the draft IC Strategy.

As the IC Strategy will be shaping the 5-year forward plan and influencing partner and place plans and strategies the ICP needs to assure stakeholders and partners across the system are involved in its development. The place level knowledge of HWBs will be an integral part of the work of the ICS to improve health and care outcomes and experiences for the population of Shropshire, Telford and Wrekin.



Legislative criteria

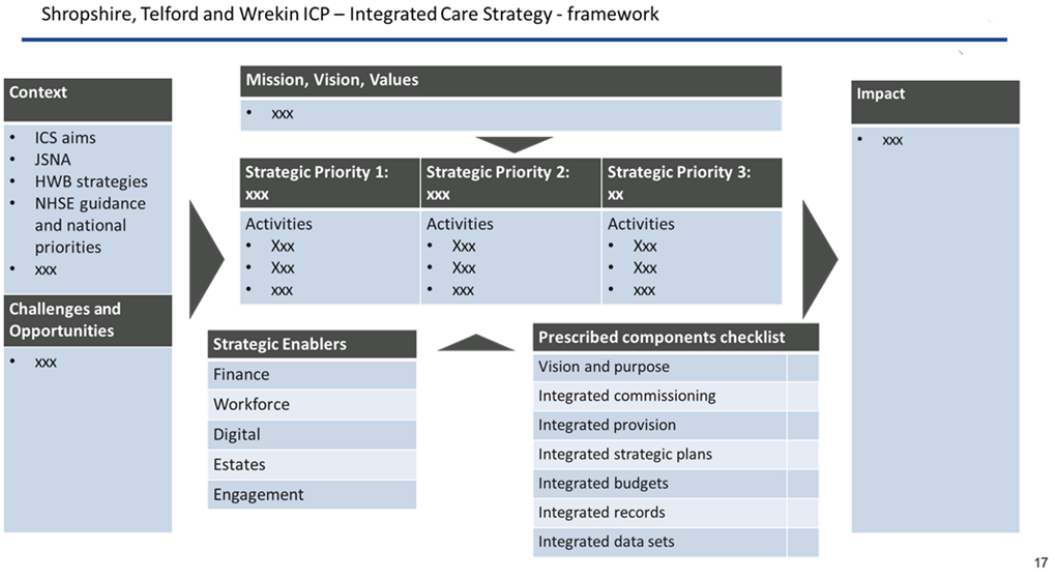
The Department of Health and Social Care published statutory guidance on the Integrated Care Strategy in July 2022, with the expectation that by December 2022 each ICP will be able to publish an interim Integrated Care Strategy. The draft strategy must include the criteria set out below in order to meet legislative requirements:

INTEGRATED CARE STRATEGY *An integrated care partnership must prepare a strategy (an "integrated care strategy") setting out how the assessed needs in relation to its area are to be met by the exercise of functions of the ICB, partner local authorities and NHS England*	
MUST	**MAY**
Involve people who live and work in the area	Include a statement on how other related public services can be more closely integrated with health and social care
Involve local Healthwatch organisations	
Have regard to the NHS Mandate	
Have regard to any guidance issued by the Secretary of State for Health and Social Care	
Consider the extent that needs can be met through section 75 agreements	
Publish each strategy and give a copy to each LA and ICB	

Key components considered for the draft IC Strategy:

Proposed Framework:

Following a desktop research exercise on strategy examples from other health organisations and engagement with a number of ICSs (facilitated by Midlands and Lancashire CSU) the framework below was selected by the working group and is proposed as the overall structure for the STW draft IC Strategy:



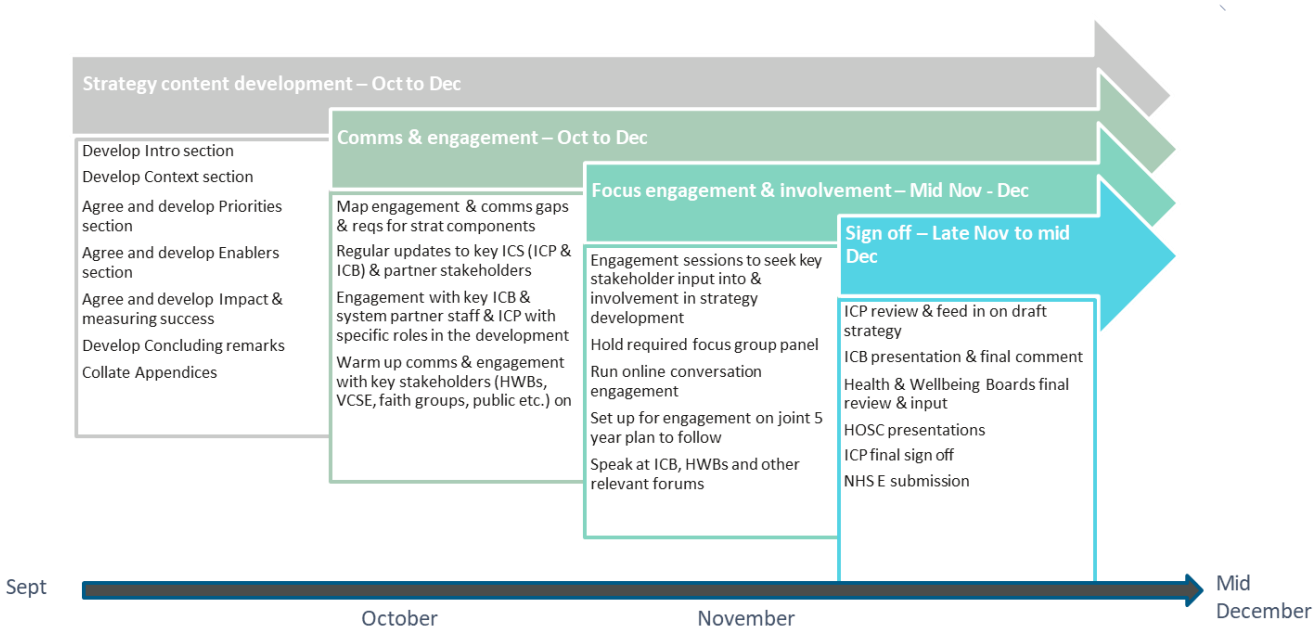
Elements from current local Health and Wellbeing Strategies, ICB strategies, and key components as set out above will be incorporated into the draft IC Strategy.

Extensive communication of and engagement with the draft IC Strategy are being planned and coordinated amongst the communication teams within the ICB, the local authorities and other system partners.

A first draft of the IC Strategy will be presented to attendees of an engagement workshop on 16 November 2022. Details of and invitations for the event will be sent out early November.

Further iterations of the draft IC Strategy will be presented to Health and Wellbeing Boards, Health and Oversight Scrutiny Committees (HOSC) and the ICB Board during November and December with the aim for the draft IC Strategy to be signed off and published by the mandated date of 31 December 2022.

Proposed comms and engagement activities



Conclusion

The Board is asked:

- to note the detail contained in the report
- to note the statutory requirements for ICBs and ICPs to develop an Integrated Care Strategy informed by the work of the HWBs and engagement with local partners and communities.
- to note the proposed Terms of Reference of the Shropshire, Telford and Wrekin ICP (attached as an appendix to this report)
- to note the agreement of the MoU for NHS STW ICB and NHSE

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	None identified	
Financial implications (Any financial implications of note)	None identified	
Climate Change Appraisal as applicable	None identified	
Where else has the paper been presented?	**System Partnership Boards**	
	Voluntary Sector	

	Other	

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

Report included and attachments

Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130)

Nicola Dymond – Executive Director of Strategy and Integration – NHS STW

Appendices

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**17th November 2022**			
Title of Paper	**Shropshire Integrated Place Partnership (SHIPP) update**			
Reporting Officer and email	Penny Bason, Head of Service, Joint Partnerships Penny.bason@shropshire.gov.uk			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	X	Joined up working	X
	Mental Health	X	Improving Population Health	X
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	X
	Workforce	X	Reduce inequalities (see below)	X
What inequalities does this paper address?	As Inequalities is a priority of SHIPP, the Board and its programmes work to reduce inequalities and health inequalities in Shropshire. The key areas of focus for this paper include CYP mental health, Personalised Care and SHIPP Metrics. The Metrics work has been done in collaboration with the Shropshire Inequalities Plan to ensure that we are working to understand how we are reducing inequalities.			

1. Executive Summary

As a reminder, the purpose of Shropshire Integrated Place Partnership (SHIPP) is to act as a partnership board of commissioners, providers of health and social care and involvement leads, in Shropshire, to ensure that the system level outcomes and priorities agreed at ICS and Programme boards are implemented at place level in Shropshire. The Board will take into account the communities and people we work with, the individuals/ citizens (including carers) that we serve, the different delivery models needed, and our focus on reducing inequalities.

SHIPP has adopted the key priorities of the HWBB as well as place-based priorities of the ICS. They are:

- Children's and Young People's Strategy
- Prevention/Healthy Lifestyles/Healthy Weight
- Mental Health, Workforce
- Community Capacity & Resilience with the VCSE
- Local Care and Personalisation (incl. involvement)
- Supporting Primary Care Networks
- Integration and One Public Estate
- Tackling health inequalities

This paper presents an overview of the Shropshire Integrated Place Partnership (SHIPP) Board meetings held in September and October and includes Chairs reports with actions.

2. Recommendations

This report is for information. The Health and Wellbeing Board is asked to recognise the work underway to address the key priorities of SHIPP, as well as the risks in the system, highlighted by the Board.

3. Report

This paper presents the Chairs reports for the Shropshire Integrated Place Partnership (SHIPP) Board held in September and October 2022 and highlights the work programme development of 2023.

The September and October 2022 meetings reported on progress and actions on the following: (Action logs can be seen in appendix A)

- Local Care Transformation Programme
- Hospital Transformation Programme
- Vaccination Programme
- Primary Care and the Fuller Report
- Personalised Care

The Board also received updates (and agreed actions) from:

- Healthwatch Shropshire
- Shropshire Inequalities Plan
- Drugs and Alcohol planning and delivery
- System Quality and Governance

Agenda items for November include Children and Young People, Working with the Voluntary and Community Sector, the Joint Strategic Needs Assessment, Local Care, and Healthy Weight Strategy.

The Board is recognised as a very positive forum to connect and progress work programmes and has demonstrated good progress against priorities.

Following the joint Health and Wellbeing Board and SHIPP workshop key development areas for 2023 will include a renewed Terms of Reference and Action Plan.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The work of SHIPP aims to reduce inequalities found in our community and to address variation in care across our services. SHIPP highlights key risks for system as discussed at the Board. These include: - Risk associated with lack of communication, involvement and co-production in the local care and hospital transformation programmes currently underway, particularly with Primary Care and Shropshire Citizens. - Risk associated with access and support for Primary Care. Primary Care highlighted that new intermediate services could not be fulfilled by Primary Care. - Risk to residents due to inadequate falls response, actions above highlighted to improve situation	
Financial implications (Any financial implications of note)	There are no direct financial implications as a result of this report.	
Climate Change Appraisal as applicable	Working to support people in local communities, reducing the need to travel is very important to the work and priorities of SHIPP.	
Where else has the paper been presented?	**System Partnership Boards**	Appendices reported to the ICS Board
	Voluntary Sector	
	Other	

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

Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130)
Cllr. Simon P. Jones – Portfolio holder for Adult Social Care and Public Health

Appendices
Appendix A Action logs for September and October 2022 meetings

Appendix A – Action logs

Approval Sought and Agreements	Outcome (Action log: September 2022)
Update on Local Care Transformation Plan	The update was noted. ***Agreed actions:*** • Develop/ Enhance Primary Care in local care, including engaging with Healthwatch as Board members • Develop citizen involvement and engagement as part of local care and report back to SHIPP • Develop better links to Personalised care, Social Prescribing as part of Proactive Prevention • Develop Falls pathway work through task and finish group as part of Proactive prevention reporting to SHIPP and Quality Assurance • Develop workshop to focus on community activity and Admission Avoidance
Update on Healthwatch activities	The update was noted. ***Agreed actions:*** • Healthwatch connect with local authority outreach team • Local Care, the ICB and Local Authority (via task and finish group), determine the current Falls Pathway (including prevention work), and determine what more needs to be done
Primary Care – GP Access	The report was noted by the board. ***Agreed actions:*** • Emerging work needed on understanding pressure on primary care and communication to the system and our citizens • See above via local care
Hospital Transformation Programme	The report was noted and endorsed by the board. ***Agreed actions:*** • SHIPP supports the HTP and keen to receive regular updates.
AOB: Vaccination Programme	The update was noted. ***Agreed actions:*** • Regular updates to SHIPP

Approval Sought and Agreements	Outcome (Action log: October 2022)
Update on Local Care Transformation Plan	The update was noted. ***Agreed actions:*** • SAC of SaTH to link with CE in Local Care around Integrated Therapies.
Update on Healthwatch activities	The update was noted
Personalisation	The MoU was approved by the board. ***Agreed actions:*** • JM to share interim Health Inequalities Report with LC of Healthwatch. • SAC to contract NS about contract with SaTH. • NW to provide intro on diabetes pathways to NS.
Shropshire Inequalities Plan	The report was approved by the board. ***Agreed actions:*** • circulate Cost of Living Resources to SHIPP.
Drugs & Alcohol Update	The report was endorsed by the board. ***Agreed actions:*** • VW to invite PM to System "Learning from Deaths Group"/join up services for those with co-occurring mental health needs and substance misuse. • CE & PM to talk about "frequent flyers" support service.
System Quality Governance	The update was noted. ***Agreed actions:*** • To be added to agenda as a regular discussion point with opportunity for partners to feed into the risk register
Fuller Report	The update was noted

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**17th November 2022**			
Title of Paper	**Better Care Fund (BCF) Update**			
Reporting Officer	Penny Bason, Head of Joint Partnerships, Shropshire Council and NHS Shropshire, Telford and Wrekin/Laura Tyler, Assistant Director, Joint Commissioning, Shropshire Council and NHS Shropshire, Telford & Wrekin			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	x	Joined up working	X
	Mental Health	x	Improving Population Health	x
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	x
	Workforce	x	Reduce inequalities (see below)	X
What inequalities does this paper address?	All BCF programmes must take inequalities into account. The programmes work within the guidance of the Shropshire Inequalities Strategy and the NHS Core 20 Plus 5 local strategy.			

1. Summary

This report provides an update from the Joint Commissioning Board and highlights the Better Care Fund Submission for 2022/23; it includes the Planning Template Appendix A and the Narrative document, Appendix B. It also provides a brief update on the BCF review being undertaken by the Joint Commissioning Board and the BCF Audit being conducted by the Integrated Care Board.

2. Recommendations

2.1 The HWBB is asked to:

- Approve the BCF Plan for 2022/23
- Agree a BCF working group as part of the governance arrangements, with membership from the Integrated Care Board, Shropshire Council, and members from provider organisations as needed.
- Note the work of the BCF review and BCF audit, with a further detailed report to be submitted at the January HWBB.

3. Report

BCF Planning

3.1 The BCF Planning Template was received in the summer 2022, with a return date of the 26th September. Although the Narrative Plan, Planning Template and Demand and Capacity template have been submitted to NHSE for approval, this is the first time the HWBB has had a chance to consider the plan and approve it. The contents, however, have been developed with partners and the Joint Commissioning Group and Board. We have been advised that the Regional NHSE team have recommended the plan for approval.

3.2 It was anticipated that the framework for 2022/23 would include a two-year plan which would offer some continuity, compared to the usual annual plans which have been subject to annual

planning guidance and released very late into the financial year, with annual metrics also changing. However, this was not the case. The plan continues as an annual plan, and the metrics have been updated from the last planning cycle.

3.3 Following regular reviews, our BCF plan continues to focus on the priorities of Prevention, Admission Avoidance and System Flow (delayed transfers).

3.4 The plan must highlight how it addresses the 4 national conditions; i) a Jointly agreed plan, ii) supporting social care, iii) out of hospital commissioned services iv) BCF policy objectives – see Appendix A Planning Template, tab 7 for more details. Additional clarification was sought this year on national condition four which requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

3.5 The plan also sought clarification on:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objectives
- Plans for supporting people to remain independent at home for longer should reference
- Steps to personalise care and deliver asset-based approaches
- Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- Multidisciplinary teams at place or neighbourhood level.

3.6 Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support
- Carrying out collaborative commissioning of discharge services to support this.

3.7 Additionally, discharge plans should include confirmation that we have carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

3.8 Shropshire's plan continues to be congruous with national policy objections and therefore the narrative document and planning template are largely a continuation of previous plans with the following key changes:

- Metric 8.1 added – Rate of Unplanned Hospital Admissions Ambulatory Care (see **Appendix A**, planning template)
- Updated narrative on Prevention, Local Care and Admission Avoidance
- Updated narrative on System Flow, including the High Impact Changes and 100 days Challenge. There was recognition of the significant overlap, and that action planning would essentially be the same for aligned areas. (See **Appendix B**, narrative template)

3.9 In addition to the Planning Narrative Templates, this year, the Better Care Fund (BCF) also requires additional information on capacity and demand plans. These plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme.

3.10 The Planning Requirements sets out guidance on how to develop Capacity and Demand Plans and provided local areas with a template to support the process – (see Appendix C).

3.11 This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23.

3.12 The template is split into three main sections.

- Demand
- Intermediate care capacity
- Spend data.

4. BCF Review – local deep dive and BCF Audit

4.1 Work is completed regarding a line-by-line review to respond to consider each budget area of the Better Care Fund. This was overviewed by commissioners in both Shropshire Council and the ICB. A working group is currently peer reviewing with discussion re key themes emerging. Early findings are that there are no projects we are spending money on that we shouldn't be, generally good oversight and governance is in place - some themes emerging - (areas for development include review all IT funding to ensure its maximising capacity, enablement beds, joint posts), as well as significant shortfall between system demand and available funding.

4.2 Additionally, the review is highlighting that the BCF timetable and process does not necessarily align with the changes we may need for the future in Shropshire. Our system is currently significantly challenged by the demands of hospital discharge, and we are progressing with remodelling reablement. Whilst it would be prudent in this situation to review the BCF for the next financial year the fact is that national criteria are not released until after spend has to be committed.

4.3 A significant proportion of the BCF funding is already allocated to supporting hospital discharge and avoidance and we are required to also spend a proportion on prevention and on carers. Changes need to support the national criteria, however in year planning documents, make planning a significant challenge for the beginning of each financial year. We know from early feedback on our BCF review that Shropshire's current spend allocation is correct against criteria and we have to assume that therefore we will not be in a position to allocate more BCF to hospital discharge in 23/24. If the BCF does set out a 2 year criteria timetable, as has been promised nationally, it should be possible to review for the following year. Finally, it is clear that the shortfall between demand and funding is very challenging for our system and in essence the BCF in total is insufficient to meet the demand in Shropshire (highlighted in the risk section). Further details of the review work, and planning for 2023/24 are being developed including proposed plans to work closely together to reduce demand through prevention activity.

4.4 ICB audit committee commissioned a BCF audit from NHS CW Audit is underway. Their remit is 'Through a process of control evaluation and testing', to examine the extent to which the key control objectives recorded below are being met:

Control Objectives

- There are appropriate governance arrangements in place over BCF for both Shropshire and Telford & Wrekin
- Funds are being utilised effectively to:- meet system objectives; transform services and deliver services in an innovative way.

Risks

- Value for money
- System Outcome & Productivity (impacting ultimately on patient care)

<table>
<tr><td>Risk assessment and opportunities appraisal
(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)</td><td colspan="2">a. The Joint Health and Wellbeing Strategy (JHWBS) requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
b. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients
c. This grant funding to support system flow, admissions avoidance and transfers of care schemes, holds significant financial risk should the grant funding stop. As such the Board is asked to approve recommendation 2.1.2 regarding a regular working group to develop the Better Care Fund further, realising more opportunities to develop integrated services, ensuring better value provision of services.
d. Increasing demand for services in the system are highlighting the need for specific joint work on prevention and considered response to projected spending gap in 2023/24.</td></tr>
<tr><td>Financial implications
(Any financial implications of note)</td><td colspan="2">The BCF financial details are included in the Planning Template, Appendix A.</td></tr>
<tr><td>Climate Change Appraisal as applicable</td><td colspan="2">All projects and commissioned services need to evaluate climate impact on all service delivery if applicable.</td></tr>
<tr><td rowspan="3">Where else has the paper been presented?</td><td>System Partnership Boards</td><td>Joint Commissioning Group, Joint Commissioning Board Members</td></tr>
<tr><td>Voluntary Sector</td><td></td></tr>
<tr><td>Other</td><td></td></tr>
<tr><td colspan="3">List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)</td></tr>
<tr><td colspan="3">Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130)
Cllr Simon Jones, Portfolio Holder for Adult Social Care and Public Health
Tanya Miles: Executive Director of People, Shropshire Council</td></tr>
<tr><td colspan="3">Appendices Appendix A BCF 2022/23 Planning Template and Appendix B BCF 2022/23 Narrative Template, Appendix C BCF Demand and Capacity Template</td></tr>
</table>

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Shropshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Cover Sheet, Narrative , N/A		
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Narrative Plan		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Narrative Plan		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	Planning Template		
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	Planning Template		
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	Planning template, Narrative Plan,		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes	Planning Template, Narrative Plan		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes	Metrics tab and Narrative Plan		

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

Shropshire Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

- Shropshire Council (including Adult Services, Children's Services, Public Health and Place)
- Shropshire, Telford and Wrekin ICB
- Voluntary and Community Sector organisations (various)
- Voluntary and Community Sector Assembly
- Healthwatch
- Shropshire Community Health Trust
- Shrewsbury and Telford Hospitals
- Midlands Foundation Partnership Trust
- Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
- individuals

How have you gone about involving these stakeholders?

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Since the previous Better Care Fund Plan (BCF), there has been good local development and learning, as well as the development of the Integrated Care Board as part of Shropshire Telford and Wrekin Integrated Care System. The system continues to work collaboratively to integrate services, reaffirm its pledges and priorities, strategically led by the Shropshire Health and Wellbeing Board and Joint Strategic Needs Assessment. STW continues to develop its post pandemic response working collaboratively to reduce inequalities and reduce the impact the pandemic and subsequent economic and health equity issues facing our families and communities. Opportunities are plenty for more joined up working and the BCF continues to support the delivery of Shropshire's HWBB and Shropshire Integrated Place Strategy and Priorities.

The HWBB Strategy has been refreshed and launch in March 2022. The new strategy proposes to work through key areas of focus (Mental Health, Children and Young People, Healthy Weight and Workforce) to deliver the following strategic priorities:

- **Reducing Inequalities** – Everyone has a fair chance to live their life well, no matter where they live, or their background.
- **Improving Population and Environmental Health** - Improving the health of the entire Shropshire population, including preventing avoidable health conditions and helping people manage existing health conditions so they don't become worse.
- **Joined up Working** - The local System (i.e. the organisations who provide or support health and care such as NHS/Council/Voluntary and Community Sector), will work together and have joint understanding of health being social and economic, not just absence of disease.
- **Working with and building strong and vibrant communities** - Working with our communities to increase access to social support and influence positive healthy lifestyles

The BCF priorities have remained completely relevant and unchanged. The priorities and key programmes areas are:

Prevention and inequalities – keeping people well and self-sufficient and in their usual place of residence; key programmes include: Healthy Lives, including community referral (Let's Talk Local, Community Development, Social Prescribing and Health coaches), Healthy Weight, new dementia vision, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts), Assistive tech (through the DFG), Population Health Management, Carers, Mental health and Early Help services for children and young people. Our inequalities work crosses all work programmes but can be articulated in this section. We have developed a Shropshire Inequalities Strategy and are implementing a number of programmes under the banner of the Core 20 Plus 5 model (articulated in the Inequalities section).

Admission Avoidance – when people are not so well, we support people to find the right service at the right time, in the community; key programmes include: Local Care (Rapid Response, Case Management, Respiratory, Virtual ward), Integrated Community Services, Carers, Winter Pressures schemes, Occupational Therapy and Mental Health.

Delayed Transfers and system flow – when people have had to go into hospital, we are working collaboratively through the Hospital Discharge Alliance, using the 9 High Impact Model, learning from Covid, Discharge to Assess and an Integrated Discharge Hub, to ensure system flow; Key areas of work include: Integrated Discharge Hub (hospital social work interface and short term support purchasing), Start Reablement Team, Integrated community services, Equipment contract, Assistive technology, and Pathway 0.

Four key elements unite all of our programmes:

- a focus on inequalities
- a focus on integration and collaborative commissioning
- taking a strengths-based, person centred approach at every stage – personalised care
- taking an evidence based approach

Governance

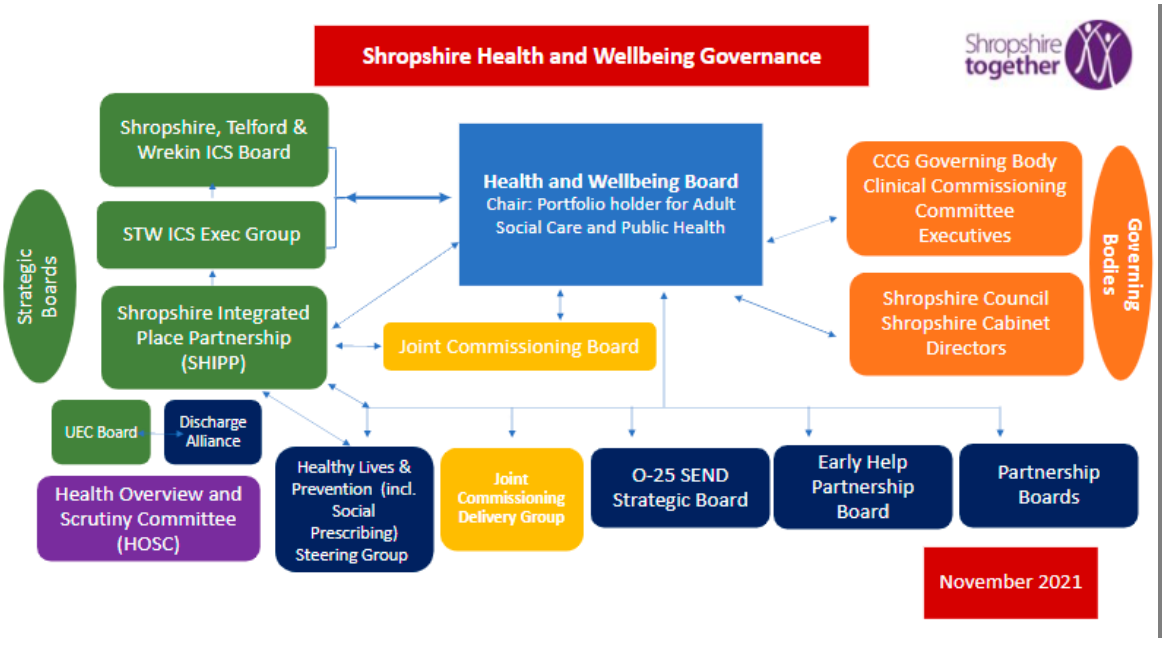
Please briefly outline the governance for the BCF plan and its implementation in your area.

The Better Care Fund programmes are developed through the Joint Commissioning Delivery Group, with governance through the Joint Commissioning Board, the Shropshire Integrated Place Partnership and the HWBB. The Governance diagram below demonstrates the interconnectedness of the programme boards, the Health and Wellbeing Board and the ICS. Endorsement and approval of the Better Care Fund plan sits with the HWBB.

Our prevention programmes are governed through Healthy Lives, Joint Commissioning Board and Shropshire Integrated Place Partnership; with final approval and endorsement through the Health and Wellbeing Board.

In addition to admission avoidance through our prevention programmes, our key admission avoidance programmes are governed through our Local Care programme, with approvals through Shropshire Integrated Place Partnership and the HWBB.

Central to delivering against the discharge targets is the Urgent & Emergency Care Board (UEC) and the Discharge Alliance, who support strategic planning and operational delivery of discharge processes, respectively, in Shropshire.



Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

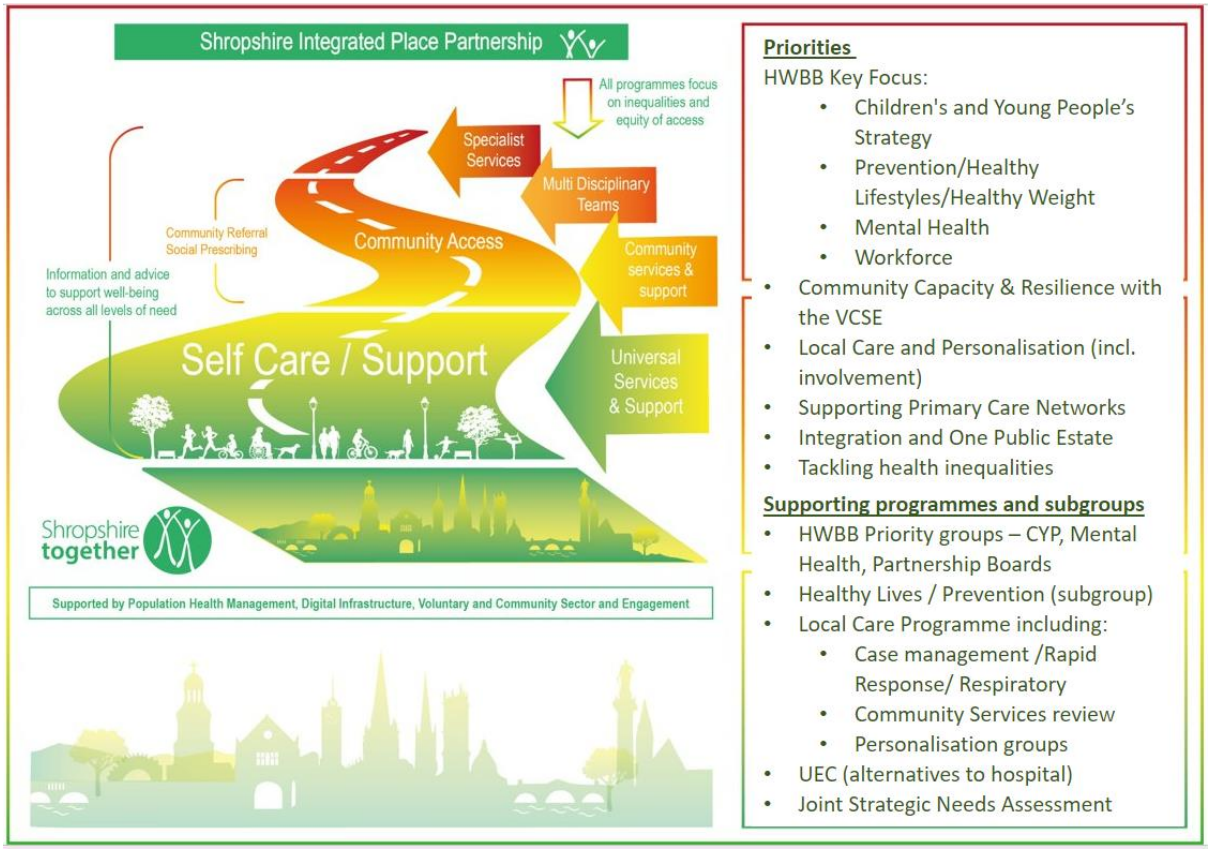
The BCF planning and delivery, the Better Care Fund work is delivered through the governance of the Joint Commissioning Board, HWBB and additionally with a focus on integration, the Shropshire Integrated Place Partnership (SHIPP). The Shropshire Integrated Place Partnership is a sub-group of our ICS Board and our Health and Wellbeing Board. The visions of our HWBB and SHIPP Board work collectively; the HWBB vision is **for Shropshire people to be the healthiest and most fulfilled in England** and our SHIPP vision highlights that we will do this by **'Working together to ensure people in Shropshire are supported to lead healthy, fulfilling lives.'**

The purpose of Shropshire Integrated Place Partnership (SHIPP) is to act as an integrated partnership board of commissioners, providers of health and social care and involvement leads, in Shropshire, to ensure that the system level outcomes and priorities agreed at ICS and Programme boards are implemented at place level in Shropshire. The Board takes into account the different communities and people we work with, the individuals/ citizens (including carers) that we serve, the different delivery models needed, and our focus on reducing inequalities. To set our direction for integrated working, the SHIPP has adopted the following principles for place-based working:

- Take a person-centred approach to all that we do; celebrating and responding to the diversity within our population.
- Follow the Public Health England guidance described in the document Place Based Approaches to reduce inequalities, which involves 3 keys segments:
    - o civic-level interventions, all aspects of public service from policy to infrastructure (including health in all policies)
    - o community-centred interventions, asset (human and physical) and strength based community development
    - o service-based interventions, including unwarranted variability in service quality and delivery (effectiveness; efficiency and accessibility), as well as embedded
- Brief Interventions and Making Every Contact Count pathways (including social prescribing).
- Seek to understand, take a Population Health Management approach to all transformation.
- Recognise the importance of system thinking for all ages and families, ensuring that inequalities are addressed from pre-birth.
- Systematically undertake integrated impact assessments to determine how its delivery could better reduce inequalities and support protected groups (9 protected characteristics); this work should look at how it can support preventing the 'causes', and the 'causes of the causes', of ill health. In particular, each service should consider how it can help people improve health behaviours around weight, smoking, and alcohol
- Utilise a system approach to co-production for service development and delivery.
- Value the community and voluntary sector and consider how the voluntary sector can work alongside statutory services to reduce inequalities.

- Promote understanding of how to prevent or reduce inequalities for staff working in all partner organisations
- Use digital resources to remove geographical barriers to place based working.

The SHIPP diagram below demonstrates how our system works together to a) firstly support people to self-care, in the communities where they live, with community support as needed, b) provide community services where they are needed, and c) provide high quality specialist services when they are needed. **The system is focussed on keeping people healthy and well in their usual place of residents, but also providing the right care at the right time through the programmes and priorities of the HWBB, SHIPP and the ICS.**



The BCF is central to delivering the aims and priorities of the ICS, HWBB and SHIPP. The work of the BCF and are captured through 3 main headings:

Prevention and inequalities – keeping people well and self-sufficient in the first place; key programmes include: Healthy Lives, including community referral (Let's Talk Local, Community Development, Social Prescribing and Health coaches), Healthy Weight, new dementia vision, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts), Assistive tech through the DFG, Population Health Management, Carers, Mental health and Early Help services for children and young people. Our inequalities work crosses all work programmes but can be articulated in this section. We have developed a Shropshire Inequalities Strategy and are implementing a number of programmes under the banner of the Core 20 Plus 5 model (articulated in the Inequalities section).

Admission Avoidance – when people are not so well, we support people in the community; key programmes include: Local Care (Rapid Response, Case Management, Respiratory), Integrated Community Services, Carers, Winter Pressures schemes, Occupational Therapy and Mental Health.

Delayed Transfers and system flow – when people have had to come into hospital, we are working collaboratively through the Hospital Discharge Alliance, using the 9 High Impact Model, learning from Covid, Discharge to Assess and an Integrated Discharge Hub, to ensure system flow; Key areas of work include: Integrated Discharge Hub (hospital social work interface and short term support purchasing), Start Reablement Team, Integrated community services, Equipment contract, Assistive technology, and Pathway 0.

Table 1 below highlights the interconnectedness between priorities and the BCF priorities and delivery programmes.

Table 1: Shropshire System Pledges and Priorities

STW ICS Pledge & * Big Ticket Items	HWBB and SHIPP Priorities	BCF Programmes (prevention, admission avoidance, system flow)
Improving safety and quality	Personalised Care	Cross Cutting, system flow
Integrating services at place and neighbourhood level * **Place Based Joint commissioning** * **Local Care**	Supporting Primary Care Networks Local Care Strong and Vibrant Communities Joined up working	Healthy Lives (including social prescribing and let's talk local) Voluntary & Community Sector contracts Discharge Alliance
Tackling the problems of ill health, health inequalities and access to health care * **MSK Transformation** * **Outpatients Transformation** * **Hospital Transformation**	Inequalities Population Health Children and Young People, Supporting Primary Care Networks Healthy Weight/ Lifestyles Local Care	Healthy Lives (including Social Prescribing and let's talk local) Discharge Alliance 9 High Impact Model
Mental Health and Learning Disability/Autism provision	Mental Health Integrated working Children and Young People	Mental Health Mental Health housing options Autism support
Economic regeneration	Integrated working Strong and Vibrant Communities	Cross cutting
Climate change	Strong and Vibrant Communities	Cross cutting

Strengthen Leadership and Governance	Joined up working	HWBB Governance, Prevention Board, Joint Commissioning Board
Enhanced engagement and accountability	Strong and Vibrant Communities	SHIPP Principles
Creating system sustainability	Joined up working	Cross cutting
Workforce *** Workforce Transformation**	Workforce	Cross cutting

As described above, our approach to collaborative and integrated working is delivered through joint planning and commissioning of services and governed by the Joint Commissioning Group and Board. Additionally, the system develops it's approaches through workshops and jointly agreeing ways of working and principles, and through jointly funded posts. (Shropshire Council and STW ICB) and appointed posts. These are:

- Assistant Director Joint Commissioning
- Head of Joint Partnerships
- Population Health Management Analyst

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Answer:

The national objectives of enabling people to stay well and independent at home for longer and providing the right care at the right place and the right time is embedded throughout our system planning (see SHIPP diagram above) and throughout our Better Care Fund themes, as our mechanism for delivery. Below describes our themes and programmes and highlights delivery of the national objectives as well as approach to integrating care to deliver better outcomes.

Prevention:

Keeping people well in the first place, and in their usual place of residents, remains a top priority for our system. Our new Prevention Board provides strategic oversight and impetus for this work and our prevention programme Healthy Lives drives forward vital preventative activity in Shropshire including, Social Prescribing (including Health Coaching and broader community referral), Shaping Places Food Insecurity project, Lifestyles and cardiovascular disease prevention, and Population Health Fellow projects (Mental Health including Complex need and CVD). The programme provides a place for preventative programmes to join and make best use of resources, integrating services where possible. It has been built on the approach we term, a team of teams. By joining forces across organisations (including Health, Care, VCSE and Primary Care Networks), we pull together funding and resource from numerous sources to deliver whole system approaches to prevention.

The pandemic and work since have demonstrated how vital our voluntary and community sector is in supporting people to remain independent and well in their own homes for as long as possible. Therefore, the Better Care Fund has ensured the continued delivery of our voluntary and community sector contracts and grants that support people in their own home, by providing a number of contracts covering Advice, Advocacy, housing as well as wellbeing and independence. The Wellbeing and Independence Service (WIPS), as an example, is delivered in communities across Shropshire, supporting people to stay well and independent at home – delaying their need for formal care and support. The WIPS contract is delivered in consortium (members are Age UK Shropshire Telford & Wrekin (Age UK STW), The Mayfair Centre, Oswestry Qube, Royal Voluntary Service (RVS) and Shropshire Rural Communities Charity (SRCC) and all members have longstanding experience of working in our communities, understand them well and have some great ideas about making a difference to the lives of our residents.

We have been able to build on this work to introduce additional activity in the system through the winter period. The WIPS contact has been expanded to receive referrals from partners organisations and to deliver additional activity through the winter months, connecting with the red cross and also facilitating hospital discharge. The service can offer - assessment and ongoing support to people identified as needing help, including:

- Transport returning home from hospital
- Settling people in at home following discharge from hospital
- Fitting of low-level equipment e.g. key safes and pendant alarms
- Collecting and delivering medications
- Shopping and delivery
- Wellbeing home visits
- Hot meal delivery
- Companionship for isolated or lonely people

The service can't offer - a crisis response or personal care, but it will work as part of the health and care system to ensure that people get the support that they need through appropriate referrals and signposting.

Admissions Avoidance:

Admission Avoidance is supported by a number of work programmes and teams that are funded or part funded by the BCF. Working collaboratively to commission and deliver these programmes is a cornerstone of the work. The programmes work together to support people at the right place and the right time. The programmes include:

- Integrated Community Service
- Local Care Programme
- Two Carers in a Car

Our Integrated Community Service (ICS) is a joint Shropshire Community Health NHS Trust & Shropshire Council team, called Integrated Community Services (ICS). The team works closely with local hospitals to identify patients who are well enough to be discharged back to their own homes with appropriate support. Once our patients have returned home, they can expect a visit from a member of the team within 24 hours to establish whether the level of care is appropriate and work with the patient to set their goals to maximise independence.

The team also works with patients needing support to avoid unnecessary hospital stay: The team works closely with all our partner organisations to ensure their patients who are unwell, but not requiring an acute hospital to treat their condition, are supported in own home.

Our Local Care Programme is our key community transformation programme, working closely with ICS) that ensures the delivery of system priorities and the BCF. The programme is one of the ICS Big Ticket programmes, and its ambition is to build on our existing good practice and develop more systematic, preventative, integrated interventions that will support independence and well-being of residents in our local communities.

The delivery of sustainable improvement requires a whole system approach to the design, testing and implementation of new models of care. The models of care will be centred around proactive prevention and care closer to home.

The COVID Pandemic has shone a bright light on the issues surrounding health inequalities across the UK. Our Local Care Programme will strive to empower our residents and communities, by building community confidence this will be an essential requirement to reducing health inequalities.

Local Care Vision

The STW system through collaboration, will work together to support individual residents in our local communities. New models of care will be designed with residents and local communities, with a focus on prevention and promoting good health and wellbeing. Residents with long term conditions will be supported to manage their care and we will respond swiftly to those in crises to avoid unplanned admissions

Our vision will be driven by a Local Care Transformation Programme of change, underpinned by the principles of:

- Collaboration - Care delivered by our local health and care teams coming together providing integrated support and care. The teams will work in partnership with residents, voluntary and community sector, using the full range of collective skill knowledge , and expertise

- Understanding and managing the needs of our residents and communities through risk stratification and case management. This will enable a more targeted approach to supporting and responding to the needs of our residents.

- Contributing to addressing Health Inequalities - through earlier interventions, embedding a systematic approach to proactive prevention, and building a strength based approach to how we empower individuals, families, and communities in achieving their aspirations for better health and wellbeing.

Two -year Vison

This is the period whereby our system will focus our efforts on the codesign, testing and where applicable the implementation of our new models of care. We will continue to work in partnership with our residents, communities and staff across health and care, to drive forward the delivery of new models of care and ways of working in the following areas:

Jo

By the end of year 5 the STW system will see

•Services in STW empowering people to have a greater say in their care
•A transformed, integrated health and social care system
•Evidence that will show improvements in population health, measured in relation to defined outcomes

•High quality, safe and clinically sustainable services meeting NHS Constitutional Standards
•Comprehensive workforce strategy detailing new health and care roles will be supporting our transformed integrated health and care system
•Embedded integrated pathways between hospital and community services

System Flow:

Our system flow is supported by a number of work programmes and teams that are funded or part funded by the BCF. The national objectives are echoed throughout each of the programmes and teams. Working with people to continue a strengths based and personsalised care conversation, ensuring choice an supporting people to their usual place of residence is of primary importance.

There are a number of programmes, teams and BCF funded schemes that support this work, including:

- Brokerage and Bed Hub services (described below)
- START – reablement service (described below)
- Local Care (described above)
- Virtual wards (described above)
- The System Discharge Alliance and Integrated Discharge Hubs (described below)
- Joint Commissioning of Reablement beds (described below)
- Community Mental Health Transformation (connected but not funded by BCF)

The System Discharge Alliance (SDA) is a whole system approach, with representation from all system partners. The aim is to move discharge towards the requirements of the White Paper (Integration and innovation: working together to improve health and social care for all 11 Feb 2021), and using the learning and building on the improvements made post the Covid 19 Discharge Requirements.

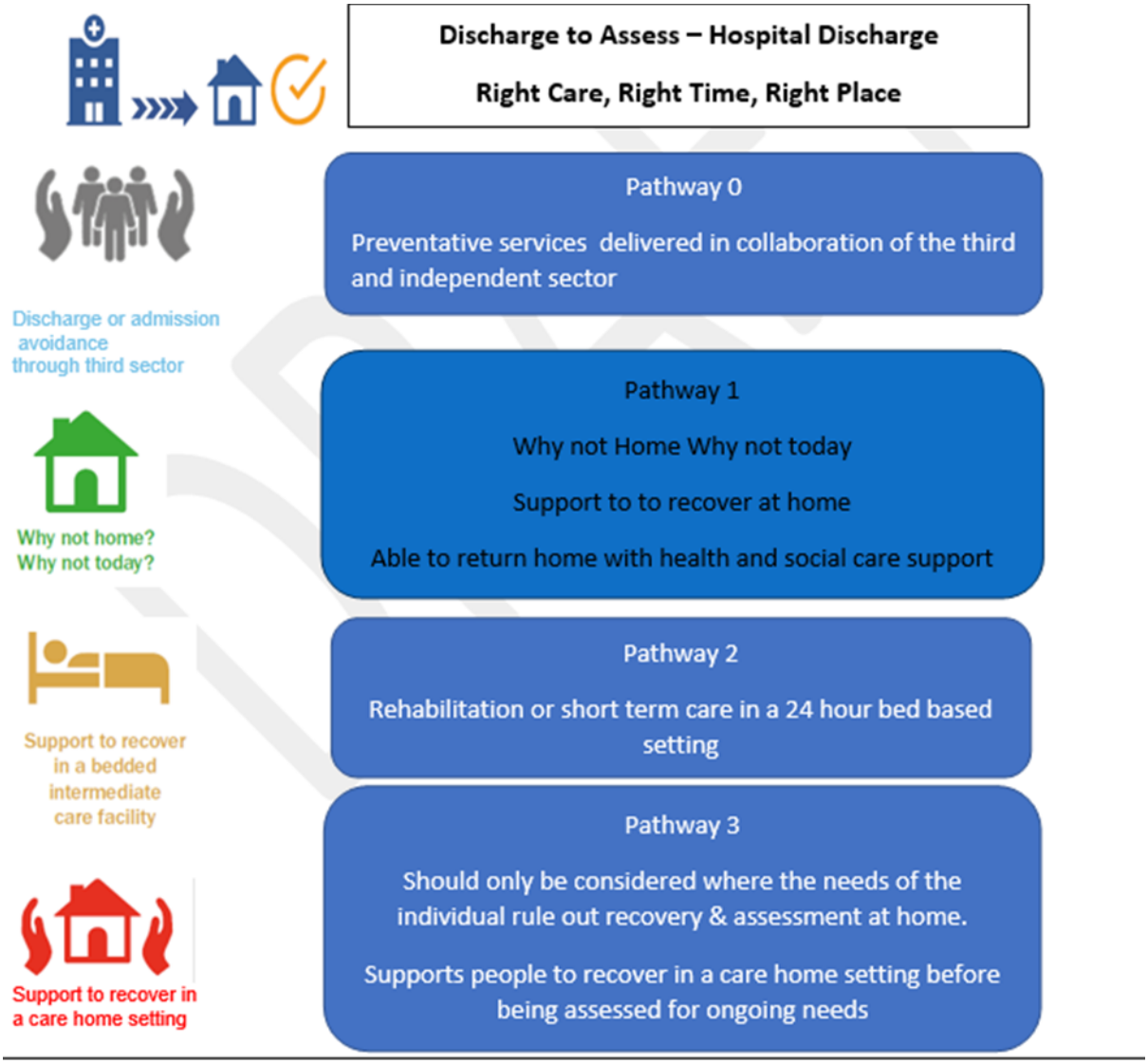
As a system we have come together to work differently to respond to the current and future challenges by;

- working together and supporting integration;
- stripping out needless bureaucracy;
- enhancing public confidence and accountability;
- additional proposals to support social care, public health, and quality and safety.

Locally our HWBB and ICS strategies call for integrated working, commissioning and action to reduce inequalities. The Discharge Alliance works to deliver these priorities as well as the BCF priorities to work together to prevent ill health, avoid admissions and to ensure timely discharge from hospital (System Flow).

Discharge to Assess model

Covid 19 challenged the way in which we work and of our delivery of services. Government guidance stated that systems must implement a Discharge to Assess (D2A) model to speed up hospital discharge times, helping patients get home quicker.



This model reduces the need for hospital-based assessment activity and places an even greater influence on the need to increase short term intervention, and reablement to maintain people's independence in the community for longer. An integrated team must work as part of a systems approach to provide the following service outcomes;

- Efficient, streamlined and consistent approach
- Reduction in Length of hospital stay
- Better patient's outcomes/experience

Local Response: Development of the Integrated Discharge Hub (IDH)

The Integrated Discharge Hub (IDH) was set up in March 2020 in response to local and national requirements, in line with Covid. The IDH brought together personnel from different parts of the system to implement the requirements and implement fast tracked changes that otherwise may have taken the system longer to achieve.

The IDH uses the 9 High Impact model and 100 days as a guide to inform all processes. The IDH ensures that once a patient is ready for discharge, all discharge arrangements are organised by the multi-professional team, with the patient, family and carers all being informed. The aim is to discharge on the same day, with the focus being to support patients to return home first, whenever possible.

As a system piece of work, this is a collaborative service partnered with Shropshire and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust (SCHT), Shropshire and Telford and Wrekin Local Authority and Powys Teaching Health Board (PTHB).

The purpose of this standard operating procedure is to set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for complex patients. The Team include Nurses, Social Workers, Therapists, Support workers and administration / coordinator roles. It aims to fully involve patients and their carers/relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care.

This standard operating procedure (SOP) provides guidance for clinical, administration staff and managers for the professional practice and operational procedures that must (i.e. mandatory) or should (i.e. advisory) be performed by Integrated Discharge Team. The overarching aim of the Integrated Discharge project team is to:

- Provide expert advice to the hospital ward teams to support in decision making for hospital discharge pathways
- Collate and complete a transfer of care/ Fact Finding Assessment for patients requiring pathway 1,2,3, services on discharge from hospital
- Proactively review and monitor patients identified with complex discharge needs to assess, plan and agree a discharge pathway and plan within the estimated discharge date.
- Focus on patients identified by the frailty team to prevent avoidable admissions from A&E through the provision of community-based care pathways allowing patients to be seamlessly step up to levels of care/support.
- Enable adults (aged 18+) to improve, maintain or manage changes in levels of independence, health and wellbeing, through a process of care, re-ablement or recuperation.
- A multi-disciplinary decision-making approach providing a person-centred service collaborated care between acute and primary care, adult social care, and voluntary sector.
- Deliver services in partnership with health and social care, forming multidisciplinary integrated teams, including support staff, therapists, social workers, mental health, medical practitioners and nurses and the falls service.
- Deliver timely, cost effective, efficient services that meet a patient's needs.

Key Changes to Practice during test of change

- IDT Ward Based Assessment agreeing discharge pathway
- IDT Ward / Board Round attendance
- Utilise revised Transfer of Care Document (FFA)
- Case Management – allocated worker to patient
- Patient Journey Facilitator dedicated to project ward 28
- Nurse Specialist (DLN) to work across all complex discharge pathways
- Community and Adult Social Care in reach – ward focused
- IDT preliminary clinical handover for community hospital bed transfers
- Capacity Hub SCHT processing Sheldon Ward referrals

- Transport planned booking

The Service which has been developed in order to implement an expert complex discharge team, working in a seamless and integrated way across partner organisations both health and social care. The Integrated Discharge Team (IDT) will proactively 'pull' and case manage a range of patients with complex discharge needs and progress these patients safely to discharge via an appropriate pathway.

System Discharge Alliance Work programme and action plan

The System Discharge Alliance (SDA) is a sub-group of the Urgent Care Operational group. The 'Alliance' recognises the collective responsibility and contributions across statutory and independent sector organisations to deliver the workstream priorities. The SDA

Workstream	Project Area	Milestones What do we want to achieve?	Key actions	Lead
Joint commissioning strategy	Community capacity	Short term, urgent requirement to model community capacity and configuration to meet beg Jul target date and funding. Long term planning to consider needs across the geographic areas, demographic complexities, target and at risk groups.	Demand and capacity modelling data in place to support planning Identify additional data ened to predict demand and future capacity needs Utilise JSNA data to predict future demand Identify similar and differential needs across Telford and Shropshire Places to support future planning. Place Based Joint Commissioning modelling will also feed	Sarah Bass/ Deborah Webster/Laura Tyler
	SDA	SDA draft plan 22/23 to be considered in line with ICS action plans and programme of work to be planned, ensuring sufficient resources in place to lead change well. SDA terms and references on roles and the right health funding to support programme work.	Development of a SDA plan that support Urgent Care Priorities Review of the ToR.	SDA
Review of re-ablement care	Enhancement of service	Short and long term plans to consider enhancement and strengthening service provision across Shropshire and Telford Review of future recruitment needs and capacity increase, winter priorities considered Review current models and look at other approaches and options with partners	Review of re-ablement care against NAIC and other Benchmarks and good practice guidelines	System Partners - LA's pending decisions re business cases
Enhanced integrated discharge	Target Operating Model	Review of our current TOM and funding offer. The review will look at current approach and benchmark our approach against others.	Review of the IDT processes and performance against national guidance and Good Practice guidelines Benchmark discharge and LOS performance System agreement of future IDT model and subsequent approach	Gemma McIver
	Alignment with community services	Community support services review to consider alternative triage options.	Review of IDT to include community capacity	Gemma McIver
Improving flow	MADE	Implementation of MADE planning to support improved patient flow across the system, recognise and unblock delays challenge, improve and simplify complex discharge	Learning Lessons report from SATH MADE events Learning Lesson Events from SCHT MADE events	Karen Evans/ Sam Townsend
	DTA model	Review DTA model to determine cost implications and options for alternative models being used	Review D2A processes and performance against national guidance and Good Practice guidelines Benchmark discharge and LOS performance System agreement of D2A model ie Pull or Push model and subsequent approach	Gemma McIver/Karen Evans
	Criteria led discharge	Discharge Goals (Outcomes) Review. System Discharge BCP Tactical Planning – forward look at pressures over key times of the year.	SATH Flow programme regular update to SDA Review of actions based on the Nine High Impact Change Metrics (HICMs)	Vanessa Whatley to confirm lead
	FFA review	Review of all current models to consider costs implications, beds capacity reviews, assessment pathways and preventative/provider offers A single assessment, that supports clear pathway flows Removing any duplications in process/ pathway	Previous benchmarking against other Good Practice areas Review of FFAs completion and reources utilised Confirm processes to complete FFAs Agree baseline metrics to measure performance	Richard Allam-Evitts
	Independence at home	Digital and community technology / wearables – that supports independence at home review – local offer	Identify opportunities for utilisation of digital and assistive technologies aross health and social care Highlight utilisation of local prototypes	Helen Cottrill/ SCC btc
	Pathways	Review & monitor high impact / performance matrix driving current pathways, with a clear focus also on zero activity and in seeking the right health funding to support each pathways	Review of current 0-3 Pathways Review of NHS processes to agree Fast Tracks, Temporary funding. Review of CHC process by the ICS Joint Commissioning	SDA

Shropshire and Telford and Wrekin works together on the High Impact Change Metrics which were reviewed alongside the 100 Day Challenge Best Practice initiatives in July 2022. There was recognition of the significant overlap and that action planning would essentially be the same for aligned areas. The Gap Analysis identified good practice and specific gaps (below) and specific actions are included within the SDA action plan above.

Good Practice identified

100 day challenge requirement	HICM link	Current position summary
Identify patients needing complex discharge support early	Change 1	Process in place: Board rounds. Patient Journey facilitators and flow coordinators; Check Chase Challenge; Long Stay Wednesday; MADE events and Lessons Learned
Ensure multi-disciplinary engagement in early discharge plan	Change 1 Change 2 Change 4	MDT approach to Long Stay Wednesday, Senior Reviews, MADE events, IDT. IDT review to be carried out as part of Local Care programme
Set expected date of discharge (EDD), and discharge within 48 hours of admission	Change 2	Two pilot wards to develop EDD (realistic date and plan towards the date)
Ensuring consistency of process, personnel and documentation in ward rounds Transport capacity to plan discharges late in day.	Change 1 Change 2	Good consistency within SCHT through MS Teams. Funding for additional transport in place to manage surges in demand
Apply seven-day working to enable discharge of patients during weekends	Change 5	Currently system partners are spreading 5 day capacity over 7 days adapted to working in SATH and RJAH. 7 day IDTs Social Care staffing across 7 days and bank holidays
Treat delayed discharge as a potential harm event		Daily Bronze review all post 5 days on worklist and daily review of cancelled discharges.
Streamline operation of transfer of care hubs	Change 3 Change 4 Change 6	Integrated TOC/ IDT Hub in place. Virtual IDT in place for real time updating of discharge planning progress. Completed reviews of the IDT effectiveness and efficiency throughout last 12 months Completing a formal review of the IDT processes.
Develop demand/capacity modelling for local and community systems	Change 2	Mature and well established approach in place across acute, community services and admission avoidance
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges. Social Care identification of available capacity across the week to support discharge planning	Change 2	Mutual Aid included within Escalation Actions. On-going capacity tracking across Health, Social Care and independent sector providers
Revise intermediate care strategies to optimise recovery and rehabilitation	Change 3 Change 4 Change 6	MDT approach to intermediate care pathways and protocols in place. Revision of Intermediate Care within Business cases. IDT review Test of Change project commencing 22/8/22 on 2 wards on RSH site

Gap analysis

100 day challenge requirement	Gaps
Identify patients needing complex discharge support early	Social Care and Independent Sector in ward/Board rounds to support early planning. Providers having early involvement/information as needs change rather than at point of discharge. Strength based, person centric approach. Therapy workforce main focus on MFFD rather than early identification of needs and interventions.
Ensure multi-disciplinary engagement in early discharge plan	Therapy capacity in SATH and SCHT. Inclusion of other key stakeholders in the MDT meetings Increased demand for complex discharge and admission avoidance without associated funding
Set expected date of discharge (EDD), and discharge within 48 hours of admission	EDD not currently evidence based. Criteria Led Discharge (CLD) is under-developed Therapy workforce main focus on MFFD rather than early identification of needs and interventions.
Ensuring consistency of process, personnel and documentation in ward rounds Transport capacity to plan discharges late in day.	Delays in completion of discharge medication, letter and booking transport Levels of Cancelled discharges on a daily basis. Robust consistent FFA's impacting confidence in accepting. Transport capacity to plan discharges late in day. Limited next day discharge planning / early readiness. Trusted Assessors completing assessments and building relationships with providers . A Portal to share daily capacity for accepting admissions. High vacancy rates across disciplines / professions
Apply seven-day working to enable discharge of patients during weekends	Lack of consistency and standardisation in relation to 7 day working arrangements, with all key stakeholders. 7 day working not modelled financially to meet the need of a fully mature and developed 7 day working arrangement. Medical and other capacity for 7 day working. Transport capacity across 7 days Limited move-on; decision-makers in providers and confidence of independent sector providers to accept over weekends.
Treat delayed discharge as a potential harm event	Need to develop a process - define this as a measure eg when is a delay a delay that is potential harm
Streamline operation of transfer of care hubs	Links between ward and IDT are not robust and streamlined. No early conversation with family clarified Need a case management (or similar approach) to ensure effective processes and communication with families. Ward staff ownership in discharge planning and connectivity to the IDT. Transport capacity to plan discharges late in day. Limited next day discharge planning / early readiness Capacity gap to deliver full case management
Develop demand/capacity modelling for local and community systems	Utilising beds to offset domiciliary care packages which risks de-skilling and more use of LT care Recruitment challenge across NHS, social care and independent sector
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Medical , nursing, therapy and care sector challenges in recruitment and retention impacting flow - limited capacity to be immediately responsive to demand across EDD, flow and discharge planning and step down from hospital Impact of fuel costs on domiciliary care providers Increased costs to fund higher agency domiciliary care rates - not sustainable System wide approach to support totality or workforce growth, recruitment and retention
Revise intermediate care strategies to optimise recovery and rehabilitation	Limited therapy capacity in SATH and SCHT. Lack of mobilisation by non-therapists within SATH and some care providers. Need to develop providers skilled to deliver Enablement plans and Trusted Assessors

Outcomes to date of Integrated Discharge Hub

- A total of 8,051 Fact Finding Assessments were completed in 2021/22 (in comparison to 6,714 FFAs in 2020/21).
- The average System Length of Stay (LoS) for patients from being Medically Fit for Discharge to discharge pre the Integrated Discharge Team was 4 days, this reduced to an average of 2.4 days for the 2020/2021 fiscal year, however increased again in 2021/22 to 5 days (this can

partly be attributed to the increase in Covid 19 contact and positive patients where isolation period was 14 and then 10 days before placement)

- 68% of total discharges from point of referral occurred within 72hrs plus. 68% of FFA referrals were completed within 24hrs.
- 54% of all Fact Finding Assessments were discharged through Pathway 1.

START reablement Team START (Short Term Assessment and Reablement Team) is our highly respected, homecare re-enablement service. START currently works alongside the Integrated Care Service (ICS) and is currently jointly commissioned by Shropshire Council and Shropshire Community Health NHS Trust, and is a locality-based health and social care team, which incorporates community and voluntary sector teams.

The service provides personal care and support to all Shropshire Council residents aged 18 and over who have been assessed as requiring short term support to help them regain the level of independence they had before they became unwell, or to achieve their personal new level of independence.

Its key objective is to support wellbeing by working alongside an individual to maximise their independence, and work with a range of people who have care and support needs as a result of age, disability or illness.

Utilising the range of support available in the county and funding opportunities, the START team provides personalised goal planning with the people it supports, whilst ensuring that all records are accurate and up to date.

The other key programmes of the BCF which support the System flow are the DFG and the Discharge Alliance, both described below.

Brokerage and Bed Hub

Our Brokerage service is managed by a highly trained team of brokers who offer an extremely effective and robust service and have effective relationships with the market and with assessors requesting care. The service is delivered for all local residents who have a Care Act Assessment or Fact Finding Assessment (hospital discharge), and as part of our integrated working, it is delivered on behalf of the Integrated Care Board as well.

Following completion of a CAA or FFA for each individual the package of care requirements are put on to a secure brokerage SharePoint site which can be accessed only by accredited providers. Initially the only details given are postcode, number of hours, and how many carers are required.

New requests into brokerage are published the same day they are requested to all providers. Alerts are sent directly to providers each day as and when new packages are published or changed.

If a Provider has the capacity to bid for the package of care they may ask to see the CAA or FFA before offering to contract for the work. The detailed assessment is only accessed for viewing through their individual secure SharePoint folder. If a provider considers they can meet the needs of the individual they may then bid for the work; each is awarded based on how quickly the care can start, how close to the times requested and cost.

A jointly commissioning Bed Hub service has been recently added to this service. Work is underway to integrate the two services, and create a full brokerage service for residential care. Once a FFA has been completed for hospital discharge, the Bed Hub service finds suitable placements and provides options and choices for discussion with the person and/or family. This can be a short-term placement while a long term solution is found or a permanent solution. Performance to date (in the 44 weeks: (08.11.2022-09.09.2022):

- 1794 requests have been received by the "bed hub" team from ICS workers. All requests have had at least 2 options sent back to them.
- The bed hub team have made over 6000 calls to care homes to source placements.(Whilst still utilising the placement map and SPiC bed checker)
- The average time to source a placement is now an hour, based on this number the team have saved close to 12,000 hours for operational workers by sourcing the placements.
- At points only 11 homes have been open to admissions with vacancies.
- Owing to the ongoing outbreaks in Care Homes the team have been required to explore Out of County options.

In addition, we jointly commissioned reablement beds - have been jointly commissioned to support hospital discharge. This service is working closely with Local Care and developing wrap around support in partnership with Primary Care. The service aim is to maximise the resident's capacity to become independent to enable their future needs to be met their own home. The resident's pathway after leaving a bed-based service may continue, accessing different home-based services. A service commissioned in a care home which has GP and therapy support which will enable people through a maximum stay of 4 weeks.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The BCF prioritises support for carers. The system recognises the additional strain caring for others causes our residents and the vital role carers play and are committed to supporting carers of all stages and ages (Carer Strategy). Young carers are supported through our Crossroads Together Young Carer Service, and the BCF funds a number of services that support Carers (directly and indirectly); these include:

- Carers Support service (described below)
- Let's Talk Local (one to one Personalised Care approach to supporting those stay well in their communities and their carers)
- Social Prescribing (Personalised Care)
- Wellbeing and Independence service
- Advice and Advocacy service
- Alzheimer society
- Care Navigation
- Autism West Midlands – support for families and carers of autistic children

The work of our programmes take a Personalised Care approach – understanding what matters to people/ individuals as a first discussion. This ethos is embedded within many of our programmes and developing in others (where we are offering Shared Decision Making training and other Personalised Care Institute accredited training).

In additional to understanding and embedding support throughout many programmes, we have a bespoke Carers support service. Our support for informal carers aims to:

- Reduce the risk of carer breakdown – carers have ongoing support and information for each stage of their journey, giving them the confidence to continue in their caring role.
- Reduce isolation and loneliness.
- Allow carers to make informed decisions on the choices available, now and for the future.
- By supporting the carer, the cared for person may also be healthier and happier reducing their feelings of anxiety and guilt.
- Ensure that people with caring duties for family and friends of all age (including parent carers and young carers) have access to the information advice and guidance they need to make informed choices.

The Carer Support team currently supports adult carers of adults. It is not a time limited service and may be working with individual carers for a short time or for longer periods of time, or carers may dip in and out of our service depending on their individual needs.
Carers can self-refer, or referrals are made via statutory, voluntary and community sector organisations.
A broad outline of support provided to adult carers of adults through the team is:

- **Information and advice** - general and personalised information for carers Provided through:
  - 1:1 discussions

- Information Line – operated daily Mon- Fri 9-00am till 5-00pm. CSP man the line on a Rota basis – each taking a day of the week.
- Carer Register – which incorporates an emergency plan and card. Every carer is contacted on registering to introduce the relevant CSP and check on what support, if any, they may require currently. We also check to see if they are on LAS, if not, with their permission, we add them to LAS. We currently have 771 carers on the Carer register - numbers are increasing by approx. 180 per quarter.
- Peer groups
- 6 monthly check in and chats - the biggest complaint received about both the Council and the previous external support provider was that after the initial assessment they received no further contact.

- **One to One Support -**providing **ongoing** support, working with carers to explore their options. The carer support team operate a 'coaching approach' to support carers to understand their choices and make their own decisions on how they would like to move forward.
  Provided through:
  - Face to face
  - Telephone
  - Virtual
  - 6 monthly check-in and chats – as a preventative service.
- **Carers Network** – provided through:
  - peer groups – physical and virtual.
  - WhatsApp
  - Networking with health, voluntary and community in their areas.
- **Future planning** – provided by:
  - 1:1 support
  - Future planning events

Raising awareness of carers and events – attending other organisations events and organising our own

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Our approach to bringing together housing, health and care is to work collaboratively across partner organisations including the Voluntary and Community Sector to support people. We take a person-centred approach to understanding and assessing needs and strengths of individuals and families, and we put in place through the DFG, the support people to live a fulfilling life, preventing needs escalating and reducing pressure on services. Our approach includes making best use of available funding from a variety of sources to find the best solutions for individuals and families.

Before a referral for major adaptations can be sent to Private Sector Housing (PSH), Occupational Therapists (OT) complete an assessment of needs to identify what is necessary and appropriate for a person. During this assessment an OT will liaise with other health professionals and, if applicable, the voluntary sector to gain a person-centred focus so that the assessment is holistic in nature and addresses the umbrella of needs going forward. Major adaptations support vulnerable people in their homes enabling them to remain independent in their own communities. They have the potential to reduce hospital admissions and readmissions brought about by slips, trips and falls. Adaptation work may also reduce the cost of care for an individual; not only can they reduce the number of care calls per day but also the number of carers supporting a person.

Through the DFG, Shropshire has made assistive tech easy to access and understand. A new directory is helping Shropshire residents access health and social care services and includes advice for how people can access assistive technology products and services.

The fund provides assistive technologies that support with preventing conditions from worsening and facilitating independent living. Assistive tech can provide reassurance to carers who are concerned for their loved ones and alleviate pressure from carers who are struggling to cope in their role. There are a range of assistive technology and telecare devices. For example, specialised bath plugs, remote monitoring devices, and falls alarms. Residents are required to have a needs assessment through the council to determine whether they are eligible for assistive products. The directory further provides an assistive technology checklist for people to go through before purchasing any devices. It covers important questions about whether the device is fit for purpose, easy to use, portable, reliable, costly, and more.

Additionally, a new project started in 2021 to identify how some of the more advanced technologies could be of benefit in Shropshire to the users across supported living, focussing on greater independence, management of daily living activities, risk management and learning and development. The project has been hugely successfully and has generated the following outcomes:

- Users across Supported Living have had the opportunity to develop their skills for more independent living
- Users have been able to build their confidence in the use of technologies to creatively meet their needs
- Family carers have felt the benefits and are thrilled to see how their loved ones develop

- Care staff and providers are seeing the benefits of how tech can reduce anxieties, repetition and frustrations / behaviours that result from continual prompting by staff which can be replaced by technology
- Risks are managed in more creative ways
- Face to face care and support can be removed / reduced safely
- SW's are learning through the implementations, how tech can benefit users which promotes more creative approaches to commissioning care
- Significantly reduced spend on care packages

In addition to the mandatory Disabled Facilities Grant, Private Sector Housing can offer several discretionary grants which can provide alternative financial assistance to people with disabilities. These types of grants can enable people to have adaptations in a more flexible and or timely manner than that of the DFG. For example, the Major Equipment Grant has a much quicker application process, including a simpler financial eligibility test. This allows the installation of equipment, such as stair lifts and hoists, to be carried out in a much more appropriate timeframe, especially for those applicants who require the replacement of faulty equipment and for people who are due to be discharged from hospital or a care setting. This also prevents admission to residential homes and hospital. Other available grants provide help to those that would not normally be financially eligible for a DFG or make relocation a possibility for clients whose homes are not practicable to adapt. By providing these discretionary grants the Council is reaching out and supporting a larger number of people within Shropshire than ever before.

Case study:

House2Home is an example of how we are working. It is different for multiple reasons…

It is a multi-agency, multi-funding and multi-option approach to resolving complex cases where disabled children and their families live in unsuitable housing. We think outside of the box, using various funding streams in non-traditional ways, focusing on finding the right home in the right place.

In Shropshire, the percentage of bungalows being built, compared to other property types, is 1%. This is primarily due to 2 things:

- Development economics - bungalows take up more land and offer reduced economic return;
- The fact that when most people think of bungalows, they think of the older population and their needs

Because of this, it is difficult to find suitable housing for a family with a disabled child or children, where a 3 or 4 bedroom bungalow may be required.

The Senior Children's Occupational Therapist (OT) approached the Housing Team for help. She was aware of families who were living in unsuitable accommodation where their current property could not be adapted. There was always a child (or children) in the property with complex needs and their current accommodation was putting their safety and wellbeing, along with that of the rest of the household, at risk.

It was apparent that there was limited suitable housing stock and households were being 'skipped as unsuitable' on the Housing Register as the properties did not already have the adaptations the families needed.

It was identified that this was a problem that was only worsening with more and more households being identified as having complex housing requirements.

The process is based on a multi-agency approach using innovative thinking to resolve complex cases.

Officers from different areas of the Council and different external agencies come together. The team includes:

- Housing Options
- Disabled Facilities Grants Officers
- Housing Register officers
- Housing Enablers
- Social Landlords
- Occupational Therapists
- Social Workers

The thoughts and wishes of the family are always paramount.

Ongoing discussion and liaison with local housing providers means we can explore both current and future stock options, as well as open market possibilities. Factors taken into consideration are, cost, affordability, and available funding. The aim is to ensure the property is a lifetime option, so it must be financially suitable too.

There are also regular conversations with local housing providers to influence developments at the pre-planning application stage.

- Disabled Facilities Grants (DFGs) - mandatory and discretionary are available to make adaptations to a home.
- S.106 monies is capital funding to support additional affordable housing beyond the policy required provision.
- Homes England Funding is used by social housing providers to assist people who need a property in a specific area but where there are no new developments planned.
- Social Housing Providers contribute capital funding towards the purchase, renovation and future maintenance of these properties.
- Homeless Prevention Grant is used to cover any shortfall in purchasing a property and to fund deposits and / or rent in advance.
- Discretionary Housing Payments (DHPs) and Local Support and Prevention Fund (LSPF) is utilised to assist with rent shortfalls, deposits, removal costs and furniture.

The following is written by the Father of a child living with a disability… prior to our involvement

"Some days are better than others and he can manage getting out of the house into his wheelchair using a cushion to negotiate the steps. Other days are worse and he has been locked in a position for hours on end crying out in pain.

<THE OT> explained that the house we were currently living in was not suitable for my son; he needed to climb the stairs on his knees to use our only bathroom and we could not fit or build a ramp into the property for him to get in and out of."

Following our involvement, things improved drastically for the family…

"Since the adaptions have been fitted the difference is amazing. We have a clear idea of how our son will manage his daily routine and the installation of a downstairs wet room will hopefully relieve the stress on his body, enabling him to function better for longer without injury.

This property is more than just a roof over our head, it is a gateway to a better life where my son is in less pain meaning tensions within the family have subsided.

I don't think that I can overstate just how much better my family's life is going to be due to this property. Our heartfelt thanks go out to all involved for all that they have done and for working above and beyond to make this happen for us."

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Inequalities and specifically health inequalities are interlinked. Action to reduce health inequalities requires action to improve outcomes across all the factors that potentially determine our health outcomes. Only around 10% of our health is impacted by the healthcare we receive, other determinants such as the places and communities in which people live, education, housing and access to green space, individual lifestyle behaviours and the quality and accessibility of health and care services (including inequalities in these determinants), can all impact on health and inequalities in health. Taking action to reduce health inequalities is both a national and a local priority, the importance of which has been dramatically highlighted through the recent Covid-19 pandemic.

Given the need for concerted action to reduce health inequalities the Shropshire Health and Wellbeing Board (H&WBB) requested development of a plan for Shropshire. They requested that the plan should recognise the importance of both health inequalities and the wider inequalities that underpin their development. As such, the prevention, admission avoidance and system flow themes of the Better Care Fund Plan all reflect how we are working to reduce inequalities.

The Shropshire Inequalities Plan highlights different needs for different population groups including:

- Those with protected characteristics (Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or believe, Sexual orientation)
- Health inclusion groups including homelessness, traveller community, sex workers, people in contact with the justice system)
- Lifestyles and Health inequalities
- Health and digital literacy
- Rural deprivation and hidden deprivation

Intersectionality and Health Inequality

It is recognised that the factors that underpin health inequalities do not operate in isolation of each other but that they interact reinforcing and amplifying their potency in damaging health. For example, when looking at links with protected characteristics in terms of sex women are more vulnerable to poverty than men primarily because they are paid less, work fewer paid hours over their lifetimes and lose income because of caring responsibilities. Female lone parent households have twice the poverty rate of male lone parents and single mothers in particular are more reliant on benefits and as such are vulnerable to welfare cuts.

In terms of race those from ethnic minority groups are more likely to work in low paid occupations or earn below the living wage. Those from black ethnic groups have higher rates of unemployment and are more likely to have insecure work. Whilst pensioner poverty has fallen over recent years some pensioners are more likely to be in poverty than others in particular those with protected characteristics, as follows:

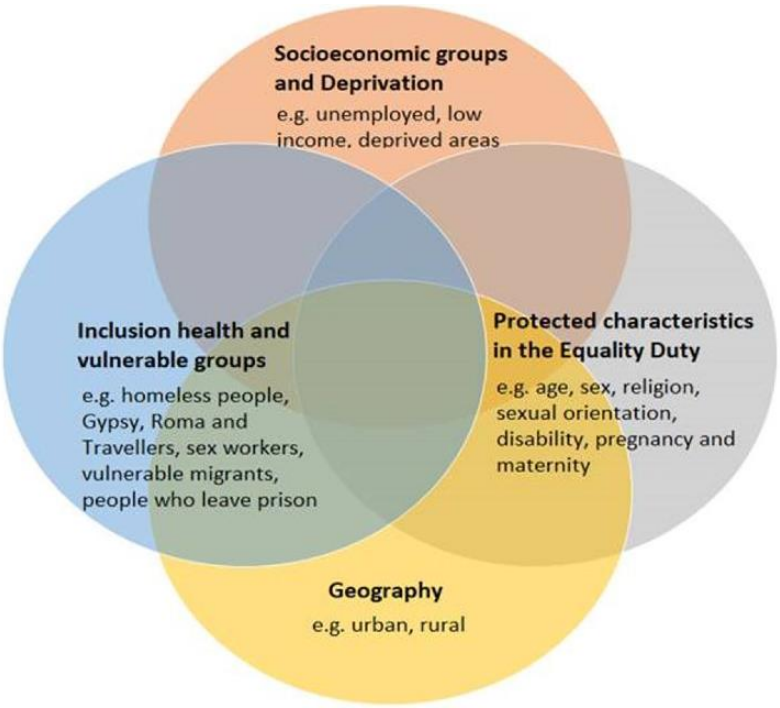
- Asian or Black pensioners
- Single female pensioners
- Pensioners with disabilities.

There is a very strong relationship between poverty and disability. Almost half of working age adults in poverty have someone who is disabled in their household. Poverty for those with disabilities is often related to the costs incurred for a disabled person to enjoy the same living standards as a non-disabled person. Disability-related benefits are included in measures of net income, but do not account for the additional costs incurred; thus, a disabled household may appear to have sufficient income whilst in reality their income is insufficient.

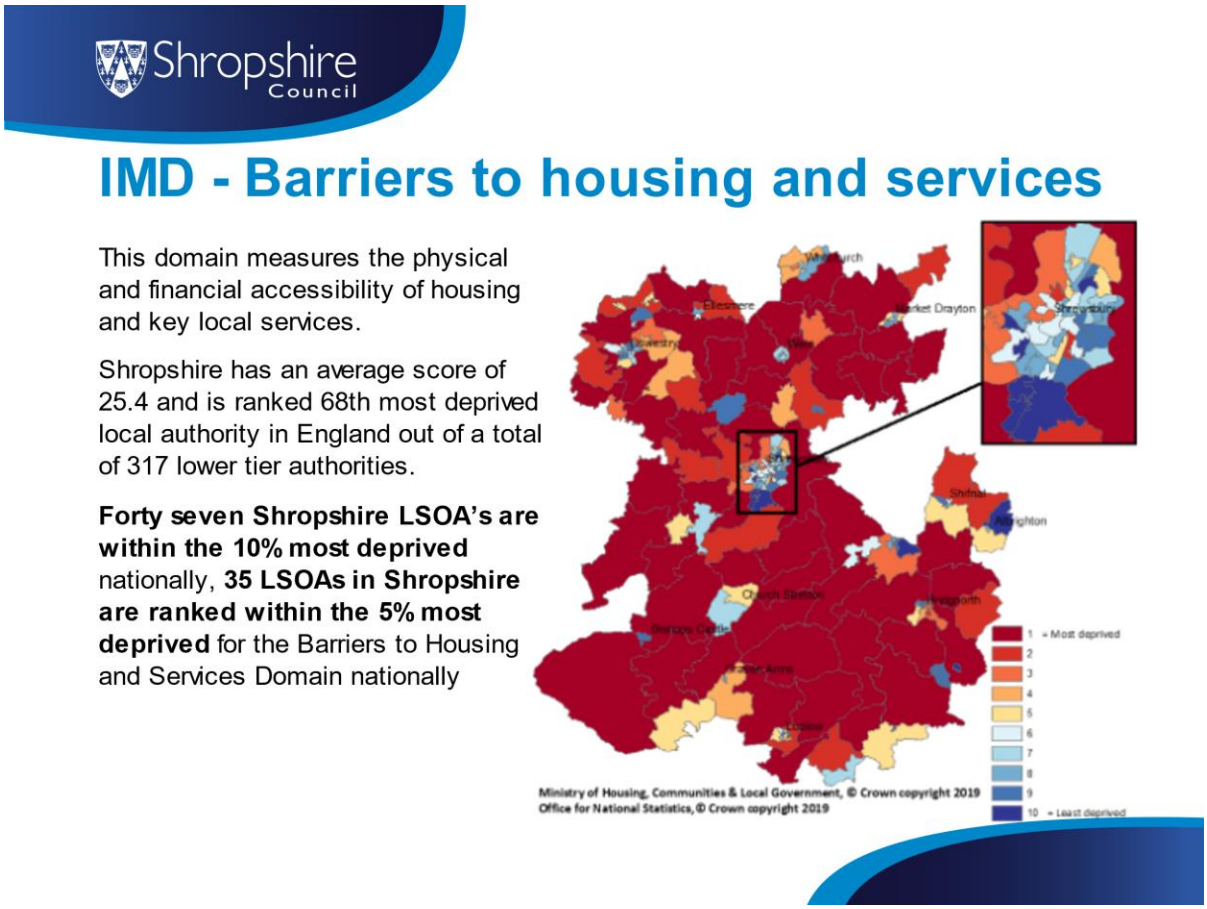
Whilst those with protected characteristics are independently more vulnerable to poverty there is an additional impact through intersectionality. For example, women with disabilities are lower paid than women without disabilities and youth unemployment rates for young people from Black, Pakistani or Bangladeshi backgrounds are more than twice the rate among white, young people.

The overlapping dimensions of health and health inequalities are recognised and are illustrated in figure 3 below.

Figure 3. The Overlapping Dimensions of Inequalities[15]



Additionally, and crucially for delivering services in Shropshire, the plan recognises the impact of rural deprivation. The , diagram below highlights an additional way to understand deprivation and access to services; which provides better insight to the needs of a rural community, where Shropshire is far worse off as indicated below, than traditional methods of considering deprivation .



The Shropshire Better Care Fund programmes and service delivery recognise the importance of the factors listed above and is making significant strides to reduce the impact of health inequality through the work we do. Key aspects of this work are embedded within the implementation of Personalised Care Approaches across programmes, working with housing colleagues through the DFG, transforming Local Care and improving system flow with a focus on the most vulnerable.

The prevention theme of our BCF has a significant focus on delivering Personalised Care, which places takes holistic approaches to understanding individuals' needs and working through community-based solutions (which are proven to reduce inequalities). Elements of this work include the Prevention contracts, Social Prescribing, Community Development contracts (as part of Social Prescribing), Let's Talk Local (ASC provision in communities), Assistive Tech through the DFG. This work has been long embedded in the BCF but it continues to grow in strength and recognition.

Delivery of specific programmes addressing the Core 20 Plus 5 are underway. A project, funded by NHSE but long-term sustainability will sit within the social prescribing community development work, is developing community cancer champions, with a focus on those geographi c areas in most need in Shropshire. Additional work includes a focus on CVD and Diabetes and connects with Primary Care inequalities delivery, ensuring integration. In STW rurality is a key concern with

regards to inequalities and part of our 'Plus' grouping. As described above rurality causes both difficulties with our population ability to get to services, as well as issues with driving up the cost of delivering services. All service development and transformation programmes must take this into consideration.

With regard to both Admissions Avoidance and System Flow our programmes take a person centred (Personalised Care) approach, focussing on a 'what matters to me' ethos. This coupled with Proactive Prevention helps services to connect with and support people who need it the most (proportionate universalism). Our reablement service START works to support all those in need, but takes particular care to ensure those who need additional help (such as debt, housing, advice), receive what they need to remain healthy and well.

Changes since the last BCF plan include:

- Shropshire Inequalities strategy launched September 2022
- Delivery of Core 20 Plus 5 programmes including the development of community cancer champions (linked to community development as part of Social Prescribing); additional work includes CVD and Diabetes prevention as well as Respciratory worth through Local Care
- Embedding Personalised Care in NHS Provider Contracts (Shrewsbury and Telford Hospitals, Shropshire Community Trust, and Robert Jones and Agnes Hunt)
- Expansion of the Social Prescribing Adult Service – delivering over 4700 referrals from beginning August 2021 to end July 22, across all 4 Shropshire PCNs
- Expansion of Social Prescribing to deliver a Children and Young People's service across all 4 Shropshire PCNs, working closely with schools and Early Help, targeting children and families in most need
- Establishment of a Social Prescribing as part of the front door to Children's Social Care , targeting children and families in most need
- Working with social care and partners to pilot social prescribing with ASC waiting lists, A&E and other health waiting lists
- Developing Assistive Tech offers through the DFG, targeting those most in need and the digitally excluded, generating savings and supporting people
- Joint Commissioning of 2 Carers in a Car – providing equitable access across the county
- Amplify the WIPS contract in winter to provide additional support at home following hospital discharge (to reduce readmission and support people to improve their health and wellbeing)
- Local care
    - Development of Rapid Response to target vulnerable
    - Development underway of improved Falls response
    - Development of neighbourhood MDTs
    - Developing Proactive Prevention
    - Developing joint approach to funding and working with our communities and working with our Voluntary and Community Sector

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful definitions and where to go for further support. This sheet provides further guidance on using the Capacity and Demand Template.

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23.

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth quarters of 2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in the guidance tab for readability if required.

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign-off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance -
https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)
- Reablement or reabilitation in a person's own home
- Intermediate care in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:
- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23

- Spend on intermediate care services in the BCF (including additional contributions).
These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Shropshire	
Completed by:	Laura Tyler	
E-mail:	laura.tyler@shropshire.gov.uk	
Contact number:		
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off	
If no, please indicate when the report is expected to be signed off:	Thu 17/11/2022	<< Please enter using the format, DD/MM/YYYY

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Executive Director People
Name:	Tanya Miles

How could this template be improved?	It seems repetative and unclear on exactly what is required, need i

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Shropshire

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	0	0	0	0	0	0
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	202	217	212	243	209	237
2: Step down beds (D2A pathway 2)	0	0	0	0	0	0
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	59	53	62	73	71	82

Any assumptions made:	pathway 0 we don't have this information. Pathway 2 are community hospital numbers so we dont have this but they will be captured in the referrals numbers to the LA via the numbers below which will inc c

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
(Please select Trust/s.....)	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)						
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST							
(Please select Trust/s.....)	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	202	217	212	243	209	237
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST							
(Please select Trust/s.....)	2: Step down beds (D2A pathway 2)						
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST							
(Please select Trust/s.....)	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)						
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST		59	53	62	73	71	82

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Shropshire

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	Vol numbers winter project, reablement current Start numbers and based on increased. Step u

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	40	40	40	40	40	40
Urgent community response	69	86	78	79	89	104
Reablement/support someone to remain at home	49	52	60	60	65	70
Bed based intermediate care (Step up)						

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Shropshire

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	pathway 1 numbers are the current numbers with START, don't keep pathway 0 numbers. Beds are mainly spot purchased so not sure what you asking. Pathway 2 is the community hospitals; the voluntary sector element is the winter uplift funding, deliverd by a consortium, to both support dishcarge and deliver admission avoidance. we have split the numbers 50/50 between discharge and community capacity. This scheme will both prevent hospital admissions, and also ensure supported hospital discharges. This activity will include:

Capacity - Hospital Discharge							
Service Area	**Metric**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
VCS services to support discharge	Monthly capacity. Number of new clients.	20	20	20	20	20	20
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.						
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	49	49	49	49	49	49
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.						
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.						

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Community

Selected Health and Wellbeing Board: Shropshire

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Intermediate care in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Current average AA numbers, Voluntary Sector are derived from winter support service, where additional activity is funded to a consortium of Voluntary sector organisations. The numbers are split 50/50 between hospital discharge and admissions avoidance. This scheme will both prevent hospital admissions, and also ensure supported hospital discharges. This activity will include: - Transport returning home from hospital

Capacity - Community							
Service Area	**Metric**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	20	20	20	20	20	20
Urgent Community Response	Monthly capacity. Number of new clients.	69	86	78	79	89	104
Reablement or reabilitation in a person's own home	Monthly capacity. Number of new clients.	23	23	23	23	23	23
Intermediate care in a person's own home	Monthly capacity. Number of new clients.						

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Shropshire

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£13,109,762
BCF related spend	£3,039,490

Comments if applicable	LA commissioned expenditure includes externally-purchased and in-house reablement services. The budget for these services (included in the BCF Planning Template) is £3,039,490, however expenditure is forecast to be £13,109,762, due to

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD Report				
Meeting Date	17th November 2022			
Title of Paper	Healthy Lives update			
Reporting Officer	Val Cross, Health and Wellbeing Strategic Manager			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	x	Joined up working	x
	Mental Health	x	Improving Population Health	x
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x
	Workforce	x	Reduce inequalities (see below)	x
What inequalities does this paper address?	Addressing inequalities is integral to the Healthy Lives programme and is reflected in all the work programmes.			
Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	There is a current gap with membership from health partners on the Healthy Lives steering group. As this is the prevention group of the Health and Wellbeing Board, there is a risk that opportunities will be missed to join up work. There are different translation services across the system, but it isn't clear what these are, and how people using the services would be able to access. Leadership for this is needed and is a risk for the Board to discuss.			
Financial implications (Any financial implications of note)	There are no financial implications identified in this update report			
Climate Change Appraisal as applicable	Not applicable for this report.			
Where else has the paper been presented?	**System Partnership Boards**			
	Voluntary Sector			
	Other			
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)				
Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130) Cllr Simon Jones, Portfolio Holder for Adult Social Care and Public Health Cllr Kirstie Hurst-Knight, Portfolio Holder for Children and Education				
Appendices				

Report

1. Summary

This paper provides a brief update on Healthy Lives, which is the prevention programme of the Health and Wellbeing Board (HWBB).

Healthy Lives has a focus on preventative health, which is key to stop people becoming ill in the first place, or help people manage their health condition and stop it from getting worse. Evidence base is used in all work.

Shropshire, Telford & Wrekin Integrated Care System (STW ICS), Shropshire Integrated Place Partnership (ShIPP) and Healthy Lives have several shared priorities, and Healthy Lives is the delivery arm of the HWBB and ShIPP, where partners come together to ensure the Joint HWB strategy is implemented. These preventative programmes include Social Prescribing, Healthy Weight and Physical Activity, food insecurity, Trauma Informed Approach, Mental Health, Killed and Seriously Injured (KSI) on Roads and Health Inequalities.

Access to health information for people who do not speak English as a first language is also a recent addition for an area of focus.

The Healthy Lives steering group meetings, which are held monthly, are not a 'reporting shop'. All members demonstrate genuine commitment in working together to progress the areas of focus above and help improve the lives of Shropshire people. Combining as a system upstream helps to make best use of resources in terms of, human - the skills mix and experience of its members, monetary - through prevention of disease and ill-health, and linking projects together to strengthen impact and avoidance of duplication of work.

2. Recent meeting activity

Recent meeting activity has included:

- Presentation on summary of the PCN Directed Enhanced Services 22/23, which enabled further understanding, discussion and linkages to social prescribing and personalised care to be made
- Presentation from Lingen Davis enabled links to libraries and Community Wellbeing Team to be made, and identified promotion opportunities around early cancer screening and detection
- 'Human library' presentation from Shropshire libraries. Potential further funding identified and offered by partner organisation to roll this out further
- Reviewed and comment on the Social Taskforce Action Plan
- Delivery of the draft Healthy Weight Strategy, and agreement that progress reporting will come through Healthy Lives
- Supported a small, but successful funding bid for Shropshire Libraries
- Healthwatch Shropshire reporting on latest surveys and reports. Links to these are shared for cascading across organisations and services
- Updates from Energize and Marches Energy Agency (MEA), enables understanding of what they offer and how the work can be linked and supported

- Area created on PCN portal, which enables partner information to be shared with GP Practices, such as cost of living resources and library IT Health literacy courses for over 65's

- The role of libraries with speech and language development and how libraires can support children and families.

The steering group has good representation from different local authority services, and the Voluntary and Community Sector, but there is a current gap with representation from health partners.

Unfortunately, the proactive representative from what was the CCG, (now Shropshire, Telford & Wrekin (STW) NHS), has recently been diverted from these meetings to a different health specific group meeting, and can no longer commit to being a full-time member. As well as needing a replacement from STW NHS, the group would benefit from representatives from all NHS Trusts, who would also be able to attend.

As this is the prevention group of the Health and Wellbeing Board, there is a risk that opportunities will be missed as a system, to join up work and raise the profile of prevention. Health colleagues on the Board are asked to consider who from their service could attend and contact Berni Lee or Val Cross.

3. Access to health information for people who do not speak English as a first language

As a result of HWBB and Health Overview Scrutiny Committee (HOSC) agenda planning, Rachel Robinson requested that access to health information/navigating the health system for people who do not speak English as a first language was progressed through the Healthy Lives Steering group and reported back to the HWBB.

A small group met to discuss this initially, and discussions that emerged included:

- There are different translation services across the system, but it isn't clear what these are, and how people using the services would be able to access. Leadership for this is needed and is a risk for the Board to discuss
- Need for web-based information that is consistent and in other languages
- Building trust of services and communication around how the English health system works is important
- A Ukrainian resource pack for GPs had been sent to GP Practices in May, and information is on the ICS website

Suggestions to move this forward included:

- A mapping exercise, asking different systems (health, care, education and other partners) what methods they use to communicate with people who have little or no English – translation services etc.
- Use of census data to see the spread of different languages across Shropshire
- Use of anonymised case studies – that demonstrate difficulties people have faced, but good practice too
- Looking at good practice locally/regionally/nationally
- Shared standard web-based information across the system

Next steps:

- Conversations have taken place recently as to if this work could be done as a subgroup of the Quality and Diversity systems group, but this is to be discussed further

4. Recommendations

- The HWBB are asked to note the contents of this report, and members from health, asked to actively consider who from their service could attend the Healthy Lives steering group. (Contact Berni Lee or Val Cross)

- There are different translation services across the system, but it isn't clear what these are, and how people using the services would be able to access. Leadership for this is needed and is a risk for the Board to discuss

SHROPSHIRE HEALTH AND WELLBEING BOARD

Meeting Date	**17th November 2022**			
Title of Paper	Shropshire Inequalities Plan			
Reporting Officer and email	Berni Lee Berni.lee@shropshire.gov.uk			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	X	Joined up working	X
	Mental Health	X	Improving Population Health	X
	Healthy Weight & Physical Activity	X	Working with and building strong and vibrant communities	X
	Workforce	X	Reduce inequalities (see below)	X
What inequalities does this paper address?	Inequalities related to: • ICS/NHS health inequality priorities • Shropshire H&WBB priorities as expressed through the Joint Health and Wellbeing Strategy • The 'wider determinants of health' as detailed in the Shropshire Plan • Socially excluded groups (also referred to as 'Health Inclusion' Groups)			

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

1. Executive Summary

Health inequalities are defined as avoidable, unfair and systematic differences in health between different population groups. Inequalities in the determinants of health (such as housing, education and access to green space) translate into health inequalities. Therefore, action to reduce health inequalities requires action to improve outcomes across all the factors that influence our health. As such, health inequalities may be driven by:

- different experiences of the wider determinants of health
- differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels
- differences in psychosocial factors, such as social networks and self-esteem
- unequal access to or experience of health services

1.2 Action to reduce health inequalities requires improving the lives of those with the worst health fastest and breaking the link between people's background and their prospects for a healthy life.

1.3 In July 2021 West Midlands NHSE/I requested that local Integrated Care Systems (ICSs) develop place-based Health Inequality Plans, illustrating how key NHS health inequality objectives would be met on a 'place footprint'. In responding to this request, it was agreed at the Health and Wellbeing Board (H&WBB) that for Shropshire a plan would be developed to include the following priority areas:

- ICS/NHS health inequality priorities (including the 5 key planning restoration priorities and the Core20-PLUS-5' priorities)
- Shropshire H&WBB priorities as expressed through the Health and Wellbeing Strategy
- The 'wider determinants of health' as detailed in the Shropshire Plan
- Socially excluded groups (also referred to as 'Health Inclusion' Groups)

The plan also includes high level details of the PCN 'Tackling Neighbourhood Health Inequalities' plans.

1.4 The plan includes brief high-level details of the programmes of work underway – being led either by the council and/or the local NHS, with activities often being delivered in partnership with our third sector partners.

1.5 The report that accompanies the plan includes a wide range of details including the following:

- The factors that underpin health inequalities and the context within which they develop and become entrenched
- A brief overview of the evidence base for reducing health inequalities
- Key aspects of the national and local policy context for reducing health inequalities
- Details of 'Core20PLUS5' framework and why 'rurality' has been identified as a 'plus' factor for the ICS
- The extent of health inequalities across Shropshire

1.6 Through developing the plan the following gaps in action have been identified:

- Comprehensive Action to Reduce Smoking Rates
- Meeting the Needs of the LBGTQ+ Community Across the Life Course
- Reference to the Accessible Information Standard

1.7 Furthermore, whilst recognising that all of the plans for the priority areas need to be delivered it has been agreed that action and impact should be closely monitored for a number of key areas as specified in section 3.8 below.

1.8 It is recognised that further work is required to develop a comprehensive approach to monitoring delivery of the plans, aligning monitoring with the metrics used in other reporting frameworks where relevant and tracking progress against key measures through an action log.

2. Recommendations

H&WBB members are asked to:

- Note the contents of the report and the details included in the Inequalities Plan, including the recommendations made in section 17 (appendix 1)
- Endorse the Inequalities Plan
- Recognise that the success of the plan in reducing inequalities is a joint system responsibility that all partners are committed to delivering
- Advise on timescales for reporting progress in reducing inequalities and health inequalities across Shropshire

3. Report

3.1 In July 2021 West Midlands NHSE/I requested that local Integrated Care Systems (ICSs) develop place-based Health Inequality Plans, illustrating how key NHS health inequality objectives would be met. Given the broad action required to reduce health inequalities it was agreed that a broader Inequalities Plan should be developed for Shropshire. This plan recognises the importance of both health inequalities and the wider

inequalities that underpin their development. Thus the Shropshire Inequalities Plan includes the following priority areas:

- ICS/NHS health inequality priorities (including the 5 key planning restoration priorities and the Core20-PLUS-5' priorities)
- Shropshire H&WBB priorities as expressed through Health and Wellbeing Strategy
- The 'wider determinants of health' as detailed in the Shropshire Plan
- Socially excluded groups (also referred to as 'Health Inclusion' Groups)

The plan also includes high level details of the PCN 'Tackling Neighbourhood Health Inequalities' plans. Further, it is recognised that there will be additional work programmes being undertaken across the system with potential impact on inequalities and health inequalities that are not included at this stage.

3.2 The intention of the plan is not to duplicate existing work programmes but to draw together current activity aimed at reducing inequalities, seek to strengthen the plans, in particular through identifying synergies between them, to identify and address any gaps in support or provision and to enable monitoring of progress towards a reduction in health inequalities. Thus, the plan includes brief high-level details of the programmes of work underway – being led either by the council and/or the local NHS, with activities often being delivered in partnership with our third sector partners.

3.3 In order to develop the Inequalities Plan a multi-agency group was convened with membership shown in appendix 1 (page 115) and development has been coordinated with NHS colleagues. Progress has been reported through the ICS's Population Health Board.

3.4 Health inequalities are defined as avoidable, unfair and systematic differences in health between different population groups. The attached report (appendix 1) includes the Inequalities plan but in addition it:

- Provides a definition of health inequality and brief detail of how health inequalities are measured
- Sets out the factors that underpin health inequalities and the context within which they develop and become entrenched
- Illustrates the way in which individual factors can interplay with each other (intersectionality) – reinforcing and worsening inequalities and health inequalities
- Summarises the impact of Covid-19 in exposing and exacerbating health inequalities
- Provides a brief overview of the evidence base for reducing health inequalities
- Summarises key aspects of the national and local policy context for reducing health inequalities
- Provides details of 'Core20PLUS5' framework and why 'rurality' has been identified as a 'plus' factor for the ICS
- Outlines the extent of health inequalities across the Shropshire population

3.5 The plan acknowledges that in tackling the complex issues that underlie health inequalities there is a need to understand problems from the perspective of those with 'lived experience' of the issue and through adopting a 'whole system approach' built on complex systems theory. Alongside this, other principles that need to underpin action include:

- Intelligence led identification of problems and evidence-based solutions
- Community centred action – co-producing solutions building on local assets working wit individuals and community and voluntary sector partners
- Those based on equitable targeting of resources
- Those built on place-based collaboration and co-production

3.6 The plan includes high level detail of the intended work programmes grouped under the Population Health Model domains, together with separate sections highlighting plans

being implemented to meet the needs of 'social inclusion' groups and the plans being implemented by PCNs as part of their work to tackle neighbourhood health inequalities. The plan includes intended milestones, process and outcome measures and these can be used to monitor progress with delivery and effectiveness in terms of improved outcomes over time.

3.7 One of the key opportunities presented through developing the plan is the scope it presents for an assessment any key gaps in actions being taken across the system. Through discussion with system partners the following gaps have been identified:

- Comprehensive Action to Reduce Smoking Rates
- Meeting the Needs of the LBGTQ+ Community Across the Life Course
- Reference to the Accessible Information Standard

3.8 Furthermore, whilst recognising that all of the plans for the priority areas need to be delivered it was agreed that action and impact should be closely monitored for the following key areas:

- The cost of living crisis and the systems response to this
- Development and implementation of plans to reduce smoking
- Maintaining a focus on delivering 'health in all policies' across the council and wider ICS (including use of the 'HEAT' tool and/or the integrated assessment framework agreed for the ICS, as appropriate)
- Strengthening the 'Early Intervention/Prevention' offer for Children, Young People and Families
- Strengthening prevention through the support of healthy lifestyles – including through making the environment in which people live more conducive to good health and considering the specific needs of those with disabilities
- Delivery of the NHS plans to meet the five clinical areas of focus included in the 'Core20PLUS5' framework
- Development and implementation of plans to tackle digital exclusion
- Further consideration of opportunities to improve work-skills among the population and increasing opportunities for higher paid work within the local economy
- Reducing dependency and the harms associated with drug and alcohol misuse, especially among young people
- Further consideration of the steps that can be taken with academic and other partners to better quantify and meet the health needs of Shropshire's rural population; exposing the rural health inequalities that exist.

Moving forward the Joint Strategic Needs Assessment (JSNA) process should enable the further identification of challenges to health and well-being and how these may impact differentially across our communities.

3.9 It is recognised that further work is required to develop a comprehensive approach to monitoring delivery of the plans. including tracking progress against key measures through an action log. It is important that any monitoring is proportionate and where relevant consistent with other reporting frameworks such as those relating to the H&WBB, the Population Health Board and the ShIPP.

It is further recommended that all staff and partners acknowledge their individual organisational and collective shared responsibility, to focus plans and the delivery of services such that variations in health and wellbeing outcomes are reduced.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	There is an opportunity in tackling inequalities and poverty in all its forms to enable young people, adults and families to achieve their full potential. Opportunities to: • Close the gap in heathy life expectancy and other key health indicators between the most and least deprived groups in society. • Recognise and take action on the specific health inequalities that affect those living in a rural region like Shropshire. • Recognise and take action to support specific health inclusion groups who experience discrimination and barriers to accessing services which increases health inequalities. The cost-of-living crisis represents a significant health risk to those already experiencing health inequalities in Shropshire. Even less vulnerable groups are likely to be affected by food and fuel poverty, as well as other negative socioeconomic effects of the crisis. This report recognises this risk and provides an opportunity to mitigate the worst impacts for those affected.
Financial implications (Any financial implications of note)	There are no immediate financial implications arising from this report. However, it is widely recognised that reducing health inequalities will bring economic benefit to the whole county, not only to those in the most deprived communities. The Health Inequality work programmes as detailed in the table in appendix 1, include key actions/milestones with dates, that those services/teams will take to progress and implement them. Most of the work programmes are ongoing, and as these have been provided for submission into this Inequality Plan, the assumption is that these have been costed and funded. However, it is possible (and to an extent to be expected) that some plans will, for a variety of different reasons, change. Any such changes will be reflected in future updates of this Health Inequalities Plan. Appendix 1 refers to the Development and Delivery of the Shropshire Plan and Revised Target Operating Model (11.3 to 11.5). There is a separate governance process underway for these projects that will consider any costs and associated savings.
Climate Change Appraisal as applicable	This report has no direct effect on energy and fuel consumption, renewable energy generation, carbon offsetting or mitigation or climate change adaptation. However, this report has indirect climate change outcomes that are related to tackling inequalities. Climate change has been identified as the most important health threat of the century, and also the "greatest opportunity to redefine the social and environmental determinants of health". The climate crisis will affect people differently depending on their susceptibility, risk and ability to cope. By addressing health inequalities, this will also increase climate change resilience. For example, by reducing housing inequality and improving home insulation we can reduce the health impacts of fuel poverty whilst also reducing greenhouse gas emissions. Also, by increasing access to public and active transport we can improve ill

	health associated with inactive lifestyles and poor services access whilst also reducing traffic-related emissions and pollution.	
Where else has the paper been presented?	**System Partnership Boards**	ShIPP
	Voluntary Sector	
	Other	

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

H&WBB January 2022: Update on Development of a Health Inequalities Plan for Shropshire

Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130)

Cllr. Simon P Jones, Portfolio Holder for Adult Social Care and Public Health.

Appendices

Appendix 1 Inequalities Report and Plan
Appendix 2 Inequalities Report and Plan Executive Summary

Shropshire Council

Executive summary

Shropshire Inequalities Plan

2022-2027

1. Introduction

1.1 Health inequalities are unfair, systematic and avoidable differences in health, and they are blighting the lives of thousands of Shropshire residents.

1.2 Inequalities in the social determinants of health translate into health inequalities. Therefore, action to reduce health inequalities requires action to improve outcomes across all the factors that influence our health. Only around 10% of our health is impacted by the healthcare we receive.

1.3 Shropshire's Health and Wellbeing Board (H&WBB) requested development of an Inequalities Plan that recognises the importance of both health inequalities and the wider inequalities that underpin their development. Amongst other things, the report also:

- Sets out the factors that underpin inequalities and health inequalities and the context within which they develop and become entrenched
- Illustrates the way in which individual factors can interplay with each other (intersectionality) – reinforcing and worsening health inequalities
- Provides a brief overview of the evidence base for reducing inequalities
- Provides a summary of local data illustrating the extent of health inequalities across Shropshire
- Details a high-level summary of current work programmes being delivered across Shropshire to address inequalities, (i.e., the Inequalities Plan)
- Provides a summary of the over-riding priorities and recommendations

Alongside this, attention is drawn to 'key areas of focus' which are considered particularly important to our work in Shropshire to reduce inequalities

2. Background and purpose of the Inequalities Plan

2.1 In responding to a request from NHSE for development of a health inequalities plan, it was agreed that for Shropshire a plan would be developed to include the following priority areas:

- ICS/NHS health inequality priorities
- Shropshire H&WBB priorities as expressed through the Joint Health and Wellbeing Strategy
- The 'wider determinants of health' as detailed in the Shropshire Plan
- Socially excluded groups (also referred to as 'Health Inclusion' Groups)

2.2 The intention of the plan is not to duplicate existing work programmes but to draw together current activity aimed at reducing health inequalities, seek to strengthen the plans and to enable monitoring of progress. The report is set out in two sections, as follows:

- **Section one:** Context. The factors that underpin health inequalities and the evidence for tackling them.
- **Section two:** Shropshire's Inequalities Plan Tackling inequalities and poverty in all its forms, enabling children, young people, adults and families to achieve their full potential.

Section 1:
Health inequalities context

The factors that underpin health inequalities and the evidence for tackling them

3. Definition of Health Inequalities and How They Are Measured

3.1 Health inequalities are defined as avoidable, unfair and systematic differences in health between different population groups. At a high-level, health inequalities are measured by differences in life expectancy and healthy life expectancy between different population groups. Mortality rates and healthy life expectancy reflect a social gradient where people living in more deprived areas live shorter lives.

3.2 The evolution of health inequalities is closely related to deprivation The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. It broadly defines deprivation on the basis of a wide range of factors, but it is recognised that deprivation is associated with poverty.

3.3 It is notable that IMD is less sensitive to the types of deprivation experienced in rural areas, and as such has limitations in defining vulnerability to poor health in areas such as Shropshire.

3.4 To provide indicators at a more granular level the Public Health Outcomes Framework (PHOF) was developed to enable measurement of progress in reducing health inequalities.

4. Causes of Health Inequalities

4.1 Population health is shaped by a complex interaction between many factors and health inequalities arise as a result of systematic variation in factors such as the following:

- different experiences of the wider determinants of health, such as the environment, income or housing
- differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels

- differences in psychosocial factors, such as social networks and self-esteem
- unequal access to or experience of health services

4.2 Action on health inequalities requires improving the lives of those with the worst health fastest and breaking the link between people's background and their prospects for a healthy life. Further details relating to specific factors underpinning health inequalities are as follows:

The Wider Determinants of Health

4.3 The wider determinants of health are a diverse range of social economic and environmental factors such as education, employment, income, and housing.

Impact of Poverty

4.4 Poverty and health are inextricably linked whereby those experiencing poverty suffer poorer health outcomes across the life course. In short poverty damages health and poor health increases the risk of poverty.

Protected Characteristics

4.5 Individuals are more at risk of poor health or of experiencing health inequalities if they belong to one of any of the groups with 'protected characteristics' as defined in the 2010 Equality Act. People in these groups frequently experience inequalities and these may also be linked to poverty or deprivation as set out in the section below (intersectionality).

Lifestyles and Health Inequalities

4.6 Smoking, poor diet, physical inactivity and harmful alcohol use are leading risk factors for preventable ill health and premature mortality. All are socioeconomically patterned meaning that they are more prevalent among disadvantaged populations, and they contribute significantly to widening health inequalities. Smoking is uniquely harmful to health, causing damage not only to smokers but also to the people around them.

Health and Digital Literacy

4.7 Health literacy refers to the extent to which individuals can find, understand and use information and services to inform health- related decisions. Low health literacy is associated with a low level of knowledge and skill in managing health risks resulting in higher levels of morbidity. As much health-related information is now delivered digitally there is an equal need to improve digital literacy.

Stigma and Health Inequalities

4.8 Stigma is defined as the co-occurrence of labelling, stereotyping, and discrimination in a context in which power is exercised. Those from disadvantaged circumstances frequently experience stigma. Stigma has been identified as an independent factor driving health inequality [(1)].

Impact of Rurality

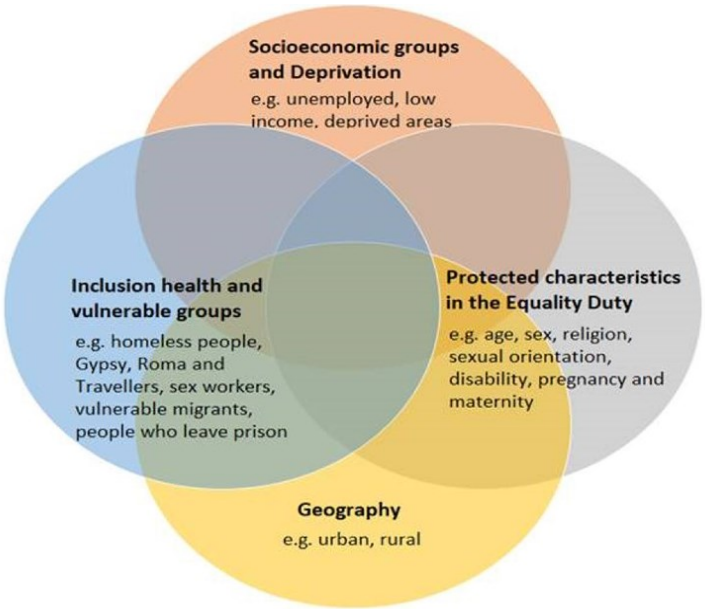
4.9 Overall, health outcomes are better in rural areas than in urban areas, however indicators can mask small pockets of significant deprivation and poor health outcomes. Current methods for identifying deprivation and health inequalities in rural areas are not adequate and consequently such inequalities are not currently being identified or addressed [(2)].

4.10 Following the publication of the recent All-Party Parliamentary Group (APPG) report into rural health further work is required nationally to fully understand and address the factors underlying inequalities in rural areas, such as Shropshire [(3)].

Intersectionality and Health Inequality

4.11 It is recognised that the factors that underpin health inequalities do not operate in isolation of each other but that they interact reinforcing and amplifying their potency in damaging health. The overlapping dimensions of health inequalities are recognised and are illustrated in figure 1 below.

Figure 1. The Overlapping Dimensions of Health Inequalities [(4)]



Impact of COVID

4.12 The impact of Covid-19 was uneven across different population groups both in the UK and across the world. As the virus disproportionately impacted on groups already facing the worst health outcomes the mortality rate from Covid-19 in the most deprived areas was more than double that of the least deprived.

5. The Evidence Base for Reducing Inequalities and Health Inequalities

5.1 Inequalities are not fixed, and evidence indicates that a comprehensive approach to tackling them can make a difference. The national Marmot reviews provide an overview of the action required to have a positive impact in terms of reducing health inequalities (5)(6). They specify the following policy areas for intervention:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

5.2 The Marmot reports provide strong evidence that health inequalities present across a social gradient and. as such proportionate universalism is recommended whereby actions are universal, but with a scale and intensity that is proportionate to the level of disadvantage.

SECTION 2:
Shropshire's Inequality Plan

Tackling inequalities and poverty in all its forms, enabling children, young people, adults and families to achieve their full potential

6. Policy Context for Reducing Inequalities and Health Inequalities

6.1 It is widely recognised that reducing health inequalities would bring economic benefit to the whole country. The government has established a Cabinet level health promotion taskforce to move forward prevention policy and a health disparities White Paper is due later this year. The government's recent 'levelling up' strategy outlines the national ambition to spread opportunity more evenly across communities addressing the factors that predispose to inequalities.

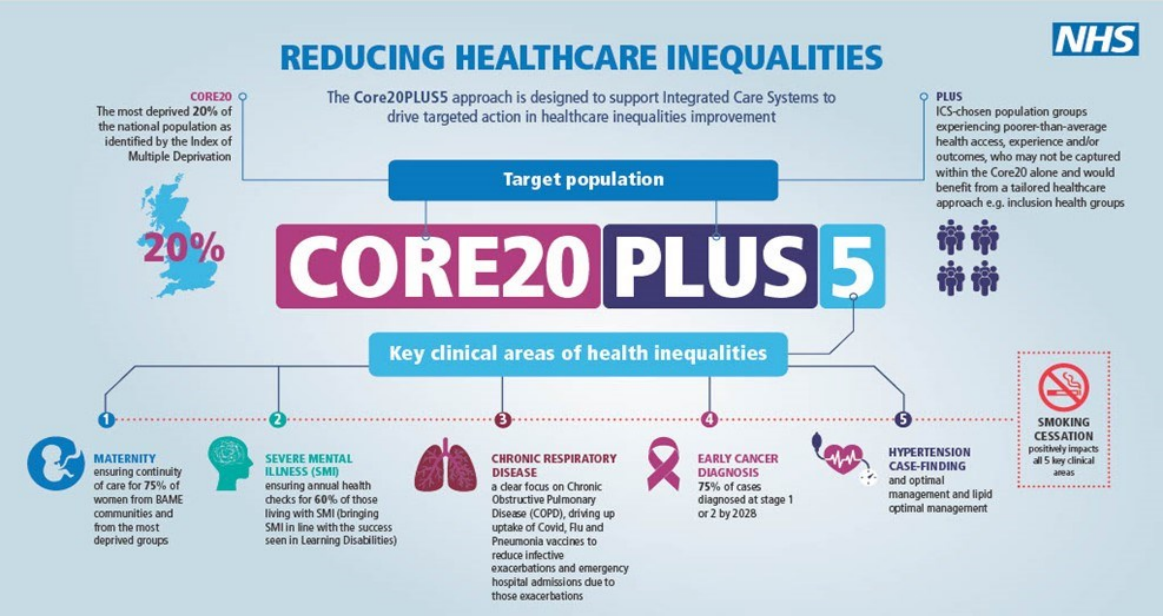
6.2 In terms of NHS policy, the 2012 Health and Social Care Act introduced duties on a range of NHS bodies to have 'due regard' to reducing health inequalities in exercising their functions (7). The NHS long term plan (LTP) (8) signalled more comprehensive action across the NHS to both strengthen the prevention of ill health and to reduce health inequalities.

6.3 More recently Integrated Care Systems (9) have been introduced across the country with the specific purpose of bringing local partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

6.4 In order to focus specific action on health inequalities NHSE/I has introduced the 'Core20PLUS5' framework to drive a reduction in health inequalities. The approach defines a target population cohort - the 'Core20' – with an optional PLUS – which for our ICS has been identified as 'rurality' These sit alongside '5' clinical areas requiring accelerated improvement, as shown in figure 2 below. (10)

Figure 2. The 'Core20PLUS5' Framework



6.5 In addition to the Core20PLUS5 approach each Primary Care Network (PCN) [11] is required to draw up specific plans to tackle neighbourhood health inequalities and the Public Health team are supporting them in taking forward this commitment.

7. Inequalities and Health Inequalities Across Shropshire

7.1 The 2021 census indicates that Shropshire has a population of 323,600 people (12). Further breakdown of the population from this census is not yet available but in the 2011 census 2% of the population were from an ethnic minority group, 5% claimed to have bad or very bad health and 9.5% were aged 75 years or over (13).

7.2 The IMD score was last calculated in 2019. Shropshire has an average score of 17.2 and is ranked as the 174th most deprived out of a total of 317 lower tier local authorities in England. When looking at smaller geographical areas – Lower Super Output Areas (LSOAs) Shropshire has LSOA's within the most deprived nationally as follows (14):

LSOAs within the most deprived 10% in

- Harlescott ward (Shrewsbury)
- Ludlow East ward

LSOAs within the most deprived 20% in

- Monkmoor ward (Shrewsbury)
- Oswestry South ward

- Meole ward (Shrewsbury)
- Castlefields and Ditherington ward (Shrewsbury)
- Market Drayton East ward
- Sundorne ward (Shrewsbury)
- Oswestry West ward

7.3 Table 1 includes some high-level indicators relevant to the assessment of health inequalities and illustrates how Shropshire compares to England and then the range in measurements across Shropshire's electoral wards.

Table 1: Indicators of Inequality Across Shropshire

Measure	England	Shropshire	Range (Ward)	Range (Ward)
IMD Score	21.7	17.2	3.7 (Copthorne)	37.6 (Harlescott)
Life expectancy at birth, (Male)	79.7	80.5	75.3 (Sundorne)	85.8 (Copthorne)
Life expectancy at birth,(Female)	83.2	83.6	79.5 (Tern)	89.6 (Clun)
Deaths all causes, all ages, (SMR)	100	96.7	65.4 (Copthorne)	145 (Worfield)
Deaths all causes, under 75, SMR	100	89.7	55.2 (Clun)	149 (Sundorne)
Preventable deaths, under 75, SMR	100	85.7	48.2 (Corvedale)	160.6 (Sundorne)

7.4 It can be seen that life expectancy for males and females and deaths as measured through the Standardised Mortality Ratio (SMR) (i.e., death rates standardised for differences in the age and sex profile of the population) can be seen to be on average better in Shropshire than in England. However, it is also evident that there is wide variation by electoral ward, with lower life expectancy within Sundorne and Tern and higher life expectancy in Copthorne and Clun.

7.5 Healthy life expectancy (HLE) is another important indicator as it measures the average number of years a person would expect to live in good health based on contemporary mortality rates and the prevalence of self-reported good health, as reported through the Annual Population Survey.

7.6 Table 2 illustrates how HLE in Shropshire compares to the England average and also provides an overall measure of inequality in HLE across the county.

There is inequality across the county with, on average, men in the least deprived areas enjoying 5.5 years in better health and the women 3.5 years.

Table 2: Healthy Life Expectancy (in years) in Shropshire and Inequality in HLE

Indicator	Shropshire	England
HLE Males	62.8	63.1
Inequality in HLE Males	5.5	9.7
HLE Females	67.1	63.9
Inequality in HLE Females	3.5	7.9

7.7 Shropshire's Joint Strategic Needs Assessment (JSNA) process will provide further insight into the health of the population at a more granular level, as will the Director of Public Health's annual report.

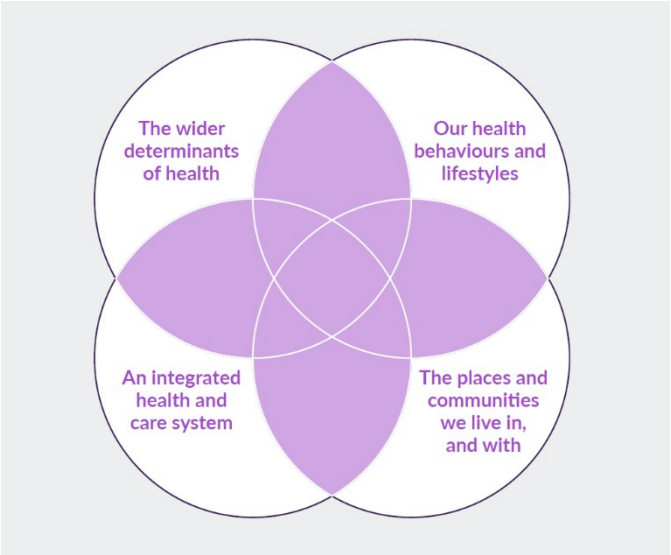
8. Development of the Inequalities Plan

Population Health Model

8.1 Across the ICS there has been a commitment to adopt a population health approach to improving health outcomes. In order to support this approach, the Population Health Model has been adopted. By using data to gain an understanding of population need and then to risk stratify populations, interventions can be targeted at those groups in greatest need of support.

8.2 Figure 3 illustrates the key components of the Population Health Model – whereby there are four interconnected pillars/areas for action that need to be addressed to secure health improvement and reduce health inequalities.

Figure 3: Population Health Model



8.3 This framework has been used to structure Shropshire's Health Inequality plan as described below

9. Underpinning principles

9.1 It is important to note that the inequalities plan is drawing together existing work programmes being taken forward across the ICS footprint and as such the principles expressed here need to be considered in all service developments and interventions. In tackling the complex issues that underlie health inequalities the following principles should underpin action:

- Understanding problems from the perspective of those with 'lived experience' of the issue
- Adopting a 'whole system approach' built on complex systems theory
- Intelligence led identification of problems and evidence-based solutions
- Community centred action – co-producing solutions building on local assets working with individuals and community and voluntary sector partners
- Equitable targeting of resources
- Place-based collaboration and co-production

10. Structure and Content of the Inequalities Plan

10.1 The plan includes high level detail of the intended work programmes being taken forward, grouped under the Population Health Model domains, together with separate sections highlighting plans to meet the needs of 'social inclusion' groups and the PCNs plans addressing neighbourhood health inequalities.

10.2 The plan has been drawn together with the support of officers across the council and the wider NHS and include intended milestones, process and outcome measures.

11. Core Programmes of Work

11.1 The Inequalities Plan is included as appendix 1 to this summary but it is important to note that it is not inclusive of every activity with the potential to impact on health inequalities. Other examples include the following:

Development and Delivery of the Shropshire Plan and Revised Target Operating Model

The Shropshire Plan is the key strategic plan for the council with 4 key priorities:

- Healthy people
- Healthy economy
- Healthy environment
- Healthy organisation

11.2 In order to deliver the plan council officers are undertaking significant work to revise the way in which the council operates – developing a new Target Operating Model (TOM). The associated work programmes will enable the council to further develop and maintain a focus on inequalities over time.

Working with our Voluntary, Community and Enterprise Sector

11.3 Shropshire has a strong history of community led approaches to help build empowered communities. Through working in partnership with the VCES many programmes of work are underway to tackle heath inequalities.

12. Identifying Gaps in Collective Action to Reduce Inequalities in Health

12.1 One of the key opportunities presented through developing this plan is the scope it presents for an assessment any key gaps in actions being taken and as such the following gaps have been identified.

Comprehensive Action to Reduce Smoking Rates

12.2 Smoking has been identified as the single largest driver of health inequalities in England. One study found that smoking accounted for a third of the difference in death rates between the lowest and highest socioeconomic groups. In addition, it has been identified that 50% of the deaths among people with Serious Mental Illness (SMI) are due to tobacco related illnesses. Tobacco control and smoking cessation services thus make a vital contribution in reducing health inequalities.

Meeting the Needs of the LBGTQ+ Community

12.3 The Health Inequalities Plan includes details of work underway to support the needs of older members of the LBGTQ+ community. However national statistics indicate that younger people (aged 16 to 24 years) were most likely to identify as LGBTQ+ in 2018 (4.4%) [15].

12.4 Given the health impacts of identifying or being identified as LBQTQ+ are significant including verbal harassment and physical violence, it is important that some assessment is made of the need for more comprehensive action in this area

Reference to the Accessible Information Standard

12.5 The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. [16]. The Standard supports organisations in ensuring that service users can access and understand the information they are given.

13. Overriding Priorities

13.1 While action to address health inequalities needs to be comprehensive and incorporate all of the planned actions included in appendix 1, the following are key areas where action and impact should be closely monitored:

- The Cost of Living Crisis
- Development and implementation of plans to reduce smoking

- Maintaining a focus on delivering ‘health in all policies’ across the council and wider ICS
- Strengthening the ‘Early Intervention/Prevention’ offer for Children, Young People and Families
- Strengthening prevention through the support of healthy lifestyles – including through making the environment in which people live more conducive to good health and considering the specific needs of those with disabilities
- Delivery of the NHS plans to meet the five clinical areas of focus included in the ‘Core20PLUS5’ framework
- Development and implementation of plans to tackle digital exclusion
- Further consideration of opportunities to improve work-skills among the population and increasing opportunities for higher paid work within the local economy (linked to UKSPF)
- Reducing dependency and the harms associated with drug and alcohol misuse, especially among young people
- Further consideration of the steps that can be taken with academic and other partners to better quantify and meet the health needs of Shropshire’s rural population; exposing the rural health inequalities that exist.

14. Key Areas of Focus

14.1 This section draws attention to key factors that are considered to be particularly relevant in further developing and implementing the Inequalities Plan in Shropshire. These factors include:

Wider Determinants of Health

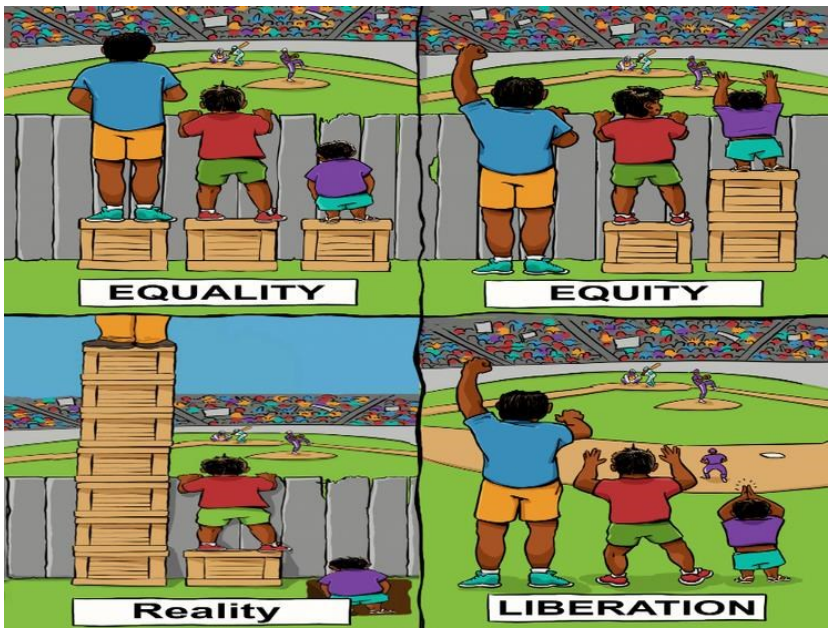
14.2 It is clear that the ‘wider determinants’ (or social determinants) of health impact in diverse ways to influence health outcomes. These same factors affect educational, employment and other outcomes in similar detrimental ways – which go on to compound disadvantage and further undermine health living opportunities. This interrelationship is illustrated in Figure 4 below.

Figure 4: Wider Determinants of Health

Proportionate Universalism

14.3 There is strong evidence that health inequalities present across a social gradient, with those living in the most deprived areas having the worst health outcomes (and likewise worse education, employment and other outcomes). As such proportionate universalism is recommended in tackling inequalities whereby actions are taken with a scale and intensity that is proportionate to the level of disadvantage. Proportionate universalism results in the application of resources equitably across the population proportionate to need, as illustrated in Figure 5.

Figure 5. Proportionate Universalism: The Equitable Distribution of Resources Depending on Need



Rurality

14.4 The rural nature of Shropshire also impacts on inequalities and on health. Furthermore, current methods for identifying deprivation and inequalities in rural areas are not adequate making it difficult to address needs. Factors that impact in particular include transport, housing and the challenges associated with accessing services. Securing well-paid work is a challenge with a predominance of low paid tourism and hospitality related jobs that are frequently insecure. Consequently, there are high levels of in-work poverty.

14.5 Further to this it is well-documented that the budget required by rural households for a minimum acceptable standard of living is considerably higher than elsewhere in the UK. This higher cost of living is partly because of distance to services, poor access to lower priced shopping centres and the cost of heating homes which are often off-grid and less well insulated.

Cost of Living Crisis (CLC)

14.6 The CLC and a recent review links the 'dangerous consequences' of living in a cold home to a child's health and future life expectancy and will push more people into poverty. More people in poverty will lead to more people experiencing ill-health. A wide range of impacts are anticipated, including the following:

- Housing costs will increase for many people - with larger mortgage repayments and anticipated rent increases in social and privately rented properties
- Fuel Poverty Energy prices rose 54% in April and are due to increase again in October. In 2020 16.5% of households in Shropshire were identified as being in fuel poverty (17), with rates highest and rising particularly in rural areas
- Food Poverty 43% of households in receipt of Universal Credit are reported to be food insecure (18). Shropshire's foodbanks are seeing an increasing number of residents seeking support. In January 2021 it was estimated that 14% of Shropshire's population were experiencing food poverty (19).
- Petrol/Diesel costs The increasing cost of travel is being felt most acutely in rural areas causing financial pressure for people needing to travel for work. Rural residents travel further than their urban counterparts.

Health in All Policies

14.7 It is recognised that adopting a Health in All Policies (HIAP) approach can support local authorities to embed action to improve health and reduce health inequalities across all of their functions and such an approach is being adopted in Shropshire.

14.8 Through adopting HIAP the factors that lead to variations in health can be identified and addressed. It can assist in enabling decisions on the distribution of resources to be made in the context of relative need, taking into account rurality as an independent but influential factor.

Joint Strategic Needs Assessment (JSNA)

14.9 The Joint Strategic Needs Assessments (JSNA) is a Statutory Duty placed on the Health and Wellbeing Board. Shropshire is currently developing 'Place-based JSNAs', focussed on smaller localities which will help build an understanding of the health and wellbeing needs of communities. By gaining local knowledge and insight and taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved, the JSNAs will be critical in informing future actions and priorities in this plan.

15. Recommendations

15.1 Building on the information set out above the following overarching recommendations are made:

- Development of a framework enabling progress in reducing inequalities to be periodically reviewed, including monitoring and tracking progress against key measures through development of an action log.

- Continue to roll out and adopt a Health in all Policies Approach to our programmes and polices

- All staff and partners acknowledge their individual organisational and our collective shared responsibility, to focus plans and implementation of services to seek to address variation in health and wellbeing outcomes.

We want everyone to have a good quality of life no matter where they live or the circumstances they were born into.

16. Inequalities and Health Inequalities Across Shropshire

Format of the Plan

Shropshire's Inequalities Plan is set out in 6 tables as follows:

- Table one: The wider determinants of health
- Table two: Healthy lifestyles
- Table three: Healthy places
- Table four: Integrated health and care system
- Table five: Social Inclusion groups
- Table six: Primary Care Network Plans

For each priority within the tables the following 'high level' information is provided:

- A description of the priority/issue and how it impacts on inequalities
- The associated work programme through which inequalities will be addressed
- The individual leading the work and the strategic group to which progress is reported
- Key actions and milestones associated with the work programme
- Key process measures associated with the work programme
- Key outcome measures associated with the work programme
- Targets related to the work programme or associated outcomes, where these apply

Please note:

Whilst all efforts have been made to ensure the contents of the plan below are correct at the time of submitting this report, it is possible (and to an extent to be expected) that some plans will - for a variety of different reasons - have been changed.

Any such changes will be reflected in future updates of this Inequalities Plan.

Table 1: Wider Determinants of Health

Population Health Domain: Wider Determinants

Marmot: (i) Create fair employment (ii) Ensure healthy living standard

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.1 Embed Health in all polices- a mechanism for screening for – and where necessary assessing the potential health impacts of developments/plans	Implementation of equality, inclusion and health screening tool (EIHIA)	Sue Lloyd, Consultant in Public Health, reporting to H&WBB	PH wider determinants team undertake 'face to face' training (March 2022) Council officers undertake 'face to face' training (March 2022) 'Leap into learning' training rolled out across the council (March 2023) Delivery of Health Impact Assessment Transport (May 2022)	100% of team trained 12 officers trained 10% of council officers trained) Health Impact Assessment complete	Number of EIHIAs completed prior to committee stage Skills and knowledge on delivery of Health Impact Assessment embedded in organisation	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.2 Housing – Influences health inequalities through the effects of housing costs, housing quality, fuel poverty and the role of housing in community life	Sufficient affordable and supported accommodation to meet identified need through production of a housing need and demand position statement which maps current provision and evidences current and future need for all tenures of housing, including specialist and supported accommodation	Jane Trethewey Laura Fisher reporting to Housing Executive Board	Undertake authority-wide housing needs survey (October 2022) Produce specialist accommodation and independent living strategy (March 2023) Produce affordable and intermediate housing options strategy (March 2023) Review and revise allocations policy (April 2023) Produce revised Housing Supplementary Planning Document (SPD) (March 2023)	Report produced Strategy published Strategy published New policy introduced SPD published	Numbers of additional affordable housing Numbers of additional specialist / supported accommodation	Minimum of 250 additional dwellings per year

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
Homelessness *see table. 5*						
1.3 Reducing fuel poverty and improving housing standards	Ensure all relevant domestic private rented property meets the Minimum Energy Efficiency Standard (MEES) Develop a sustainable affordable warmth strategy Delivery the private housing assistance policy.	Jane Trethewey / Laura Fisher reporting to Housing Executive Board	Undertake escalated enforcement approach. (September 2022 to March 2023) Strategy which sets out initiatives to tackle fuel poverty, whilst providing a road map for homes becoming net zero carbon. (February 2023)	Number of homes with Housing Health Safety Rating System (HHSRS) category 1 and 2 hazards Publish strategy Total number of Disabled Facilities Grants (DFGs) and major equipment grants provided Number of Disabled Facilities Grants (DFGs) provided	Reduce number of households living in fuel poverty. In 2020 16.5% of households (almost 23,000) were estimated to be in fuel poverty	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.4 Economy and skills – people lacking skills and job opportunities leads to unemployment, poverty and ill-health There is a need to create improved employment prospects through local economic policy and enabling infrastructure, education, skills, lifelong learning and labour market programmes. These need to be targeted to maximise opportunities to reduce health inequalities, improve health across the County and to seize opportunities to create economic growth. [1]	Improving overall employment rate/average earnings	Tracy Darke and Matt Potts, reporting back into the newly created Shropshire Economic Partnership Board	Adoption of Economic Growth Strategy with wellbeing & health embedded as a core value. The document is currently open for public consultation. Expected adoption and formal launch (December 2022)	Annual survey of hours and earnings	Median gross workplace earnings for full-time workers Annual Population Survey including NVQ level data Census data will also include specific qualification data	Shropshire 9% less than the national average (2021) Gap between national and Shropshire full time earnings closed by at least 50% by the end of the Economic Growth Strategy lifecycle (2027) * *Metric is subject to change and sign off of the Economic Growth Strategy following public consultation

[1] Shropshire Council (2022) Invest Shropshire

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.4 continued.,	Targeting skills development programmes	Tracy Darke and Matt Potts, reporting back into the newly created Shropshire Economic Partnership Board	Recruitment of senior skills and workforce development officer post. (Starting: September 2022). Targeting ESF programmes to support NEETs, the unemployed and those needing upskilling in work. Provide careers advice and guidance. Support transition arrangements into education, employment or training (TBC) UKSPF programme currently in development and will incorporate programmes under the banner of People and Skills, ultimately replacing ESF funded programmes. Submission of Investment Plan to Government (August 2022). Programme delivery (Expected: Autumn 2022)	Development of skills plan and associated engagement with FE, HE and private providers, and businesses Regular monitoring of ESF contracts. Maintaining the connections with providers offering programmes. Link internally with other groups/areas within the Council with an aim to reduce NEET figures UKSPF – Details TBC subject to sign off of Investment Plan by Government	16-17-year-olds NEET figures	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.4 continued.,	Supporting employment among those with Learning Disabilities (LD)/Mental Health (MH)/Long-Term Health Conditions (LTCs)	LD – Natalie Hawkins MH – Ruth Davies Enable manager – Roshni Shrosbree	Currently bidding for additional LD and MH funding. (Ongoing)	ASCOF 1E – Proportion of adults with learning disabilities in paid employment. 1F: Proportion of adults in contact with secondary mental health services in paid employment.	Gap in the employment rate between those with a learning disability and the overall employment rate	
1.5 Workforce – COVID led to unemployment/lower paid/less stable employment. We will work to make Shropshire workplaces fair, happy and healthy places for people to work in and promote wellbeing for all (See 1.4 also)	'Thrive at Work' West Midlands award. Shropshire Council has received foundation accreditation and now working towards bronze level	Carol Fox Reporting to: Workforce and Information Management Team Resources Management Team Health, Safety and Welfare Group	Foundation accreditation received (November 2021) Undertaking Bronze level at present (December 2022) Silver level achieved (March 2023)	Submission for bronze award December 2022	Shropshire Council will have an equitable wellbeing offer for all staff	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.6 **Education including SEND –** lower educational achievement is associated with poorer health and health inequalities. Inequalities in childhood are closely associated with measurably poorer health outcomes in adults and comparatively higher numbers of Adverse Childhood Experiences	Addressing sizable gaps in attainment between disadvantaged pupils and others	Steve Compton and school advisors Reporting to DMT	Where there are sizeable gaps in attainment follow up during School Improvement Assistance (SIA) visits (including interrogation of other factors) (Ongoing) All schools publish pupil premium and recovery premium plans Recovery Premium Funding plans are reviewed by the SIA (Ongoing)	School readiness: % of children with free school meal status achieving a good level of development at the end of Reception School readiness: % of children with free school meal status achieving the expected level in the phonics screening check in Year 1	Children with free school meal status achieving a good level of development at the end of Reception Children with free school meal status achieving the expected level in the phonics screening check in Year 1	
1.7 **Early years**	Improving outcomes for 24U children Improve uptake of 24U places (already above national but still leaves 20+% of our most vulnerable children not in a setting)	Alison Rae Reporting to EIS	Deliver Early Talk training to all 0-3 settings focussing on the settings with 24U children first. (From September 2022) Improve letter to parents to have more impact End of term (July 2022.)	% reduction in grey and black outcomes with Ages and Stages Questionnaire (ASQ) for 2-year-olds. % Uptake of 24U places increases	Improved outcomes for 24U children	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.8 Post 16	Partnership work to provide appropriate post 16 offer	Steve Compton/Matt Potts reporting to Early Help Partnership Board	Link with post 16 providers to ensure that all support options for young people/adults is available (Ongoing)	% reduction in NEETS	16-17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known Participation data for 16-17-year-olds	
1.9 Virtual School (responsible for education of children who are looked after)	Look at the SDQ (Strength and Difficulties questionnaire process) and how SDQs are used effectively at Personal Education Plans (PEP)s to identify and act on needs The SDQ is built into the PEP platform and there is a process in the meeting where the social/emotional needs of each Looked-After Child is discussed and planned for	Jo Kelly reporting to Children and Young Peoples' Board	To meet with Children Looked After (CLA) Service Manager and nurses. Agree way forwards e.g. PEP platform (Early September 2022) The scales on the PEP indicate improving outcomes for social and emotional well-being and relationships/behaviour. PEP Audit to include social and emotional wellbeing scales that are in the new PEP (launches 5th September) (Audit: November 2022)	2 scales in new PEP (social and emotional wellbeing and relationships and wellbeing) will measure improvements. Plan to run report that can show where the children are at by the end of the autumn term and again at end of summer term	Average Attainment 8 score (Average Attainment 8 score for all pupils in state-funded schools, based on local authority of pupil residence) Average Attainment 8 score of children in care (Key stage 4 average Attainment 8 score of CLA continuously for at least twelve months at the end of March (excluding children in respite care). Attainment & progress outcomes for CLA are in line with or better than the national averages	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
SEND						
1.10 Speech and language focus Too many children in reception year do not achieve at least the expected levels across all goals in 'communication and language' and 'literacy' areas of learning	Reduce the waiting list for Speech and Language therapy services	Stephanie Jones reporting to SEND Board/ Children and Young Peoples Board	All Early Years/Primary School settings to receive training on Speech, language and communication (September 2022) % of children achieving expected level of 'communication, language and literacy' to be reviewed in 2023 and annually until 2025	% of education and early years setting trained to deliver speech, language and communication intervention collected locally % of children on waiting lists for speech and language therapy collected locally	More children will achieve expected level of 'communication, language and literacy' (This may be impacted by Covid-19)	% of children achieving expected level across all goals in the 'communication and language' and 'literacy' areas of learning at the end of reception year will increase by 25% by **2025**. (Baseline set using 2019 data) No clear target set to date

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.11 Transport - impacts on health – systems need to be safe and accessible for all, enable active travel and use of public transport and minimise harmful impacts on population groups and the environment	Local Transport Plan 4 (LTP4)	Infrastructure Department, Place Directorate Steve Smith and Victoria Merrill. reporting to Place DMT on outcomes / recommendations from the Project Steering Group (cross-organisational representation)	Cabinet approval of draft portfolio of documents. Dates to be updated pending issue of new DfT guidance on LTPs expected (Spring 2023) Annual review of interventions and targets (Annual)	KPIs to be agreed through LTP4 to include decarbonisation/ improving quality of life	KPIs to be agreed through LTP4 to include decarbonisation/ improving quality of life	No targets set to date.

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.11 continued., The LTP4 considers and prioritises the mobility needs of people, places, and activities in promoting and maintaining healthy, equitable and sustainable communities. Local cycling and walking infrastructure plan (LCWIP) to encourage and enable sustainable physical activity in daily life for all population groups	Local cycling and walking infrastructure plan (LCWIP)	Rose Dovey reporting to Cabinet and Full Council	LCWIP finalised (March 2023)	Increased proportion of county with access to good quality cycleways and walking in areas of deprivation and low physical activity.	Shropshire as a zero-carbon county Healthier living for Shropshire residents. Reduced congestion and car dependency 	No targets set to date

Table 2: Healthy Lifestyles

Population Health Domain: Healthy Lifestyle Behaviours

Marmot: (iii) CYP and adults – maximise capability and control
(iv.a) strengthen Ill-health prevention (lifestyles)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.1 Smoking – is the single largest driver of health inequalities in England. In addition, 50% of the deaths among people with Serious Mental Illness (SMI) are due to tobacco related illnesses The NHS is introducing new Tobacco Dependency Treatment services and public health need to reconsider what community support can be provided to smokers to enable them to quit	The NHS will lead the implementation of new or revised smoke-free pathways, as follows: • Maternity services • Acute Inpatient services • Mental Health Inpatient services	Lead - Emma Pyrah Reporting to: NHS Tobacco Dependency Treatment Steering Group	Maternity service commences and all national requirements including data recording and reporting fully met (August 2022) Acute service commences and all national requirements including data recording and reporting fully met (TBC 2022) Mental health services workforce education and socialising the model completed (Autumn 2022)	Data collection and monitoring systems need to be developed based on national guidance. In the first instance the data will be reported at provider level and will include: • Number of acute inpatients with completed smoking • Number of MH inpatients with completed smoking • Number of maternity bookings with completed smoking Smoking status at 28 days will also be captured for the above categories	TBC in the context of national KPIs for the TDT programme	

	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
	Public Health will lead on developing community-based smoking cessation support for: (i) Patients discharged following receipt of Tobacco Dependency Treatment (ii) Community based smokers	Berni Lee reporting to Healthy Lives Steering Group	Liaise with NHS colleagues and LPC/ community pharmacies to provide national 'advanced smoking cessation service' for those discharged (December 2022) Complete data modelling to inform capacity planning, service delivery options and costs for 'in-house' service (December 2022)	Number of pharmacies offering the service Number of smoking quitters supported through pharmacies Service model agreed and commissioning commenced	Smoking Prevalence 18+ Smoking Prevalence in adults in routine and manual occupations Smoking at time of delivery (SATOD) Smoking Attributable Mortality Smoking Attributable Hospital Admissions Number (%) smokers successfully quit at 4 and 12 weeks	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.2 Healthy Weight/ Obesity impairs health increasing the risk of several diseases. Socio-economic factors play a key role in driving obesity with adults and more so children in the most deprived areas having higher obesity prevalence than the least deprived areas	Development of Healthy Weight Strategy (HWS)	Berni Lee reporting to Healthy Lives Steering Group	Complete analysis of public/stakeholder survey to inform draft strategy (December 2022) HWS drafted (March 2023) Consultation on draft HWS completed (June2023) Final HWS presented to HWBB (September 2023)	Draft HWS produced Number of groups consulted Number of responses received	Obesity in early pregnancy Breastfeeding prevalence at 6-8 weeks Reception: Prevalence of overweight (including obesity) Year 6: Prevalence of overweight (including obesity) Percentage of adults (aged 18+) classified as overweight or obese	
	Establish work programme to promote healthy weight environment	Berni Lee reporting to Healthy Lives Steering Group	Agree priority areas for action (February 2023)	TBC (depends on priorities agreed)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.2 continued.,	Roll-out of NHS provided Digital Weight Management Programme (DWMP) for those with type 2 diabetes or hypertension with a BMI of 30+ (adjusted for ethnicity)	Tracey Jones, reporting to Population Health Board	Practices actively encouraged to sign up to Weight Management DES (June 2022) Practices actively encouraged to sign up to make referrals to DWMP (Ongoing) Staff encouraged to self-refer to DWMP (Ongoing)	Number (%) practices signed up to WM DES Number patients offered/take up of DWMP Number of staff self-referring to DWMP		
	Provision of Tier 2 adult Weight Management (T2WM) Services Supporting weight management among children and young people	Berni Lee reporting to Healthy Lives Steering Group	Extend contract for commissioned Adult T2WM service (June 2022) Complete service promotion with key stakeholders to maximise direct and self-referral for eligible adults (June 2022) Agree specification for 'in-house' weight management service (or alternative) (December 2022) Agree resource and specification for weight management support among C&YP (December 2022)	Contract extended Number of referrals to service by source Number (%) of referrals completing T2WMP TBC (depends on specification) TBC (depends on specification)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.3 Physical activity	Together We Move social movement established	Penny Bason reporting to Healthy Lives Steering Group	Stakeholder event (5th July 2022) Digital / data hub developed – to share practice / learning and encourage inspiration (October 2022) Communities of learning established (September – December 2022) Framework for action developed (January – March 2023) Resource for front line professionals developed (September 2022)	Number of attendees Number of champions registered Number of learning events held, and reports produced/distributed Number of organisations signed up Resource produced and distributed	Percentage of less active children and young people Percentage of physically inactive adults	Reduction in less active C&YP (27.8% December 2021) Reduction in physically inactive adults (26.6% April 2022)
	Approach to building physical activity into disease management programmes developed					

Table 3: Healthy Places

Population Health Domain: Healthy Places and Communities

Marmot: (v) Create healthy and sustainable places and communities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.1 Air Pollution - impacts on respiratory and cardiovascular health – particularly affecting those living in more deprived communities and who are at higher risk (e.g., through ill health, long term health conditions)	Implementation of Air Quality Management Area (AQMA) plans in Shrewsbury and Bridgnorth to reduce NO_2 concentrations Provide required / relevant air quality data and input into relevant areas of policy to target further pollutant reductions. <u>Planning / New Development</u> Review new development planning permission applications to consider impact on local air quality	Kieron Smith reporting to Air Quality Steering Group	Review Air Quality Action Plan (AQAP) for AQMA's to target reductions in NO_2 concentrations and select targeted interventions where necessary. (February 2023) Continue proactive monitoring for air pollution across the county. Report to Defra annually Environmental Protection will provide consultation / request air quality measures on applications with relevant air quality considerations (ongoing)	Council approval of Revised AQAP Maintain network of Diffusion Tube monitors and 2 real-time Earthsense Zephyr Monitors Number of planning applications assessed for potential impacts	Meet UK guidance values in next 5 years– to be decided on action plan review Maintain air quality measurements within the UK guideline values (excluding AQMAs) % Responded to within relevant consultee timescale (7/14/21 days)	TBC To work toward meeting WHO interim air quality target values

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.1 continued.,	Commitment from LTP to reduce business mileage and reduce pollutants from fleet vehicles	Will Nabih reporting to ICS Climate Group	Organisations to enable the option of agile (hybrid) working where there is no negative impact on service delivery (ongoing) ICS to develop a system Green Travel Plan, ensuring a hierarchy of travel starting with active travel. (Plan has been approved by ICB Board) Ensure that, for new (fleet) purchases and (fleet) lease arrangements, the system (and organisations) solely purchases and leases cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs) (Ongoing) Electric Vehicle (EV) charging infrastructure at base sites	Organisations have hybrid working policies and procedures Document published (April 2023) The NHS will cut business mileages and fleet air pollutant emissions by 20% (by 2023/24)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.2 Planning decisions impact on health equity for example through creating healthy environments through accessible quality green infrastructure that supports cohesive communities	The Local Plan: Healthy places including: Implementation of new Health and Wellbeing policy (SP6)	Eddie West Joy Tetsill Andy Wigley reporting to Cabinet / Full Council	Adoption of The Local Plan (March 2023) Staff awareness training on SP6 requirements 100% of staff trained (March 2023) Community Infrastructure Levy/section 106 investment in healthy places (ongoing)	100% of staff trained by early 2023 Provision of quality green space & infrastructure	Number of planning consents which reference SP6 in planning conditions The quantum of quality/usable open/green space in new developments	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.3 Licensing decisions impact on health through: • controlling alcohol supply and gambling activities • protecting children and other vulnerable people from being harmed or exploited by the illegal supply of alcohol and illegal gambling activities • supporting effective management of the evening and night-time economy to reduce crime and improve safety	Licensing Act Policy Statement 5-yearly review Gambling Act Policy Statement 3-yearly review	Frances Darling Strategic Licencing Committee Full Council	**Licensing Act Policy Statement** Revised Policy April 2024 Preparation of draft revised Policy (April to June 2023) Consultation period (July to September 2023) Policy approved by full Council (December 2023) **Gambling Act Policy Statement** Revised Policy January 2025 Preparation of draft revised Policy (January to June 2024) Consultation period (July to September 2024) Policy approved by full Council (December 2024)	**Licensing Act** Prevention of crime and disorder Public safety Prevention of public nuisance Protection of children from harm **Gambling Act** Prevent gambling from being: • Source of crime or disorder • Associated with crime or disorder • Used to support crime Gambling is conducted in a fair and open way	Police data to track crime and disorder trends over time PHOF – PHE (Child and Maternal Health, school age children supplementary indicators) Admissions for alcohol specific conditions (under 18s)	Downward trends

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.4 Culture, Leisure - and creative sectors make a significant contribution to physical, mental and community health and well-being through providing people and families access to affordable activities and experiences. They can contribute to tackling health inequalities through delivering educational opportunity, promoting community cohesion and generating economic growth	Accessible and inclusive volunteering opportunities at Shropshire Museums to develop communication, confidence, technical and employability skills and combats social isolation	Becky Benson .	New opportunities made available to social prescribing networks. SEND employability skills programme (from April 2022)	5 Partners Volunteers 5 social prescribing referrals 5 SEND programme participants 50 older volunteering participants		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.4 continued.,	Shropshire libraries **Bookstart** Supporting Home Learning Environment to help develop Early Years Speech Language & Communication skills universally as well as targeted programmes such as Bookstart Early Years and SEND Offer as well as the Storytime resources	Annabel Gittins reporting to Libraries and Reading Agency Evaluations Group	Distributing all 470 1-2yrs packs And 1240 3-4 yrs. packs to most disadvantaged families (1 April 2022 to 31 March 2023)	Managing transition to new Bookstart Early Years Offer	Numbers of families receiving books since lockdown	
	Summer Reading Challenge (SRC) & HAF Programme. Pleasure & attainment reading for those most disadvantaged children (majority FSM)	Annabel Gittins reporting to Libraries and Reading Agency Evaluations Group	Progress chart for each setting to measure uptake and progression through the challenge (School summer holidays 2022)	Progress chart for each setting to measure uptake and progression through the challenge	More children reaching their reading target through the summer. Improving the return to school and attitude to learning	To reach 80% of all children attending HAF activities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.5 **Food Insecurity** has a physical and mental wellbeing impact on everyone experiencing it. Food insecurity in childhood can have life-long implications impacting on educational achievement and general development and wellbeing	Implementation of the Shaping Places for Healthier Lives Food Insecurity Work Programme in SW Shropshire	Emily Fay reporting to Healthy Lives Steering Group	Development of learning and feedback structure which brings partners and people with lived experience together from across the system (December 2022) Identify pilot economic solution(s) to reduce food insecurity including help for people to maximise their incomes agreed (April 2023) Plan for frontline staff training to improve navigation of the system for people with multiple areas of need agreed (April 2023) Agree pilot social solutions which reduce food insecurity including trialling communications to reframe food insecurity and reduce stigma (June 2023) Develop communications plan for health professionals around food insecurity and health inequalities (June 2023) Plan to develop co-produced community led solutions which reduce food insecurity agreed (June 2023)	Learning and feedback plan produced Pilot economic solution(s) agreed Programme for staff training agreed Plan to reframe food insecurity agreed Communications plan for health professionals developed Plan for community led projects agreed	TBC with support from external evaluation provided by PPL/Cordis Bright	

Table 4: Integrated Health and Care System

Population Health Domain: Integrated Health and Care System

Marmot: (vi) Give every child the best start in life
(iv.b) strengthen Ill-health prevention (transformation/disease programmes

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.1 Restore NHS services inclusively (to include 20% most deprived LSOAs (Core 20) and ethnic minorities). Evidence suggests these are the groups for whom heath inequalities have widened most during the pandemic	ICB strategic health inequalities plan advocates addressing health inequalities as a core principle of all programmes of work. In following this approach there will be multiple leads for programmes of work across NHS priorities As a consequence of the pandemic there have been growing waiting lists for outpatient procedures	Julie Garside ICB Director of Performance and Planning Reporting to ICB Board TBC (vacant) ICB Director of Elective Care	Requirement produce board reports of waiting data differentiated by deprivation quintile and ethnicity incorporated into NHS Trust contracts. and to be adopted by the ICB (March 2022) Analysis of current referrals into outpatient services using methodology developed for vaccination programme (end of Q1) Map demand/access inequality +analyse outpatient procedure codes for areas of focus (September 2022)	NHS Trust and ICB reports show access by most deprived quintile and ethnicity EQIAS for all provider elective recovery plans	Service access rates by most deprived quintile/ethnicity No of planned care procedures in targeted populations	Level up access across STW in areas of selected focus

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.1 continued., Council Directors to determine action required to assure equitable access to council provided and commissioned services	Consider development of data management strategy to include measures enabling assessment of access rates	Helen Watkinson Reporting to New group and linked to data quality governance	Develop programme of intervention for selected clinical areas (October 2022) Implement targeted approach (April 2023) Decision on development of data management strategy (November 2022)	TBC dependent on decision	TBC	
1.2 Rurality Deprivation indicators can mask small pockets of significant deprivation and poor health outcomes in rural areas. Drivers of inequalities include social exclusion and isolation, access to and awareness of services. This is not captured in the 'Core20'	Secure support from NHSE/I, OHID and other national expert bodies to determine most appropriate method of assessing inequitable access to services for rural populations and inequitable outcomes	Tracey Jones/Berni Lee Reporting to Population Health Board	Progress discussions with NHSE/I, OHID, Institute of Health Equity UCL and Lincoln International Institute for Rural Healthcare (October 2022) Agree approach to be adopted (or piloted) across the ICS (December 2022)		TBC	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.3 **Mitigate digital exclusion** resulting from barriers such as poor access, connectivity, confidence, or skills. With increased use of digital services there is a danger of increased inequality.	Digital Exclusion Programme, as part of Digital Target Operating Model	Nigel Newman reporting to Digital TOM Board	Full details of digital exclusion workstream specified (October 2022) Interdependencies with other council work programmes identified (December 2022)	TBA	TBA	Equitable access to services and support for all population groups
	Contractual requirements to ensure providers are collecting and monitoring the impact of digital access in relation to service provided and evidence of alternatives for those who cannot access via digital means including evidence of safeguarding considerations.	System Data and contractual leads reporting to Digital System Strategy Group	Inclusion of requirements re information standards and data collection within the NHS contracts. April 22. Included in schedule 2N Identification of digital inclusion and reduction of digital health inequalities as a key principle in draft system Digital Strategy (By June 2022)	Reports to ICB boards and committees relating to assurance requirements of mitigating against digital exclusion by provider leads. Inclusion in sustainability and transformation developments EQIA of digital means of service access/ delivery and appropriate mitigation plans	Increased uptake of digital means of access to healthcare Assurance of appropriate alternatives and levels of access to these	
	To work collaboratively with partners to increase digital inclusion	System Digital lead Rebecca Gallimore. Director of Digital Transformation, Reporting to Digital System Strategy Group	Finalise Digital Strategy and data transformation plan (Sept 22) Implement Digital Strategy including upskilling workforce (By December 2022 onwards)			

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.3 continued	To actively promote and consider impact on digital inclusion in sustainability and transformation projects	Nigel Newman reporting to Digital TOM Board System Data and contractual leads reporting to Digital System Strategy Group Shropshire Telford and Wrekin ICS Digital Lead + LA Digital leads	Establishment of LA + NHS digital inclusion group April 22 Development of Digital Inclusion programme, including VCSE projects include device loan schemes and building digital literacy with digitally excluded groups at Place level; (By September 2022) Implementation of digital inclusion programmes (By December 2022)	Inclusion in sustainability and transformation programmes evidence of digital skill mapping and training for staff as appropriate.	Individual digital inclusion projects will have identifying measures of project success in terms of original outcomes i.e. increased self-reported confidence in use of digital technologies	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.4 **Datasets are complete** – disadvantaged groups need to be identified thus collection of ethnicity, other protected characteristics, and details of 'health inclusion' groups need to be recorded consistently across services.	Systems are asked to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. Systems should also implement mandatory ethnicity data reporting, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.	Individual provider organisation Data Leads + Executive Leads for inequalities in provider organisations Craig Kynaston System Head of Business Intelligence reporting to Population Health Board	Requirement in NHS Contract Schedule 2N to identify baseline and develop a programme of improvement for data collection (April 2022) Agreement of primary care to data sharing from practices into Aristotle tools (July 2022) Agreement of system data sharing approach across system (December 2022) Production of Digital and Data Strategy. (April 2023) Adoption by system of the Aristotle health inequalities platform and tools (Beginning April 2023)	Production of data improvement plans ICB monitoring of data collection via provider Contract review meetings	Improved percentage of recorded identified protected characteristics Improved access to linked datasets to analyse Health Inequalities Inclusion of Health inequalities analysis in service /system transformational programmes	Achievement of agreed data improvement plans per provider

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.4 continued.,			In line with the ICS Intelligence Function Guidance – Implement cross-system information governance arrangements, particularly between primary and secondary care and local government partners, that enable the safe and timely flow of information across the ICS and support the Integrated Care Board (ICB) to deliver its functions (March 2023) Adopt the What Good Looks Like framework principles including development of an ICS-wide intelligence platform with a fully linked, longitudinal dataset to enable population segmentation, risk stratification and population health management (April 2023)		Governance processes will allow data linkage for health and social care in a legal and compliant manner at system level	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.4 continued., Council Directors to determine action required to assure data sets are complete (protected characteristics) for council provided and commissioned services	Consider development of data management strategy to include measures to ensure appropriate collection of protected characteristics data	Helen Watkinson Reporting to New group and linked to data quality governance	Decision on development of data management strategy (November 2022)	TBC dependent on decision	TBC	
4.5 Strengthen leadership and accountability- this underpins delivery of the other key priorities Tackling inequality is not a separate programme and should be embedded in all decision-making, strategies, and delivery plans	Identification of executive level lead to ensure health inequalities embedded in its organisations business as usual and transformation programmes Development of system Health inequalities Plan as part of operational planning processes ensuring alignment to work of both Local Authorities and Population health Management Approach	Individual provider NHS organisations reporting to ICB ICB SRO Health Inequalities + provider leads	Named organisational leads identified (April 2022) Draft system plan (March 2022) Operational Plan submission and approval (April 2022) ICB Strategic Plan +accompanying high level plan approval (July 2022)	Implementation of actions within the high-level implementation plan accompanying the strategic plan	Reports to ICB to demonstrate how inequalities have been considered as part of decision making, strategies and delivery plans Delivery of health inequality commitments in operational plan	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.6 **Population Health Management** (*ie not one of the specified 5 priorities* but a local one involves the use of intelligence led methodology to inform health and care planning and the development of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex need	Population Health Enabling Workstream Establishing the 'engine room' for Population Health Management (PHM)	System Lead for PHM SRO TBC Reporting to Population Health Board/ Shropshire Health and Wellbeing Board (HWBB)	System lead for PHM identified. (October 2022) Review capacity requirements within the 'engine room' (October 2022) Requirements for 'engine room' agreed through Chief Executives Group and ICB Board (June 2022) Training being delivered (ongoing) Develop competency framework to support ongoing training/development (by November 2022) Requirements clarified and next steps defined (December 2022) Work programme refreshed (January 2023)	Engine room staff upskilled through training Competency framework in place to support ongoing training/development	Functioning and skilled 'engine room' for PHM	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.7 Personalisation/ Personalised Care Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities. Social Care have been using Personalised approaches for some time – this work about embedding culture change throughout Health and Care	Increase the number of Children and Young People (CYP) who have asthma personal care and support plans (delivered by GP, Community Nurse and Hospital)	Nicola Siekierski reporting to ShIPP Shropshire HWBB ICS CYP Board	Recruitment of Band 6 Asthma Nurse in GP Practices to identify CYP with an asthma diagnosis who require an Asthma Management Review, the service will prioritise areas of high deprivation to offer out appointments. (May 2022) Asthma App -offered as a personalised tool to enable CYP to self-manage their Asthma symptoms (June 2022) Co-Production of CYP Creative Health activities to support CYP with a diagnosis of Asthma. Expressions of Interest are currently being offered out across the creative communities to access grant funding for activities such as yoga, swimming, or singing which help manage the symptoms of breathlessness (March 2022)	Asthma nurse in post Numbers of CYP accessing the app. Uptake of Creative Health Activities by CYP Evaluation of health and wellbeing outcomes for CYP with Mental Health issues who have accessed Creative Health offers	CYP with asthma will manage their condition more effectively which will increase personal wellbeing and help reduce incidence of health interventions needed through mismanagement of condition Reduction in hospital admissions for asthma in CYP	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.7 continued.,	Clinical staff in all PCNs complete the Personalised Care Institute 30 min e-learning refresher training for Shared Decision Making (SDM) conversations	Emma Pyrah reporting to Primary Care Commissioning Committee (PCCC)	Commissioned providers (May 2022) All PCN clinical staff trained (September 2022) As part of a broader social prescribing service, a PCN and commissioner must jointly work with stakeholders including local authority commissioners, VCSE partners and local clinical leaders, to design, agree and commenced delivery of a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs. This plan must take into account views of the people with lived experience (October 2022)			

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.7 continued.,			A PCN must review cohort definition and extend the offer of proactive social prescribing based on an assessment of population needs and PCN capacity (March 2023) PCNs must audit a sample of the Patients current experiences of shared decision making through use of a validated tool and must document their consideration and implementation of any improvements to SDM conversations made as a result (March 2023)			

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
Accelerate Prevention Programmes that proactively engage those at greatest risk of poor health outcomes (incorporating core20+50):						
4.8 COVID and flu vaccination The COVID-19 pandemic has highlighted existing health inequalities for ethnic minority groups and those living in more socioeconomically deprived areas in the UK. With higher levels of severe outcomes in these groups, equitable vaccination coverage should be prioritised[2] Barriers to vaccine uptake include perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders[3]	A separate vaccination group has been set up within the ICS to look at uptake and delivery in vulnerable/at risk groups	Steve Ellis /Rachel Robinson reporting to Health and Wellbeing Board	Identify priority groups – rolling programme (Ongoing) Identify appropriate vaccination sites/delivery – rolling programme (Ongoing) Vaccination outreach plan in place – rolling programme (Ongoing) Vaccine delivery Covid-19 Influenza	Covid-19 vaccine outreach plan in place Number of areas of low uptake identified Proportion of areas of low uptake allocated a pop-up during campaign period Number of vaccination sites delivering to vulnerable/at risk groups	Place-based vaccine coverage: COVID-19 Flu IMD deciles % uptake age 12+, 18+, age 50+ * Uptake % by ethnicity Uptake % among individuals identified in at-risk groups (e.g. LD, SMI etc)	95% cover Covid-19 vaccination Regionally comparable cover in ages12+, 18+, age 50+ IMD 1,2 & 3 deciles for each vaccination campaign period Regionally comparable cover of individuals on GP Learning Disability Register deciles for each vaccination campaign period

[2] Inequalities in coverage of COVID-19 vaccination: A population register based cross-sectional study in Wales, UK - PMC (nih.gov)

[3] Factors influencing COVID-19 vaccine uptake among minority ethnic groups (publishing.service.gov.uk)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.9 Annual health checks for people with a learning disability (LD) People with a LD have poorer physical and mental health than other people and die younger. Many of these deaths are avoidable and not inevitable Annual Health Checks can identify undetected health conditions early, ensure the appropriateness of ongoing treatments and establish trust and continuity care	Work to increase the inclusion of all those with LD who should be on a GP LD register Improve the proportion of those on the register who receive a high-quality annual health check	Janet Gittins, LD Delivery Group reporting to LD&A Board	Monthly monitoring of registers list size and completed LDAHCs (Ongoing). Support provided to GP practices through service commissioned from MPFT to cleanse registers and complete LDAHCs. (Ongoing) Quality audit review pilot undertaken winter 2021. Audits to commence in (July 2022)	Increase in number (%) of people on a practice LD register Increase in number (%) on LD register who receive an annual health check which includes a Health Action Plan. Increase in number (%) on register who have received vaccinations (flu, covid) Reduction in health check DNAs Increase in those aged 14-21 on the LD register and accessing a LDAHC Improvement in quality of LDAHCs completed	TBC	Deliver annual HCs for 75% of those aged over 14 years on the practice LD register

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.9 Annual health checks for those with SMI. People with severe mental illness (SMI) have a life expectancy that is 15–20 years lower than the general population. This is partly due to physical health needs being overlooked. Smoking is the largest avoidable cause of premature death and individuals with SMI also have double the risk of obesity and diabetes, and three times the risk of hypertension	MPFT-commissioned to support development of an integrated physical health care pathway, including a dedicated clinical team, supporting GP practices	Claire Parker/Gail Owen reporting to Mental Health Transformation Board Claire Parrish MPFT & Gail Owen reporting to SMI PH Check Operational Group	Integrated pathway developed (March 2023) GP registers cleansed to ensure accurate population (December 2022) Additional posts for SMI and physical health recruited to (December 2022) Poster developed by Designs in Mind, going to print. Leaflet design on going (October 2022) Approach to co-production agreed (September 2022) Working on piloting an app to support outreach and help with compliance for the 6 categories (September 2022) Affinion devices received by MPFT, plans for training underway (October 2022) Looking at working with Charitable organisations around health and wellbeing activities for SMI, LD and A (December 2022) Resolution of inoperability issues/ data transfer between RIO and EMIS (September 2022). Pilot scheme has been successful.	Number of physical health checks completed (as % of those on GP SMI register) Number of physical health checks completed by MPFT Action plan is in place to drive forward progress Monthly reporting has been requested by NHSE, (Commencing September 2022) Increase in SMI PH checks % completed	Excess under 75 mortality in adults with severe mental illness Excess mortality in adults with severe mental illness	60% of patients on GP SMI registers receive physical health check PA

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.10 Continuity of carer. (CoC) Women from the poorest backgrounds and mothers from Black, Asian, and Minority Ethnic (BAME)* groups are at higher risk of poor birth outcomes. Women who receive continuity of carer (the same midwife (or team) caring for them during pregnancy, birth and postnatally) are 16% less likely to lose their baby and 24% less likely to experience pre-term birth. Continuity of carer will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in outcomes (Reference for BAME terminology https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/)	There are several initiatives to support this area including Digital Inclusion and Maternity HUB development as part of a broader strategy, plus further enhancements on patient plans	Nick McDonnell reporting to LMNS Board/ ICB Board	Following the first Ockenden review and NHS England Chief Nursing Officers CoC risk approach, SaTH have developed and will submit a revised CoC delivery plan for the 15th of June. This model will have Trust Board and LMNS Board approval and will look to identify how and when the trust will meet Local, Regional and National requirements. Further plans and milestones will be agreed following feedback on this (TBC)	Number (%) of women booked onto CoC pathway Number (%) of women in receipt of CoC Number (%) of BAME women in receipt of CoC Number (%) of women in lowest 20% quintile in receipt of CoC	Preterm births: % of deliveries Neonatal and stillbirth rate	Continuity of carer for 75% of women from BAME communities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.11 **Chronic Respiratory Disease**: Respiratory disease is the third biggest killer in the UK and cases of Chronic Obstructive Pulmonary Disorder (COPD) and deaths from lung cancer or pneumonia are higher among those living and working in more deprived areas. Vaccination is particularly beneficial to those with chronic respiratory disease preventing acute illness and hospitalisations For COPD drive uptake of vaccines to reduce exacerbations/ emergency hospital admissions	For COPD drive uptake of vaccines to reduce exacerbations/ emergency hospital admissions	Steve Ellis Programme & Service Director and Deputy Senior Responsible Officer Covid-19 Vaccination Service reporting to Health Protection Board	Continue offer of evergreen Covid vaccination offer - targeted comms via Primary Care (Part of summer plan - (August 2022) If part of JCVI recommendation for Autumn Booster, agree targeted comms around the benefits of vaccination for those with chronic respiratory disease. (Autumn plan by December 2022)	Vaccination rate among those with COPD/chronic respiratory disease Flu vaccination coverage – at risk individuals	Under 75 mortality rates from respiratory disease considered preventable	Autumn COVID Booster - 90% Flu Vaccination - 85%

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.12 **Early Cancer Diagnosis**: Cancer that is diagnosed at an early stage, when it is small and hasn't spread, is more likely to be treated successfully. Late diagnosis is more common among deprived communities and among ethnic minority groups. The national ambition is that by 2028 75% of cancer cases will be diagnosed at an early stage (stage 1 or 2)	Meet early diagnosis objectives specified in local cancer strategy	Andrew Dalton, STW screening lead reporting to System Cancer Strategy Board	Restore compliance with the Faster Diagnosis Standard (FDS) across cancer pathways (December 2022) Community Diagnostic Hub (CDH) service operational (December 2022)	Cancer sites meeting/not meeting FDS CDH open	% of cancers diagnosed at stage 1 or 2 Under 75 mortality rate from cancer Under 75 mortality rate from cancer considered preventable	75% of cases diagnosed at stage 1 or 2 by 2028
			Improvement to all cancer pathways to ensure compliance with the 7 Rapid Diagnostic Centre (RDC) principles (April 2024)	Cancer sites meeting/not meeting RDC principles		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.12 continued.,	Meet objectives to restore and expand cancer screening services as specified in local cancer strategy	Andrew Dalton, STW screening lead reporting to System Cancer Strategy Board	Reduce Breast Cancer screening round length to achieve target interval (re-screen within 36 months of previous screen) (December 2024)	Breast screening uptake Breast screening round interval Bowel and cervical screening uptake	Number (%) of screen detected cancers	
	Cancer personal care and support plans Specifically addressing Health inequalities in screening and presentation as part of wave one core connectors programme	Tracey Jones reporting to Population Health Board	Co-ordinator post to develop Community Cancer Champions in Shropshire through third sector delivery partner Development of system implementation plan (May 2022) Recruitment of co-ordinator (June 2022)	Number of salaried / volunteer Connector roles and other programme roles Scale of activity undertaken by Connectors e.g., measures of engagement	Increase screening uptake in communities where this is low Raise awareness of symptoms that should prompt presentation to health care providers	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.12 continued.,			Development of KPIs (June 2022) Implementation of approach Q2 onwards Evaluation report as part of national wave one bid (March 2023)	Scale of impact of Connectors e.g.: attendance and input at Place/ICS governance groups attendance, and input with Service Providers re service deign and access attendance, and input with Core5 networks at Place/System level		
4.13 **Hypertension Case-Finding**: High blood pressure is a key risk factor for the development of cardiovascular disease (CVD). High blood pressure is frequently undetected and sometimes undertreated particularly among more deprived communities, some ethnic minority groups and those with some disabilities	Development of CVD prevention plan (to include hypertension (high blood pressure) case finding.	Emma Pyrah reporting to Population Health Board	CVD prevention plan agreed (December 2022) Comprehensive hypertension case finding plans and hypertension treatment plans implemented (December 2022)	Number (%) of registered patients on hypertension register Number (%) of patients on hypertension register being treated to target % of patients aged 45+ years with BP on record in last 5 years	Under 75 mortality rate from cardiovascular diseases considered preventable	80% of expected number with hypertension identified 80% of those with hypertension optimally treated

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.14 **Diabetes -** Significant inequalities exist in the risk of developing type 2 diabetes (linked to obesity and ethnicity), together with inequalities in access to health services and in health outcomes. The NHS Diabetes Prevention Programme supports those at high risk of type 2 diabetes to reduce their risk	Diabetes Transformation Programme	Fiona Smith reporting to Diabetes Programme Board	Diabetes Programme Board established (September 2022) Training matrix and competency framework designed for each practice/PCN and training delivered to practice staff (June 2023) Revise pathways to prevention programme ensuring appropriate targeting of those at risk (December 2022) Increased capacity in X-pert programme (T2 diabetics) (April 2023) Increased capacity in Daphne programme (T1 diabetics) (April 2023) Revise pathways structured education programmes ensuring appropriate	 Increase in recorded prevalence of diabetes (improved detection) Increase in % of patients with T1 and T2 diabetes receiving all 8 care processes and achieving all 3 treatment targets Improved quality and increase in referrals Increase in referrals from people from ethnic minority backgrounds	Reduced numbers of amputations, cardiovascular events and stroke. Reduction in additional risk of mortality for those with diabetes compared to general population In longer term a reduction in prevalence of Type 2 Diabetes	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.14 continued.,			targeting of those at risk (December 2022)	Increase in beneficiaries of X-pert including increased numbers from people from ethnic minority backgrounds Increase in beneficiaries of Daphne including increased numbers from people from ethnic minority backgrounds Increase in treatment targets reached (BP, Cholesterol, HbA1c)		
			Education course established for the housebound (April 2023) Education course established for those with a Learning Disability (April 2023)	Increase in number of housebound in receipt of education Increase in number with LD in receipt of education		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.15 **Children & Young People (CYP)** COVID has had a huge impact on many families, and particular focus will be CYP mental health and wellbeing. In addition, plans to create a Trauma Informed workforce will be implemented	Creative Health opportunities for CYP, including SEND Personalised care – physical health checks for CYP with SEND Personalised Care and Support Plans (PCSP) for Children and Young People who are accessing a Social Prescribing Link Worker	Nicola Siekierski reporting to Shropshire Integrated Place Partnership (ShIPP)	Take up of Creative Health opportunities to fill at least 75% of places being funded by this project. (June 2023) Evaluations to be completed by all successful providers of Creative Health activities, to include attendance, CYP feedback on the activity, lessons learned, patient reported outcomes using measures of health and wellbeing and the start and completion of the activities. Evaluations completed (June 2023) Feedback on this document to be collected and reported back to the CYP Social Prescribing Group as it is rolled out. Feedback on CYP PCSP end of each quarter. (Initially June 2022)	Numbers taking up the offer - Fill at least 75% of places Improvement in CYP's health and wellbeing score post non-clinical Creative Health intervention		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.16 Trauma Informed Workforce Trauma affects not only those who are directly exposed to it, but also to those around them (Van Der Kolk: 2014). Along with acute physical and emotional effects, children that have Adverse Childhood Experiences (ACEs) can show: reduced cognitive and social development, reduced school engagement, early adoption of health-harming behaviours, increased risk of health conditions and juvenile offending.[4] ¾ juvenile offenders have been exposed to traumatic victimisation and 11-50% have PTSD, Ko et al. 2008. Creation of a Trauma Informed Workforce across the whole system, using a tiered core training offer which is consistent, understood and will be used in practice forms part of this work	Roll out of Resilience Screening and workshops to all workforces to create awareness Identification of training package, and roll-out	Val Cross reporting to Health & Wellbeing Board	Workshops and screenings scheduled, feedback gathered and completed (November 2022) Identify training packages and levels required (by December 2022) Start to roll out in pilot area of Oswestry (December 2022)	Number of professionals accessing training, collation of feedback to inform work going forward Through Steering Group Training in area completed July 2023, and implementation in services and practice. Sustainable model to be used	Number of organisations who attended workshop Number of organisations accessing training packages and implementing in practice	

[4] Health and financial costs of adverse childhood experiences in 28 European countries: a systematic review and meta-analysis (thelancet.com)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.17 Healthy Start Offer- Need to increase the uptake of the Healthy start offer for those eligible in Shropshire	Increase uptake of the Healthy Start Offer for eligible families through improved comms/health promotion across Shropshire	Steph Jones/Anne-Marie Speke Reporting to Children & Young people's Board	Health Promotional material to be finalised by (March 2023)	Healthy Start uptake statistics reported on nationally. % of entitled beneficiaries over eligible beneficiaries	% of uptake by those eligible for healthy start offer to increase by 5% by 2024 To achieve or exceed the national baseline % of uptake of Healthy Start	
4.18 Oral Health- Improve outcomes and reduce % of dental decay in Children and Young People in Shropshire	Targeted supervised toothbrushing programme for 3-5 y/o led by Shropshire Community Dental Service, targeted in areas of high deprivation, which will be inclusive of CYP with SEND	Steph Jones/Anne-Marie Speke Reporting to Children and Young Peoples Board	A targeted programme aims to reduce the levels of tooth decay in Shropshire through supervised toothbrushing	Proportion of schools and early years setting staff rating supervised toothbrushing training as either good or excellent Number (or %) of early years settings and schools offered a Supervised Toothbrushing Scheme Number (or %) of settings taking part Number of early years and school staff involved in STS trained The % of schools briefed on the NDEP	% of early years settings or school setting staff rating supervised toothbrushing training as good or excellent Programme- Evaluated annually. Aim to have evaluated 2021-2022 impact by September 2023	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 **Best Start in Life:** Improving access to Early Help for families and CYP across Shropshire	Workstream has formed to work to improve Early help access across the whole system/partnership. Various opportunities to develop projects across the wider system through test and learn sites, that are based on a set of criteria relating to reducing health inequalities, that are needs led, and outcomes driven	Jo Robins/Fran Doyle/Penny Bason/Mel France Reporting to Early Help /Prevention Board	Joint work to develop new ways of working between early help teams, prevention, and NHS workforces Test out an integrated service delivery model in an area of need which adopts a multi-disciplinary across NHS and Local Govt. (April 2023) Develop a project board of senior leaders to support integration (September 2022) Formation of project group of reps from public health, Early Help, Children's Social Care, Education) (June 2022) Expansion of CYP Social Prescribing taking referrals from schools, GP practices and service providers (By January 2023)	Mapping of existing practice, and identification of evidence and best practice models from across the country and via the Early Intervention Foundation, OHID. Series of workshops to include service managers Creation of a multi-disciplinary team to test out joint working Develop vision and costings of resources for scale up Embed the approach into other service areas for Early Help, and create multiple offers for families and young people to participate in		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 continued.,			Expansion of a wider 'creative health offer' for CYP and families which is embedded into service provision, based on the learning from the current test and learn site (December 2023) Development of a test and learn triage approach that is easily and readily accessible and responsive, for families, CYP and local organisations which incorporates CYP Social Prescribing. (February 2023) Recruit two Social Workers, to support schools in two targeted areas where need is high and where interventions for YP are available (February 2023) Develop a joint approach through the newly recruited Family Support Workers, to build a team based on early intervention which support the Best Start and builds on a joint approach with the public health nursing service. (March 2023)	Identify opportunities where posts can in reach to the community and where common agendas such as breastfeeding support offer can be promoted and delivered to provide parents with greater levels of support Create a team approach to working with schools, engage with lead schools to agree an approach and ensure ongoing dialogue continues to shape the offer. Ensure schools are brought into the approach		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 continued.,			Development of a co-ordinated offer for schools which reflects service areas in the council, is based on need and targeted appropriately to schools using previous resources such as WISH, nutrition, PHSE, mental health and wider health issues. (April 2023) Development of a co-ordinated training offer for schools, based on need using best practice models and evidence of what works, targeted appropriately to needs. (February 2023) Needs assessment for children which includes population health data, acknowledges service data and uses predictive modelling for future service design/development. (March 2023)	Identify the various training resources and offers that currently go into schools and create one offer Collate together various sources of data into one document which clearly outlines needs of various groups and considers a range of conditions (health, care and wellbeing)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 continued.,			Analytical and business planning support to the Stepping Stones project through the development of a modelling tool that predicts numbers future numbers of LAC. (June 2022) Expansion of the existing Stepping Stones project to scale up service delivery. (February 2023) (See also Table 5 – Looked After Children category)	Produce a model tool that helps to predict demand at various points. Use the model to influence service models Develop a business case for the Stepping Stones project		
4.20 Children/Families in Need	Test out a multi-disciplinary team model working between the public health nursing service, Early Help, and Children's social care teams	Jo Robins/Mel France Reporting to Early Help/Prevention Board	Establish a practitioner group that meets regularly to identify common goals/challenges and identify ways of overcoming them. (June 2022) Ensure the integrated practitioner group received trauma informed training programme and parental conflict training. (January 2023)	Actions for change identified via practitioners that demonstrate challenges but changes Range of organisations committing to the practitioner group Range of practitioners participating in the group Use of learning to repeat the process in other areas of need across Shropshire	Reduction in the number of duplicated visits from different organisations for each family Increase in early identification of families and children at risk	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.20 continued.,	Supported by developments such as social prescribing, peer support for ante-natal care, peri-natal period, trauma informed and strengths-based training, parental conflict training Development of a community-based prevention offer in the Oswestry location that supports CYP/Families	Val Cross/Penny Bason/Steph Jones Reporting Early Help/Prevention Board Jo Robins/Mel France Reporting to Early Intervention/Prevention Board	Establish a peer support programme for parents that offers support during the ante natal period. (April 2023) Cross reference to trauma informed training programme and parental conflict training Establish a community collaborative that is led by the VCSE and supported by the LA to consider gaps, challenges and re-build a local preventative offer for CYP and families. (June 2022) Develop/Support the collaborative so that it becomes self-sustaining and involves multiple partners across the VCSE, working with Town Council By (July 2023)	A peer support programme is established in the Oswestry area that is delivered by the VCSE	Reduction in post-natal depression Identification of early risks associated with vulnerable families with actions to improve Improvement in uptake of access to local services Reduction in social isolation of pre and post birth parents Increase in uptake of parenting courses Number and range of organisations who attended workshop Number and range of organisations offering support for CYP and families	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.20 continued.,					Additional capacity created to support families and CYP experiencing multiple issues Projects developed and implemented that support reduction in domestic violence, improve maternal mental health, Reduce child exclusions, improves CYP mental health, improve access to food and access to local services Partner engagement and commitment across NHS, Fire and Rescue, Police, to support the development	
4.21 Complex need – focuses on those who experience multiple disadvantage. This may be linked to substance misuse,	Improved life expectancy for those with Serious Mental Illness (SMI)	Gordon Kochane Reporting to Health and Wellbeing Board	Post of Population Health Fellow to support the development of a Complex Needs Assessment & Strategy Date: In post (October 2022)	Needs Assessment complete by 30.09.22 Strategy complete: 30.09.22	Improved life expectancy of those with Serious Mental Illness (SMI)	TBD

4.21 continued., domestic abuse, social problems, housing/ homelessness, debt or other issues					Better joined up working and understanding of how to support those with complex need	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.22 **Mental Health (Mental Health Transformation Plan)** Mental illness can be a key risk factor for health inequality. Once **mental disorder** has arisen, it is associated with a range of further **inequalities**. These include increased **health r**isk behaviour, reduced educational and employment outcomes, increased physical illness, and significantly reduced life expectancy, as well as discrimination The community mental health transformation aims to move away from siloed, hard-to-reach services towards joined-up care and whole population approaches	1) Health Equity Assessments have been completed for each PCN area and are the basis for which we target our VCSE engagement in the Programme. They included: - A summary of national evidence relating to inequalities amongst SMI - Current patient profile and how this compares to national trends - A detailed look at the prevalence of wider determinant and behavioural issues that drive demand Taking this data, we have decided to pilot initial grant scheme and additional commissioned services at North Shropshire PCN and PCNs in Telford and Wrekin (our test sites) **Under-represented Groups (Grant Scheme)** <u>North Shropshire</u> Men over-40. <u>Telford and Wrekin</u> 18-25-year olds. BAME communities.	Cathy Riley – SRO for Mental Health STW ICS	VCSE Services including Grant scheme live (December 2022).	To be confirmed: Number of adults and older adults have had at least one contact from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum Number of adults and older adults have had at least 2+ contacts from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum Number of adults and older adults receiving 2+ contacts in a dedicated 'personality disorder' pathway or service provision (including primary care, VCS, and MH services)	To be confirmed	To improve access for groups that have been identified in population health data as under-represented

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.22 continued.,	**Wider-Determinants (Additional Services)** 1. Housing 2. Financial Wellbeing 3. Lifestyle Services Landau are commissioned to deliver the grant scheme.			Number of adults and older adults receiving 2+ contacts in a dedicated community rehabilitation pathway or service provision (including primary care, VCS, and MH services)		
4.22 continued., Increase the number of patients offered a MECC conversation in line with training targets / Increase the number of staff trained to deliver MECC conversations across the Care Group - MPFT has reenergised its approach to MECC and has trained nearly 600 frontline staff to deliver brief interventions in the last 12 months. 2022-23 will see MPFT continue to grow these numbers	Increase the number of staff trained to deliver MECC conversations across the Care Group	Cathy Riley – SRO for Mental Health STW ICS	MECC training delivered (Ongoing)	Number of staff MECC trained	Increase the number of patients offered a MECC conversation (not currently measured/monitored)	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.23 Suicide Prevention A targeted approach to upskill the workforce on suicide risk and awareness of how to intervene has been taken with the launch of a Suicide Prevention training programme in Shropshire. skilling up the workforce to create awareness of suicide risk and the range of resources available to mitigate risk	Promote the range of training offers and resources for prevention of suicide and self-harm across the system including commitment that all workforce within the system should have at least a basic awareness of suicide risk and local support available	Gordon Kochane Reporting to STW Suicide Prevention Network Shropshire Action Group T&W Action Group	Agree Learning & Development workforce strategy for suicide/self-harm training to be included within PDPs[5]. Work started. (Date: TBC)	Evaluation forms, and plans for follow up surveys for how people have used their learning in their roles Potential commissioning/ funding a training review for suicide to see if it has had desired impact and reach	Reduction in intentional self-harm attendances at A&E %/Numbers of workforce trained and from which programme	To achieve our zero-suicide ambition PHOF indicator: Emergency Hospital Admissions for Intentional Self-Harm

[5] Self-harm and suicide prevention | Health Education England (hee.nhs.uk)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.23 continued.,			Commitment for all staff within health and social care in Shropshire to have completed the Zero Suicide Alliance free online training as part of mandatory training. Launch event delayed. (Date: TBC) Workforce most likely to need to deliver an intervention to a person presenting with suicide ideation of who is self-harming to have accessed the Suicide First Aid (SFA) Intervention training and/or Self Harm intervention training SFA 3 x sessions offered (June, Oct & Dec. 2022) Self-Harm (May 2022) Frontline health, social care and third sector workforce who support higher risk of suicide cohorts to have either completed the Suicide Awareness training. 4 x sessions offered (May July Sept. Nov. 2022)	Use of Suicide Real Time Surveillance to monitor trends/themes and patterns of possible/probable suicide for targeted response	% of "priority" agencies who have accessed training Number of "hits" on ICS webpage for suicide resources	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.24 Social Prescribing (as an element of Personalised Care) Social prescribing in Shropshire is an integrated programme between Primary Care, Public Health and the Voluntary, Community and Enterprise sector (VCSE) that supports those in most need A Children and Young People's (CYP) Social Prescribing pilot in the SW is operational	Children and Young People's (CYP) Social Prescribing being part of the Early help offer. This focusses particularly on CYP mental and emotional wellbeing	Fran Doyle/Penny Bason reporting to Early Help Partnership Board Health and Wellbeing Board Shropshire Integrated Place Partnership	Business case submitted (March 2023) Evaluation of Children and Young People (CYP) pilot (December 2022)	Integration to Early Help as an offer for CYP and their families countywide	Improvements in Health and Wellbeing scores post SP intervention	TBD
4.25 Integrated Impact Assessment (IIA)– embed assessment of**:** Social Inclusion Equality Health Inequalities Quality Climate Change Economic Impact of all developments	Integrated Impact Assessment to be adopted across the ICS for project work - for all change programmes	Edna Boampong Reporting to Population Health Board	Draft Screener tool developed to include HEAT tool as part of initial screener (June 2022) Online screener tool fully developed within system PMO platform. (August 2022)	IIA criteria in place for the use of the tool March 2023 IIA in developed IIA in use		TBD

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.25 continued.,			Development of methodology document. Development of Baseline template and full IIA templates. (August 2022) Adoption and implementation programme. (September 2022) Audit of tool application in practice. (March 2023)			

Table 5: Social Inclusion Groups

Social Inclusion Groups

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.1 **Domestic Abuse** affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status. Domestic abuse includes coercive, controlling, abusive and violent behaviour and can also occur between family members Temporary accommodation is not in the interest of the health and wellbeing of the household	Reduce homelessness due to domestic abuse (Identified in Shropshire Safeguarding Community Partnership Strategic Plan and Priorities 2020 – 2023)	Laura Fisher Shropshire Council Local Partnership Board and SSCP Domestic Abuse Group	Needs assessment completed (November 2022) Strategy completed (January 2023)	Needs assessment and strategies completed	Reduce homelessness due to domestic abuse SSCP business plan data	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.2 **Exploitation** (including transitional safeguarding) affects people of all ages regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status but in particular, children and young people and adults with additional care and support needs	Review the effectiveness of the Child Exploitation Pathway (Identified in Shropshire Safeguarding Community Partnership Strategic Plan and Priorities 2020 – 2023)	Jeanette Hill Shropshire Council SSCP Exploitation Group	A pilot weekly Adult Exploitation Pathway: Active Case Review Meeting/triage is currently underway, which is attended by the multi-agency partnership including: Adult Services Children's Services West Mercia Police Health We Are With You (Ongoing)	More young people will have a transition plan in place where concerns of exploitation are identified. More adults with care and support needs with risk factors around exploitation will have an appropriate plan of support in place	Needs will be identified and more young people at point of transition/adults will have plans of support in place to reduce escalation of risk/need Improved partnership information sharing	
5.3 **Homeless** Housing also in wider determinants	**Preventing homelessness:** Develop homeless and rough sleeping prevention strategy	Laura Fisher reporting to Housing Executive Board	Strategy which seeks to prevent homelessness and rough sleeping and ensure that those households who do become homeless are provided with an excellent service. (March 2023)	Strategy published	Percentage of successful homeless preventions Percentage of successful homeless reliefs Number of households owed main duty Number of rough sleepers at any one time	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.4 **Learning Disability** Ensuring the right care, support and accommodation is available at the right time to ensure individuals are able to achieve their aspirations and reach their potential	Variety of accommodation options available to house adult individuals and enable their greater independence LD and A 3-year road map	Vacant post to be filled Steve Ladd (Shropshire Council) Val Walsh (CCG) Reporting to LD&A Board Learning Disability Partnership Board	Property platform to provide data - determine accommodation to be commissioned and where (October 2022) Partnership working to implement/progress: housing developers, RSL's, planning and policy departments (January 2024)	Property Platform data	ASCOF- number of adult individuals with a learning disability living in their own home	
5.5 **Autism** Autistic people experience greater health inequalities including cardiovascular disease, epilepsy and poor mental health. NHS England » National Autism team update	Expansion of ASD Forensic Service Telford/Shropshire Creation of ASD mental health liaison Telford/Shropshire role	Val Walsh (CCG) Reporting to LD&A Board Autism Partnership Board	Increased recruitment to extend service to Shropshire (Complete) Recruit ASD MH liaison Clinician (Complete)	Numbers discharged Numbers discharged in a timely manner	Supporting Autistic People with Forensic risks to be discharged from hospital Supporting Autistic People who also have mental health problems to be discharged in a timely manner	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.6 Gypsy and traveller families Gypsies, Travellers and Roma are among the most disadvantaged people in the country and have poor outcomes in key areas such as health and education. Parliament UK: 2017		John Taylor Reporting to Head of Property and Development, Shropshire Council	Development of an 8-plot transit site in Shrewsbury (April 2022) Employ a Gypsy & Traveller Support Officer (Complete) Review SC Gypsy/Traveller caravan sites plot application process (June 2022) Anticipated site will be developed within the next 12 months (August 2023)	Report has approval from Cabinet to proceed with planning application. Appointed Officer April 2022 Reviewed June 2022	Meet the identified need for a transit site as per the GTAA recommendations	Support the Welfare, Education, housing requirements
5.7 Asylum seekers/ refugees	Government resettlement schemes -Syrian, Afghan and Ukrainian programmes	Laura Fisher Shropshire Council Reporting to DMT	Syrian: Resettle additional 5 families as per commitment to government 2022/23 Afghan: Resettle 5 families as per commitment to government 2022/23	Number of individuals/families resettled. Syrian and Afghan families: target of 5 families each. Ukrainian: No target. Dependent on how many people opt to be hosts	Syrian, Afghan and Ukrainian individuals/families resettled in safe accommodation which will impact positively on their health and wellbeing	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.7 continued.,		Ukrainian Visitors Steering Group	Ukrainian: Date: March 2022 DBS initiated Property inspected Welfare check completed Emergency payment made Monthly gift of £350 made Asylum Dispersal Awaiting update from government re: future numbers / duties	Numbers registered with GP. Data collected by Housing as part of monitoring for government / Home Office		
5.8 **Unpaid Carers** Affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status	Carers not identified early in their caring journey resulting in delayed support that may prevent crisis and provide a better quality of life for the carer	Margarete Davies Reporting to Shropshire Family Carers Partnership Board	Training provided to health and social care staff to help identify carers. (From September 2022)	Number of training sessions offered to GP Practice staff By: 2023 This will help carers access appointments for themselves and the people they are caring for. It will improve carer registration on GP practice systems (Carer flag) so that carers can be offered vaccinations and any other health related benefit for carers	Number of GP Practice staff attending Number of GP Practice asking if someone is an unpaid carer as a routine question Improved carer registrations on GP practice systems (carer flag) so that carers can be offered vaccinations and any other health support	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.9 Physical disabilities	Community equipment service aligned to Disabled Facility Grant offer, to complete adaptations to increase support and independence	Laura Fisher Reporting to Housing Services Management	New Disabled Facilities Grant (DFG) guidance published on March 2022 widening the scope, area of its coverage to include equipment when tied to the adaptation (Ongoing)	Reduce the time wating for DFG and equipment Local DFG process to reflect change in new DFG guidance and information	Increase number of people of all ages with disabilities or complex needs who can live in the community with improved independence	
	Recommissioning of Community equipment service	Deb Webster/Laura Fisher Reporting to Joint commissioning delivery group	Working across the ICS, T&W and Shropshire to provide a seamless allocation of equipment across all ages and disabilities. (Ongoing)	One access route (TBC) to health and social care equipment not identified through funding pathway. Seamless allocation of equipment to all age groups. Closer working across identified areas to maximise development of equipment provision across all fields.	Easy access to range of equipment and information for all ages and disabilities. Development of pathways to streamline prescription and ordering and improve waiting times. Equipment supplier tenders to be opened Summer 2023 Equipment supplier commissioned by Autumn 2023.	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.10 LGBTQ+ People who identify as LGBTQ+ experience disproportionately worse health outcomes and have poorer experiences when accessing health services. Kings Fund:2021 Staff awareness and understanding of LGBT communities to help improve experience for LGBT people using our services. (adapted from National LGBT action plan priorities)	Safer Ageing, No Discrimination) SAND takes a targeted approach to increasing LGBT+ inclusion, challenging discrimination, promoting accessibility and equality of opportunity for LGBT+ people ageing in Shropshire, Telford and Wrekin. The Covenant – Safe Ageing No Discrimination (lgbtsand.com)	Tamsin Waterhouse Reporting to LGBTQ+ covenant planning working group (ICS have a support group for LGBTQ+ staff)	Shropshire Council signed up and committed to the pledge March 2022 LGBTQ+ covenant planning group first meeting May 2022, with monthly meetings thereafter Currently Adult Social Care in main, so not cross council yet. Action plan will be developed and reviewed. (October 2022)	Commitment made through the pledge to: providing the best possible quality services for older and old LGBT+ people Commit to learning what life can be – and has been – like for different LGBT+ people. Commit to vocally and visually supporting groups working with and for older and old LGBT+ people Commit to creating meaningful opportunities for LGBT+ people and groups to 'influence' what you do Commit to assess and evidence change, including work carried out to engage LGBT+ people (within the group/organisation and outside it)	This is a new group, and Action Plan will help to monitor progress	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.10 continued.,	Shropshire agreed to be a test site for some research being conducted by the University of Birmingham into Social Work practice when working with LGBTQ+ adults	Tamsin Waterhouse	University to visit and discuss. (November 2022)	Provision of information on what is being doing well, and where we need to improve		
5.11 Services personnel and their families (including veterans)	GP Friendly accreditation scheme	Sean McCarthy Health and Wellbeing Board Shropshire Armed Forces Covenant Strategic Board	Engagement with CCG and PCN's to raise awareness of the accreditation (Ongoing)	Number of GP surgeries contacted	Number of GP Practices signing up to the GP friendly accreditation scheme.	10 GP practices during 2022
5.12 Drug and Alcohol Misuse affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status	Review publish & implement the Drug and Alcohol Strategy 2020-2023. (Identified in Shropshire Safeguarding Community Partnership (SSCP) Strategic Plan and Priorities 2020 – 2023)	Paula Mawson / Ian Houghton SSCP Drug and Alcohol Misuse Group Shropshire Council Combating Drugs Partnership – ICS Group with TWC & PCC as SRO	National Guidance Milestones: SRO & geography agreed for new Combating Drugs Partnership (CDP) (August 2022) CDP Terms of Reference (TOR) & governance agreed (September 2022) Completion of Needs Assessment (by November 2022)	Production of the CDP ToR Governance routes agreed for the CDP and place partnership Data analysis and engagement with people with lived experience and professionals to inform the needs assessment	Public Health Outcomes Framework -Successful completion of alcohol and drug treatment -Reduced deaths from drug and alcohol misuse -Admission episodes for alcohol related conditions	To be agreed as part of the performance framework development by December 22

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.12 continued.,	Deliver the local requirements of the National Drugs Strategy, From Harm to Hope, strategic priorities to: • Break supply chains, • Deliver a world class treatment & recovery system • Achieve a shift in the demand for drugs		Local Strategy & Delivery Plan agreed (December 2022) Local Performance Framework agreed (December 2022) Ongoing reporting of progress. (From April 23)	Local Strategy & Business Plan updated in light of new guidance Approval of the local strategy refresh with HWBB Local performance framework developed in light of the recommendations in the needs assessment and national guidance	Local performance framework will be developed to measure performance against the national outcomes framework from April 23	
5.13 Looked After Children Shropshire Council has statutory responsibilities to children and young people who are 'looked after' (cared for) by the Council and who have previously been looked after up to the age of 25	Within Social Care the Stepping Stones Programme is designed to enable more children to live safely at home, or to live in a foster home rather than residential care (See also Table 4 – Best Start in Life category)	Donessa Gray/Pippa Murphy Social Care/Early Help	Develop a business case and evaluation framework (May 2022) Upscale Business case agreed July 2022 (TOMS) Recruitment to additional posts (January 2023) Parent and baby assessment centre opening (October 2022)	Documents written by health colleagues – March 2022 Review and progress May 2022 Business case written by project Manager Ongoing project review and monitoring against targets set out in business case (financial and social outcomes)	Reduce the number of children suffering significant harm and enable them to remain safely in the care of their family Reduce number of children needing to remain in residential provision out of area and increase number who can safely return home	Reduce numbers by 15 by March 2024 15 by March 2024

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.14 Ethnic minority Groups	Provide outreach support to local Bulgarian and other Eastern European communities in Shropshire. Working at the core of the Communities Driving Change to understand issues relating to health and wellbeing, that are felt to be most important to communities themselves, and to identify gaps in service, engage and support community led action to address these issues	Hannah Thomas/Penny Bason ShIPP	Weekly drop-in sessions offering Welfare Support in Oswestry: support has included food provision, home essentials and internet access, registration of local services such as doctors/dentists/jobs, housing and financial difficulties. (April 2022) Extra session on Sunday (May 2022) Supporting Schools: Already in some primary schools in Oswestry supporting families with translation, cultural understanding (Ongoing) Drop in for Bulgarian/Eastern European students in Oswestry - barriers in school. Will then work with families. (April 2022) To develop an offer to deliver Blood Pressure and AF checks within the community which will support a wider piece of work around case finding (Ongoing)	Data collected on numbers accessing and reasons why	Eastern European individuals and families are enabled to live their lives well, and are able to access welfare support, translation and education understanding. Help to ensure that access to local services are planned and delivered in a way which best meet the needs of the local community	Estimate: 5 families or individuals per week 1 school per month Translation

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.15 Prisoners and their families	**Human Library** Pilot Human Library project with the Stoke Heath Prison to deliver mini Human Library event with 6 prisoners with equality responsibilities, as a first Human Library event in the world.	Mirka Duxberry Reports to: Head of Library Service	April/May 2022 + more events throughout 2022 to be decided Pilot completed – 6/6/2022 - First Prison to Host a Human Library - The Human Library Organization Two further events planned for Oct/Nov 2022 and March 2023	Direct impact evaluations (group/individuals)	Engagement around equality and diversity discussions, challenging unconscious biases	Prisoners Prison officers Prison culture

Table 6: Primary Care Network Health Inequality Plans

Tackling neighbourhood health inequalities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
6.1 **Primary Care Networks (PCN) inequalities plan** PCN's must: Appoint a lead for tackling health inequalities within the PCN. A PCN must identify a population within the PCN experiencing inequality in health provision and/or outcomes and develop a plan to tackle the unmet needs of that population	***North Shropshire***: Foodbank population are offered screen on iPad using a ReQoL-20 survey in person, with a PCN mental health practitioner or a Foodbank volunteer. If users identify as requiring further support, they will be triaged by the PCN mental health practitioners ***SE Shropshire*** Blood pressure, cholesterol and atrial fibrillation monitoring, focussed on Highley. Community events with Public Health, GP fellow and Clinical Pharmacists present to undertake screening	Emma Pyrah Reports to: TBC	Offer of short Mental health questionnaire to Foodbank population, to identify if mental health support needed. Operating in Whitchurch Foodbank (Ongoing). Likely to start in Oswestry (Autumn 2022) and Market Drayton to follow (Date: TBC) Opportunistic blood pressure, cholesterol and atrial fibrillation monitoring *Intervention in place.* Referral to a healthy lives advisor for lifestyle advice and direction. Refer back to GP for more complex issues and medication. (1 event: May 2022, agreeing next steps: Ongoing)	Intervention with support that will be local, and in the familiar setting of their GP practice or Foodbank Trusted community preventative intervention	Improve access to local GP and mental health services for food bank users Reduced mental health emergencies and better mental health outcomes for this population Improve trust and familiarity with health services Reduced blood pressure readings and healthier lives with reduced in inequalities and better access to healthcare in communities	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
6.1 continued.,	***SW Shropshire*** Opportunistic BP check. Short, user-friendly MPFT recommended wellbeing screen offered in Foodbanks by PCN pharmacy technician and/or mental health practitioner Both underpinned with a protocol around how to direct individuals to further services should a potential issue be identified		Opportunistic BP check and Re-Qol-20 survey (wellbeing screen) offered in Foodbanks by PCN pharmacy technician and/or mental health practitioner, with protocols should an issue arise Operating in Craven Arms and Church Stretton Food Banks (Ongoing) Engagement with all food banks in the SW (December 2022)	Intervention with support that will be local, and in the familiar setting of their GP practice or Foodbank	Higher rate of detection of raised blood pressure and surrogate outcomes for improved outcomes in the longer run Development of a BP case-finding service with our local pharmacy partners and GP practices To help with development of a robust resilience screening tool Follow up of any individuals identified with a physical and/or mental health need to see if it resulted in an improved outcome/ engagement and any gaps	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
	Shrewsbury Increasing physical activity in more deprived populations		Provision of free health and wellbeing coaches and access to variety of group activities via Shrewsbury Town in the Community (STITC). Self-referral via email or telephone (Ongoing) Recruitment of care co-ordinator to support health inequalities work, with an emphasis on patient engagement (In place)	Individuals assisted to identify their physical and Mental health goals and how to achieve them	Improved physical activity levels in the population Ideal outcomes would be decreased levels of obesity, hypertension and cardiovascular disease but these may take some time to become apparent	

17. References

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/
2. APPG Rural Health and Care | NCRHC
3. https://www.sciencedirect.com/science/article/pii/S0743016719310514 APPG Rural Health and Care | NCRHC
4. Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)
5. Fair Society Healthy Lives full report (parliament.uk)
6. Marmot Review 10 Years On - IHE (instituteofhealthequity.org)
7. Health and Social Care Act 2012 (legislation.gov.uk).
8. NHS Long Term Plan v1.2 August 2019
9. NHS England » What are integrated care systems?
10. core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)
11. NHS England » Network Contract DES
12. Microsoft Word - Census Table First Results- Rounded (shropshire.gov.uk)
13. Shropshire's profile | Shropshire Council
14. IMD_Overall_2019.pub (shropshire.gov.uk)
15. Sexual orientation, UK - Office for National Statistics (ons.gov.uk)
16. NHS England » Accessible Information Standard – Overview 2017/2018
17. Financial hardship and economic vulnerability in England | LG Inform (local.gov.uk)
18. United Kingdom Food Security Report 2021: Theme 4: Food Security at Household Level - GOV.UK (www.gov.uk).
19. Financial hardship and economic vulnerability in England | LG Inform (local.gov.uk)

Shropshire Council

This page is intentionally left blank

Shropshire Council

Shropshire Inequalities Plan

2022-2027

Contents

Inequalities plan

"Richer communities get healthier – and healthier communities get richer. Healthy people work more, learn more and earn more"
(Rt Hon Sajid Javid, Secretary of State for Health and Social Care 8 March 2022)

1. Introduction

1.1 Health inequalities are unfair, systematic, and avoidable differences in health, and they are blighting the lives of thousands of Shropshire residents.

1.2 Inequalities in the social determinants of health translate into health inequalities. Therefore, action to reduce health inequalities requires action to improve outcomes across all the factors that influence our health. Only around 10% of our health is impacted by the healthcare we receive. Wider determinants of health such as the places and communities in which people live, education, housing, access to green space and individual lifestyle behaviours collectively have a much greater impact on health. In order to promote equitable health outcomes, inequalities in the wider determinants of health need to be eliminated. Taking action to reduce health inequalities is both a national and a local priority, the importance of which has been dramatically highlighted through the recent Covid-19 pandemic.

1.3 Given the need for concerted action to reduce health inequalities the Shropshire Health and Wellbeing Board (H&WBB) requested development of an Inequalities Plan which is included in this report. They requested that the plan should recognise the importance of both health inequalities and the wider inequalities that underpin their development. This report also:

- Gives background to the development of the Inequalities Plan
- Provides a definition of health inequality and brief detail of how health inequalities are measured
- Sets out the factors that underpin inequalities and health inequalities and the context within which they develop and become entrenched
- Illustrates the way in which individual factors can interplay with each other (intersectionality) – reinforcing and worsening health inequalities
- Summarises the impact of Covid-19 in exposing and exacerbating health inequalities
- Provides a brief overview of the evidence base for reducing inequalities

- Summarises key aspects of the national and local policy context for reducing health inequalities
- Provides a summary of local data illustrating the extent of health inequalities across Shropshire
- Details a high-level summary of current work programmes being delivered across Shropshire to address inequalities, (ie the Inequalities Plan)
- Provides reference to the cost-of-living crisis and action being taken locally to mitigate its impact on health inequalities
- Identifies key strengths and gaps in the local response to inequalities
- Acknowledges the need for a monitoring framework to be developed enabling progress in reducing inequalities to be periodically reviewed
- Provides a summary of the over-riding priorities and recommendations

Alongside this, attention is drawn to 'key areas of focus' which are considered particularly important to our work in Shropshire to reduce inequalities

2. Background and purpose of the Inequalities Plan

2.1 In July 2021 West Midlands NHSE/I asked local Integrated Care Systems (ICSs) to develop place-based Health Inequality Plans, illustrating how key NHS health inequality objectives would be met. In responding to this request, it was agreed that for Shropshire a plan would be developed to include the following priority areas:

- ICS/NHS health inequality priorities
- Shropshire H&WBB priorities as expressed through the Joint Health and Wellbeing Strategy
- The 'wider determinants of health' as detailed in the Shropshire Plan
- Socially excluded groups (also referred to as 'Health Inclusion' Groups)

2.2 The intention of the plan is not to duplicate existing work programmes but to draw together current activity aimed at reducing health inequalities, seek to strengthen the plans, in particular through identifying synergies between them, to identify and address any gaps in support or provision and to enable monitoring of progress towards a reduction in inequalities and health inequalities. As such this report includes high-level brief details of the

programmes of work underway – being led either by the council and/or the local NHS, with activities often being delivered in partnership with our third sector partners.

2.3 In order to develop Shropshire's Inequalities Plan a multi-agency group was convened with membership as shown in appendix 1 and development was coordinated alongside local NHS colleagues with progress reported through the ICS's Population Health Board.

2.4 This report is set out in two sections, as follows:

- **Section one:** Context**.** The factors that underpin health inequalities and the evidence for tackling them.
- **Section two:** Shropshire's Inequalities Plan. Tackling inequalities and poverty in all its forms, enabling children, young people, adults, and families to achieve their full potential.

Section 1:
Health inequalities context

The factors that underpin health inequalities and the evidence for tackling them

3. Definition of Health Inequalities and How They Are Measured

3.1 Health inequalities are defined as avoidable, unfair, and systematic differences in health between different population groups.

3.2 At a high-level, health inequalities are measured by differences in life expectancy and healthy life expectancy between different population groups. Mortality rates and healthy life expectancy reflect a social gradient where people living in more deprived areas live shorter lives with more years spent in poorer health. Likewise, those with disabilities – in particular those with a learning disability or severe mental illness die at an earlier age then the general population.

3.3 In recent years growth in life expectancy has stalled in the population as a whole and inequalities in life expectancy by deprivation have grown wider. Inequalities in healthy life expectancy are even wider than inequalities in life expectancy and as such people in more deprived areas spend, on average, a far greater part of their already far shorter lives in poor health [(1)].

3.4 The evolution of health inequalities is closely related to deprivation The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. It broadly defines deprivation on the basis of a wide range of factors relating to an individual's living conditions, including levels of income, employment, education and local levels of crime. Deprivation is associated with poverty, but people may be considered to be living in poverty if they lack the financial resources to meet their needs, whereas people can be regarded as deprived if they lack any kind of resources, not just income.

3.5 Whilst IMD is widely used to measure deprivation it is important to note that it is less sensitive to the types of deprivation experienced in rural areas, and as such has limitations in defining vulnerability to poor health in areas such as Shropshire.

Socio-economic status (SES) is commonly measured using a range of different indicators and is related to deprivation[(2)]. However, SES is essentially

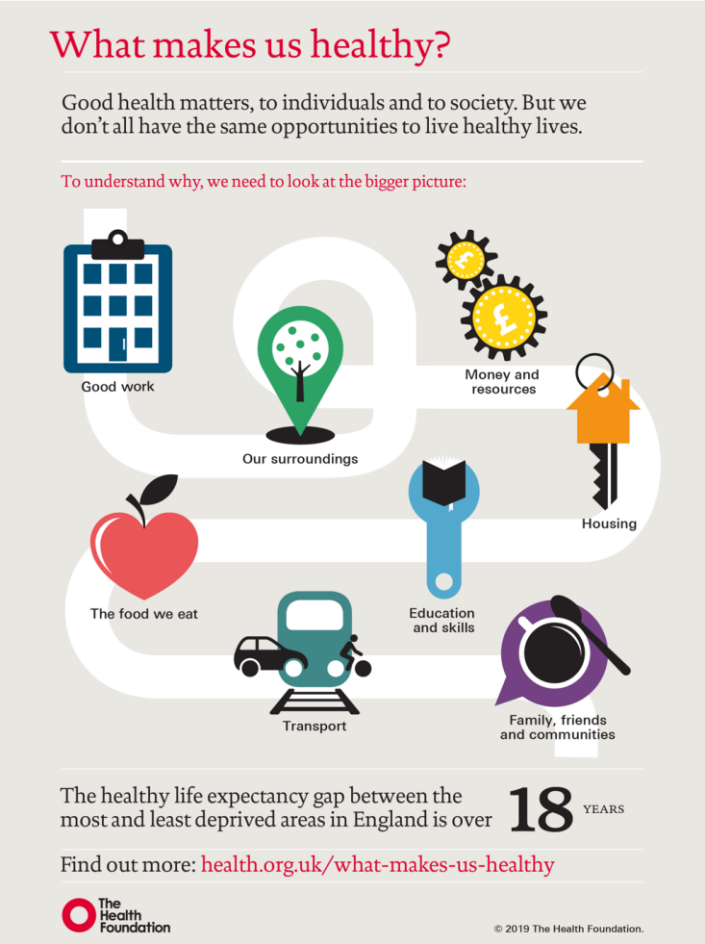
based on the type of work a person does and it too is related to health and health inequalities. For example, people in higher managerial and professional occupations are more likely to have a higher income, own their own home and enjoy better health than those in manual/low skill occupations.

3.6 To provide indicators at a more granular level the Public Health Outcomes Framework (PHOF) was developed in 2013 to enable measurement of progress in reducing health inequalities. The PHOF sets out a vision for public health, desired outcomes, and the indicators to help measure how well public health is being improved and protected across the England.

4. Causes of Health Inequalities

4.1 Population health is shaped by a complex interaction between many factors These include the places and communities in which people live, the wider determinants of health such as education, housing and access to green space, individual lifestyle behaviours and the quality and accessibility of health and care services, as summarised in figure 1, and described in more detail below.

Figure 1. What Makes Us Healthy



4.2 Health inequalities arise as a result of systematic variations in these factors across a population. As such, health inequalities may be driven by:

- different experiences of the wider determinants of health, such as the environment, income, or housing
- differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels
- differences in psychosocial factors, such as social networks and self-esteem
- unequal access to or experience of health services.

4.3 The factors that underpin health inequalities are inter-related and disadvantages that are concentrated in particular parts of the population and can be mutually reinforcing, as described in more detail below. Lower socio-economic groups, for example, tend to have a higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives. Furthermore, the interactions between the factors that drive Health Inequalities are complex and multidirectional, such that people can find it more difficult to move away from unhealthy behaviours if they are worse off in terms of a range of wider determinants of health [(3)].

4.4 Action on health inequalities requires improving the lives of those with the worst health fastest and breaking the link between people's background and their prospects for a healthy life. However, interventions to tackle health inequalities need to reflect the complexity of how health inequalities are created and perpetuated, or they could be counterproductive. For example, interventions to tackle a behavioural risk such as a poor diet should address the wider network of factors that influence this behaviour such as access to affordable healthy food, marketing and advertising regulations and the ease with which support can be accessed.

Further details relating to specific factors underpinning health inequalities are as follows:

The Wider Determinants of Health

4.5 The wider determinants of health are a diverse range of social economic and environmental factors, such as education, employment, income, and housing. These factors, individually and in combination with each other determine the extent to which people have the physical, social and personal resources to identify and achieve goals and deal positively with changes in their circumstances. Variation in the experience of the wider determinants of health (ie social inequalities) is considered the fundamental cause (the 'causes of the causes') of health outcomes.

4.6 The impact of disadvantage accumulates over the life course meaning that the future life-chances and health outcomes for children and young people exposed to disadvantage such as poor housing or low household income are

shaped by this experience. The more disadvantage and the longer this is sustained the poorer health outcomes are likely to be.

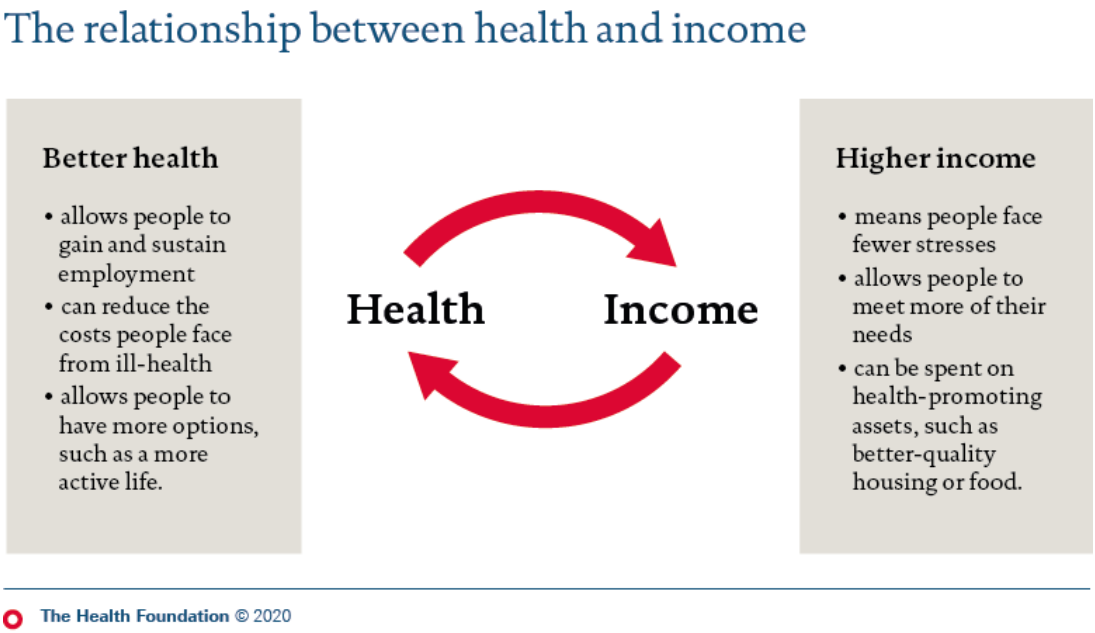
4.7 Research indicates that the wider determinants of health have a greater influence on health than health care, behaviours or genetics [4], however this evidence is not matched with the public's understanding of what influences health with a tendency for an individual's choices or behaviours, together with access to health care being perceived as more important influences on health than the wider determinants [5].

Impact of Poverty

4.8 Poverty and health are inextricably linked whereby those experiencing poverty suffer poorer health outcomes across the life course. In short poverty damages health and poor health increases the risk of poverty.

4.9 The way in which poverty impacts on health is complex and interfaces with other determinants of health such as housing, employment and education, however income in its' own right is a major determinant of health. Having an adequate income can help people to avoid stress and to feel in control of their lives. It also enables individuals and families to access experiences and material resources through which they can adopt and maintain healthy lifestyles and feel supported by a financial safety net. Through these mechanisms, people with an adequate income are more able to access the opportunities needed to live a long healthy and productive life. This relationship between health and income is summarised in figure 2 below.

Figure 2. The Relationship Between Health and Income



Protected Characteristics

4.10 Individuals more at risk of poor health or of experiencing health inequalities include those with 'protected characteristics. The protected characteristics defined in the 2010 Equality Act include [6]:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sexual orientation

4.11 They are referred to as 'protected characteristics' because individuals can be discriminated against on the basis of any of these factors, and as a consequence their access to services and support can be affected ultimately damaging their health and/or mental well-being. It can be seen that some of the characteristics, such as race, are fixed, but the majority can change over a person's lifetime.

4.12 People in these groups frequently experience inequalities and these may also be linked to poverty or deprivation as set out in the section below (intersectionality).

Health Inclusion Groups

4.13 Inclusion health is a term used to describe any population group that is socially excluded. This can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery but can also include other socially excluded groups.

4.14 Individuals in these groups often experience stigma and discrimination, frequently leading to barriers in accessing healthcare and other support services. Consequently, people belonging to inclusion health groups frequently suffer from multiple health issues leading to extremely poor health outcomes, often much worse than the general population and tend to die at a younger age [7].

Lifestyles and Health Inequalities

4.15 Smoking, poor diet, physical inactivity and harmful alcohol use are leading risk factors for preventable ill health and premature mortality. All are socioeconomically patterned meaning that they are more prevalent among disadvantaged populations, and they contribute significantly to widening health inequalities. Smoking is uniquely harmful to health, causing damage not only

to smokers but also to the people around them. Smoking is one of the main causes of health inequalities in England, with the harm concentrated in disadvantaged communities and groups.

4.16 Whilst there is an emphasis on promoting individual behaviour change to reduce unhealthy lifestyles (e.g., weight loss programmes) the evidence indicates that population-level interventions that are less reliant on individual agency/decision-making but instead aim to alter the environments in which people live should be implemented in order that inequalities are reduced [8].

Health and Digital Literacy

4.17 Health literacy refers to the extent to which individuals can find, understand and use information and services to inform health- related decisions and actions for themselves and others. Low health literacy is associated with a low level of knowledge and skill in managing health risks resulting in higher levels of morbidity greater difficulty managing long-term conditions, and higher premature mortality.

4.18 As much health-related information is now delivered digitally there is an equal need to improve digital literacy. Although the numbers of people in the UK lacking basic digital skills are reported to be falling, approximately 4% of UK households in 2020 lacked internet access and 4.8 million people had never gone online. Those from disadvantaged backgrounds will be over-represented among those lacking digital skills/access and the combination of low digital and health literacy risks exacerbating health inequalities [9].

Stigma and Health Inequalities

4.19 Stigma is defined as the co-occurrence of labelling, stereotyping, and discrimination in a context in which power is exercised. Those from disadvantaged circumstances, and those with protected characteristics and/or those belonging to socially excluded (health inclusion) groups frequently experience stigma. Such stigma is a significant source of stress and has a substantial effect on population health, similar to other social determinants of health. As such stigma has been identified as an independent factor driving health inequality [10].

Impact of Rurality

4.20 Overall, health outcomes are better in rural areas than in urban areas, however indicators can mask small pockets of significant deprivation and poor health outcomes. Current methods for identifying deprivation and health inequalities in rural areas are not adequate and consequently such inequalities are not currently being identified or addressed [11].

4.21 The nature of rural deprivation differs from that in urban areas, in particular with respect to transport, housing and the challenges associated with accessing services. Furthermore, whilst poverty is often conceived of as an

urban issue research has demonstrated comparable levels of poverty among rural and urban communities over an18-year period [12].

4.22 Access to well-paid work is a challenge in rural areas with a predominance of low paid tourism and hospitality related jobs that are frequently insecure and unpredictable. Consequently, there are high levels of in-work poverty. Lack of public transport and high costs compound challenges for those needing to develop skills and/or access employment opportunities. Further to this it is well-documented that the budget required by rural households to achieve a minimum acceptable standard of living is considerably higher than elsewhere in the UK. This higher cost of living is partly because of distance to services, poor access to lower priced shopping centres and the cost of heating homes which are often off-grid and less well insulated.

4.23 For example, a price comparison exercise across five towns in South-West Shropshire covering the independent shops and major supermarkets within them, showed that the price difference for the total cost of the items in the basket ranged from £18.51 in Ludlow to £43.69 in Clun, a difference of £25.18 which shows the higher cost of shopping locally in rural locations [13].

4.24 Following the publication of the recent All-Party Parliamentary Group (APPG) report into rural health it is clear that further work is required nationally to fully understand and address the factors underlying health inequalities in rural areas, such as Shropshire [14].

Intersectionality and Health Inequality

4.25 It is recognised that factors that underpin health inequalities do not operate in isolation of each other, but interact, reinforcing and amplifying their potency in damaging health. So, when looking at links with protected characteristics in terms of sex, women are more vulnerable to poverty than men primarily because they are paid less, work fewer paid hours over their lifetimes and lose income because of caring responsibilities. Female lone parent households have twice the poverty rate of male lone parents and single mothers in particular are more reliant on benefits and are thus vulnerable to welfare cuts.

4.26 In terms of race, those from ethnic minority groups are more likely to work in low paid occupations or earn below the living wage. Those from black ethnic groups have higher rates of unemployment and are more likely to have insecure work. Whilst pensioner poverty has fallen over recent years some pensioners are more likely to be in poverty than others in particular those with protected characteristics, as follows:

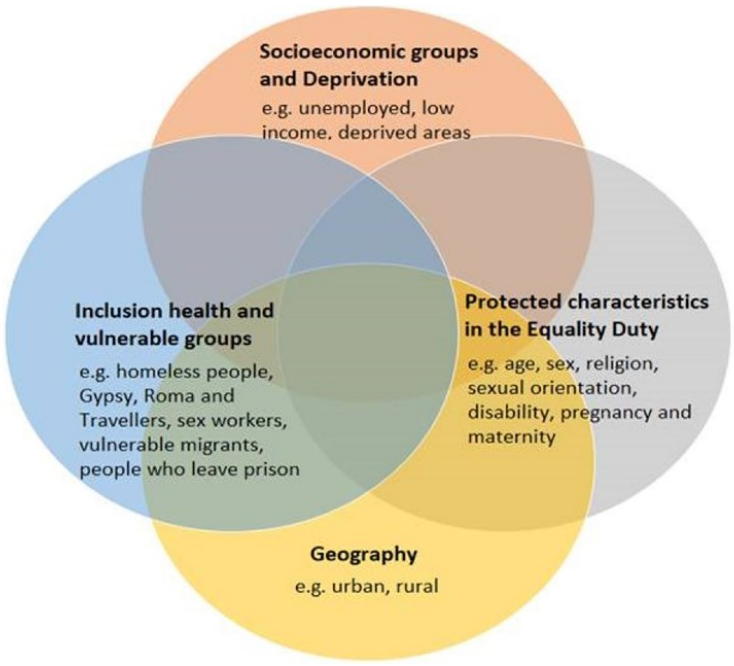
- Asian or Black pensioners
- Single female pensioners
- Pensioners with disabilities.

4.27 There is a very strong relationship between poverty and disability. Almost half of working age adults in poverty have someone who is disabled in their household. Poverty for those with disabilities is often related to the costs incurred for a disabled person to enjoy the same living standards as a non-disabled person. Disability-related benefits are included in measures of net income, but do not account for the additional costs incurred; thus, a disabled household may appear to have sufficient income whilst in reality their income is insufficient.

4.28 Whilst those with protected characteristics are independently more vulnerable to poverty there is an additional impact through intersectionality. For example, women with disabilities are lower paid than women without disabilities and youth unemployment rates for young people from Black, Pakistani, or Bangladeshi backgrounds are more than twice the rate among white, young people.

4.29 The overlapping dimensions of health and health inequalities are recognised and are illustrated in figure 3 below.

Figure 3. The Overlapping Dimensions of Health Inequalities [15]



Impact of COVID

4.30 The impact of Covid-19 was uneven across different population groups both in the UK and across the world. Health inequalities were exposed through the pandemic as the virus disproportionately impacted on groups already facing the worst health outcomes. The mortality rate from Covid-19 in the most deprived areas was more than double that of the least deprived. In addition,

some ethnic minority communities and people with disabilities experienced significantly higher Covid-19 mortality rates than the rest of the population.

4.31 The economic and social consequences of measures to contain the virus worsened these inequalities further, with people in crowded housing, on a low wage, unstable and frontline work experiencing more poverty and vulnerability to disease than other population groups [16].

4.32 The consequences of the pandemic and measures required to contain it will drive health inequalities in the foreseeable future because, for example, school closures particularly disrupted the learning of poorer children, leading to lower attainment which will have a legacy in terms of poorer future employment prospects for those affected. Mental health worsened for groups (women and younger adults) who had poorer mental health pre-pandemic. In addition, lockdowns and social distancing particularly reduced the ability of younger, lower-earning, and less educated people to work.

4.33 Importantly, as a result of the pandemic, there is increased awareness of what inequalities and health inequalities are and the ways in which they impact on people's lives. Locally relationships with communities and third sector groups were strengthened as a consequence of the action taken during the pandemic and as such present an opportunity for more collaborative action to improve health in the future.

5. The Evidence Base for Reducing Inequalities and Health Inequalities

5.1 Inequalities are not fixed, and evidence indicates that a comprehensive approach to tackling them can make a difference. Evidence also shows that having a more equitable society benefits the whole population, not just those living in the most deprived areas or currently experiencing the worst outcomes [17].

5.2 The national Marmot reviews provide a comprehensive overview of the action required to have a positive impact in terms of reducing health inequalities [18][19]. The reports emphasise the importance of early years development and in improving the socio-economic circumstances in which people grow, live, work and age and specify the following policy areas for intervention:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all

- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

5.3 The important role that communities play is also emphasised with a recognised need to work in partnership with communities, co-producing solutions and building community capacity and resilience. Given the wide range of causes of health inequalities, a joined-up, place-based approach is necessary to tackle the complex causal pathways that operate across the life course.

5.4 The Marmot reports provide strong evidence that health inequalities present across a social gradient, with those living in the most deprived areas having the worst outcomes. As such proportionate universalism is recommended whereby actions are universal, but with a scale and intensity that is proportionate to the level of disadvantage.

5.5 It is also recognised that adopting a Health in All Policies approach can support local authorities to embed action on health inequalities across all of their functions and such an approach is being adopted in Shropshire.

SECTION 2:
Shropshire's Inequality Plan

Tackling inequalities and poverty in all its forms, enabling children, young people, adults and families to achieve their full potential

6. Policy Context for Reducing Inequalities and Health Inequalities

6.1 It is widely recognised that reducing health inequalities would bring economic benefit to the whole country. The government has established a Cabinet level health promotion taskforce to move forward prevention policy and a health disparities White Paper is due later this year. The government's recent 'levelling up' strategy outlines the national ambition to spread opportunity more evenly across communities addressing the factors that predispose to health inequalities. One of the 12 'missions' within the strategy is to close the gap in healthy life expectancy between local areas where it is highest and lowest by 2030. This is widely recognised as being an ambitious target that will require concerted action across multiple policy agendas simultaneously in order to be successful [20].

6.2 In terms of NHS policy, the 2012 Health and Social Care Act introduced duties on a range of NHS bodies to have 'due regard' to reducing health inequalities in exercising their functions [21]. The NHS long term plan (LTP)[22] signalled more comprehensive action across the NHS to both strengthen the prevention of ill health and to reduce health inequalities. The LTP incorporates the delivery of a number of transformation programmes that have the potential to make a significant contribution in reducing inequalities. These include:

- **Maternity transformation –** with increased roll-out of 'continuity of carer' and a reduction in smoking in pregnancy
- **Cancer and Cardiovascular Disease transformation –** with increased opportunity for early diagnosis and treatment
- **Diabetes prevention –** with earlier identification and the provision of expert support

6.3 There is also a focus on improving children's health, respiratory health and mental health. These developments present significant opportunities for reducing health inequalities.

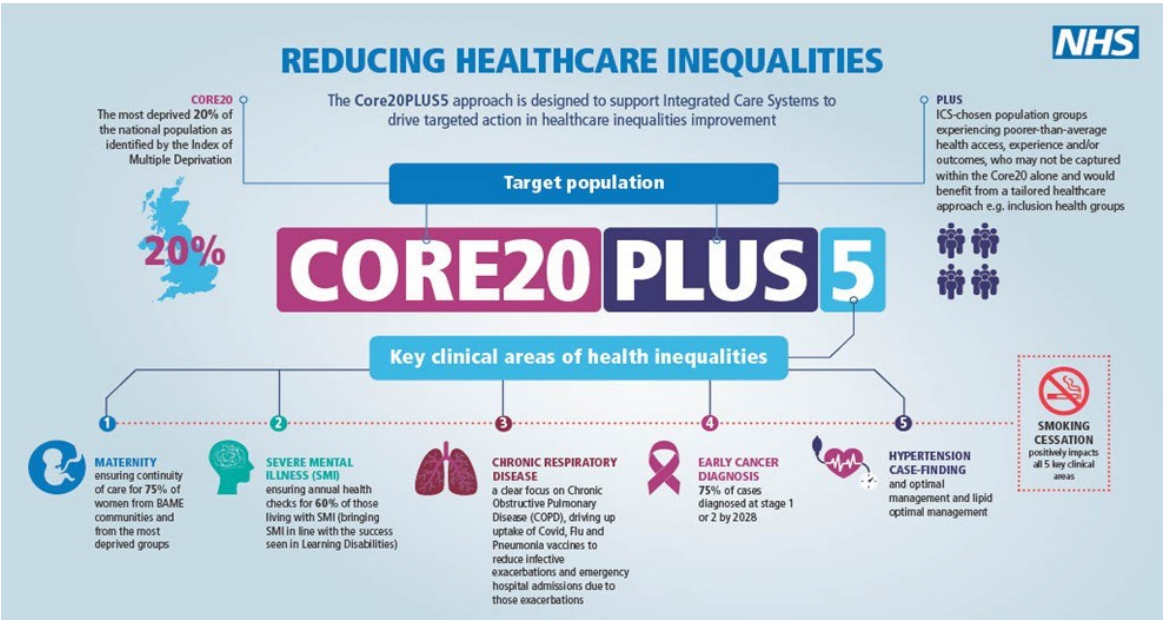
6.4 More recently Integrated Care Systems [23] have been introduced across the country with the specific purpose of bringing local partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

6.5 Shropshire Council is an active partner within the local ICS and will be working alongside NHS colleagues in achieving these objectives.

6.6 In order to focus specific action on health inequalities NHSE/I has introduced the 'Core20PLUS5' framework to drive a reduction in health inequalities. The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' clinical areas requiring accelerated improvement, as shown in figure 4 below [24].

Figure 4. The 'Core20PLUS5' Framework



6.7 In addition to the Core20PLUS5 approach each Primary Care Network (PCN) [25] is required to draw up specific plans to tackle neighbourhood health inequalities and the Public Health team are supporting them in taking forward this commitment.

7. Inequalities and Health Inequalities Across Shropshire

7.1 The 2021 census indicates that Shropshire has a population of 323,600 people [26]. Further breakdown of the population from this census is not yet available but in the 2011 census 2% of the population were from an ethnic minority group, 5% claimed to have bad or very bad health and 9.5% were aged 75 years or over [27].

7.2 The IMD score as described in paragraph 3.4 above, was last calculated in 2019. Shropshire has an average score of 17.2 and is ranked as the 174th most deprived out of a total of 317 lower tier local authorities in England. When looking at smaller geographical areas – Lower Super Output Areas (LSOAs) Shropshire has 2 LSOA's within the 10% most deprived LSOAs nationally and a further 7 sit within the most deprived 20% of LSOAs nationally, as follows [28]:

A LSOA within the most deprived 10% in

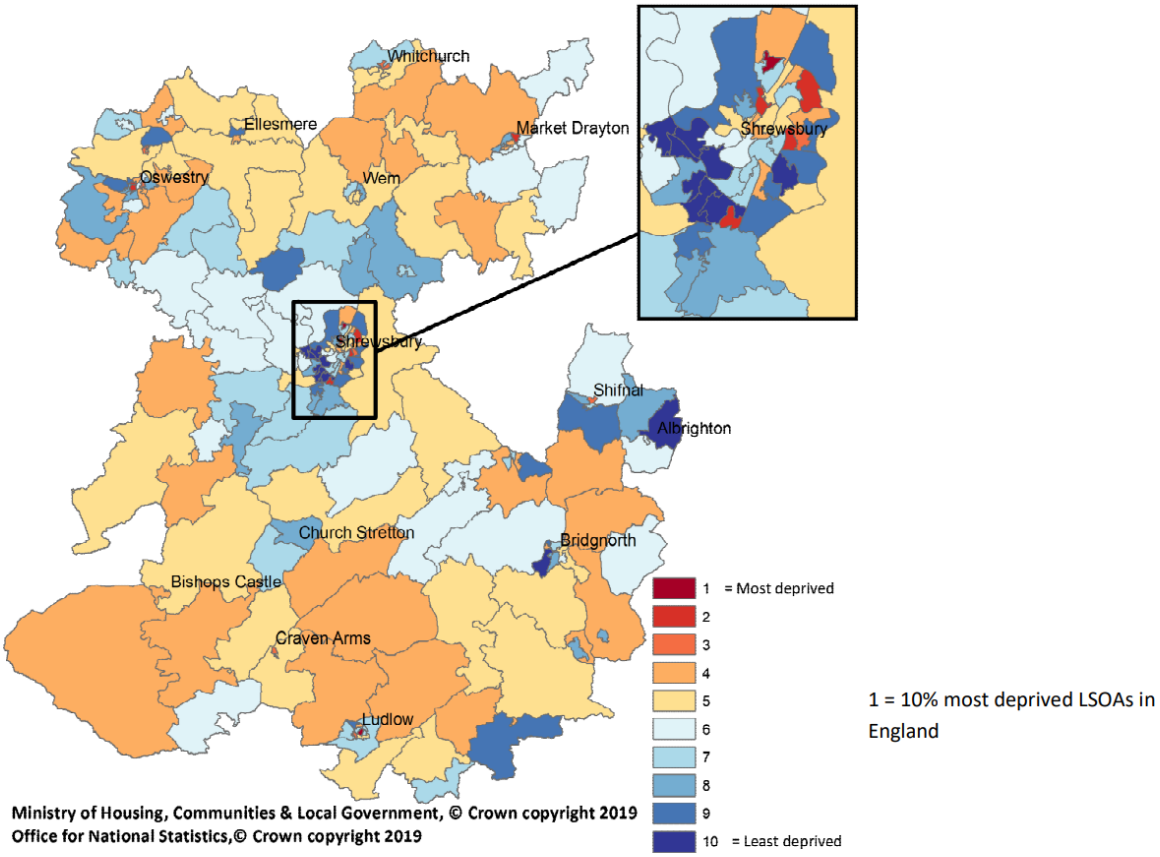
- Harlescott ward (Shrewsbury)
- Ludlow East ward

A LSOA within the most deprived 20% in

- Monkmoor ward (Shrewsbury)
- Oswestry South ward
- Meole ward (Shrewsbury)
- Castlefields and Ditherington ward (Shrewsbury)
- Market Drayton East ward
- Sundorne ward (Shrewsbury)
- Oswestry West ward

7.3 Figure 5 maps LSOAs by their deprivation decile with the red areas being the most deprived areas and the dark blue areas the least deprived areas

Figure 5: Map of LSOAs by Deprivation Decile



7.4 It follows that worse health outcomes might be expected for residents living within the most deprived LSOAs but the extent to which this is evident in ward statistics will depend on the overall population of the ward and the proportion of the population that sits within the deprived decile.

7.5 Table 1 includes some high-level indicators relevant to the assessment of health inequalities and illustrates how Shropshire compares to England and then the range in measurements across Shropshire's electoral wards.

Table 1: Indicators of Inequality Across Shropshire

Measure	England	Shropshire	Range (Ward)	Range (Ward)
IMD Score	21.7	17.2	3.7 (Copthorne)	37.6 (Harlescott)
Life expectancy at birth, (Male)	79.7	80.5	75.3 (Sundorne)	85.8 (Copthorne)
Life expectancy at birth,(Female)	83.2	83.6	79.5 (Tern)	89.6 (Clun)
Deaths all causes, all ages, (SMR)	100	96.7	65.4 (Copthorne)	145 (Worfield)
Deaths all causes, under 75, SMR	100	89.7	55.2 (Clun)	149 (Sundorne)
Preventable deaths, under 75, SMR	100	85.7	48.2 (Corvedale)	160.6 (Sundorne)

7.6 It can be seen that based on IMD on average Shropshire (17.2) is less deprived than England (21.7) (but noting that IMD does not adequately reflect rural deprivation and as such this cannot be accounted for). It can also be seen that there is wide variation in average IMD by electoral ward with Copthorne having a score of 3.7 as compared to Harlescott at 37.6.

7.7 Life expectancy for males and females and deaths as measured through the Standardised Mortality Ratio (SMR) (i.e., death rates standardised for differences in the age and sex profile of the population so they can be compared on a 'like for like' basis) can be seen to be on average better in Shropshire than in England. However, it is also evident that there is wide variation by electoral ward, with lower life expectancy within Sundorne and Tern and higher life expectancy in Copthorne and Clun.

7.8 Appendix 2 includes further detail of life expectancy for males and females by electoral ward.

7.9 In looking at the SMR it can be seen that compared to England the death rate (for all causes and all ages) is 34.6% less in Copthorne ward but 45% higher in Worfield. Likewise, for deaths under 75 years the death rate is 44.8% lower in Clun than in England as a whole and 49% worse in Sundorne. This pattern is mirrored for preventable deaths aged under 75 where again the Sundorne population compare less well – having a death rate 60% higher than the national average for this health indicator.

7.10 Appendix 3 provides details of the SMR for deaths considered preventable in those aged under 75 years by electoral ward.

7.11 Healthy life expectancy (HLE) is another important indicator in the context of health inequalities as it measures the average number of years a person would expect to live in good health based on contemporary mortality rates and the prevalence of self-reported good health, as reported through the Annual Population Survey.

Table 2: Healthy Life Expectancy (in years) in Shropshire and Inequality in HLE

Indicator	Shropshire	England
HLE Males	62.8	63.1
Inequality in HLE Males	5.5	9.7
HLE Females	67.1	63.9
Inequality in HLE Females	3.5	7.9

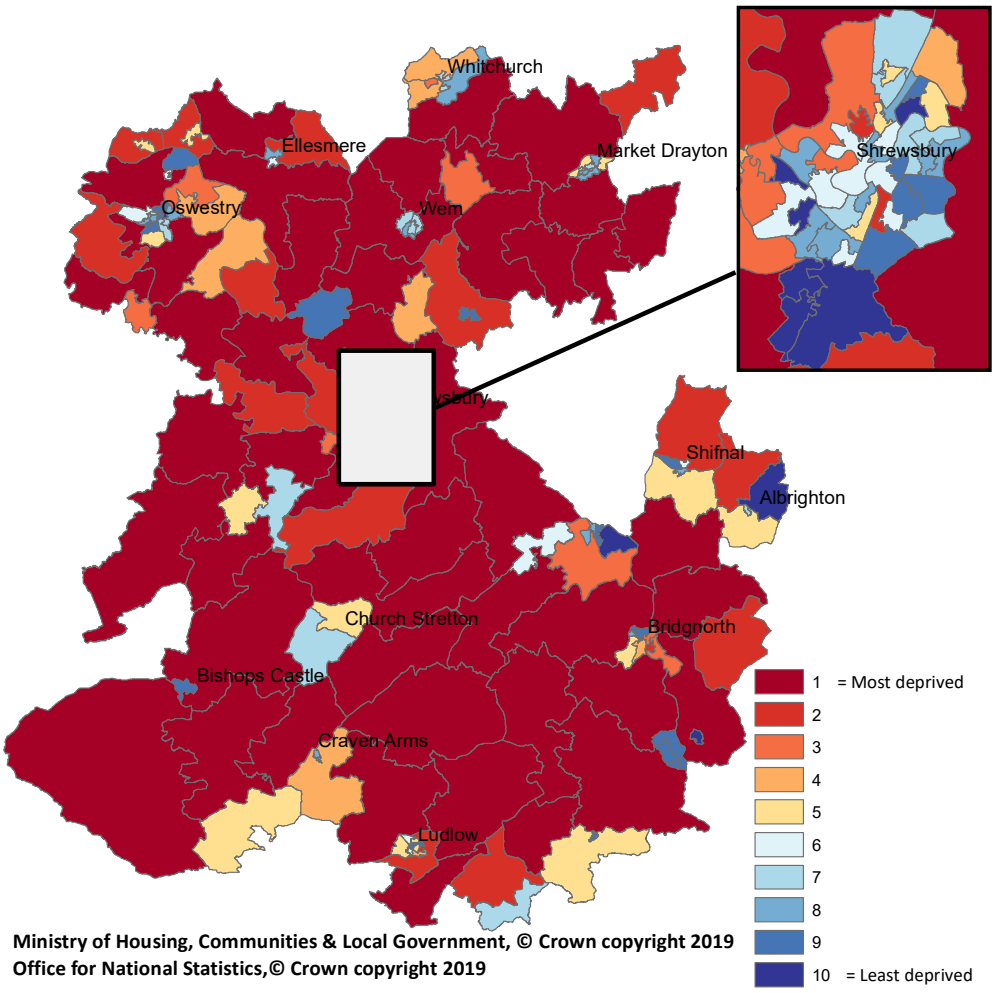
7.12 Table 2 illustrates how HLE in Shropshire compares to the England average and also provides an overall measure of inequality in HLE across the county. It can be seen that males in Shropshire have a lower HLE than the England average, whilst females in Shropshire have more years in good health than the England average. There is inequality across the county (i.e., the difference in HLE across deprivation deciles within Shropshire) with, on average, men in the least deprived areas enjoying 5.5 years in better health and the women 3.5 years.

7.13 In order to illustrate the impact of rurality on deprivation figure 6 maps the 'Barriers to Housing and Services' domain of the IMD. This domain measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services (such as distance to shops and services), and 'wider barriers' which includes issues relating to access to housing such as affordability and homelessness [(29)].

7.14 For this domain Shropshire has an average score of 25.4 and is ranked as the 68th most deprived local authority in England out of a total of 317 lower tier authorities. Forty-seven of Shropshire LSOA's are within the 10% most deprived nationally and 35 LSOAs in Shropshire are ranked within the 5% most deprived for the Barriers to Housing and Services domain nationally.

7.15 It is notable that this domain is weighted less heavily (9.3% towards the total IMD score) as compared to other domains such as employment (22.5% towards the total IMD score). This illustrates how IMD might not be appropriately weighted for the type of deprivation experienced in rural areas.

Figure 6: Map of LSOAs by Decile for the 'Barriers to Housing and Services' Domain of the IMD



Ministry of Housing, Communities & Local Government, © Crown copyright 2019
Office for National Statistics,© Crown copyright 2019

7.16 As described in section 4 above there are a wide range of factors that make individuals and communities vulnerable to health inequalities. Table 3 provides details of the numbers of individuals that fall within a selection of 'vulnerable' groups. Whilst not all vulnerable groups are included below the table does provide an illustration of the large number of individuals who are at risk of experiencing inequalities in their health.

Table 3: Illustration of the Number of Vulnerable Individuals in Shropshire

Vulnerable Group	Number *
Children in absolute low-income families	8,922[a]
Children in relative low-income families	11,038[b]
Children in care	504[c]
Children in receipt of Free School Meals	6,598
Number of excluded pupils	1,375
Number of NEETs	590
Number claiming Universal Credit (in employment)	8,555
Number claiming Universal Credit (not in employment)	10,432
Number on PIP payments	12,881
Number claiming carers allowance	5,532
Number homeless	253
Number living in fuel poverty (16.5% of households) n=145,430 households with 2.2 persons per household	52,791
Number on SMI register	2,830
Number on LD register	1,806
TOTAL	**124, 107****

See appendix 4 for data sources

** (NB: There will be double counting between these groups but counterbalanced by vulnerable groups not included e.g. LGBTQ+, carers not in receipt of carer's allowance, people with disabilities not in receipt of benefits or on the LD register, those experiencing domestic abuse, those with common mental health disorders, sensory impairment, digitally excluded individuals etc)

7.17 All groups who are vulnerable to experiencing health inequalities tend to be vulnerable to experiencing poorer access to services. This was apparent during the roll-out of COVID vaccinations whereby data indicates that vaccination uptake in certain population groups was less good than for others. Appendix 5 shows vaccination uptake by deprivation decile and shows that uptake in more deprived population groups is lower than those living in more prosperous areas.

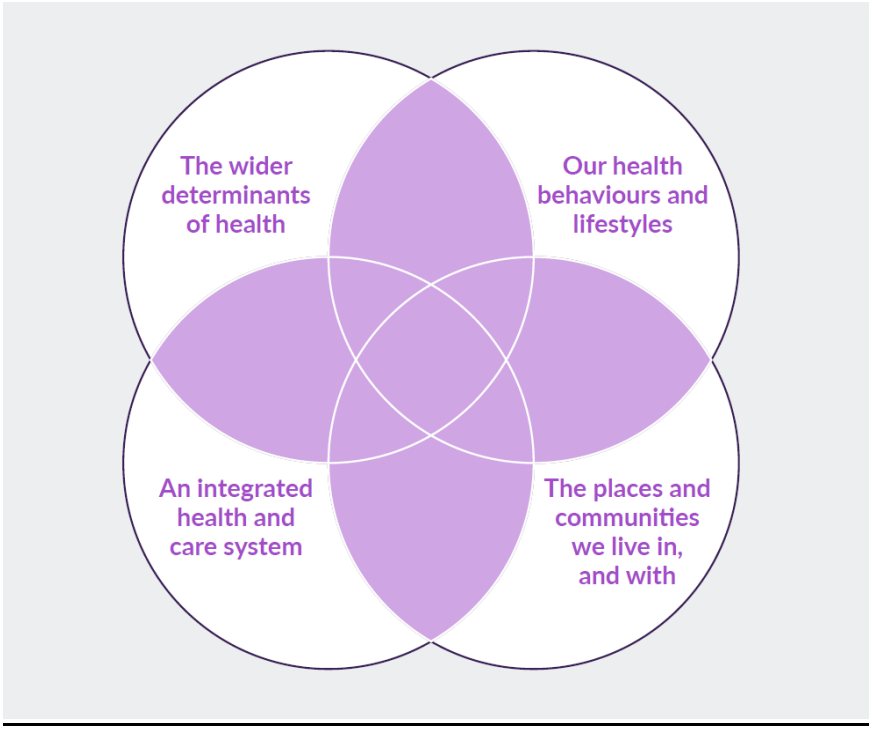
7.18 Shropshire's Joint Strategic Needs Assessment (JSNA) process will provide further insight into the health of the population at a more granular level, as will the Director of Public Health's annual report.

8. Development of the Inequalities Plan

Population Health Model

8.1 Across the ICS there has been a commitment to adopt a population health approach to improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities across the entire population. In order to support this approach, the Population Health Model has been adopted. By using data to gain an understanding of population need and then to risk stratify populations, interventions can be targeted at those groups in greatest need of support.

Figure 7: Population Health Model



8.2 Figure 7 illustrates the key components of the Population Health Model – whereby there are four interconnected pillars/areas for action that need to be addressed to secure health improvement and reduce health inequalities.

These are:

1. **The Wider Determinants of Health** - working in partnership to tackle health inequalities through addressing the social determinants of health such as education, employment, income, housing and transport
2. **Healthy Behaviours and Lifestyles** - aligning and coordinating prevention programmes to maximise impact and reduce barriers to healthy lifestyle choices
3. **The Places and Communities Where we Live** - working with our communities and other partners to co-produce health improvement solutions, based on local needs and assets
4. **An Integrated Care System** - health and social care commissioners and providers working together to commission and deliver services that meet the needs of Shropshire's population

8.3 This framework has been used to structure Shropshire's Health Inequality plan as described below.

9. Underpinning principles

9.1 It is important to note that the inequalities plan is drawing together existing work programmes being taken forward across the ICS footprint and as such the principles expressed here need to be considered in all service developments and interventions. Achieving this will be enabled through adopting the Health in all Policies approach [30] and through the adoption of the HEAT tool [31], as recommended by NHSE.

9.2 In tackling the complex issues that underlie health inequalities there is a need to recognise the importance of understanding problems from the perspective of those with 'lived experience' of the issue and adopting a 'whole system approach' built on complex systems theory (i.e. simplistic approaches ('sticking plasters') are not effective solutions to complex problems). Other principles that will underpin action include:

- Intelligence led identification of problems and evidence-based solutions
- Community centred action – co-producing solutions building on local assets working with individuals and community and voluntary sector partners
- Those based on equitable targeting of resources
- Those built on place-based collaboration and co-production

10. Structure and Content of HI Plan

10.1 The plan includes high level detail of the intended work programmes being taken forward to address NHS and Health and Wellbeing Board priorities, grouped under the Population Health Model domains, together with separate sections highlighting plans being implemented to meet the needs of 'social inclusion' groups and the plans being implemented by PCNs as part of their work to tackle neighbourhood health inequalities.

10.2 The structure of the plan together with a selection of the priorities included within each of the Population Health Model domains is illustrated in Table 4.

Table 4. Structure of Inequalities Plan

Wider Determinants	Healthy Behaviours and Lifestyles	Healthy places and communities	Integrated Health and Care
Marmot: *(i) Create fair employment* *(ii) Ensure healthy living standard*	*Marmot:* *(ii) CYP and adults – maximise capability and control* *(iv.a) Strengthen Ill-health prevention (lifestyles)*	*Marmot:* *(v) Create healthy and sustainable places and communities*	*Marmot:* *(vi) Give every child the best start in life* *(iv.b) Strengthen Ill-health prevention (transformation/ disease programmes)*
Inequalities Work Programme			
Embed Health in all polices	Smoking/tobacco dependency treatment	Air Quality/climate change	Rural inequalities
Housing	Healthy weight (incl NHS DWMP)	Planning	Population Health Management
Economy and skills	Physical Activity	Licensing	Restore NHS services inclusively
Workforce	Alcohol	Culture, Leisure	Mitigate digital exclusion
Education		Food Insecurity	Datasets are complete
Transport			COVID and flu vaccination
			Annual health checks LD and SMI

10.3 The source of the priorities included in the plan is detailed in appendix 6. Alongside these priorities details of the work programmes in place to deliver improvements to the 'wider determinants of health' and for social inclusion groups have also been included. From a council perspective these plans are consistent with meeting the aspirations of the Shropshire Plan.

10.4 The plan has been drawn together with the support of officers across the council and the wider NHS and reflects the plans that are currently or imminently being implemented. The plan includes intended milestones, process and outcome measures and these can be used to monitor progress with delivery and effectiveness in terms of improved outcomes over time.

11. Additional/Core Programmes of Work

11.1 The Inequalities Plan is detailed at the end of this section, but it is important to note that it is not inclusive of every activity, service or function with the potential to impact on health inequalities. Almost any health or support service has the opportunity to reduce health inequalities if it is targeted and delivered in the right way. Conversely if such services and work programmes are universally available and not targeted, they run the risk of widening inequalities.

11.2 Some of the core services and previous council investments and developments that could impact positively in reducing in health inequalities include the following:

Development and Delivery of the Shropshire Plan and Revised Target Operating Model

11.3 The Shropshire Plan is the overarching strategic plan for the council with 4 key priorities:

- Healthy people
- Healthy economy
- Healthy environment
- Healthy organisation

11.4 The plan makes a clear commitment to tackling inequalities and poverty in all its forms and recognises the importance of having an economy that enables skills development giving improved job prospects for the population as a vital ingredient for success. Further to this the Shropshire Plan seeks to develop and support safe, sustainable, diverse and

inclusive communities and to work in partnership to achieve shared priorities delivering improved services and opportunities for the Shropshire population.

11.5 In order to deliver the plan council officers are undertaking significant work to revise the way in which the council operates – developing a new Target Operating Model (TOM) to deliver strategic objectives in the most effective and efficient way. The following key work programmes will enable the council to further develop and maintain a focus on inequalities over the coming years:

- **Shropshire Local –** promoting accessibility to services, in particular for those with additional needs
- **Breaking Cycles –** tackling intergenerational disadvantage
- **Commissioning –** integrating approaches so complex needs can be best met
- **Digital Council –** that will include activity to address digital exclusion, a key driver of inequality

Working with our Voluntary, Community and Enterprise Sector

11.6 Shropshire has a strong history of community led approaches to help build connected and empowered communities. Shropshire Council has a good relationship with Voluntary, Community and Enterprise Sector organisations (VCES) through the Voluntary and Community Sector Assembly (and the Compact). Through working in close partnership on many projects and transformation programmes, and through a range of contracts and grant programmes work is underway to tackle heath inequalities.

Early Help/Supporting Families

11.7 Supporting Families launched in March 2021 and builds on the previous Troubled Families programme. The key focus of the programme is to build the resilience of vulnerable families [32] providing the right support at the right time. In Shropshire the Supporting Families programme is delivered through the Early Help service and provides targeted interventions for families with complex interconnected problems.

Shropshire Council, with system partners is creating a new vision and way of working with CYP and families based on a stronger and wider prevention offer which brings together service areas and programmes.

Delivering Social Value

11.8 The Social Value Act 2012 requires the public sector to ensure that the money it spends on services or goods creates the greatest possible economic, social and environmental value for local communities [33]. Implementing Social Value involves making procurement decisions in a way that ensures wider benefits are considered throughout the commissioning cycle. Examples of the type of Social Value that might be achieved could be a commitment from a contractor to pay a living wage to their employees or to employ target groups such as

young unemployed people, alongside delivering the service being commissioned. As such implementing Social Value approaches can positively support other local efforts to reduce health inequalities.

The Holiday Activities and Food (HAF) Programme

11.9 The holiday activities and food (HAF) programme allows children and young people aged 4 to 16, who are in receipt of benefits related free school meals (FSMs) and those who have been referred onto HAF by a professional to access free holiday provision during the Easter, Summer and Christmas school holidays. Funded by the DfE, the programme is being delivered across all local authorities over the next three years.

The UK Shared Prosperity Fund (UKSPF)

11.10 There are, and always will be, emerging opportunities through which the council and its partners can strengthen their approach to tackling inequalities. For example, over the coming months council officers will lead development of plans to draw down monies through the UK Shared Prosperity Fund (UKSPF). The overarching objective of the fund is, “Building pride in place and increasing life chances”. The programme covers three investment priorities that offer significant opportunity to reduce health inequalities, as follows:

- Community and Place
- Supporting Local Business
- People and Skills (including the ring-fenced Multiply allocation for improve the core skills and employability of adults)

11.11 Further details relating to these core work programmes are included in appendix 7.

12. Cost of Living Crisis

12.1 It is notable that since work on the Inequalities Plan started in September 2021 national and international circumstances have fundamentally changed in ways that will only worsen health inequalities.

12.2 The UK is currently experiencing an unprecedented Cost of Living Crisis (CLC) with inflation expected to reach a 40-year high as prices for food, fuel and other essential goods increase faster than household incomes. People are now expected to see the biggest fall in living standards in any single financial year since ONS records began in 1956-57. As a result, increasing numbers of people are unable to meet their basic living needs including adequate heating, nutrition and essentials such as clothing. While the entire UK population are affected by rising prices, the impact has, and will be, felt most by those living on a low income.

12.3 The average financial shortfall for a household is estimated to be £8,600 with 34.2% of the population living below the Minimum Income Standard from April 2022(34). Shropshire has a relatively low wage economy, with gross weekly full time pay of £584.60 against a UK average of £613.10) [(35).] Prior to the CLC low-income households were already financially challenged with18% in rent arrears, 12% in council tax arrears and 12% in electricity/gas arrears [(36).] Their hardship is expected to be compounded as inflation for lower earners is predicted to be 14% as they spend a higher proportion of their income on energy and food.

12.4 As a consequence of this cost-of-living squeeze, a wide range of impacts are anticipated, including the following:

- **Housing costs** will increase for many people - with larger mortgage repayments and anticipated rent increases in social and privately rented properties.
- **Fuel Poverty** Energy prices rose 54% in April and are due to increase again in October. In 2020 16.5% of households in Shropshire were identified as being in fuel poverty [(37)], with rates highest and rising particularly in rural areas. Many households in rural Shropshire rely on Oil or Liquid Petroleum Gas (LPG) central heating which is not subject to any price cap and spreading payments is not always possible, giving rise to particularly acute and severe financial pressure.
- **Food Poverty** 43% of households in receipt of Universal Credit are reported to be food insecure [(38).] Shropshire's foodbanks are seeing an increasing number of residents seeking support. In January 2021 it was estimated that 14% of Shropshire's population were experiencing food poverty [(39)].
- **Petrol/Diesel costs** The increasing cost of travel is being felt most acutely in rural areas causing financial pressure for people needing to travel for work. This increase disproportionately impacts on people who live in more rural areas and have to travel further for work, education and health and care. Rural residents travel further than their urban counterparts. On average those in small rural settlements travel more miles in a year than those in urban settings – 44% more miles in 2018/19. In the context of fuel prices this adds significant additional costs for rural residents and the cost pressure will likely result in further reduced access to services.

12.5 The CLC will push more people into poverty, and more people in poverty will lead to more people experiencing ill-health. There are key population groups who are likely to face particular hardship and as such be particularly vulnerable to ill-health including:

- **People with a long-term illness or disability** who are unable to work full time. This group are often on a fixed low income and face additional costs due to their illness or disability (an average of £583 per month extra for

people with disabilities). Increasing energy costs pose a particular challenge [40].

- **Low-income households** including those working in the care sector. Universal Credit claimants in Shropshire roughly doubled in 2020 and have remained at a similar level since. Nearly half of claimants are in work. Workers in the care sector are being impacted by the increases in fuel costs, particularly when working in rural Shropshire.
- **Older people.** Over 75,000 people in Shropshire receive a state pension, and 7335 receive Pension Credit. Older people need to keep their homes warm and are struggling with additional energy costs. A recent Age UK report showed the impact on older people living in the UK, with above average rates in Shropshire [41].
- **Families with children.** In 2020/21 8922 children in Shropshire lived in absolute low-income households and 11038 children lived in relative low-income households. Single parent households and families with 3+ children are reported to be most impacted by the cost-of-living increases.
- **Rural households.** People in rural households already experience higher costs for housing, transport and energy. The increase in the cost of living, combined with the distance to access key services will add additional cost for these people.

12.6 In order to mitigate the impacts of the CLC as far as is possible a Social Taskforce group has been meeting to review the evidence relating to the crisis in order to:

- Quantify the likely impacts of the CLC on different population groups
- Review the current support available
- Identify additional support required in the short and medium term
- Review communications to the general population, to the groups most severely affected and to front-line staff in health, care and other support agencies

12.7 The key priorities within the action plan developed by the Social Taskforce are enclosed as appendix 8. The CLC plan was considered by the H&WBB in July, but it is recognised that on-going review of the impacts and support available will be required as it is understood that the worst impacts of the CLC are yet to bite – particularly following the planned October energy price increase.

13. Identifying Gaps in Collective Action to Reduce Inequalities in Health

13.1 One of the key opportunities presented as a consequence of developing this plan is the scope it presents for an assessment any key gaps in actions being taken across the system. Through discussion with the steering group, with colleagues within the NHS and across the council and with the VCSA the following gaps have been identified.

Comprehensive Action to Reduce Smoking Rates

13.2 Smoking has been identified as the single largest driver of health inequalities in England. One study found that smoking accounted for a third of the difference in death rates between the lowest and highest socioeconomic groups. In addition, it has been identified that 50% of the deaths among people with Serious Mental Illness (SMI) are due to tobacco related illnesses. Tobacco control and smoking cessation services thus make a vital contribution in reducing health inequalities.

13.3 The recent Khan review [42] emphasises the need to make it as hard as possible for people to smoke, and as easy as possible to quit, leading to a smokefree generation. It points out that there are multiple benefits of making smoking obsolete in terms of improved population health alongside social and economic benefits. There is a key recognition that smoking impacts most on the poorest, the least educated, the least skilled and the underemployed. The report points out that the governments ambition for 'levelling up' will not be delivered without tackling smoking.

13.4 The report identifies 4 critical recommendations, as follows:

- Increased investment in smokefree 2030 policies and local stop smoking services
- Increase the age of sale in a bid to stop young people starting to smoke
- Promote vaping as an effective, although not risk-free, alternative to smoking
- Improve prevention in the NHS through fully delivering the commitments in the Long-Term Plan

Meeting the Needs of the LBGTQ+ Community Across the Life Course

13.5 The Health Inequalities Plan includes details of work underway to support the needs of older members of the LBGTQ+ community. However national statistics indicate that younger people (aged 16 to 24 years) were most likely to identify as LGBTQ+ in 2018 (4.4%) [43].

Given the health impacts of identifying or being identified as LBQTQ+ are significant including verbal harassment and physical violence, it is important that some assessment is made of the need for more comprehensive action in this area [44][45]. It is recognised that the imminent publication of the most recent census results will provide important context for action in Shropshire.

Reference to the Accessible Information Standard

13.6 The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need is provided through health and care services [46]. The Standard tells organisations how they should make sure that service users can access and understand the information they are given. This includes making sure that people get information in accessible formats. It is a legal requirement that all organisations that provide NHS care or adult social care must meet the requirements of the standard in full but there is emerging evidence that this is not always the case [47].

14. Overriding Priorities

14.1 While action to address health inequalities needs to be comprehensive and incorporate all of the planned actions included in the plan, the overriding short-term priority has to be the actions and priorities agreed through the Social Taskforce to address the CLC. Beyond this the following are key areas where action and impact should be closely monitored:

- Development and implementation of plans to reduce smoking
- Maintaining a focus on delivering ‘health in all policies’ across the council and wider ICS
- Strengthening the ‘Early Intervention/Prevention’ offer for Children, Young People and Families
- Strengthening prevention through the support of healthy lifestyles – including through making the environment in which people live more conducive to good health and considering the specific needs of those with disabilities
- Delivery of the NHS plans to meet the five clinical areas of focus included in the ‘Core20PLUS5’ framework
- Development and implementation of plans to tackle digital exclusion
- Further consideration of opportunities to improve work-skills among the population and increasing opportunities for higher paid work within the local economy (linked to UKSPF)

- Reducing dependency and the harms associated with drug and alcohol misuse, especially among young people
- Further consideration of the steps that can be taken with academic and other partners to better quantify and meet the health needs of Shropshire's rural population; exposing the rural health inequalities that exist.

15. Governance – Monitoring Delivery of the Inequality Plan

15.1 It is recognised that further work is required to develop a comprehensive approach to monitoring delivery of the plans included in the Inequality Plan. It is important that any monitoring is proportionate and where relevant consistent with other reporting frameworks such as those relating to the H&WBB, the Population Health Board and the Shropshire Integrated Place Partnership (ShIPP).

16. Key Areas of Focus for Shropshire

16.1 There are some particular issues identified in this report that are considered to be key areas of focus for Shropshire. Whilst these issues are referenced above, they are drawn together in this section as follows:

Social Determinants of Health

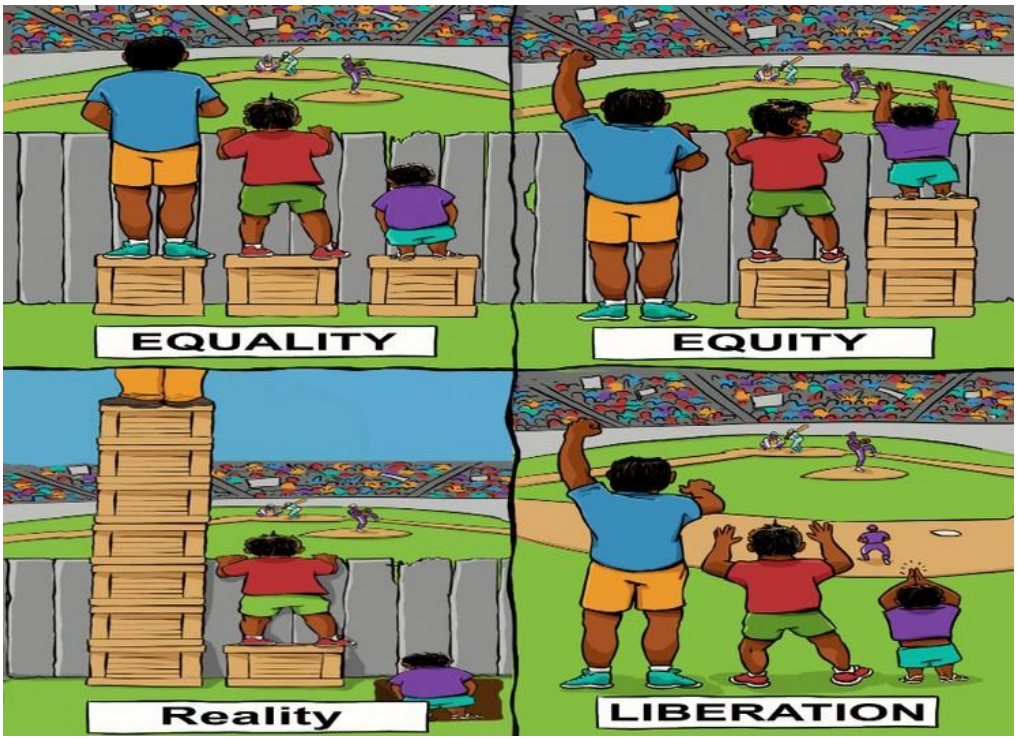
(i) It is clear that the 'wider determinants' (or social determinants) of health impact in diverse ways to influence health outcomes. These same factors affect educational, employment and other outcomes in similar detrimental ways – which go on to compound disadvantage and further undermine health living opportunities. This interrelationship is illustrated in Figure 8 over page.

Figure 8: Social Determinants of Health

Proportionate Universalism

(ii) There is strong evidence that health inequalities present across a social gradient, with those living in the most deprived areas having the worst health outcomes (and likewise worse education, employment and other outcomes). As such proportionate universalism is recommended in tackling inequalities whereby actions are universal, but with a scale and intensity that is proportionate to the level of disadvantage. Proportionate universalism results in the application of resources equitably across the population proportionate to need, as illustrated in Figure 9.

Figure 9. Proportionate Universalism: The Equitable Distribution of Resources Depending on Need



Rurality

(iii) The rural nature of Shropshire also impacts on inequalities and on health. Furthermore, current methods for identifying deprivation and inequalities in rural areas are not adequate making it difficult to identify and address them.

There are a range of relevant factors that impact in particular with respect to transport, housing and the challenges associated with accessing services. Securing well-paid work is a challenge in rural areas with a predominance of low paid tourism and hospitality related jobs that are frequently insecure and unpredictable. Consequently, there are high levels of in-work poverty.

Further to this it is well-documented that the budget required by rural households to achieve a minimum acceptable standard of living is considerably higher than elsewhere in the UK. This higher cost of living is partly because of distance to services, poor access to lower priced shopping centres and the cost of heating homes which are often off-grid and less well insulated.

All of these factors mean that the cost of living crisis (CLC) will be felt more sharply in Shropshire than in more urban areas of the country.

Cost of Living Crisis (CLC)

(iv) The CLC and a recent review links the 'dangerous consequences' of living in a cold home to a child's health and future life expectancy and will push more people into poverty, and more people in poverty will lead to more people experiencing ill-health. A wide range of impacts are anticipated, including the following:

- Housing costs will increase for many people - with larger mortgage repayments and anticipated rent increases in social and privately rented properties
- Fuel Poverty Energy prices rose 54% in April and are due to increase again in October. In 2020 16.5% of households in Shropshire were identified as being in fuel poverty (37), with rates highest and rising particularly in rural areas
- Food Poverty 43% of households in receipt of Universal Credit are reported to be food insecure (38). Shropshire's foodbanks are seeing an increasing number of residents seeking support. In January 2021 it was estimated that 14% of Shropshire's population were experiencing food poverty (39).
- Petrol/Diesel costs The increasing cost of travel is being felt most acutely in rural areas causing financial pressure for people needing to travel for work. Rural residents travel further than their urban counterparts. In the context of fuel prices this adds significant additional costs for rural residents and the cost pressure will likely result in further reduced access to services.

Health in All Policies

(v) It is recognised that adopting a Health in All Policies (HIAP) approach can support local authorities to embed action to improve health and reduce health inequalities across all of their functions and such an approach is being adopted in Shropshire.

Through adopting HIAP the factors that lead to variations in health can be identified and addressed. It can assist in enabling decisions on the distribution of resources to be made in the context of relative need, taking into account rurality as an independent but influential factor.

Joint Strategic Needs Assessment (JSNA)

(vi) The Joint Strategic Needs Assessments (JSNA) is a Statutory Duty placed on the Health and Wellbeing Board. Shropshire is currently developing 'Place-based JSNAs', focussed on our smaller localities which will help us to collectively understand the health and wellbeing needs of communities, understand the unique needs of people in a given location by working together to gain local knowledge and insight and take an asset-based

approach that seeks to highlight the strengths, capacity and knowledge of all those involved. The place JSNAs will be critical in underpinning the identification of needs and inequalities to inform future actions and priorities in this plan

17. Recommendations

17.1 Building on the governance requirements, priorities and key areas of focus set out above the following overarching recommendations are made:

- Development of a framework enabling progress in reducing-inequalities to be periodically reviewed, including monitoring and tracking progress against key measures through development of an action log
- Continue to roll out and adopt a Health in all approach to our programmes and polices
- All staff and partners acknowledge their individual organisational and our collective shared responsibility, to focus plans and implementation of services to seek to address variation in health and wellbeing outcomes.

We want everyone to have a good quality of life no matter where they live or the circumstances they were born into.

18. Shropshire's Inequalities Plan

Format of the Plan

Shropshire's Inequalities Plan is set out in 6 tables as follows:

- Table one: The wider determinants of health
- Table two: Healthy lifestyles
- Table three: Healthy places
- Table four: Integrated health and care system
- Table five: Social Inclusion groups
- Table six: Primary Care Network Plans

For each priority within the tables the following 'high level' information is provided:

- A description of the priority/issue and how it impacts on inequalities
- The associated work programme through which inequalities will be addressed
- The individual leading the work and the strategic group to which progress is reported
- Key actions and milestones associated with the work programme
- Key process measures associated with the work programme
- Key outcome measures associated with the work programme
- Targets related to the work programme or associated outcomes, where these apply

Please note:

Whilst all efforts have been made to ensure the contents of the plan below are correct at the time of submitting this report, it is possible (and to an extent to be expected) that some plans will - for a variety of different reasons - have been changed.

Any such changes will be reflected in future updates of this Inequalities Plan.

Table 1: Wider Determinants of Health

Population Health Domain: Wider Determinants

Marmot: (i) Create fair employment (ii) Ensure healthy living standard

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.1 **Embed Health in all polices**- a mechanism for screening for – and where necessary assessing the potential health impacts of developments/plans	Implementation of equality, inclusion and health screening tool (EIHIA)	Sue Lloyd, Consultant in Public Health, reporting to H&WBB	PH wider determinants team undertake 'face to face' training (March 2022) Council officers undertake 'face to face' training (March 2022) 'Leap into learning' training rolled out across the council (March 2023) Delivery of Health Impact Assessment Transport (May 2022)	100% of team trained 12 officers trained 10% of council officers trained) Health Impact Assessment complete	Number of EIHIAs completed prior to committee stage Skills and knowledge on delivery of Health Impact Assessment embedded in organisation	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.2 Housing – Influences health inequalities through the effects of housing costs, housing quality, fuel poverty and the role of housing in community life	Sufficient affordable and supported accommodation to meet identified need through production of a housing need and demand position statement which maps current provision and evidences current and future need for all tenures of housing, including specialist and supported accommodation	Jane Trethewey Laura Fisher reporting to Housing Executive Board	Undertake authority-wide housing needs survey (October 2022) Produce specialist accommodation and independent living strategy (March 2023) Produce affordable and intermediate housing options strategy (March 2023) Review and revise allocations policy (April 2023) Produce revised Housing Supplementary Planning Document (SPD) (March 2023)	Report produced Strategy published Strategy published New policy introduced SPD published	Numbers of additional affordable housing Numbers of additional specialist / supported accommodation	Minimum of 250 additional dwellings per year

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
Homelessness *see table. 5*						
1.3 Reducing fuel poverty and improving housing standards	Ensure all relevant domestic private rented property meets the Minimum Energy Efficiency Standard (MEES) Develop a sustainable affordable warmth strategy Delivery the private housing assistance policy.	Jane Trethewey / Laura Fisher reporting to Housing Executive Board	Undertake escalated enforcement approach. (September 2022 to March 2023) Strategy which sets out initiatives to tackle fuel poverty, whilst providing a road map for homes becoming net zero carbon. (February 2023)	Number of homes with Housing Health Safety Rating System (HHSRS) category 1 and 2 hazards Publish strategy Total number of Disabled Facilities Grants (DFGs) and major equipment grants provided Number of Disabled Facilities Grants (DFGs) provided	Reduce number of households living in fuel poverty. In 2020 16.5% of households (almost 23,000) were estimated to be in fuel poverty	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.4 **Economy and skills –** people lacking skills and job opportunities leads to unemployment, poverty and ill-health There is a need to create improved employment prospects through local economic policy and enabling infrastructure, education, skills, lifelong learning and labour market programmes. These need to be targeted to maximise opportunities to reduce health inequalities, improve health across the County and to seize opportunities to create economic growth. [1]	Improving overall employment rate/average earnings	Tracy Darke and Matt Potts, reporting back into the newly created Shropshire Economic Partnership Board	Adoption of Economic Growth Strategy with wellbeing & health embedded as a core value. The document is currently open for public consultation. Expected adoption and formal launch (December 2022)	Annual survey of hours and earnings	Median gross workplace earnings for full-time workers Annual Population Survey including NVQ level data Census data will also include specific qualification data	Shropshire 9% less than the national average (2021) Gap between national and Shropshire full time earnings closed by at least 50% by the end of the Economic Growth Strategy lifecycle (2027) * *Metric is subject to change and sign off of the Economic Growth Strategy following public consultation

[1] Shropshire Council (2022) Invest Shropshire

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.4 continued.,	Targeting skills development programmes	Tracy Darke and Matt Potts, reporting back into the newly created Shropshire Economic Partnership Board	Recruitment of senior skills and workforce development officer post. (Starting: September 2022). Targeting ESF programmes to support NEETs, the unemployed and those needing upskilling in work. Provide careers advice and guidance. Support transition arrangements into education, employment or training (TBC) UKSPF programme currently in development and will incorporate programmes under the banner of People and Skills, ultimately replacing ESF funded programmes. Submission of Investment Plan to Government (August 2022). Programme delivery (Expected: Autumn 2022)	Development of skills plan and associated engagement with FE, HE and private providers, and businesses Regular monitoring of ESF contracts. Maintaining the connections with providers offering programmes. Link internally with other groups/areas within the Council with an aim to reduce NEET figures UKSPF – Details TBC subject to sign off of Investment Plan by Government	16-17-year-olds NEET figures	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.4 continued.,	Supporting employment among those with Learning Disabilities (LD)/Mental Health (MH)/Long-Term Health Conditions (LTCs)	LD – Natalie Hawkins MH – Ruth Davies Enable manager – Roshni Shrosbree	Currently bidding for additional LD and MH funding. (Ongoing)	ASCOF 1E – Proportion of adults with learning disabilities in paid employment. 1F: Proportion of adults in contact with secondary mental health services in paid employment.	Gap in the employment rate between those with a learning disability and the overall employment rate	
1.5 Workforce – COVID led to unemployment/lower paid/less stable employment. We will work to make Shropshire workplaces fair, happy and healthy places for people to work in and promote wellbeing for all (See 1.4 also)	'Thrive at Work' West Midlands award. Shropshire Council has received foundation accreditation and now working towards bronze level	Carol Fox Reporting to: Workforce and Information Management Team Resources Management Team Health, Safety and Welfare Group	Foundation accreditation received (November 2021) Undertaking Bronze level at present (December 2022) Silver level achieved (March 2023)	Submission for bronze award December 2022	Shropshire Council will have an equitable wellbeing offer for all staff	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.6 Education including SEND – lower educational achievement is associated with poorer health and health inequalities. Inequalities in childhood are closely associated with measurably poorer health outcomes in adults and comparatively higher numbers of Adverse Childhood Experiences	Addressing sizable gaps in attainment between disadvantaged pupils and others	Steve Compton and school advisors Reporting to DMT	Where there are sizeable gaps in attainment follow up during School Improvement Assistance (SIA) visits (including interrogation of other factors) (Ongoing) All schools publish pupil premium and recovery premium plans Recovery Premium Funding plans are reviewed by the SIA (Ongoing)	School readiness: % of children with free school meal status achieving a good level of development at the end of Reception School readiness: % of children with free school meal status achieving the expected level in the phonics screening check in Year 1	Children with free school meal status achieving a good level of development at the end of Reception Children with free school meal status achieving the expected level in the phonics screening check in Year 1	
1.7 Early years	Improving outcomes for 24U children Improve uptake of 24U places (already above national but still leaves 20+% of our most vulnerable children not in a setting)	Alison Rae Reporting to EIS	Deliver Early Talk training to all 0-3 settings focussing on the settings with 24U children first. (From September 2022) Improve letter to parents to have more impact End of term (July 2022.)	% reduction in grey and black outcomes with Ages and Stages Questionnaire (ASQ) for 2-year-olds. % Uptake of 24U places increases	Improved outcomes for 24U children	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.8 Post 16	Partnership work to provide appropriate post 16 offer	Steve Compton/Matt Potts reporting to Early Help Partnership Board	Link with post 16 providers to ensure that all support options for young people/adults is available (Ongoing)	% reduction in NEETS	16-17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known Participation data for 16-17-year-olds	
1.9 Virtual School (responsible for education of children who are looked after)	Look at the SDQ (Strength and Difficulties questionnaire process) and how SDQs are used effectively at Personal Education Plans (PEP)s to identify and act on needs The SDQ is built into the PEP platform and there is a process in the meeting where the social/emotional needs of each Looked-After Child is discussed and planned for	Jo Kelly reporting to Children and Young Peoples' Board	To meet with Children Looked After (CLA) Service Manager and nurses. Agree way forwards e.g. PEP platform (Early September 2022) The scales on the PEP indicate improving outcomes for social and emotional well-being and relationships/behaviour. PEP Audit to include social and emotional wellbeing scales that are in the new PEP (launches 5th September) (Audit: November 2022)	2 scales in new PEP (social and emotional wellbeing and relationships and wellbeing) will measure improvements. Plan to run report that can show where the children are at by the end of the autumn term and again at end of summer term	Average Attainment 8 score (Average Attainment 8 score for all pupils in state-funded schools, based on local authority of pupil residence) Average Attainment 8 score of children in care (Key stage 4 average Attainment 8 score of CLA continuously for at least twelve months at the end of March (excluding children in respite care). Attainment & progress outcomes for CLA are in line with or better than the national averages	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
SEND **1.10 Speech and language focus** Too many children in reception year do not achieve at least the expected levels across all goals in 'communication and language' and 'literacy' areas of learning	Reduce the waiting list for Speech and Language therapy services	Stephanie Jones reporting to SEND Board/ Children and Young Peoples Board	All Early Years/Primary School settings to receive training on Speech, language and communication (September 2022) % of children achieving expected level of 'communication, language and literacy' to be reviewed in 2023 and annually until 2025	% of education and early years setting trained to deliver speech, language and communication intervention collected locally % of children on waiting lists for speech and language therapy collected locally	More children will achieve expected level of 'communication, language and literacy' (This may be impacted by Covid-19)	% of children achieving expected level across all goals in the 'communication and language' and 'literacy' areas of learning at the end of reception year will increase by 25% by **2025**. (Baseline set using 2019 data) No clear target set to date

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.11 Transport - impacts on health – systems need to be safe and accessible for all, enable active travel and use of public transport and minimise harmful impacts on population groups and the environment	Local Transport Plan 4 (LTP4)	Infrastructure Department, Place Directorate Steve Smith and Victoria Merrill. reporting to Place DMT on outcomes / recommendations from the Project Steering Group (cross-organisational representation)	Cabinet approval of draft portfolio of documents. Dates to be updated pending issue of new DfT guidance on LTPs expected (Spring 2023) Annual review of interventions and targets (Annual)	KPIs to be agreed through LTP4 to include decarbonisation/ improving quality of life	KPIs to be agreed through LTP4 to include decarbonisation/ improving quality of life	No targets set to date.

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
1.11 continued., The LTP4 considers and prioritises the mobility needs of people, places, and activities in promoting and maintaining healthy, equitable and sustainable communities. Local cycling and walking infrastructure plan (LCWIP) to encourage and enable sustainable physical activity in daily life for all population groups	Local cycling and walking infrastructure plan (LCWIP)	Rose Dovey reporting to Cabinet and Full Council	LCWIP finalised (March 2023)	Increased proportion of county with access to good quality cycleways and walking in areas of deprivation and low physical activity.	Shropshire as a zero-carbon county Healthier living for Shropshire residents. Reduced congestion and car dependency 	No targets set to date

Table 2: Healthy Lifestyles

Population Health Domain: Healthy Lifestyle Behaviours

Marmot: (iii) CYP and adults – maximise capability and control
(iv.a) strengthen Ill-health prevention (lifestyles)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.1 Smoking – is the single largest driver of health inequalities in England. In addition, 50% of the deaths among people with Serious Mental Illness (SMI) are due to tobacco related illnesses The NHS is introducing new Tobacco Dependency Treatment services and public health need to reconsider what community support can be provided to smokers to enable them to quit	The NHS will lead the implementation of new or revised smoke-free pathways, as follows: • Maternity services • Acute Inpatient services • Mental Health Inpatient services	Lead - Emma Pyrah Reporting to: NHS Tobacco Dependency Treatment Steering Group	Maternity service commences and all national requirements including data recording and reporting fully met (August 2022) Acute service commences and all national requirements including data recording and reporting fully met (TBC 2022) Mental health services workforce education and socialising the model completed (Autumn 2022)	Data collection and monitoring systems need to be developed based on national guidance. In the first instance the data will be reported at provider level and will include: • Number of acute inpatients with completed smoking • Number of MH inpatients with completed smoking • Number of maternity bookings with completed smoking Smoking status at 28 days will also be captured for the above categories	TBC in the context of national KPIs for the TDT programme	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.1 continued.,	Public Health will lead on developing community-based smoking cessation support for: (i) Patients discharged following receipt of Tobacco Dependency Treatment (ii) Community based smokers	Berni Lee reporting to Healthy Lives Steering Group	Liaise with NHS colleagues and LPC/ community pharmacies to provide national 'advanced smoking cessation service' for those discharged (December 2022) Complete data modelling to inform capacity planning, service delivery options and costs for 'in-house' service (December 2022)	Number of pharmacies offering the service Number of smoking quitters supported through pharmacies Service model agreed and commissioning commenced	Smoking Prevalence 18+ Smoking Prevalence in adults in routine and manual occupations Smoking at time of delivery (SATOD) Smoking Attributable Mortality Smoking Attributable Hospital Admissions Number (%) smokers successfully quit at 4 and 12 weeks	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.2 Healthy Weight/ Obesity impairs health increasing the risk of several diseases. Socio-economic factors play a key role in driving obesity with adults and more so children in the most deprived areas having higher obesity prevalence than the least deprived areas	Development of Healthy Weight Strategy (HWS)	Berni Lee reporting to Healthy Lives Steering Group	Complete analysis of public/stakeholder survey to inform draft strategy (December 2022) HWS drafted (March 2023) Consultation on draft HWS completed (June2023) Final HWS presented to HWBB (September 2023)	Draft HWS produced Number of groups consulted Number of responses received	Obesity in early pregnancy Breastfeeding prevalence at 6-8 weeks Reception: Prevalence of overweight (including obesity) Year 6: Prevalence of overweight (including obesity) Percentage of adults (aged 18+) classified as overweight or obese	
	Establish work programme to promote healthy weight environment	Berni Lee reporting to Healthy Lives Steering Group	Agree priority areas for action (February 2023)	TBC (depends on priorities agreed)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.2 continued.,	Roll-out of NHS provided Digital Weight Management Programme (DWMP) for those with type 2 diabetes or hypertension with a BMI of 30+ (adjusted for ethnicity)	Tracey Jones, reporting to Population Health Board	Practices actively encouraged to sign up to Weight Management DES (June 2022) Practices actively encouraged to sign up to make referrals to DWMP (Ongoing) Staff encouraged to self-refer to DWMP (Ongoing)	Number (%) practices signed up to WM DES Number patients offered/take up of DWMP Number of staff self-referring to DWMP		
	Provision of Tier 2 adult Weight Management (T2WM) Services Supporting weight management among children and young people	Berni Lee reporting to Healthy Lives Steering Group	Extend contract for commissioned Adult T2WM service (June 2022) Complete service promotion with key stakeholders to maximise direct and self-referral for eligible adults (June 2022) Agree specification for 'in-house' weight management service (or alternative) (December 2022) Agree resource and specification for weight management support among C&YP (December 2022)	Contract extended Number of referrals to service by source Number (%) of referrals completing T2WMP TBC (depends on specification) TBC (depends on specification)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
2.3 Physical activity	Together We Move social movement established Approach to building physical activity into disease management programmes developed	Penny Bason reporting to Healthy Lives Steering Group	Stakeholder event (5th July 2022) Digital / data hub developed – to share practice / learning and encourage inspiration (October 2022) Communities of learning established (September – December 2022) Framework for action developed (January – March 2023) Resource for front line professionals developed (September 2022)	Number of attendees Number of champions registered Number of learning events held, and reports produced/distributed Number of organisations signed up Resource produced and distributed	Percentage of less active children and young people Percentage of physically inactive adults	Reduction in less active C&YP (27.8% December 2021) Reduction in physically inactive adults (26.6% April 2022)

Table 3: Healthy Places

Population Health Domain: Healthy Places and Communities

Marmot: (v) Create healthy and sustainable places and communities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.1 Air Pollution - impacts on respiratory and cardiovascular health – particularly affecting those living in more deprived communities and who are at higher risk (e.g., through ill health, long term health conditions)	Implementation of Air Quality Management Area (AQMA) plans in Shrewsbury and Bridgnorth to reduce NO_2 concentrations Provide required / relevant air quality data and input into relevant areas of policy to target further pollutant reductions. <u>Planning / New Development</u> Review new development planning permission applications to consider impact on local air quality	Kieron Smith reporting to Air Quality Steering Group	Review Air Quality Action Plan (AQAP) for AQMA's to target reductions in NO_2 concentrations and select targeted interventions where necessary. (February 2023) Continue proactive monitoring for air pollution across the county. Report to Defra annually Environmental Protection will provide consultation / request air quality measures on applications with relevant air quality considerations (ongoing)	Council approval of Revised AQAP Maintain network of Diffusion Tube monitors and 2 real-time Earthsense Zephyr Monitors Number of planning applications assessed for potential impacts	Meet UK guidance values in next 5 years– to be decided on action plan review Maintain air quality measurements within the UK guideline values (excluding AQMAs) % Responded to within relevant consultee timescale (7/14/21 days)	TBC To work toward meeting WHO interim air quality target values

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.1 continued.,	Commitment from LTP to reduce business mileage and reduce pollutants from fleet vehicles	Will Nabih reporting to ICS Climate Group	Organisations to enable the option of agile (hybrid) working where there is no negative impact on service delivery (ongoing) ICS to develop a system Green Travel Plan, ensuring a hierarchy of travel starting with active travel. (Plan has been approved by ICB Board) Ensure that, for new (fleet) purchases and (fleet) lease arrangements, the system (and organisations) solely purchases and leases cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs) (Ongoing) Electric Vehicle (EV) charging infrastructure at base sites	Organisations have hybrid working policies and procedures Document published (April 2023) The NHS will cut business mileages and fleet air pollutant emissions by 20% (by 2023/24)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.2 Planning decisions impact on health equity for example through creating healthy environments through accessible quality green infrastructure that supports cohesive communities	The Local Plan: Healthy places including: Implementation of new Health and Wellbeing policy (SP6)	Eddie West Joy Tetsill Andy Wigley reporting to Cabinet / Full Council	Adoption of The Local Plan (March 2023) Staff awareness training on SP6 requirements 100% of staff trained (March 2023) Community Infrastructure Levy/section 106 investment in healthy places (ongoing)	100% of staff trained by early 2023 Provision of quality green space & infrastructure	Number of planning consents which reference SP6 in planning conditions The quantum of quality/usable open/green space in new developments	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.3 Licensing decisions impact on health through: • controlling alcohol supply and gambling activities • protecting children and other vulnerable people from being harmed or exploited by the illegal supply of alcohol and illegal gambling activities • supporting effective management of the evening and night-time economy to reduce crime and improve safety	Licensing Act Policy Statement 5-yearly review Gambling Act Policy Statement 3-yearly review	Frances Darling Strategic Licencing Committee Full Council	**Licensing Act Policy Statement** Revised Policy April 2024 Preparation of draft revised Policy (April to June 2023) Consultation period (July to September 2023) Policy approved by full Council (December 2023) **Gambling Act Policy Statement** Revised Policy January 2025 Preparation of draft revised Policy (January to June 2024) Consultation period (July to September 2024) Policy approved by full Council (December 2024)	**Licensing Act** Prevention of crime and disorder Public safety Prevention of public nuisance Protection of children from harm **Gambling Act** Prevent gambling from being: • Source of crime or disorder • Associated with crime or disorder • Used to support crime Gambling is conducted in a fair and open way	Police data to track crime and disorder trends over time PHOF – PHE (Child and Maternal Health, school age children supplementary indicators) Admissions for alcohol specific conditions (under 18s)	Downward trends

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.4 Culture, Leisure - and creative sectors make a significant contribution to physical, mental and community health and well-being through providing people and families access to affordable activities and experiences. They can contribute to tackling health inequalities through delivering educational opportunity, promoting community cohesion and generating economic growth	Accessible and inclusive volunteering opportunities at Shropshire Museums to develop communication, confidence, technical and employability skills and combats social isolation	Becky Benson .	New opportunities made available to social prescribing networks. SEND employability skills programme (from April 2022)	5 Partners Volunteers 5 social prescribing referrals 5 SEND programme participants 50 older volunteering participants		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.4 continued.,	Shropshire libraries **Bookstart** Supporting Home Learning Environment to help develop Early Years Speech Language & Communication skills universally as well as targeted programmes such as Bookstart Early Years and SEND Offer as well as the Storytime resources	Annabel Gittins reporting to Libraries and Reading Agency Evaluations Group	Distributing all 470 1-2yrs packs And 1240 3-4 yrs. packs to most disadvantaged families (1 April 2022 to 31 March 2023)	Managing transition to new Bookstart Early Years Offer	Numbers of families receiving books since lockdown	
	Summer Reading Challenge (SRC) & HAF Programme. Pleasure & attainment reading for those most disadvantaged children (majority FSM)	Annabel Gittins reporting to Libraries and Reading Agency Evaluations Group	Progress chart for each setting to measure uptake and progression through the challenge (School summer holidays 2022)	Progress chart for each setting to measure uptake and progression through the challenge	More children reaching their reading target through the summer. Improving the return to school and attitude to learning	To reach 80% of all children attending HAF activities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
3.5 Food Insecurity has a physical and mental wellbeing impact on everyone experiencing it. Food insecurity in childhood can have life-long implications impacting on educational achievement and general development and wellbeing	Implementation of the Shaping Places for Healthier Lives Food Insecurity Work Programme in SW Shropshire	Emily Fay reporting to Healthy Lives Steering Group	Development of learning and feedback structure which brings partners and people with lived experience together from across the system (December 2022) Identify pilot economic solution(s) to reduce food insecurity including help for people to maximise their incomes agreed (April 2023) Plan for frontline staff training to improve navigation of the system for people with multiple areas of need agreed (April 2023) Agree pilot social solutions which reduce food insecurity including trialling communications to reframe food insecurity and reduce stigma (June 2023) Develop communications plan for health professionals around food insecurity and health inequalities (June 2023) Plan to develop co-produced community led solutions which reduce food insecurity agreed (June 2023)	Learning and feedback plan produced Pilot economic solution(s) agreed Programme for staff training agreed Plan to reframe food insecurity agreed Communications plan for health professionals developed Plan for community led projects agreed	TBC with support from external evaluation provided by PPL/Cordis Bright	

Table 4: Integrated Health and Care System

Population Health Domain: Integrated Health and Care System

Marmot: (vi) Give every child the best start in life
(iv.b) strengthen Ill-health prevention (transformation/disease programmes

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.1 Restore NHS services inclusively (to include 20% most deprived LSOAs (Core 20) and ethnic minorities). Evidence suggests these are the groups for whom heath inequalities have widened most during the pandemic	ICB strategic health inequalities plan advocates addressing health inequalities as a core principle of all programmes of work. In following this approach there will be multiple leads for programmes of work across NHS priorities As a consequence of the pandemic there have been growing waiting lists for outpatient procedures	Julie Garside ICB Director of Performance and Planning Reporting to ICB Board TBC (vacant) ICB Director of Elective Care	Requirement produce board reports of waiting data differentiated by deprivation quintile and ethnicity incorporated into NHS Trust contracts. and to be adopted by the ICB (March 2022) Analysis of current referrals into outpatient services using methodology developed for vaccination programme (end of Q1) Map demand/access inequality +analyse outpatient procedure codes for areas of focus (September 2022)	NHS Trust and ICB reports show access by most deprived quintile and ethnicity EQIAS for all provider elective recovery plans	Service access rates by most deprived quintile/ethnicity No of planned care procedures in targeted populations	Level up access across STW in areas of selected focus

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.1 continued., Council Directors to determine action required to assure equitable access to council provided and commissioned services	Consider development of data management strategy to include measures enabling assessment of access rates	Helen Watkinson Reporting to New group and linked to data quality governance	Develop programme of intervention for selected clinical areas (October 2022) Implement targeted approach (April 2023) Decision on development of data management strategy (November 2022)	TBC dependent on decision	TBC	
4.2 Rurality Deprivation indicators can mask small pockets of significant deprivation and poor health outcomes in rural areas. Drivers of inequalities include social exclusion and isolation, access to and awareness of services. This is not captured in the 'Core20'	Secure support from NHSE/I, OHID and other national expert bodies to determine most appropriate method of assessing inequitable access to services for rural populations and inequitable outcomes	Tracey Jones/Berni Lee Reporting to Population Health Board	Progress discussions with NHSE/I, OHID, Institute of Health Equity UCL and Lincoln International Institute for Rural Healthcare (October 2022) Agree approach to be adopted (or piloted) across the ICS (December 2022)		TBC	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.3 Mitigate digital exclusion resulting from barriers such as poor access, connectivity, confidence, or skills. With increased use of digital services there is a danger of increased inequality.	Digital Exclusion Programme, as part of Digital Target Operating Model Contractual requirements to ensure providers are collecting and monitoring the impact of digital access in relation to service provided and evidence of alternatives for those who cannot access via digital means including evidence of safeguarding considerations. To work collaboratively with partners to increase digital inclusion	Nigel Newman reporting to Digital TOM Board System Data and contractual leads reporting to Digital System Strategy Group System Digital lead Rebecca Gallimore. Director of Digital Transformation, Reporting to Digital System Strategy Group	Full details of digital exclusion workstream specified (October 2022) Interdependencies with other council work programmes identified (December 2022) Inclusion of requirements re information standards and data collection within the NHS contracts. April 22. Included in schedule 2N Identification of digital inclusion and reduction of digital health inequalities as a key principle in draft system Digital Strategy (By June 2022) Finalise Digital Strategy and data transformation plan (Sept 22) Implement Digital Strategy including upskilling workforce (By December 2022 onwards)	TBA Reports to ICB boards and committees relating to assurance requirements of mitigating against digital exclusion by provider leads. Inclusion in sustainability and transformation developments EQIA of digital means of service access/ delivery and appropriate mitigation plans	TBA Increased uptake of digital means of access to healthcare Assurance of appropriate alternatives and levels of access to these	Equitable access to services and support for all population groups

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.3 continued	To actively promote and consider impact on digital inclusion in sustainability and transformation projects	Nigel Newman reporting to Digital TOM Board System Data and contractual leads reporting to Digital System Strategy Group Shropshire Telford and Wrekin ICS Digital Lead + LA Digital leads	Establishment of LA + NHS digital inclusion group April 22 Development of Digital Inclusion programme, including VCSE projects include device loan schemes and building digital literacy with digitally excluded groups at Place level; (By September 2022) Implementation of digital inclusion programmes (By December 2022)	Inclusion in sustainability and transformation programmes evidence of digital skill mapping and training for staff as appropriate.	Individual digital inclusion projects will have identifying measures of project success in terms of original outcomes i.e. increased self-reported confidence in use of digital technologies	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.4 Datasets are complete – disadvantaged groups need to be identified thus collection of ethnicity, other protected characteristics, and details of 'health inclusion' groups need to be recorded consistently across services.	Systems are asked to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. Systems should also implement mandatory ethnicity data reporting, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.	Individual provider organisation Data Leads + Executive Leads for inequalities in provider organisations Craig Kynaston System Head of Business Intelligence reporting to Population Health Board	Requirement in NHS Contract Schedule 2N to identify baseline and develop a programme of improvement for data collection (April 2022) Agreement of primary care to data sharing from practices into Aristotle tools (July 2022) Agreement of system data sharing approach across system (December 2022) Production of Digital and Data Strategy. (April 2023) Adoption by system of the Aristotle health inequalities platform and tools (Beginning April 2023)	Production of data improvement plans ICB monitoring of data collection via provider Contract review meetings	Improved percentage of recorded identified protected characteristics Improved access to linked datasets to analyse Health Inequalities Inclusion of Health inequalities analysis in service /system transformational programmes	Achievement of agreed data improvement plans per provider

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.4 continued.,			In line with the ICS Intelligence Function Guidance – Implement cross-system information governance arrangements, particularly between primary and secondary care and local government partners, that enable the safe and timely flow of information across the ICS and support the Integrated Care Board (ICB) to deliver its functions (March 2023) Adopt the What Good Looks Like framework principles including development of an ICS-wide intelligence platform with a fully linked, longitudinal dataset to enable population segmentation, risk stratification and population health management (April 2023)		Governance processes will allow data linkage for health and social care in a legal and compliant manner at system level	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.4 continued., Council Directors to determine action required to assure data sets are complete (protected characteristics) for council provided and commissioned services	Consider development of data management strategy to include measures to ensure appropriate collection of protected characteristics data	Helen Watkinson Reporting to New group and linked to data quality governance	Decision on development of data management strategy (November 2022)	TBC dependent on decision	TBC	
4.5 Strengthen leadership and accountability- this underpins delivery of the other key priorities Tackling inequality is not a separate programme and should be embedded in all decision-making, strategies, and delivery plans	Identification of executive level lead to ensure health inequalities embedded in its organisations business as usual and transformation programmes Development of system Health inequalities Plan as part of operational planning processes ensuring alignment to work of both Local Authorities and Population health Management Approach	Individual provider NHS organisations reporting to ICB ICB SRO Health Inequalities + provider leads	Named organisational leads identified (April 2022) Draft system plan (March 2022) Operational Plan submission and approval (April 2022) ICB Strategic Plan +accompanying high level plan approval (July 2022)	Implementation of actions within the high-level implementation plan accompanying the strategic plan	Reports to ICB to demonstrate how inequalities have been considered as part of decision making, strategies and delivery plans Delivery of health inequality commitments in operational plan	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.6 Population Health Management (*ie not one of the specified 5 priorities* but a local one involves the use of intelligence led methodology to inform health and care planning and the development of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex need	Population Health Enabling Workstream Establishing the 'engine room' for Population Health Management (PHM)	System Lead for PHM SRO TBC Reporting to Population Health Board/ Shropshire Health and Wellbeing Board (HWBB)	System lead for PHM identified. (October 2022) Review capacity requirements within the 'engine room' (October 2022) Requirements for 'engine room' agreed through Chief Executives Group and ICB Board (June 2022) Training being delivered (ongoing) Develop competency framework to support ongoing training/development (by November 2022) Requirements clarified and next steps defined (December 2022) Work programme refreshed (January 2023)	Engine room staff upskilled through training Competency framework in place to support ongoing training/development	Functioning and skilled 'engine room' for PHM	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.7 Personalisation/ Personalised Care Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities. Social Care have been using Personalised approaches for some time – this work about embedding culture change throughout Health and Care	Increase the number of Children and Young People (CYP) who have asthma personal care and support plans (delivered by GP, Community Nurse and Hospital)	Nicola Siekierski reporting to ShIPP Shropshire HWBB ICS CYP Board	Recruitment of Band 6 Asthma Nurse in GP Practices to identify CYP with an asthma diagnosis who require an Asthma Management Review, the service will prioritise areas of high deprivation to offer out appointments. (May 2022) Asthma App -offered as a personalised tool to enable CYP to self-manage their Asthma symptoms (June 2022) Co-Production of CYP Creative Health activities to support CYP with a diagnosis of Asthma. Expressions of Interest are currently being offered out across the creative communities to access grant funding for activities such as yoga, swimming, or singing which help manage the symptoms of breathlessness (March 2022)	Asthma nurse in post Numbers of CYP accessing the app. Uptake of Creative Health Activities by CYP Evaluation of health and wellbeing outcomes for CYP with Mental Health issues who have accessed Creative Health offers	CYP with asthma will manage their condition more effectively which will increase personal wellbeing and help reduce incidence of health interventions needed through mismanagement of condition Reduction in hospital admissions for asthma in CYP	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.7 continued.,	Clinical staff in all PCNs complete the Personalised Care Institute 30 min e-learning refresher training for Shared Decision Making (SDM) conversations	Emma Pyrah reporting to Primary Care Commissioning Committee (PCCC)	Commissioned providers (May 2022) All PCN clinical staff trained (September 2022) As part of a broader social prescribing service, a PCN and commissioner must jointly work with stakeholders including local authority commissioners, VCSE partners and local clinical leaders, to design, agree and commenced delivery of a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs. This plan must take into account views of the people with lived experience (October 2022)			

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.7 continued.,			A PCN must review cohort definition and extend the offer of proactive social prescribing based on an assessment of population needs and PCN capacity (March 2023) PCNs must audit a sample of the Patients current experiences of shared decision making through use of a validated tool and must document their consideration and implementation of any improvements to SDM conversations made as a result (March 2023)			

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
Accelerate Prevention Programmes that proactively engage those at greatest risk of poor health outcomes (incorporating core20+50):						
4.8 COVID and flu vaccination The COVID-19 pandemic has highlighted existing health inequalities for ethnic minority groups and those living in more socioeconomically deprived areas in the UK. With higher levels of severe outcomes in these groups, equitable vaccination coverage should be prioritised[2] Barriers to vaccine uptake include perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders[3]	A separate vaccination group has been set up within the ICS to look at uptake and delivery in vulnerable/at risk groups	Steve Ellis /Rachel Robinson reporting to Health and Wellbeing Board	Identify priority groups – rolling programme (Ongoing) Identify appropriate vaccination sites/delivery – rolling programme (Ongoing) Vaccination outreach plan in place – rolling programme (Ongoing) Vaccine delivery Covid-19 Influenza	Covid-19 vaccine outreach plan in place Number of areas of low uptake identified Proportion of areas of low uptake allocated a pop-up during campaign period Number of vaccination sites delivering to vulnerable/at risk groups	Place-based vaccine coverage: COVID-19 Flu IMD deciles % uptake age 12+, 18+, age 50+ * Uptake % by ethnicity Uptake % among individuals identified in at-risk groups (e.g. LD, SMI etc)	95% cover Covid-19 vaccination Regionally comparable cover in ages12+, 18+, age 50+ IMD 1,2 & 3 deciles for each vaccination campaign period Regionally comparable cover of individuals on GP Learning Disability Register deciles for each vaccination campaign period

[2] Inequalities in coverage of COVID-19 vaccination: A population register based cross-sectional study in Wales, UK - PMC (nih.gov)

[3] Factors influencing COVID-19 vaccine uptake among minority ethnic groups (publishing.service.gov.uk)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.9 Annual health checks for people with a learning disability (LD) People with a LD have poorer physical and mental health than other people and die younger. Many of these deaths are avoidable and not inevitable Annual Health Checks can identify undetected health conditions early, ensure the appropriateness of ongoing treatments and establish trust and continuity care	Work to increase the inclusion of all those with LD who should be on a GP LD register Improve the proportion of those on the register who receive a high-quality annual health check	Janet Gittins, LD Delivery Group reporting to LD&A Board	Monthly monitoring of registers list size and completed LDAHCs (Ongoing). Support provided to GP practices through service commissioned from MPFT to cleanse registers and complete LDAHCs. (Ongoing) Quality audit review pilot undertaken winter 2021. Audits to commence in (July 2022)	Increase in number (%) of people on a practice LD register Increase in number (%) on LD register who receive an annual health check which includes a Health Action Plan. Increase in number (%) on register who have received vaccinations (flu, covid) Reduction in health check DNAs Increase in those aged 14-21 on the LD register and accessing a LDAHC Improvement in quality of LDAHCs completed	TBC	Deliver annual HCs for 75% of those aged over 14 years on the practice LD register

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.9 Annual health checks for those with SMI. People with severe mental illness (SMI) have a life expectancy that is 15–20 years lower than the general population. This is partly due to physical health needs being overlooked. Smoking is the largest avoidable cause of premature death and individuals with SMI also have double the risk of obesity and diabetes, and three times the risk of hypertension	MPFT-commissioned to support development of an integrated physical health care pathway, including a dedicated clinical team, supporting GP practices	Claire Parker/Gail Owen reporting to Mental Health Transformation Board Claire Parrish MPFT & Gail Owen reporting to SMI PH Check Operational Group	Integrated pathway developed (March 2023) GP registers cleansed to ensure accurate population (December 2022) Additional posts for SMI and physical health recruited to (December 2022) Poster developed by Designs in Mind, going to print. Leaflet design on going (October 2022) Approach to co-production agreed (September 2022) Working on piloting an app to support outreach and help with compliance for the 6 categories (September 2022) Affinion devices received by MPFT, plans for training underway (October 2022) Looking at working with Charitable organisations around health and wellbeing activities for SMI, LD and A (December 2022) Resolution of inoperability issues/ data transfer between RIO and EMIS (September 2022). Pilot scheme has been successful.	Number of physical health checks completed (as % of those on GP SMI register) Number of physical health checks completed by MPFT Action plan is in place to drive forward progress Monthly reporting has been requested by NHSE, (Commencing September 2022) Increase in SMI PH checks % completed	Excess under 75 mortality in adults with severe mental illness Excess mortality in adults with severe mental illness	60% of patients on GP SMI registers receive physical health check PA

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.10 Continuity of carer. (CoC) Women from the poorest backgrounds and mothers from Black, Asian, and Minority Ethnic (BAME)* groups are at higher risk of poor birth outcomes. Women who receive continuity of carer (the same midwife (or team) caring for them during pregnancy, birth and postnatally) are 16% less likely to lose their baby and 24% less likely to experience pre-term birth. Continuity of carer will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in outcomes (Reference for BAME terminology https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/)	There are several initiatives to support this area including Digital Inclusion and Maternity HUB development as part of a broader strategy, plus further enhancements on patient plans	Nick McDonnell reporting to LMNS Board/ ICB Board	Following the first Ockenden review and NHS England Chief Nursing Officers CoC risk approach, SaTH have developed and will submit a revised CoC delivery plan for the 15th of June. This model will have Trust Board and LMNS Board approval and will look to identify how and when the trust will meet Local, Regional and National requirements. Further plans and milestones will be agreed following feedback on this (TBC)	Number (%) of women booked onto CoC pathway Number (%) of women in receipt of CoC Number (%) of BAME women in receipt of CoC Number (%) of women in lowest 20% quintile in receipt of CoC	Preterm births: % of deliveries Neonatal and stillbirth rate	Continuity of carer for 75% of women from BAME communities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.11 Chronic Respiratory Disease: Respiratory disease is the third biggest killer in the UK and cases of Chronic Obstructive Pulmonary Disorder (COPD) and deaths from lung cancer or pneumonia are higher among those living and working in more deprived areas. Vaccination is particularly beneficial to those with chronic respiratory disease preventing acute illness and hospitalisations For COPD drive uptake of vaccines to reduce exacerbations/ emergency hospital admissions	For COPD drive uptake of vaccines to reduce exacerbations/ emergency hospital admissions	Steve Ellis Programme & Service Director and Deputy Senior Responsible Officer Covid-19 Vaccination Service reporting to Health Protection Board	Continue offer of evergreen Covid vaccination offer - targeted comms via Primary Care (Part of summer plan - (August 2022) If part of JCVI recommendation for Autumn Booster, agree targeted comms around the benefits of vaccination for those with chronic respiratory disease. (Autumn plan by December 2022)	Vaccination rate among those with COPD/chronic respiratory disease Flu vaccination coverage – at risk individuals	Under 75 mortality rates from respiratory disease considered preventable	Autumn COVID Booster - 90% Flu Vaccination - 85%

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.12 Early Cancer Diagnosis: Cancer that is diagnosed at an early stage, when it is small and hasn't spread, is more likely to be treated successfully. Late diagnosis is more common among deprived communities and among ethnic minority groups. The national ambition is that by 2028 75% of cancer cases will be diagnosed at an early stage (stage 1 or 2)	Meet early diagnosis objectives specified in local cancer strategy	Andrew Dalton, STW screening lead reporting to System Cancer Strategy Board	Restore compliance with the Faster Diagnosis Standard (FDS) across cancer pathways (December 2022) Community Diagnostic Hub (CDH) service operational (December 2022)	Cancer sites meeting/not meeting FDS CDH open	% of cancers diagnosed at stage 1 or 2 Under 75 mortality rate from cancer Under 75 mortality rate from cancer considered preventable	75% of cases diagnose d at stage 1 or 2 by 2028
4.12 continued.,			Improvement to all cancer pathways to ensure compliance with the 7 Rapid Diagnostic Centre (RDC) principles (April 2024)	Cancer sites meeting/not meeting RDC principles		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.12 continued.,	Meet objectives to restore and expand cancer screening services as specified in local cancer strategy	Andrew Dalton, STW screening lead reporting to System Cancer Strategy Board	Reduce Breast Cancer screening round length to achieve target interval (re-screen within 36 months of previous screen) (December 2024)	Breast screening uptake Breast screening round interval Bowel and cervical screening uptake	Number (%) of screen detected cancers	
	Cancer personal care and support plans Specifically addressing Health inequalities in screening and presentation as part of wave one core connectors programme	Tracey Jones reporting to Population Health Board	Co-ordinator post to develop Community Cancer Champions in Shropshire through third sector delivery partner Development of system implementation plan (May 2022) Recruitment of co-ordinator (June 2022)	Number of salaried / volunteer Connector roles and other programme roles Scale of activity undertaken by Connectors e.g., measures of engagement	Increase screening uptake in communities where this is low Raise awareness of symptoms that should prompt presentation to health care providers	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.12 continued.,			Development of KPIs (June 2022) Implementation of approach Q2 onwards Evaluation report as part of national wave one bid (March 2023)	Scale of impact of Connectors e.g.: attendance and input at Place/ICS governance groups attendance, and input with Service Providers re service deign and access attendance, and input with Core5 networks at Place/System level		
4.13 Hypertension Case-Finding: High blood pressure is a key risk factor for the development of cardiovascular disease (CVD). High blood pressure is frequently undetected and sometimes undertreated particularly among more deprived communities, some ethnic minority groups and those with some disabilities	Development of CVD prevention plan (to include hypertension (high blood pressure) case finding.	Emma Pyrah reporting to Population Health Board	CVD prevention plan agreed (December 2022) Comprehensive hypertension case finding plans and hypertension treatment plans implemented (December 2022)	Number (%) of registered patients on hypertension register Number (%) of patients on hypertension register being treated to target % of patients aged 45+ years with BP on record in last 5 years	Under 75 mortality rate from cardiovascular diseases considered preventable	80% of expected number with hypertension identified 80% of those with hypertension optimally treated

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.14 Diabetes - Significant inequalities exist in the risk of developing type 2 diabetes (linked to obesity and ethnicity), together with inequalities in access to health services and in health outcomes. The NHS Diabetes Prevention Programme supports those at high risk of type 2 diabetes to reduce their risk	Diabetes Transformation Programme	Fiona Smith reporting to Diabetes Programme Board	Diabetes Programme Board established (September 2022) Training matrix and competency framework designed for each practice/PCN and training delivered to practice staff (June 2023) Revise pathways to prevention programme ensuring appropriate targeting of those at risk (December 2022) Increased capacity in X-pert programme (T2 diabetics) (April 2023) Increased capacity in Daphne programme (T1 diabetics) (April 2023) Revise pathways structured education programmes ensuring appropriate	 Increase in recorded prevalence of diabetes (improved detection) Increase in % of patients with T1 and T2 diabetes receiving all 8 care processes and achieving all 3 treatment targets Improved quality and increase in referrals Increase in referrals from people from ethnic minority backgrounds	Reduced numbers of amputations, cardiovascular events and stroke. Reduction in additional risk of mortality for those with diabetes compared to general population In longer term a reduction in prevalence of Type 2 Diabetes	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.14 continued.,			targeting of those at risk (December 2022)	Increase in beneficiaries of X-pert including increased numbers from people from ethnic minority backgrounds Increase in beneficiaries of Daphne including increased numbers from people from ethnic minority backgrounds Increase in treatment targets reached (BP, Cholesterol, HbA1c)		
			Education course established for the housebound (April 2023) Education course established for those with a Learning Disability (April 2023)	Increase in number of housebound in receipt of education Increase in number with LD in receipt of education		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.15 Children & Young People (CYP) COVID has had a huge impact on many families, and particular focus will be CYP mental health and wellbeing. In addition, plans to create a Trauma Informed workforce will be implemented	Creative Health opportunities for CYP including SEND Personalised care – physical health checks for CYP with SEND Personalised Care and Support Plans (PCSP) for Children and Young People who are accessing a Social Prescribing Link Worker	Nicola Siekierski reporting to Shropshire Integrated Place Partnership (ShIPP)	Take up of Creative Health opportunities to fill at least 75% of places being funded by this project. (June 2023) Evaluations to be completed by all successful providers of Creative Health activities, to include attendance, CYP feedback on the activity, lessons learned, patient reported outcomes using measures of health and wellbeing and the start and completion of the activities. Evaluations completed (June 2023) Feedback on this document to be collected and reported back to the CYP Social Prescribing Group as it is rolled out. Feedback on CYP PCSP end of each quarter. (Initially June 2022)	Numbers taking up the offer - Fill at least 75% of places Improvement in CYP's health and wellbeing score post non-clinical Creative Health intervention		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.16 Trauma Informed Workforce Trauma affects not only those who are directly exposed to it, but also to those around them (Van Der Kolk: 2014). Along with acute physical and emotional effects, children that have Adverse Childhood Experiences (ACEs) can show: reduced cognitive and social development, reduced school engagement, early adoption of health-harming behaviours, increased risk of health conditions and juvenile offending.[4] ¾ juvenile offenders have been exposed to traumatic victimisation and 11-50% have PTSD, Ko et al. 2008. Creation of a Trauma Informed Workforce across the whole system, using a tiered core training offer which is consistent, understood and will be used in practice forms part of this work	Roll out of Resilience Screening and workshops to all workforces to create awareness Identification of training package, and roll-out	Val Cross reporting to Health & Wellbeing Board	Workshops and screenings scheduled, feedback gathered and completed (November 2022) Identify training packages and levels required (by December 2022) Start to roll out in pilot area of Oswestry (December 2022)	Number of professionals accessing training, collation of feedback to inform work going forward Through Steering Group Training in area completed July 2023, and implementation in services and practice. Sustainable model to be used	Number of organisations who attended workshop Number of organisations accessing training packages and implementing in practice	

[4] Health and financial costs of adverse childhood experiences in 28 European countries: a systematic review and meta-analysis (thelancet.com)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.17 Healthy Start Offer- Need to increase the uptake of the Healthy start offer for those eligible in Shropshire	Increase uptake of the Healthy Start Offer for eligible families through improved comms/health promotion across Shropshire	Steph Jones/Anne-Marie Speke Reporting to Children & Young people's Board	Health Promotional material to be finalised by (March 2023)	Healthy Start uptake statistics reported on nationally. % of entitled beneficiaries over eligible beneficiaries	% of uptake by those eligible for healthy start offer to increase by 5% by 2024 To achieve or exceed the national baseline % of uptake of Healthy Start	
4.18 Oral Health- Improve outcomes and reduce % of dental decay in Children and Young People in Shropshire	Targeted supervised toothbrushing programme for 3-5 y/o led by Shropshire Community Dental Service. Targeted in areas of high deprivation, which will be inclusive of CYP with SEND	Steph Jones/Anne-Marie Speke Reporting to Children and Young Peoples Board	A targeted programme aims to reduce the levels of tooth decay in Shropshire through supervised toothbrushing	Proportion of schools and early years setting staff rating supervised toothbrushing training as either good or excellent Number (or %) of early years settings and schools offered a Supervised Toothbrushing Scheme Number (or %) of settings taking part Number of early years and school staff involved in STS trained The % of schools briefed on the NDEP	% of early years settings or school setting staff rating supervised toothbrushing training as good or excellent Programme-Evaluated annually. Aim to have evaluated 2021-2022 impact by September 2023	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 Best Start in Life: Improving access to Early Help for families and CYP across Shropshire	Workstream has formed to work to improve Early help access across the whole system/partnership. Various opportunities to develop projects across the wider system through test and learn sites, that are based on a set of criteria relating to reducing health inequalities, that are needs led, and outcomes driven	Jo Robins/Fran Doyle/Penny Bason/Mel France Reporting to Early Help /Prevention Board	Joint work to develop new ways of working between early help teams, prevention, and NHS workforces Test out an integrated service delivery model in an area of need which adopts a multi-disciplinary across NHS and Local Govt. (April 2023) Develop a project board of senior leaders to support integration (September 2022) Formation of project group of reps from public health, Early Help, Children's Social Care, Education) (June 2022) Expansion of CYP Social Prescribing taking referrals from schools, GP practices and service providers (By January 2023)	Mapping of existing practice, and identification of evidence and best practice models from across the country and via the Early Intervention Foundation, OHID. Series of workshops to include service managers Creation of a multi-disciplinary team to test out joint working Develop vision and costings of resources for scale up Embed the approach into other service areas for Early Help, and create multiple offers for families and young people to participate in		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 continued.,			Expansion of a wider 'creative health offer' for CYP and families which is embedded into service provision, based on the learning from the current test and learn site (December 2023) Development of a test and learn triage approach that is easily and readily accessible and responsive, for families, CYP and local organisations which incorporates CYP Social Prescribing. (February 2023) Recruit two Social Workers, to support schools in two targeted areas where need is high and where interventions for YP are available (February 2023) Develop a joint approach through the newly recruited Family Support Workers, to build a team based on early intervention which support the Best Start and builds on a joint approach with the public health nursing service. (March 2023)	Identify opportunities where posts can in reach to the community and where common agendas such as breastfeeding support offer can be promoted and delivered to provide parents with greater levels of support Create a team approach to working with schools, engage with lead schools to agree an approach and ensure ongoing dialogue continues to shape the offer. Ensure schools are brought into the approach		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 continued.,			Development of a co-ordinated offer for schools which reflects service areas in the council, is based on need and targeted appropriately to schools using previous resources such as WISH, nutrition, PHSE, mental health and wider health issues. (April 2023) Development of a co-ordinated training offer for schools, based on need using best practice models and evidence of what works, targeted appropriately to needs. (February 2023) Needs assessment for children which includes population health data, acknowledges service data and uses predictive modelling for future service design/development. (March 2023)	Identify the various training resources and offers that currently go into schools and create one offer Collate together various sources of data into one document which clearly outlines needs of various groups and considers a range of conditions (health, care and wellbeing)		

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.19 continued.,			Analytical and business planning support to the Stepping Stones project through the development of a modelling tool that predicts numbers future numbers of LAC. (June 2022) Expansion of the existing Stepping Stones project to scale up service delivery. (February 2023) (See also Table 5 – Looked After Children category)	Produce a model tool that helps to predict demand at various points. Use the model to influence service models Develop a business case for the Stepping Stones project		
4.20 Children/Families in Need	Test out a multi-disciplinary team model working between the public health nursing service, Early Help, and Children's social care teams	Jo Robins/Mel France Reporting to Early Help/Prevention Board	Establish a practitioner group that meets regularly to identify common goals/challenges and identify ways of overcoming them. (June 2022) Ensure the integrated practitioner group received trauma informed training programme and parental conflict training. (January 2023)	Actions for change identified via practitioners that demonstrate challenges but changes Range of organisations committing to the practitioner group Range of practitioners participating in the group Use of learning to repeat the process in other areas of need across Shropshire	Reduction in the number of duplicated visits from different organisations for each family Increase in early identification of families and children at risk	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.20 continued.,	Supported by developments such as social prescribing, peer support for ante-natal care, peri-natal period, trauma informed and strengths-based training, parental conflict training Development of a community-based prevention offer in the Oswestry location that supports CYP/Families	Val Cross/Penny Bason/Steph Jones Reporting Early Help/Prevention Board Jo Robins/Mel France Reporting to Early Intervention/Prevention Board	Establish a peer support programme for parents that offers support during the ante natal period. (April 2023) Cross reference to trauma informed training programme and parental conflict training Establish a community collaborative that is led by the VCSE and supported by the LA to consider gaps, challenges and re-build a local preventative offer for CYP and families. (June 2022) Develop/Support the collaborative so that it becomes self-sustaining and involves multiple partners across the VCSE, working with Town Council By (July 2023)	A peer support programme is established in the Oswestry area that is delivered by the VCSE	Reduction in post-natal depression Identification of early risks associated with vulnerable families with actions to improve Improvement in uptake of access to local services Reduction in social isolation of pre and post birth parents Increase in uptake of parenting courses Number and range of organisations who attended workshop Number and range of organisations offering support for CYP and families Additional capacity created to support families and CYP experiencing multiple issues	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.20 continued.,					Projects developed and implemented that support reduction in domestic violence, improve maternal mental health, Reduce child exclusions, improves CYP mental health, improve access to food and access to local services Partner engagement and commitment across NHS, Fire and Rescue, Police, to support the development	
4.21 Complex need – focuses on those who experience multiple disadvantage. This may be linked to substance misuse, domestic abuse, social problems, housing/ homelessness, debt or other issues	Improved life expectancy for those with Serious Mental Illness (SMI)	Gordon Kochane Reporting to Health and Wellbeing Board	Post of Population Health Fellow to support the development of a Complex Needs Assessment & Strategy Date: In post (October 2022)	Needs Assessment complete by 30.09.22 Strategy complete: 30.09.22	Improved life expectancy of those with Serious Mental Illness (SMI) Better joined up working and understanding of how to support those with complex need	TBD

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.22 Mental Health (Mental Health Transformation Plan) Mental illness can be a key risk factor for health inequality. Once mental disorder has arisen, it is associated with a range of further inequalities. These include increased health **r**isk behaviour, reduced educational and employment outcomes, increased physical illness, and significantly reduced life expectancy, as well as discrimination The community mental health transformation aims to move away from siloed, hard-to-reach services towards joined-up care and whole population approaches	1) Health Equity Assessments have been completed for each PCN area and are the basis for which we target our VCSE engagement in the Programme. They included: - A summary of national evidence relating to inequalities amongst SMI - Current patient profile and how this compares to national trends - A detailed look at the prevalence of wider determinant and behavioural issues that drive demand Taking this data, we have decided to pilot initial grant scheme and additional commissioned services at North Shropshire PCN and PCNs in Telford and Wrekin (our test sites) **Under-represented Groups (Grant Scheme)** North Shropshire Men over-40. Telford and Wrekin 18-25-year olds. BAME communities.	Cathy Riley – SRO for Mental Health STW ICS	VCSE Services including Grant scheme live (December 2022).	To be confirmed: Number of adults and older adults have had at least one contact from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum Number of adults and older adults have had at least 2+ contacts from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum Number of adults and older adults receiving 2+ contacts in a dedicated 'personality disorder' pathway or service provision (including primary care, VCS, and MH services)	To be confirmed	To improve access for groups that have been identified in population health data as under-represented

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.22 continued.,	**Wider-Determinants (Additional Services)** 1. Housing 2. Financial Wellbeing 3. Lifestyle Services Landau are commissioned to deliver the grant scheme.			Number of adults and older adults receiving 2+ contacts in a dedicated community rehabilitation pathway or service provision (including primary care, VCS, and MH services)		
4.22 continued., Increase the number of patients offered a MECC conversation in line with training targets / Increase the number of staff trained to deliver MECC conversations across the Care Group - MPFT has reenergised its approach to MECC and has trained nearly 600 frontline staff to deliver brief interventions in the last 12 months. 2022-23 will see MPFT continue to grow these numbers	Increase the number of staff trained to deliver MECC conversations across the Care Group	Cathy Riley – SRO for Mental Health STW ICS	MECC training delivered (Ongoing)	Number of staff MECC trained	Increase the number of patients offered a MECC conversation (not currently measured/monitored)	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.23 Suicide Prevention A targeted approach to upskill the workforce on suicide risk and awareness of how to intervene has been taken with the launch of a Suicide Prevention training programme in Shropshire. skilling up the workforce to create awareness of suicide risk and the range of resources available to mitigate risk	Promote the range of training offers and resources for prevention of suicide and self-harm across the system including commitment that all workforce within the system should have at least a basic awareness of suicide risk and local support available	Gordon Kochane Reporting to STW Suicide Prevention Network Shropshire Action Group T&W Action Group	Agree Learning & Development workforce strategy for suicide/self-harm training to be included within PDPs[5]. Work started. (Date: TBC)	Evaluation forms, and plans for follow up surveys for how people have used their learning in their roles Potential commissioning/ funding a training review for suicide to see if it has had desired impact and reach	Reduction in intentional self-harm attendances at A&E %/Numbers of workforce trained and from which programme	To achieve our zero-suicide ambition PHOF indicator: Emergency Hospital Admissions for Intentional Self-Harm

[5] Self-harm and suicide prevention | Health Education England (hee.nhs.uk)

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.23 continued.,			Commitment for all staff within health and social care in Shropshire to have completed the Zero Suicide Alliance free online training as part of mandatory training. Launch event delayed. (Date: TBC) Workforce most likely to need to deliver an intervention to a person presenting with suicide ideation of who is self-harming to have accessed the Suicide First Aid (SFA) Intervention training and/or Self Harm intervention training SFA 3 x sessions offered (June, Oct & Dec. 2022) Self-Harm (May 2022) Frontline health, social care and third sector workforce who support higher risk of suicide cohorts to have either completed the Suicide Awareness training. 4 x sessions offered (May July Sept. Nov. 2022)	Use of Suicide Real Time Surveillance to monitor trends/themes and patterns of possible/probable suicide for targeted response	% of “priority” agencies who have accessed training Number of “hits” on ICS webpage for suicide resources	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.24 Social Prescribing (as an element of Personalised Care) Social prescribing in Shropshire is an integrated programme between Primary Care, Public Health and the Voluntary, Community and Enterprise sector (VCSE) that supports those in most need A Children and Young People's (CYP) Social Prescribing pilot in the SW is operational	Children and Young People's (CYP) Social Prescribing being part of the Early help offer. This focusses particularly on CYP mental and emotional wellbeing	Fran Doyle/Penny Bason reporting to Early Help Partnership Board Health and Wellbeing Board Shropshire Integrated Place Partnership	Business case submitted (March 2023) Evaluation of Children and Young People (CYP) pilot (December 2022)	Integration to Early Help as an offer for CYP and their families countywide	Improvements in Health and Wellbeing scores post SP intervention	TBD
4.25 Integrated Impact Assessment (IIA)– embed assessment of**:** Social Inclusion Equality Health Inequalities Quality Climate Change Economic Impact of all developments	Integrated Impact Assessment to be adopted across the ICS for project work for all change programmes	Edna Boampong Reporting to Population Health Board	Draft Screener tool developed to include HEAT tool as part of initial screener (June 2022) Online screener tool fully developed within system PMO platform. (August 2022)	IIA criteria in place for the use of the tool March 2023 IIA in developed IIA in use		TBD

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
4.25 continued.,			Development of methodology document. Development of Baseline template and full IIA templates. (August 2022) Adoption and implementation programme. (September 2022) Audit of tool application in practice. (March 2023)			

Table 5: Social Inclusion Groups

Social Inclusion Groups

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.1 Domestic Abuse affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status. Domestic abuse includes coercive, controlling, abusive and violent behaviour and can also occur between family members Temporary accommodation is not in the interest of the health and wellbeing of the household	Reduce homelessness due to domestic abuse (Identified in Shropshire Safeguarding Community Partnership Strategic Plan and Priorities 2020 – 2023)	Laura Fisher Shropshire Council Local Partnership Board and SSCP Domestic Abuse Group	Needs assessment completed (November 2022) Strategy completed (January 2023)	Needs assessment and strategies completed	Reduce homelessness due to domestic abuse SSCP business plan data	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.2 Exploitation (including transitional safeguarding) affects people of all ages regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status but in particular, children and young people and adults with additional care and support needs	Review the effectiveness of the Child Exploitation Pathway (Identified in Shropshire Safeguarding Community Partnership Strategic Plan and Priorities 2020 – 2023)	Jeanette Hill Shropshire Council SSCP Exploitation Group	A pilot weekly Adult Exploitation Pathway: Active Case Review Meeting/triage is currently underway, which is attended by the multi-agency partnership including: Adult Services Children's Services West Mercia Police Health We Are With You (Ongoing)	More young people will have a transition plan in place where concerns of exploitation are identified. More adults with care and support needs with risk factors around exploitation will have an appropriate plan of support in place	Needs will be identified and more young people at point of transition/adults will have plans of support in place to reduce escalation of risk/need Improved partnership information sharing	
5.3 Homeless Housing also in wider determinants	**Preventing homelessness:** Develop homeless and rough sleeping prevention strategy	Laura Fisher reporting to Housing Executive Board	Strategy which seeks to prevent homelessness and rough sleeping and ensure that those households who do become homeless are provided with an excellent service. (March 2023)	Strategy published	Percentage of successful homeless preventions Percentage of successful homeless reliefs Number of households owed main duty Number of rough sleepers at any one time	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.4 Learning Disability Ensuring the right care, support and accommodation is available at the right time to ensure individuals are able to achieve their aspirations and reach their potential	Variety of accommodation options available to house adult individuals and enable their greater independence LD and A 3-year road map	Vacant post to be filled Steve Ladd (Shropshire Council) Val Walsh (CCG) Reporting to LD&A Board Learning Disability Partnership Board	Property platform to provide data - determine accommodation to be commissioned and where (October 2022) Partnership working to implement/progress: housing developers, RSL's, planning and policy departments (January 2024)	Property Platform data	ASCOF- number of adult individuals with a learning disability living in their own home	
5.5 Autism Autistic people experience greater health inequalities including cardiovascular disease, epilepsy and poor mental health. NHS England » National Autism team update	Expansion of ASD Forensic Service Telford/Shropshire Creation of ASD mental health liaison Telford/Shropshire role	Val Walsh (CCG) Reporting to LD&A Board Autism Partnership Board	Increased recruitment to extend service to Shropshire (Complete) Recruit ASD MH liaison Clinician (Complete)	Numbers discharged Numbers discharged in a timely manner	Supporting Autistic People with Forensic risks to be discharged from hospital Supporting Autistic People who also have mental health problems to be discharged in a timely manner	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.6 Gypsy and traveller families Gypsies, Travellers and Roma are among the most disadvantaged people in the country and have poor outcomes in key areas such as health and education. Parliament UK: 2017		John Taylor Reporting to Head of Property and Development, Shropshire Council	Development of an 8-plot transit site in Shrewsbury (April 2022) Employ a Gypsy & Traveller Support Officer (Complete) Review SC Gypsy/Traveller caravan sites plot application process (June 2022) Anticipated site will be developed within the next 12 months (August 2023)	Report has approval from Cabinet to proceed with planning application. Appointed Officer April 2022 Reviewed June 2022	Meet the identified need for a transit site as per the GTAA recommendations	Support the Welfare, Education, housing requirements
5.7 Asylum seekers/ refugees	Government resettlement schemes -Syrian, Afghan and Ukrainian programmes	Laura Fisher Shropshire Council Reporting to DMT	Syrian: Resettle additional 5 families as per commitment to government 2022/23 Afghan: Resettle 5 families as per commitment to government 2022/23	Number of individuals/families resettled. Syrian and Afghan families: target of 5 families each. Ukrainian: No target. Dependent on how many people opt to be hosts	Syrian, Afghan and Ukrainian individuals/families resettled in safe accommodation which will impact positively on their health and wellbeing	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.7 continued.,		Ukrainian Visitors Steering Group	Ukrainian: Date: March 2022 DBS initiated Property inspected Welfare check completed Emergency payment made Monthly gift of £350 made Asylum Dispersal Awaiting update from government re: future numbers / duties	Numbers registered with GP. Data collected by Housing as part of monitoring for government / Home Office		
5.8 Unpaid Carers Affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status	Carers not identified early in their caring journey resulting in delayed support that may prevent crisis and provide a better quality of life for the carer	Margarete Davies Reporting to Shropshire Family Carers Partnership Board	Training provided to health and social care staff to help identify carers. (From September 2022)	Number of training sessions offered to GP Practice staff By: 2023 This will help carers access appointments for themselves and the people they are caring for. It will improve carer registration on GP practice systems (Carer flag) so that carers can be offered vaccinations and any other health related benefit for carers	Number of GP Practice staff attending Number of GP Practice asking if someone is an unpaid carer as a routine question Improved carer registrations on GP practice systems (carer flag) so that carers can be offered vaccinations and any other health support	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.9 Physical disabilities	Community equipment service aligned to Disabled Facility Grant offer, to complete adaptations to increase support and independence	Laura Fisher Reporting to Housing Services Management	New Disabled Facilities Grant (DFG) guidance published on March 2022 widening the scope, area of its coverage to include equipment when tied to the adaptation (Ongoing)	Reduce the time wating for DFG and equipment Local DFG process to reflect change in new DFG guidance and information	Increase number of people of all ages with disabilities or complex needs who can live in the community with improved independence	
	Recommissioning of Community equipment service	Deb Webster/Laura Fisher Reporting to Joint commissioning delivery group	Working across the ICS, T&W and Shropshire to provide a seamless allocation of equipment across all ages and disabilities. (Ongoing)	One access route (TBC) to health and social care equipment not identified through funding pathway. Seamless allocation of equipment to all age groups. Closer working across identified areas to maximise development of equipment provision across all fields.	Easy access to a~~n increased~~ range of equipment and information for all ages and disabilities. Development of pathways to streamline prescription and ordering and improve waiting times. Equipment supplier tenders to be opened Summer 2023 Equipment supplier commissioned by Autumn 2023.	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.10 LGBTQ+ People who identify as LGBTQ+ experience disproportionately worse health outcomes and have poorer experiences when accessing health services. Kings Fund:2021 Staff awareness and understanding of LGBT communities to help improve experience for LGBT people using our services. (adapted from National LGBT action plan priorities)	Safer Ageing, No Discrimination) SAND takes a targeted approach to increasing LGBT+ inclusion, challenging discrimination, promoting accessibility and equality of opportunity for LGBT+ people ageing in Shropshire, Telford and Wrekin. The Covenant – Safe Ageing No Discrimination (lgbtsand.com)	Tamsin Waterhouse Reporting to LGBTQ+ covenant planning working group (ICS have a support group for LGBTQ+ staff)	Shropshire Council signed up and committed to the pledge March 2022 LGBTQ+ covenant planning group first meeting May 2022, with monthly meetings thereafter Currently Adult Social Care in main, so not cross council yet. Action plan will be developed and reviewed. (October 2022)	Commitment made through the pledge to: providing the best possible quality services for older and old LGBT+ people Commit to learning what life can be – and has been – like for different LGBT+ people. Commit to vocally and visually supporting groups working with and for older and old LGBT+ people Commit to creating meaningful opportunities for LGBT+ people and groups to 'influence' what you do Commit to assess and evidence change, including work carried out to engage LGBT+ people (within the group/organisation and outside it)	This is a new group, and Action Plan will help to monitor progress	

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.10 continued.,	Shropshire agreed to be a test site for some research being conducted by the University of Birmingham into Social Work practice when working with LGBTQ+ adults	Tamsin Waterhouse	University to visit and discuss. (November 2022)	Provision of information on what is being doing well, and where we need to improve		
5.11 Services personnel and their families (including veterans)	GP Friendly accreditation scheme	Sean McCarthy Health and Wellbeing Board Shropshire Armed Forces Covenant Strategic Board	Engagement with CCG and PCN's to raise awareness of the accreditation (Ongoing)	Number of GP surgeries contacted	Number of GP Practices signing up to the GP friendly accreditation scheme.	10 GP practices during 2022
5.12 Drug and Alcohol Misuse affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status	Review publish & implement the Drug and Alcohol Strategy 2020-2023. (Identified in Shropshire Safeguarding Community Partnership (SSCP) Strategic Plan and Priorities 2020 – 2023)	Paula Mawson / Ian Houghton SSCP Drug and Alcohol Misuse Group Shropshire Council Combating Drugs Partnership – ICS Group with TWC & PCC as SRO	National Guidance Milestones: SRO & geography agreed for new Combating Drugs Partnership (CDP) (August 2022) CDP Terms of Reference (TOR) & governance agreed (September 2022) Completion of Needs Assessment (by November 2022)	Production of the CDP ToR Governance routes agreed for the CDP and place partnership Data analysis and engagement with people with lived experience and professionals to inform the needs assessment	Public Health Outcomes Framework -Successful completion of alcohol and drug treatment -Reduced deaths from drug and alcohol misuse -Admission episodes for alcohol related conditions	To be agreed as part of the performance framework development by December 22

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.12 continued.,	Deliver the local requirements of the National Drugs Strategy, From Harm to Hope, strategic priorities to: • Break supply chains, • Deliver a world class treatment & recovery system • Achieve a shift in the demand for drugs		Local Strategy & Delivery Plan agreed (December 2022) Local Performance Framework agreed (December 2022) Ongoing reporting of progress. (From April 23)	Local Strategy & Business Plan updated in light of new guidance Approval of the local strategy refresh with HWBB Local performance framework developed in light of the recommendations in the needs assessment and national guidance	Local performance framework will be developed to measure performance against the national outcomes framework from April 23	
5.13 Looked After Children Shropshire Council has statutory responsibilities to children and young people who are 'looked after' (cared for) by the Council and who have previously been looked after up to the age of 25	Within Social Care the Stepping Stones Programme is designed to enable more children to live safely at home, or to live in a foster home rather than residential care (See also Table 4 – Best Start in Life category)	Donessa Gray/Pippa Murphy Social Care/Early Help	Develop a business case and evaluation framework (May 2022) Upscale Business case agreed July 2022 (TOMS) Recruitment to additional posts (January 2023) Parent and baby assessment centre opening (October 2022)	Documents written by health colleagues – March 2022 Review and progress May 2022 Business case written by project Manager Ongoing project review and monitoring against targets set out in business case (financial and social outcomes)	Reduce the number of children suffering significant harm and enable them to remain safely in the care of their family Reduce number of children needing to remain in residential provision out of area and increase number who can safely return home	Reduce numbers by 15 by March 2024 15 by March 2024

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.14 Ethnic minority Groups	Provide outreach support to local Bulgarian and other Eastern European communities in Shropshire. Working at the core of the Communities Driving Change to understand issues relating to health and wellbeing, that are felt to be most important to communities themselves, and to identify gaps in service, engage and support community led action to address these issues	Hannah Thomas/Penny Bason ShIPP	Weekly drop-in sessions offering Welfare Support in Oswestry: support has included food provision, home essentials and internet access, registration of local services such as doctors/dentists/jobs, housing and financial difficulties. (April 2022) Extra session on Sunday (May 2022) Supporting Schools: Already in some primary schools in Oswestry supporting families with translation, cultural understanding (Ongoing) Drop in for Bulgarian/Eastern European students in Oswestry - barriers in school. Will then work with families. (April 2022) To develop an offer to deliver Blood Pressure and AF checks within the community which will support a wider piece of work around case finding (Ongoing)	Data collected on numbers accessing and reasons why	Eastern European individuals and families are enabled to live their lives well, and are able to access welfare support, translation and education understanding. Help to ensure that access to local services are planned and delivered in a way which best meet the needs of the local community	Estimate: 5 families or individuals per week 1 school per month Translation

Priority Group/Issues	Health Inequalities Related Work Programmes	Lead Individual/ Strategic Group	Key actions/ milestones (date)	Key process measures	KPIs/Key outcome measures	Target
5.15 Prisoners and their families	**Human Library** Pilot Human Library project with the Stoke Heath Prison to deliver mini Human Library event with 6 prisoners with equality responsibilities, as a first Human Library event in the world.	Mirka Duxberry Reports to: Head of Library Service	April/May 2022 + more events throughout 2022 to be decided Pilot completed – 6/6/2022 - First Prison to Host a Human Library - The Human Library Organization Two further events planned for Oct/Nov 2022 and March 2023	Direct impact evaluations (group/individuals)	Engagement around equality and diversity discussions, challenging unconscious biases	Prisoners Prison officers Prison culture

Table 6: Primary Care Network Health Inequality Plans

Tackling neighbourhood health inequalities

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
6.1 **Primary Care Networks (PCN) inequalities plan** PCN's must: Appoint a lead for tackling health inequalities within the PCN. A PCN must identify a population within the PCN experiencing inequality in health provision and/or outcomes and develop a plan to tackle the unmet needs of that population	***North Shropshire***: Foodbank population are offered screen on iPad using a ReQoL-20 survey in person, with a PCN mental health practitioner or a Foodbank volunteer. If users identify as requiring further support, they will be triaged by the PCN mental health practitioners ***SE Shropshire*** Blood pressure, cholesterol and atrial fibrillation monitoring, focussed on Highley. Community events with Public Health, GP fellow and Clinical Pharmacists present to undertake screening	Emma Pyrah Reports to: TBC	Offer of short Mental health questionnaire to Foodbank population, to identify if mental health support needed. Operating in Whitchurch Foodbank (Ongoing). Likely to start in Oswestry (Autumn 2022) and Market Drayton to follow (Date: TBC) Opportunistic blood pressure, cholesterol and atrial fibrillation monitoring Intervention in place. Referral to a healthy lives advisor for lifestyle advice and direction. Refer back to GP for more complex issues and medication. (1 event: May 2022, agreeing next steps: Ongoing)	Intervention with support that will be local, and in the familiar setting of their GP practice or Foodbank Trusted community preventative intervention	Improve access to local GP and mental health services for food bank users Reduced mental health emergencies and better mental health outcomes for this population Improve trust and familiarity with health services Reduced blood pressure readings and healthier lives with reduced in inequalities and better access to healthcare in communities	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
6.1 continued.,	***SW Shropshire*** Opportunistic BP check. Short, user-friendly MPFT recommended wellbeing screen offered in Foodbanks by PCN pharmacy technician and/or mental health practitioner Both underpinned with a protocol around how to direct individuals to further services should a potential issue be identified		Opportunistic BP check and Re-Qol-20 survey (wellbeing screen) offered in Foodbanks by PCN pharmacy technician and/or mental health practitioner, with protocols should an issue arise Operating in Craven Arms and Church Stretton Food Banks (Ongoing) Engagement with all food banks in the SW (December 2022)	Intervention with support that will be local, and in the familiar setting of their GP practice or Foodbank	Higher rate of detection of raised blood pressure and surrogate outcomes for improved outcomes in the longer run Development of a BP case-finding service with our local pharmacy partners and GP practices To help with development of a robust resilience screening tool Follow up of any individuals identified with a physical and/or mental health need to see if it resulted in an improved outcome/ engagement and any gaps	

Priority/Issues	Health Inequalities Work Programmes	Lead Individual/ Strategic Group	Key Actions/ Milestones (dates)	Key Process Measures	KPIs/Key Outcome Measures	Target
	Shrewsbury Increasing physical activity in more deprived populations		Provision of free health and wellbeing coaches and access to variety of group activities via Shrewsbury Town in the Community (STITC). Self-referral via email or telephone (Ongoing) Recruitment of care co-ordinator to support health inequalities work, with an emphasis on patient engagement (In place)	Individuals assisted to identify their physical and Mental health goals and how to achieve them	Improved physical activity levels in the population Ideal outcomes would be decreased levels of obesity, hypertension and cardiovascular disease but these may take some time to become apparent	

19. References

1. What are health inequalities? | The King's Fund (kingsfund.org.uk)
2. PowerPoint Presentation (publishing.service.gov.uk)
3. What are health inequalities? | The King's Fund (kingsfund.org.uk)
4. Wider Determinants of Health - OHID (phe.org.uk)
5. https://www.health.org.uk/publications/long-reads/building-public-understanding-of-health-and-health-inequalities
6. Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)
7. Inclusion Health: Applying All Our Health - GOV.UK (www.gov.uk)
8. https://www.health.org.uk/publications/reports/addressing-the-leading-risk-factors-for-ill-health
9. https://www2.deloitte.com/content/dam/Deloitte/uk/Documents/life-sciences-health-care/deloitte-uk-foph-negating-the-gap.pdf
10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/
11. APPG Rural Health and Care | NCRHC
12. Poverty dynamics in Rural Britain 1991–2008: Did Labour's social policy reforms make a difference? - ScienceDirect
13. Food Insecurity Project: South-West Shropshire | Healthwatch Shropshire
14. APPG Rural Health and Care | NCRHC
15. Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

References continued.,

16. WP202201-Inequality-and-the-Covid-crisis-in-the-United-Kingdom.pdf (ifs.org.uk)

17. Reducing inequalities in health: towards a brave old world? | The King's Fund (kingsfund.org.uk)

18. Fair Society Healthy Lives full report (parliament.uk)

19. Marmot Review 10 Years On - IHE (instituteofhealthequity.org)

20. Levelling up white paper aims to address health inequalities (gmjournal.co.uk)

21. Health and Social Care Act 2012 (legislation.gov.uk).

22. NHS Long Term Plan v1.2 August 2019

23. NHS England » What are integrated care systems?

24. core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

25. NHS England » Network Contract DES

26. Microsoft Word - Census Table First Results- Rounded (shropshire.gov.uk)

27. Shropshire's profile | Shropshire Council

28. IMD_Overall_2019.pub (shropshire.gov.uk)

29. The English Indices of Deprivation 2019 (publishing.service.gov.uk)

30. health-all-policies-hiap--8df.pdf (local.gov.uk)

31. Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

References continued.,

32. 'Supporting Families 2021 to 2022 and beyond'

33. 1b_Social_value-Briefing.pdf (publishing.service.gov.uk)

34. 23.4 million people unable to afford the cost of living this spring | New Economics Foundation

35. Household income inequality, UK - Office for National Statistics (ons.gov.uk)

36. Millions of low-income households pulled under by arrears as living costs rise - Credit Connect (credit-connect.co.uk)

37. Financial hardship and economic vulnerability in England | LG Inform (local.gov.uk)

38. United Kingdom Food Security Report 2021: Theme 4: Food Security at Household Level - GOV.UK (www.gov.uk).

39. https://lginform.local.gov.uk/reports/view/lga-research/ficlga-research-report-financial-hardship-and-economic-vulnerability?mod-area=E92000001&mod-group=AllRegions_England&mod-type=namedComparisonGroupFinancial hardship and economic vulnerability in England | LG Inform (local.gov.uk)

40. Disability Price Tag | Disability charity Scope UK

41. it-doesnt-add-up---campaign-report.pdf (ageuk.org.uk)

42 Making smoking obsolete: summary - GOV.UK (www.gov.uk)

43 Sexual orientation, UK - Office for National Statistics (ons.gov.uk)

44. National LGBT Survey: Summary Report - GOV.UK (www.gov.uk)

45. LGBTQ+ facts and figures | Stonewall.

46. NHS England » Accessible Information Standard – Overview 2017/2018

47. Accessible Information Standards Survey - Deafinate Matters CIC

20. Appendix 1

Membership of Inequalities Plan Steering Group

Berni Lee	Consultant in Public Health, Health Improvement – Shropshire Council
Val Cross	Health and Wellbeing Strategic Manager – Shropshire Council
Sarah Dodds	Feedback Insight Team Leader Communications & Engagement – Shropshire Council
Sarah Hampson	Insight Officer Communications & Engagements – Shropshire Council
Jane Trethewey	Assistant Director Homes & Communities – Shropshire Council
Tracy Darke	Assistant Director Economy & Place – Shropshire Council
Tracey Jones	Deputy Director Partnerships – Shropshire Telford & Wrekin Commissioning Groups
Lois Dale	Rurality and Equalities Specialist, Resources Directorate – Shropshire Council
Alice Sheppard	GP Trainee/Population Health Fellow – Shropshire Council
Melanie Holland	Strategy & Development Manager, Homes & Communications – Shropshire Council
Penny Bason	Head of Service – Joint Partnerships – Shropshire Partnership
Lynn Cawley	Chief Officer – Healthwatch Shropshire
Heather Osbourne	Chief Executive – Age UK Shropshire Telford & Wrekin

21. Appendix 2

Life Expectancy for Males by Electoral Ward

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	79.7	79.6	79.7
Shropshire	-	80.5	80.2	80.8
Copthorne	-	85.8	83.2	88.4
Burnell	-	85.1	82.6	87.6
Harlescott	-	83.9	76.8	91.0
Loton	-	83.6	81.0	86.3
Clun	-	83.4	80.7	86.1
Radbrook	-	83.3	81.0	85.5
Llanymynech	-	83.2	81.1	85.3
Abbey	-	83.1	81.2	84.9
Bagley	-	83.0	81.2	84.7
Clee	-	82.9	80.8	85.0
The Meres	-	82.6	80.4	84.9
St Oswald	-	82.5	80.5	84.5
Alveley and Claverley	-	82.5	80.1	85.0
Corvedale	-	82.3	79.8	84.9
Ruyton and Baschurch	-	82.3	79.4	85.2
Bridgnorth West and Tasley	-	82.0	80.0	84.0
Bayston Hill, Column and Sutton	-	82.0	80.6	83.4
Prees	-	82.0	79.9	84.0
Whitchurch South	-	81.8	79.8	83.9
Longden	-	81.8	78.1	85.6
Shifnal South and Cosford	-	81.8	79.5	84.1
Shifnal North	-	81.6	78.7	84.4
Shawbury	-	81.4	79.5	83.4
Church Stretton and Craven Arms	-	81.4	79.7	83.1
Hodnet	-	81.4	79.6	83.2
Porthill	-	81.1	79.2	83.0
Ellesmere Urban	-	81.1	78.7	83.5
Oswestry South	-	81.0	78.7	83.3
Ludlow South	-	81.0	78.7	83.3
Broseley	-	80.9	79.3	82.5
Market Drayton East	-	80.8	78.7	83.0
Wem	-	80.4	78.6	82.3
Battlefield	-	80.4	78.0	82.8
Brown Clee	-	80.3	78.6	82.1
Severn Valley	-	80.3	77.6	83.0
Bishop's Castle	-	80.3	77.5	83.1
Belle Vue	-	80.3	78.2	82.3
Chirbury and Worthen	-	80.2	76.2	84.2
Albrighton	-	80.2	77.9	82.5
Gobowen, Selattyn and Weston Rhyn	-	80.1	78.2	82.0
Cheswardine	-	80.1	77.9	82.3
Monkmoor	-	79.9	77.8	81.9
Highley	-	79.8	76.9	82.6
Much Wenlock	-	79.7	76.1	83.3
Rea Valley	-	79.6	77.1	82.1
Whittington	-	79.3	77.3	81.3
Cleobury Mortimer	-	79.0	76.6	81.4
Bridgnorth East and Astley Abbotts	-	78.8	76.7	81.0
Worfield	-	78.8	76.8	80.7
Oswestry West	-	78.7	76.2	81.2
Ludlow East	-	78.5	75.6	81.3
St Martin's	-	78.5	75.7	81.2
Underdale	-	78.4	75.3	81.4
Market Drayton West	-	78.3	76.2	80.3
Tern	-	78.1	75.9	80.4
Bowbrook	-	78.1	75.4	80.8
Meole	-	78.0	75.2	80.9
Castlefields and Ditherington	-	77.7	75.0	80.4
Oswestry East	-	77.6	75.9	79.3
Ludlow North	-	77.5	72.6	82.3
Quarry and Coton Hill	-	76.7	74.2	79.3
Whitchurch North	-	76.6	74.7	78.5
Sundorne	-	75.3	72.7	77.9

Life expectancy for Females by Electoral Ward

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	83.2	83.2	83.3
Shropshire	-	83.6	83.3	83.9
Clun	-	89.6	86.7	92.4
Llanymynech	-	89.3	86.0	92.7
Bishop's Castle	-	88.1	86.0	90.2
Copthorne	-	87.7	84.9	90.5
Longden	-	86.9	84.0	89.9
Burnell	-	86.9	84.9	88.8
Bridgnorth West and Tasley	-	86.6	84.9	88.2
Ludlow South	-	86.5	84.6	88.4
Loton	-	85.7	81.9	89.6
Clee	-	85.7	82.7	88.7
Alveley and Claverley	-	85.6	83.7	87.6
Oswestry West	-	85.6	83.5	87.7
Belle Vue	-	85.5	83.6	87.3
Shifnal South and Cosford	-	85.4	83.4	87.3
Shifnal North	-	85.2	83.5	86.8
Ellesmere Urban	-	85.2	83.3	87.0
Chirbury and Worthen	-	85.0	81.5	88.4
Ruyton and Baschurch	-	84.9	82.7	87.1
Bagley	-	84.9	83.2	86.6
Oswestry South	-	84.8	82.7	87.0
Corvedale	-	84.7	80.3	89.1
Church Stretton and Craven Arms	-	84.6	83.1	86.0
Radbrook	-	84.4	82.2	86.7
Bowbrook	-	84.4	82.0	86.9
Battlefield	-	84.4	81.1	87.6
Albrighton	-	84.3	82.2	86.4
Prees	-	84.2	81.6	86.8
Porthill	-	84.0	81.3	86.7
Bayston Hill, Column and Sutton	-	84.0	82.5	85.5
Highley	-	83.9	81.2	86.6
Severn Valley	-	83.8	80.7	86.9
Much Wenlock	-	83.8	81.2	86.5
Rea Valley	-	83.7	82.0	85.3
Hodnet	-	83.6	81.6	85.6
Whitchurch North	-	83.5	82.2	84.8
Broseley	-	83.3	81.2	85.4
Gobowen, Selattyn and Weston Rhyn	-	83.3	81.7	84.9
Wem	-	83.2	81.4	85.1
Cleobury Mortimer	-	83.2	81.4	85.0
Shawbury	-	83.0	81.1	84.9
Harlescott	-	82.9	80.8	85.0
Whitchurch South	-	82.8	81.0	84.7
Market Drayton West	-	82.8	80.9	84.8
The Meres	-	82.8	79.5	86.1
Abbey	-	82.6	79.4	85.8
Ludlow East	-	82.6	80.7	84.5
Whittington	-	82.6	80.8	84.4
Ludlow North	-	82.4	80.2	84.5
Bridgnorth East and Astley Abbotts	-	82.3	80.7	83.9
Meole	-	82.3	79.8	84.8
Market Drayton East	-	82.1	79.8	84.5
Monkmoor	-	82.1	80.0	84.3
Cheswardine	-	82.0	79.9	84.2
Underdale	-	82.0	79.4	84.6
Brown Clee	-	81.8	79.4	84.1
Castlefields and Ditherington	-	81.7	79.1	84.3
Oswestry East	-	81.3	79.5	83.1
St Martin's	-	81.2	78.5	84.0
St Oswald	-	80.8	77.1	84.4
Worfield	-	80.2	77.2	83.2
Quarry and Coton Hill	-	79.7	76.7	82.6
Sundorne	-	79.6	76.6	82.7
Tern	-	79.5	75.9	83.0

22. Appendix 3 Deaths from causes considered preventable, under 75 years, SMR

Area	Count	Value	95% Lower CI	95% Upper CI
England	342,988	100.0	99.7	100.3
Shropshire	2,033	85.7	82.0	89.5
Sundorne	39	160.6	113.9	220.0
Underdale	42	151.8	109.2	205.5
Castlefields and Ditherington	42	147.1	105.8	199.3
St Martin's	46	135.9	99.5	181.3
Highley	38	128.1	90.6	175.9
Oswestry West	33	126.2	86.8	177.2
Quarry and Coton Hill	38	124.5	87.9	171.2
Harlescott	36	120.8	84.6	167.2
Ludlow East	35	117.6	81.7	164.0
Bridgnorth East and Astley Abbotts	69	116.8	90.8	148.0
Market Drayton West	69	112.9	87.8	143.0
Battlefield	30	109.6	73.9	156.5
Bowbrook	32	109.1	74.3	154.4
Whitchurch North	56	108.9	82.3	141.5
Tern	40	107.6	76.7	146.7
Oswestry East	65	106.8	82.4	136.1
Monkmoor	32	101.0	69.0	142.5
Oswestry South	31	99.7	67.7	141.5
Ludlow North	33	97.8	67.1	137.7
Wem	62	96.5	73.9	123.9
Whittington	31	95.9	64.9	136.6
Chirbury and Worthen	25	92.9	60.1	137.1
Severn Valley	32	89.8	61.2	127.1
Market Drayton East	37	88.4	62.2	121.9
Meole	27	86.9	57.3	126.4
Brown Clee	30	86.3	58.0	123.6
St Oswald	30	85.3	57.6	121.8
Gobowen, Selattyn and Weston Rhyn	43	84.3	61.0	113.5
Broseley	34	83.5	57.8	116.6
Ludlow South	26	82.2	53.5	121.0
Hodnet	26	81.5	53.0	119.9
Rea Valley	27	80.0	52.7	116.4
Shifnal North	30	79.9	53.9	114.1
Cleobury Mortimer	53	78.9	59.0	103.4
Bridgnorth West and Tasley	42	77.6	55.8	105.1
Belle Vue	24	77.3	49.5	115.0
Much Wenlock	28	77.3	51.1	112.0
Worfield	24	76.9	49.3	114.4
Porthill	22	76.3	47.8	115.5
Albrighton	25	73.7	47.7	108.8
Whitchurch South	25	73.1	47.3	107.9
Bayston Hill, Column and Sutton	72	72.7	56.9	91.5
Shawbury	24	72.4	46.4	107.8
Abbey	23	71.9	45.3	108.3
Ellesmere Urban	21	69.3	42.9	105.9
Shifnal South and Cosford	25	69.1	44.7	102.1
Ruyton and Baschurch	20	68.3	41.7	105.4
Alveley and Claverley	25	66.5	43.0	98.2
Loton	21	65.6	40.4	100.9
Bishop's Castle	22	65.4	40.8	99.6
The Meres	25	63.0	40.6	93.4
Radbrook	20	62.4	38.1	96.4
Clee	24	62.1	39.8	92.3
Llanymynech	22	59.6	37.1	90.7
Longden	19	58.6	35.3	91.6
Copthorne	17	58.0	33.4	93.4
Church Stretton and Craven Arms	46	57.5	42.1	76.7
Cheswardine	17	56.5	32.9	90.4
Prees	21	55.5	34.4	84.9
Clun	21	54.9	33.8	84.4
Burnell	20	54.5	33.1	84.7
Bagley	16	49.7	28.1	81.4
Corvedale	17	48.2	27.8	77.7

23. Appendix 4

Data Sources for Vulnerable Groups in Shropshire

Vulnerable Group	Number *
Children in absolute low-income families	8,922[a]
Children in relative low-income families	11,038[b]
Children in care	504[c]
Children in receipt of Free School Meals	6,598[d]
Number of excluded pupils	1,375[e]
Number of NEETs	590[f]
Number claiming Universal Credit (in employment)	8,555[g]
Number claiming Universal Credit (not in employment)	10,432[h]
Number on PIP payments	12,881[i]
Number claiming carers allowance	5,532[j]
Number homeless	253[k]
Number living in fuel poverty (16.5% of households) n=145,430 households with 2.2 persons per household	52,791[l]
Number on SMI register	2,830[m]
Number on LD register	1,806[n]
Total	**124, 107****

** **(NB:** There will be double counting between these groups but counterbalanced by vulnerable groups not included eg. LGBTQ+, carers not in receipt of carer's allowance, people with disabilities not in receipt of benefits or on the LD register, those experiencing domestic abuse, those with common mental health disorders, digitally excluded individuals etc)

a. **Children in absolute low-income families** Children in absolute low-income households (20/21) https://stat-xplore.dwp.gov.uk

b. **Children in relative low-income families** Children in Relative low-income households (20/21) https://stat-xplore.dwp.gov.uk

c. **Children in care (fingertips 2020)**

d. **Free school meals known to be eligible for free school meals** https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics

e. **Number of excluded pupils (fingertips)**

f. **Number of NEETs(fingertips 2020)**

g. **Number claiming UC in employment April 2022** https://stat-xplore.dwp.gov.uk

h. **Number claiming UC not in employment April 2022** https://stat-xplore.dwp.gov.uk

i. **Number on PIP payments PIP Cases with entitlement, Caseload by local authority** https://stat-xplore.dwp.gov.uk

j. **Number of carers claiming carers allowance** https://stat-xplore.dwp.gov.uk

k. **Number homeless** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072068/Statutory_Homelessness_Stats_Release_Oct-Dec_2021.pdf

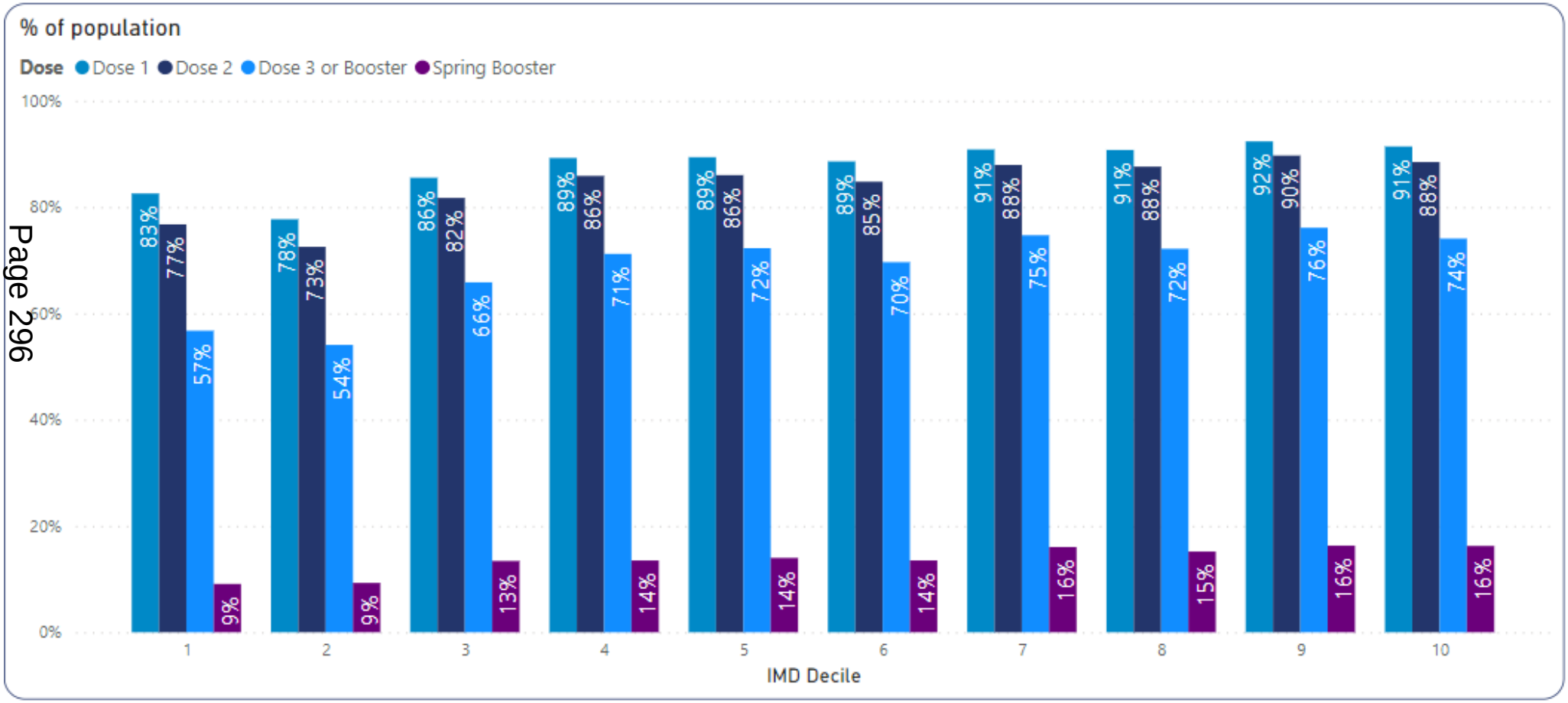
l. **Number living in fuel poverty** 16.5% of households identified as being in fuel poverty in 2020
Financial hardship and economic vulnerability in Shropshire | LG Inform (local.gov.uk)
Housing and households | Shropshire Council

m. **SMI register (QoF data)** QOF 2020-21 | NHS Digital

n. **LD register (QoF data)** QOF 2020-21 | NHS Digital

24. Appendix 5

Vaccination coverage by IMD Decile to 30/06/22



25. Appendix 6

Source of Priorities for Inequalities Plan

NHS Planning Guidance Report template - NHSI website (england.nhs.uk)	
Priority	**Explanation/rationale from source**
Restore NHS services inclusively (to include 20% most deprived LSOAs and ethnic minorities)	It is critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.
Mitigate digital exclusion	Systems are asked to ensure that: • providers offer face-to-face care to patients who cannot use remote services • more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups • they take account of their assessment of the impact of digital consultation channels on patient access
Datasets are complete	Systems are asked to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, eg for people experiencing post- COVID syndrome. Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.
Strengthen leadership and accountability	Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme.

Priority	Explanation/rationale from source
Accelerate Prevention Programmes that proactively engage those at greatest risk of poor health outcomes	Uptake of the **COVID and flu vaccination**. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021. Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including: • Ongoing management of **long-term conditions • Annual health checks for people with a learning disability.** • **Annual health checks for people with serious mental illness** • In maternity care, implementing **continuity of carer** for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.
Population Health Management (i.e. not one of the specified 5 priorities but mentioned)	The development of primary and community services and implementation of population health management will be led at place level, with Primary Care Networks as the building blocks of local healthcare integration.
NHS LTP Prevention Priorities NHS Long Term Plan v1.2 August 2019	
Smoking	By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. The model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments. A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings

Priority	Explanation/rationale from source
Obesity/Diabetes	The NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity) By 2022/23, we also expect to **treat up to a further 1,000 children a year for severe complications related to their obesity**, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. The NHS Diabetes Prevention Programme supports those at high risk of type 2 diabetes to reduce their risk. We are now committing to fund a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option to widen patient choice and target inequality. Expanding the Diabetes Prevention Programme is a key vehicle for tackling health inequalities, with a significantly higher take up from BAME groups than the general population. We will also continue to support local health systems to address inequality of access to multidisciplinary foot care teams and specialist nursing support for people who have diabetes. Medical research has shown that some people with type 2 diabetes can achieve remission through adoption of a very low-calorie diet. This allowed nearly half of patients to stop taking anti-diabetic drugs and still achieve non-diabetic range glucose levels. We will therefore test an NHS programme supporting very low-calorie diets for obese people with type 2 diabetes. The NHS will continue to take action on healthy NHS premises. All trusts will be required by the NHS standard contract to deliver against the hospital food standards (2019).
Alcohol	Over the next five years, those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs using funding from their clinical commissioning groups (CCGs) health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services.
Air Pollution	The NHS will work to reduce air pollution from all sources. Specifically, we will cut business mileages and fleet air pollutant emissions by 20% by 2023/24.

Priority	Explanation/rationale from source
The following are included in the LTP but were not identified as 'must do's' for ICSs	
Antimicrobial resistance	*The health service will continue to support implementation and delivery of the government's new five-year action plan on Antimicrobial Resistance.*
Homelessness	*People affected by homelessness die, on average, around 30 years earlier than the general population. 31% of people affected by homelessness have complex needs, and additional financial, interpersonal, and emotional needs that make engagement with mainstream services difficult. 50% of people sleeping rough have mental health needs, but many parts of the country with large numbers of rough sleepers do not have specialist mental health support and access to mainstream services is challenging. We will invest up to £30 million extra on meeting the needs of rough sleepers,* ***to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support****, integrated with existing outreach services.*
Carers and Young Carers	*Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, finance concerns, stress, and social isolation. Quality marks for carer-friendly GP practices, developed with the Care Quality Commission (CQC), will help carers identify GP services that can accommodate their needs. We will encourage the national adoption of carer's passports and set out guidelines for their use based on trials in Manchester and Bristol. These will be complemented by developments to electronic health records that allow people to share their caring status with healthcare professionals wherever they present.* *Carers should not have to deal with emergencies on their own. We will ensure that more carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it. Up to 100,000 carers will benefit from 'contingency planning' conversations and have their plans included in Summary Care Records, so that professionals know when and how to call those plans into action when they are needed.* *Young carers feel say they feel invisible and often in distress, with up to 40% reporting mental health problems arising from their experience of caring. Young Carers should not feel they are struggling to cope on their own. The NHS will roll out 'top tips' for general practice which have been developed by Young Carers, which include access to preventive health and social prescribing, and timely referral to local support services. Up to 20,000 Young Carers will benefit from this more proactive approach by 23/24.*

Priority	Explanation/rationale from source
Gambling	*We will invest in expanding NHS specialist clinics to help more people with serious gambling problems. Over 400,000 people in England are problem gamblers and two million people are at risk, but current treatment only reaches a small number through one national clinic. We will therefore expand geographical coverage of NHS services for people with serious gambling problems, and work with partners to tackle the problem at source*
Partner with local VCS	*The NHS will continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups.*
Sept 30th Operational Guidance C1400-2122-priorites-and-operational-planning-guidance-oct21-march21.pdf (england.nhs.uk)	
Update on March Guidance	We will also continue the focus on the five priority areas for tackling health inequalities and redouble our efforts to see sustained progress across the areas detailed in the NHS Long Term Plan, including: • early cancer diagnosis, • hypertension detection, • respiratory disease, • annual health checks for people with severe mental illness, • continuity of maternity carer, and • improvements in the care of children and young people. To support this, we are improving the quality and presentation of health inequalities data and will shortly set out further details of our approach. We are also asking that all NHS Board performance reports include reporting by deprivation and ethnicity Continue to ensure health inequalities are considered within elective recovery plans and progress is tracked through board level performance reports. Systems are also asked to support their PCNs to work closely with local communities to address health inequalities.

Core20Plus5 core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)	
Priority	**Explanation/rationale from source**
Core 20	The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).
Plus	ICS-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. NB: For Shropshire this is defined as 'Rurality'
5 clinical groups	1. **Maternity:** ensuring continuity of care for **75% of women from BAME** communities and from the most deprived groups 2. **Severe Mental Illness** (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities) 3. **Chronic Respiratory Disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) **driving up uptake of Covid, Flu and Pneumonia vaccines** to reduce infective exacerbations and emergency hospital admissions due to those exacerbations 4. **Early Cancer Diagnosis**: 75% of cases diagnosed at stage 1 or 2 by 2028 5. **Hypertension Case-Finding**: to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke

Priority	Explanation/rationale from source
Local ICS Priorities	
Integrated health equity and equality assessment framework	The intention is to develop one standardised overarching framework for delivering a variety of assessments that all fall under the umbrella of an Integrated Impact Assessment (IIA). The plan is to standardise the way this process is completed across the system (a measurable, gold standard approach), but also recognise that projects differ in size and resources and not all elements are relevant to every project. The IIA framework is intended to encompass the following elements: • Social Inclusion • Equality - across the 9 protected characteristics and also e.g. deprivation, carers, dementia, refugees (we need a mechanism to determine which other characteristics are relevant to a project) • Health Inequalities (as part of broader Health and Wellbeing?) • Quality (including clinical effectiveness, patient safety and user experience) • Climate Change • Economic Impact
Complex need	This will involve population level data analysis of prevalence of certain diagnoses and social determinants associated with high risk of developing complex needs. There will be a focus on making best use of local resources, targeting a population who have low, moderate, or serious mental illness, who experience multiple disadvantage and have complex lives. This disadvantage may take the form of (but not limited to) substance misuse, domestic abuse, social problems, housing/ homelessness, debt, or other issues. The life expectancy gap between those with Severe Mental Illness and the rest of the population is one of the worst nationally. Key anticipated outcomes include: ○ improved individual emotional and mental health and wellbeing ○ improved physical health of those with complex needs ○ reduced homelessness ○ better joined up services, and service offer ○ improved asset-based approaches to supporting people in local communities ○ Reduce impact on services (health, social care)

Priority	Explanation/rationale from source
Personalisation (if this is separate to Population Health Management)	Personalised care means people having choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. This means a shift in power and decision-making, to enable people to have a voice, to be heard and be connected to each other and their communities. The following need to be enabled: • Care and support planning and shared decision-making – ensuring person-centred conversations with people about their life to inform their care plan • Personal health budgets and choice – to put people in control of their care • Social Prescribing – connecting people to communities, and the necessity of investing in and working with communities to ensure they have the capacity to support each other • Support for self-management – to help people better manage their health and wellbeing, through self-management education, health coaching and peer support
Shropshire Health and Well Being Board Priorities hwbb-draft-strategy-22-27.pdf (shropshire.gov.uk)	
Joined up working	The local System will work together and have joint understanding of health being social and economic, not just absence of disease. Partnership Boards will work more closely together to reduce duplication and make the best use of the skills and knowledge of people within them, and to engage with people who use our services.
Improving Population Health	Using a population health approach, we will aim to improve the health of the entire Shropshire population. This will include action: to reduce the occurrence of ill health; to deliver appropriate health and care services; on the wider determinants of health; and primary prevention as well as support (secondary prevention) for those currently on long waiting lists for procedures.
Working with and building strong and vibrant communities	Shropshire has a strong, vibrant community, many which have their own proud identity. We will work with our communities to reduce inequalities, promote prevention, increase access to social support and influence positive health behaviours. We will also pool information and resource to support people in our communities.

Priority	Explanation/rationale from source
Reduce Inequalities	We will have a clear and focused approach to health inequalities, including targeted work, and help give everyone in Shropshire a fair chance to live their life well, no matter where they live. Medical treatment alone cannot tackle inequalities and the biggest impact on our health and wellbeing includes having a job and income, access to education, and a decent home to live in
Focus 1: Workforce	During COVID many people have lost their job or had to take lower paid and less stable employment. We will work to make Shropshire workplaces fair, happy and healthy places for people to work in and promote wellbeing for all, no matter where they are employed.
Focus 2: Mental Health	The 5-year Mental Health Strategy for Shropshire and Telford & Wrekin will guide our ambitions over the next five years. This strategy has a 'life course' approach from pregnancy to childhood to older age.
Focus 3: C&YP	COVID has had a huge impact on many families, and particular focus will be CYP mental health and wellbeing. In addition, plans to create a Trauma Informed workforce will be implemented. This will enable understanding of certain behaviours and help promote resilience for our young people.
Focus 4: Healthy Weight and Physical Activity	Our ambition is to reduce levels of obesity in Shropshire across all ages. This priority will be linked to alcohol, smoking and mental health, through preventative work around Musculoskeletal (MSK) conditions, respiratory health, Cardio-vascular disease (CVD), and cancer risk; food insecurity and reasons around obesity will all be included.
Other Priorities	
Social Prescribing	Social Prescribing will remain a HWBB priority, and a pilot to expand the programme for children and young people in south-west Shropshire has commenced.
Alcohol	An estimated 35,319 adults in Shropshire aged 18-65 drink more than the Chief Medical Officer's guidelines of 14 units per week. Children affected by parental alcohol misuse are more likely to have physical, psychological, and behavioural problems, and alcohol is the 3rd leading risk factor for death and disability after smoking and obesity. PHE data for KSI on roads shows alcohol related collisions in Shropshire are significantly higher than the rest of England and the West Midlands, and successful alcohol treatment as lower than the rest of England. We will monitor this through the Alcohol Strategy and reporting to HWBB.

Priority	Explanation/rationale from source
Domestic Abuse	Domestic abuse affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status. Domestic abuse is coercive, controlling, abusive and violent behaviour. Such violence can also be directed towards children, other family members or friends of the victim. Some 30,475 women in Shropshire will experience domestic abuse during their lifetime
County Lines	County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and adults (including those with care and support needs) to move, [locally supply] and store the drugs and money. They will often use coercion, intimidation, violence (including sexual violence) and weapons. Shropshire Safeguarding Partnership report annually to the HWBB.
Smoking in Pregnancy	Babies born to mothers who smoke are more likely to suffer from respiratory disease as well as being at greater risk of sudden infant death. For mothers there is an increased risk of miscarriage, stillbirth, premature delivery and having a low-birth-weight baby. Rates of smoking in early pregnancy remain higher in Shropshire compared to the England average. The HWBB will continue to have smoking in pregnancy as a priority until rates decrease further.
Food Insecurity	Food insecurity has a physical and mental impact on the wellbeing of everyone experiencing it. Food insecurity remains a HWBB priority, and the developing Healthy Weight Strategy and our partnership with Shropshire Food Poverty Alliance to help address this issue will continue.
Suicide Prevention	Shropshire and Telford & Wrekin Suicide Prevention Network have launched a wallet sized Z-Card providing brief advice for anyone contemplating suicide or who is worried about someone else, along with primary contact numbers for immediate support. A targeted approach to upskill the workforce on suicide risk and awareness of how to intervene has been taken with the launch of a Suicide Prevention training programme in Shropshire.
Killed or Seriously Injured on Roads	More accidents occur on rural roads compared to urban roads in Shropshire and there are a similar proportion of traffic accidents on both urban roads and rural roads with a 30mph limit. Although COVID-19 has reduced traffic on Shropshire roads and thus those KSI, the risks will increase as the pandemic declines. Thus, KSI on roads will remain a HWBB priority

Priority	Explanation/rationale from source
Air Quality	Shropshire Council's 2020 Air Quality Annual Status Report (ASR) report that Air pollution is associated with a number of adverse health impacts. It is recognised as a contributing factor in the onset of heart disease and cancer. Additionally, air pollution particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions. There is also often a strong correlation with equalities issues because areas with poor air quality are also often the less affluent areas. Shropshire Council has a Climate Strategy and Action Plan and Shropshire, Telford & Wrekin ICS has climate change as a pledge.

26. Appendix 7

Core Work Programmes with Impact on Health Inequalities

Some of the core services and previous council investments and developments that could impact positively in reducing in health inequalities include the following:

Working with our Voluntary, Community and Enterprise Sector

Shropshire has a strong history of community led approaches to help build connected and empowered communities. Shropshire Council has a good relationship with Voluntary, Community and Enterprise Sector organisations (VCES) through the Voluntary and Community Sector Assembly (and the Compact). Through working in close partnership on many projects and transformation programmes, and through a range of contracts and grant programmes work is underway to tackle heath inequalities.

More widely the Integrated Care System recognises that prevention of ill health and a focus on inequalities is fundamental to longer-term sustainability of the system. Coproducing solutions with our communities, in partnership with the VCSE, is fundamental to both harnessing community ability and capacity, as well as improving population health. Strategically and operationally, the VCSE is an important partner in improving health, wellbeing, and care outcomes.

Consequently, the ICS has been developing its relationship with the sector and has recently signed a Memorandum of Understanding to clarify how all parties will work together. Despite these good working relationships, learning from Covid indicates that we have much more to do, and the public sector must consider how it supports the sustainability and growth of the VCSE if we are to address current and future health challenges.

Early Help/Supporting Families

The council delivers specific Early Help services including Targeted Early Help, Parenting, Family Information Service, and support for schools. The Council partners with schools, health services (including the Healthy Child Programme) and others to deliver a multi-agency offer to improve outcomes for children and families.

Shropshire Council, with system partners is creating a new vision and way of working with CYP and families based on a stronger and wider prevention offer which brings together service areas and programmes. This supports the integrated approach across people, place, wellbeing and health and provides a multiplicity of opportunities to enhance service offers and connections between service areas.

For families, children, and young people this builds on the work of Early Help, the Strengthening Families programme, (launched in 2021) bringing in the public health programmes and different commissioned services.

The results of these changes will ensure there is a re-emphasis on the importance of the first 1001 days of a child's life, enhancement of family help services through the creation of a network of family hubs, investment in infant and parental mental health, breastfeeding support, parenting programmes, speech and language development and delivering on key recommendations from the Early Years Healthy Development review , and the continuation of the Supporting Families programme, targeting support to Shropshire's most vulnerable children and families. The work will also build on the developing local evidence base around CYP Social Prescribing and drive forward prevention programmes based on community activity and partnerships with the NHS and our voluntary and community sector.

Delivering Social Value

The Social Value Act 2012 requires the public sector to ensure that the money it spends on services or goods creates the greatest possible economic, social, and environmental value for local communities. 1b_Social_value-Briefing.pdf (publishing.service.gov.uk) Implementing Social Value involves making procurement decisions in a way that ensures wider benefits are considered throughout the commissioning cycle. Examples of the type of Social Value that might be achieved could be a commitment from a contractor to pay a living wage to their employees or to employ target groups such as young unemployed people, alongside delivering the service being commissioned. As such implementing Social Value approaches can positively support other local efforts to reduce health inequalities.

Shropshire Council has a well-developed strategic approach to achieving Social Value through commissioning with guidance and support for commissioners and agreed priority areas that should be considered in seeking Social Value. More recently the development of a Social Value Fund has been piloted whereby contractors can take up the option of making a cash contribution in lieu of delivering Social Value through a contract. This offers the potential for a more flexible approach to securing Social Value that will be further evaluated over the coming months. There could be scope to secure additional benefits through Social Value by working collaboratively with other public sector commissioners and providers across the ICS, but this would require further exploration.

The Holiday Activities and Food (HAF) Programme

The holiday activities and food (HAF) programme allows children and young people aged 4 to 16, who are in receipt of benefits related free school meals (FSMs) and those who have been referred onto HAF by a professional to access free holiday provision during the Easter, Summer and Christmas school holidays. Funded by the DfE, the programme is being delivered across all local authorities over the next three

years. It has been nationally funded because of a recognition that children from low-income households are:

- less likely to access organised out-of-school activities
- more likely to experience 'unhealthy holidays' in terms of nutrition and physical health
- more likely to experience social isolation

A dynamic comprehensive HAF programme is being delivered across Shropshire benefiting children and young people in receipt of FSMs as well as other groups such as

- children assessed as being in need, at risk or vulnerable
- young carers
- looked-after children or previously looked after children
- children with an education, health and care (EHC) plan
- children who have low attendance rates at school or who are at risk of exclusion
- children living in areas of high deprivation or from low-income households who are not in receipt of FSMs

The Shropshire HAF programme is being delivered by the council in partnership with schools, voluntary and community organisations, and childcare providers across the county. The programme has been shown to hugely benefit the children and young people who live in the most challenging circumstances and continues to achieve a range of positive outcomes. Shropshire HAF celebration and feedback | Shropshire Council

The UK Shared Prosperity Fund (UKSPF)

There are, and always will be, emerging opportunities through which the council and its partners can strengthen their approach to tackling inequalities. For example, over the coming months council officers will lead development of plans to draw down monies through the UK Shared Prosperity Fund (UKSPF). The overarching objective of the fund is, "Building pride in place and increasing life chances". The programme covers three investment priorities that offer significant opportunity to reduce health inequalities, as follows:

- Community and Place
- Supporting Local Business
- People and Skills (including the ring-fenced Multiply allocation for improve the core skills and employability of adults)

27. Appendix 8

Social Task Force Action Plan to Address Cost of Living Crisis

Working together the Forum, through the Poverty and Hardship sub-group, have developed an action plan, the most significant gaps currently are the need to:

1) Review capacity across the system to support people in Shropshire with the cost-of-living crisis. Consider which resources and skills are available. Triage and offer specialist support for those in need.

2) Improved information sharing between partners in relation to the cost-of-living crisis to ensure that partner organisations are kept informed of up-to-date information on assistance available so they can cascade to the people they support (eg, Household support fund, HAF scheme).

3) Joint working to create protocols around more common debts.

4) Workforce training/Improved signposting information for frontline staff and volunteers to boost their knowledge of support available and increase confidence to hold difficult conversations around the increases in the cost of living.

5) Data & Insight. Continue to review what insight is held on groups most likely to be impacted by the cost-of-living crisis. Plan an event to learn what data is available. Do community organisations have case studies or insight which might help to identify the best way to support the groups identified in this plan? Can we target those at greatest risk?

6) Work with Stakeholders to review the Household Support Fund allocation to date. What worked well? How can we target better to vulnerable groups identified?

7) Joint communications on the cost-of-living crisis highlighting help available, including panels on Shropshire Radio. Key messages include: encouraging householders to contact Marches Energy Agency (MEA) now for help with energy efficiency measures over the summer to help householders get ready for Autumn/Winter & Energy advice; communications around how to make best use of the £650 government support payment and promotion of Breathing Space to prevent government support payments being allocated to overdraft/debt repayments/rent arrears.

8) Assessment of the impact of the cost-of-living crisis on the workforce, including how it will impact their ability to effectively do their jobs. A key focus on workers on lower incomes, particularly the impact on carers.

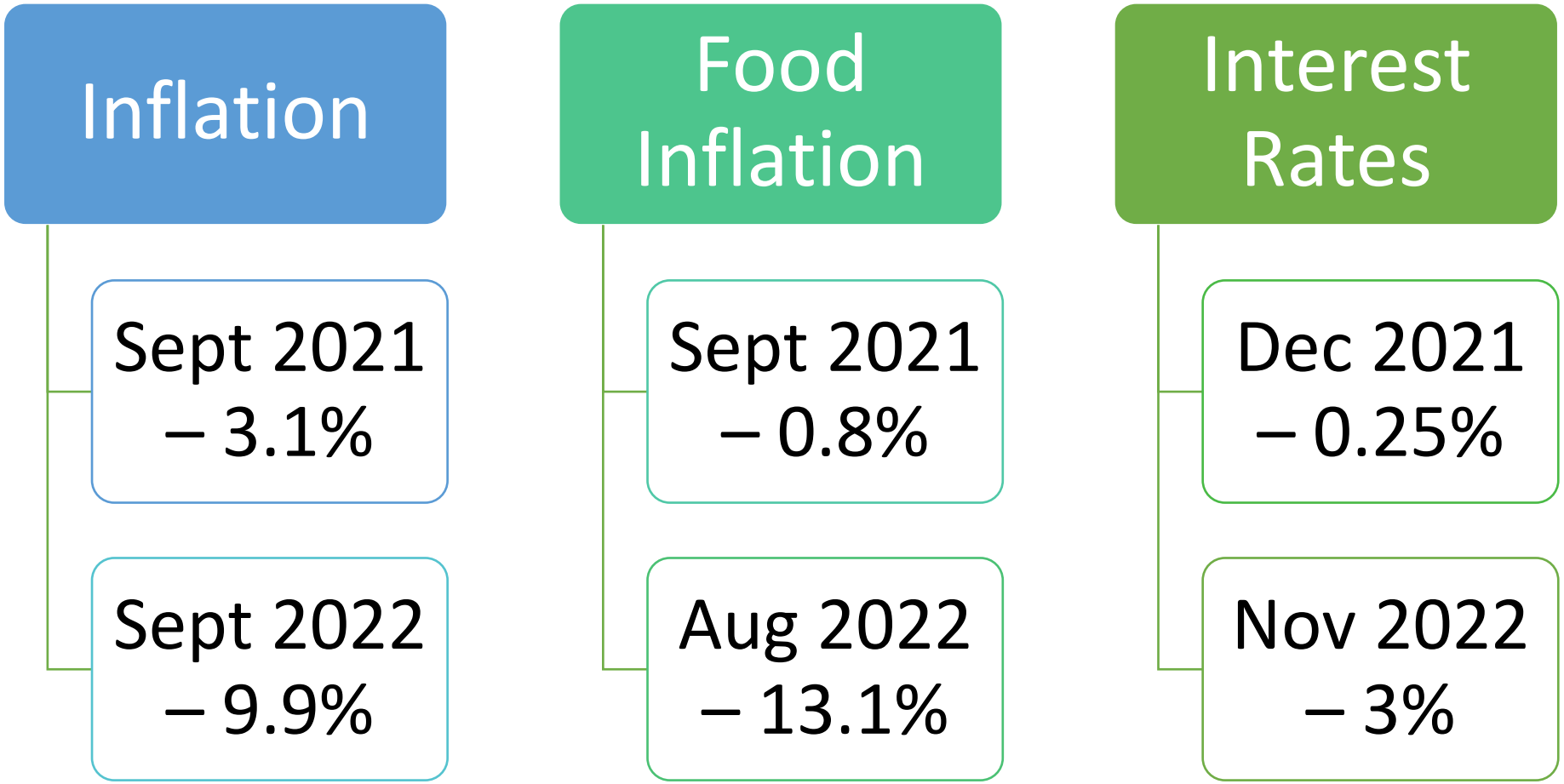
Shropshire Council

Cost of living crisis in Shropshire

Emily Fay, Programme Manager, Public Health

emily.fay@shropshire.gov.uk

Cost of Living Increases

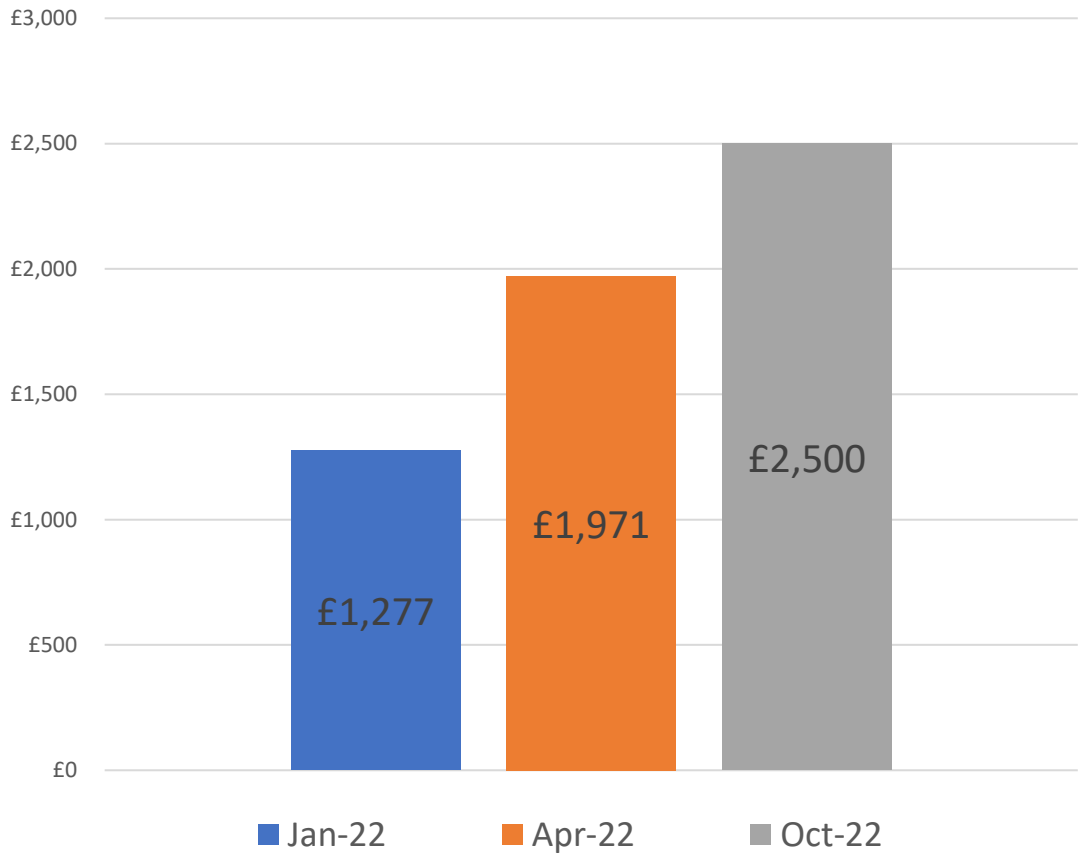


Government Support

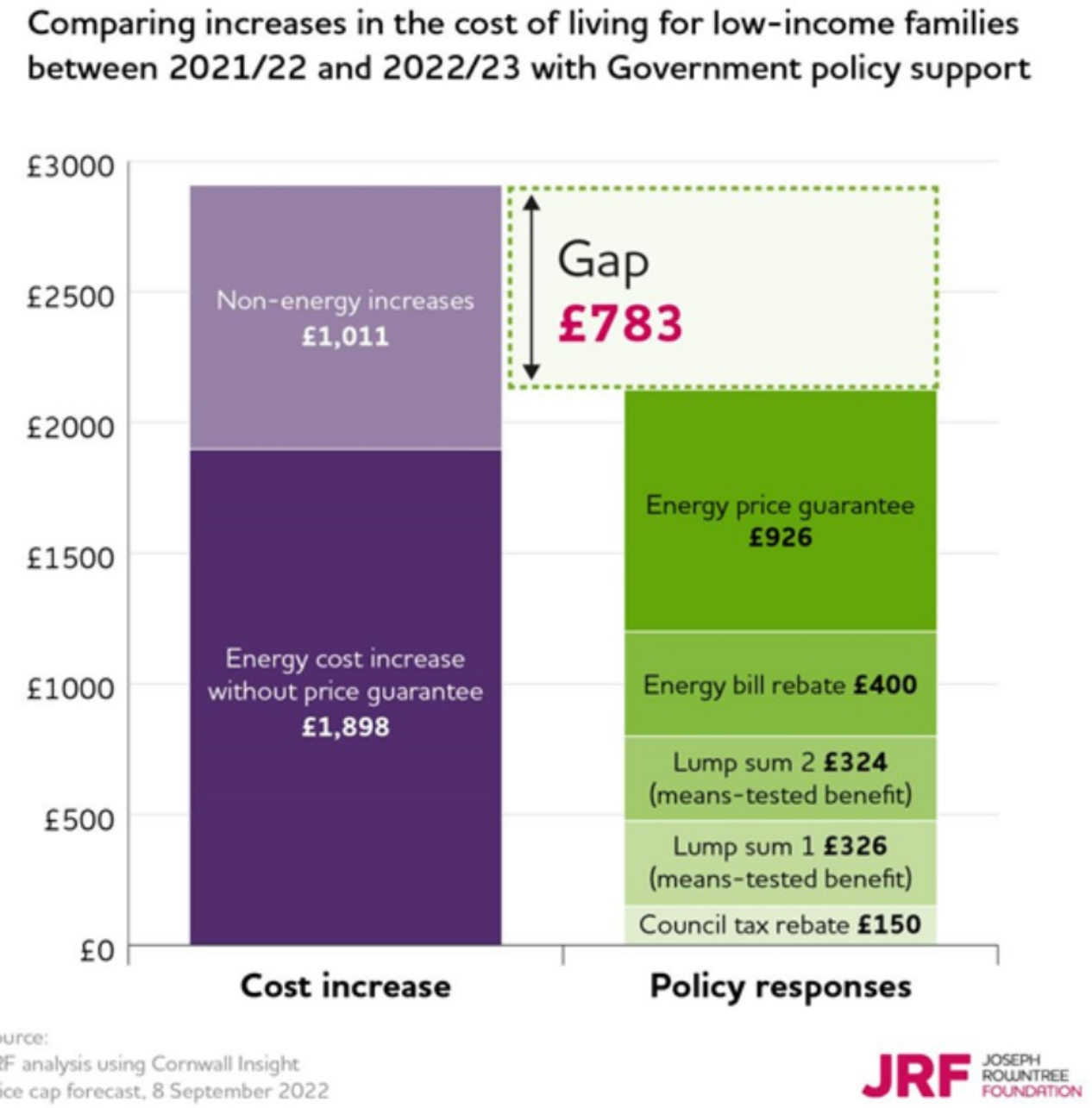
May: Support with Cost of living

- £400 Energy Bills Support Scheme
  - for all Households
  - paid in 6 instalments from October via energy bill
- £650 Cost of Living Payment
  - for households on benefits
  - £326 paid in July, second payment in the Autumn
- £150 disabilities (Due Sept)
- £300 pensioners (paid as part of Winter fuel payment from mid Nov).

September: Energy Price Cap - 'the cap is not a cap'



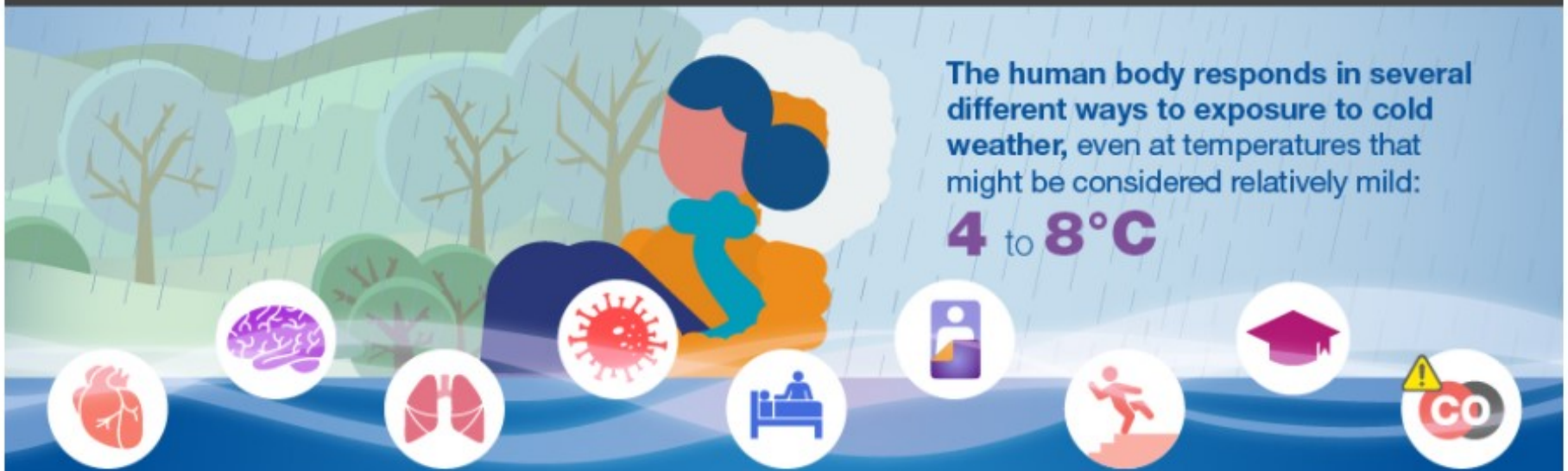
£800 gap on average for low-income households this year. Gap will increase next year.



Public Health England

Health Matters

The direct and indirect health effects of winter weather



The human body responds in several different ways to exposure to cold weather, even at temperatures that might be considered relatively mild:

4 to **8°C**

Direct effects:

- heart attack
- stroke
- respiratory disease
- influenza
- falls and injuries
- hypothermia

Indirect effects:

- snow and ice may cause disruption to healthcare services
- cold homes and fuel poverty are linked with poor mental health and social isolation
- reduced education and employment success
- carbon monoxide poisoning

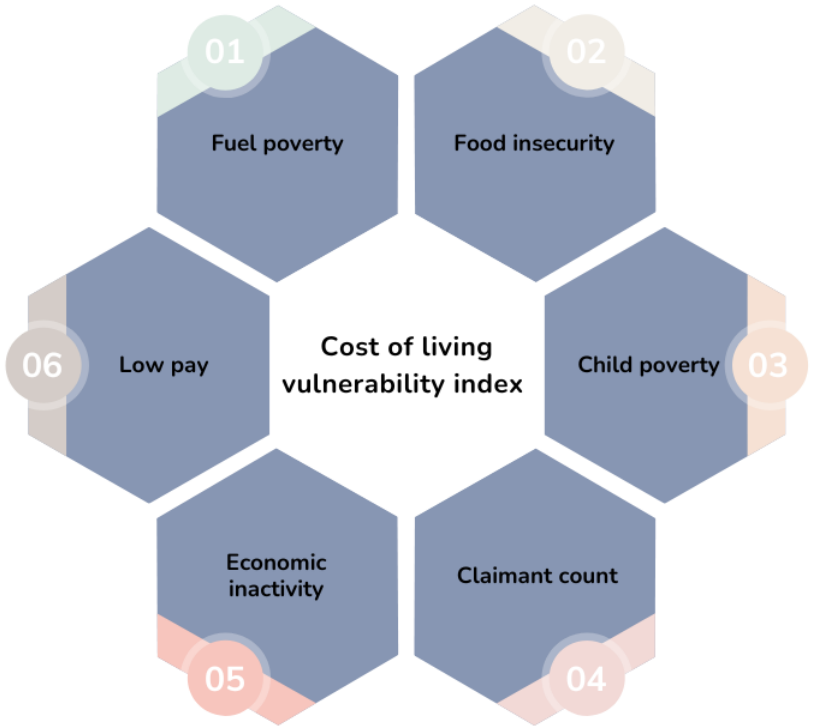
An economic crisis with public health implications

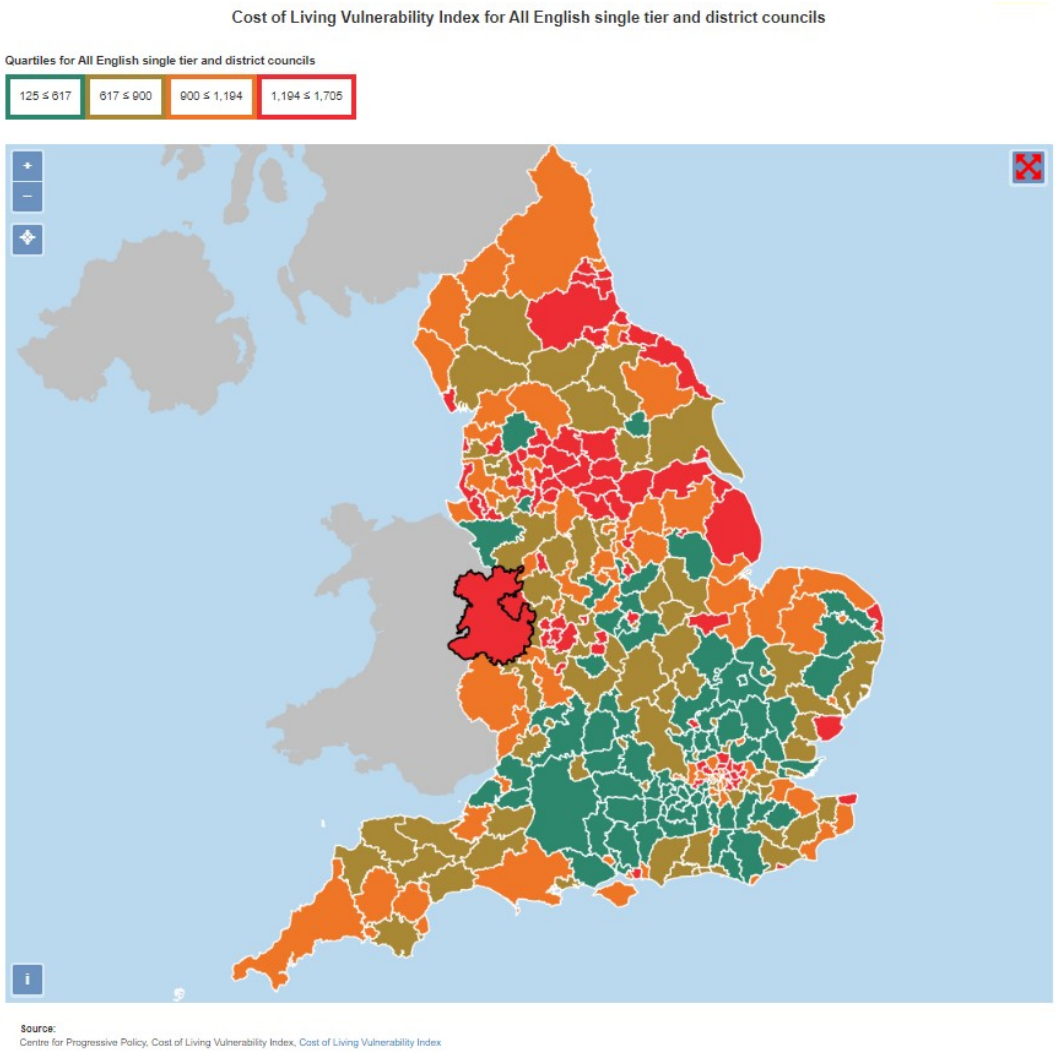
Cold homes- increased risk of cardio-vascular problems, mould and damp exacerbate respiratory conditions, arthritis and other mobility issues suffer

Food budgets squeezed- healthier foods more expensive, cost of cooking hot meals

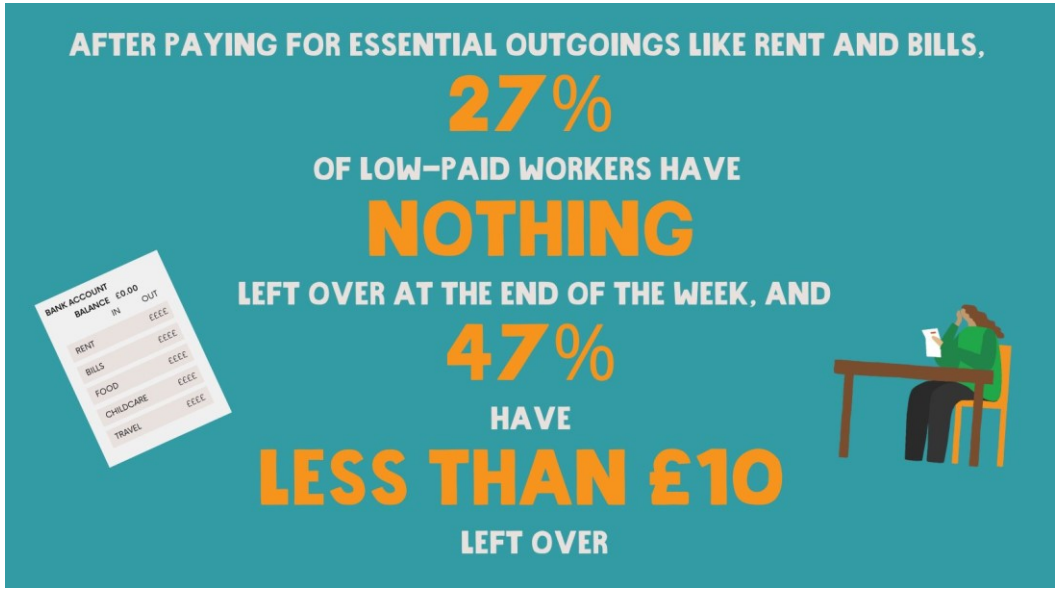
Mental health issues- exacerbated/ prompted by money worries and substandard living conditions

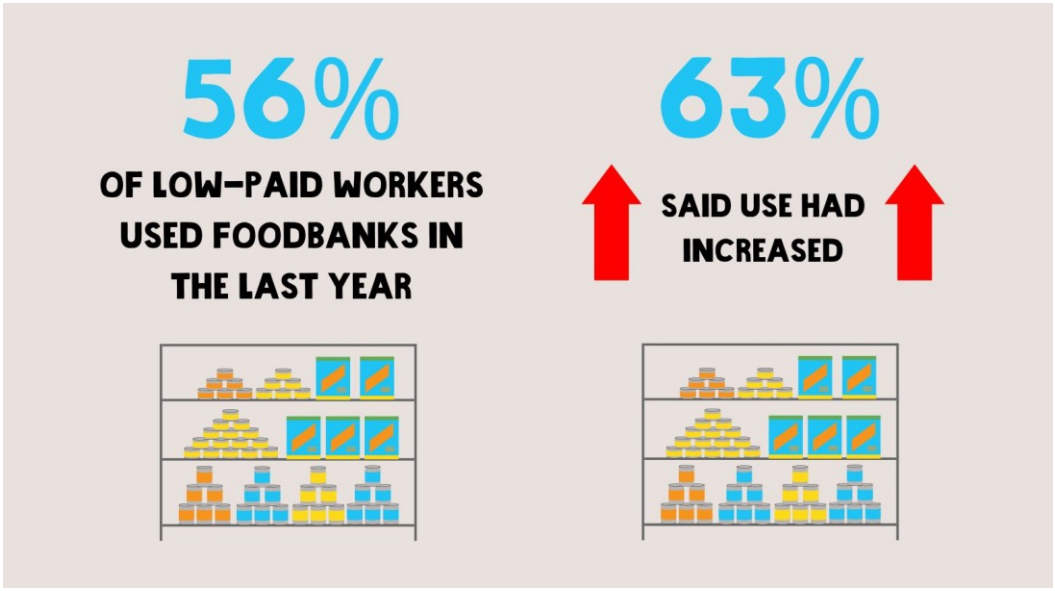
Cost of Living Vulnerability Index



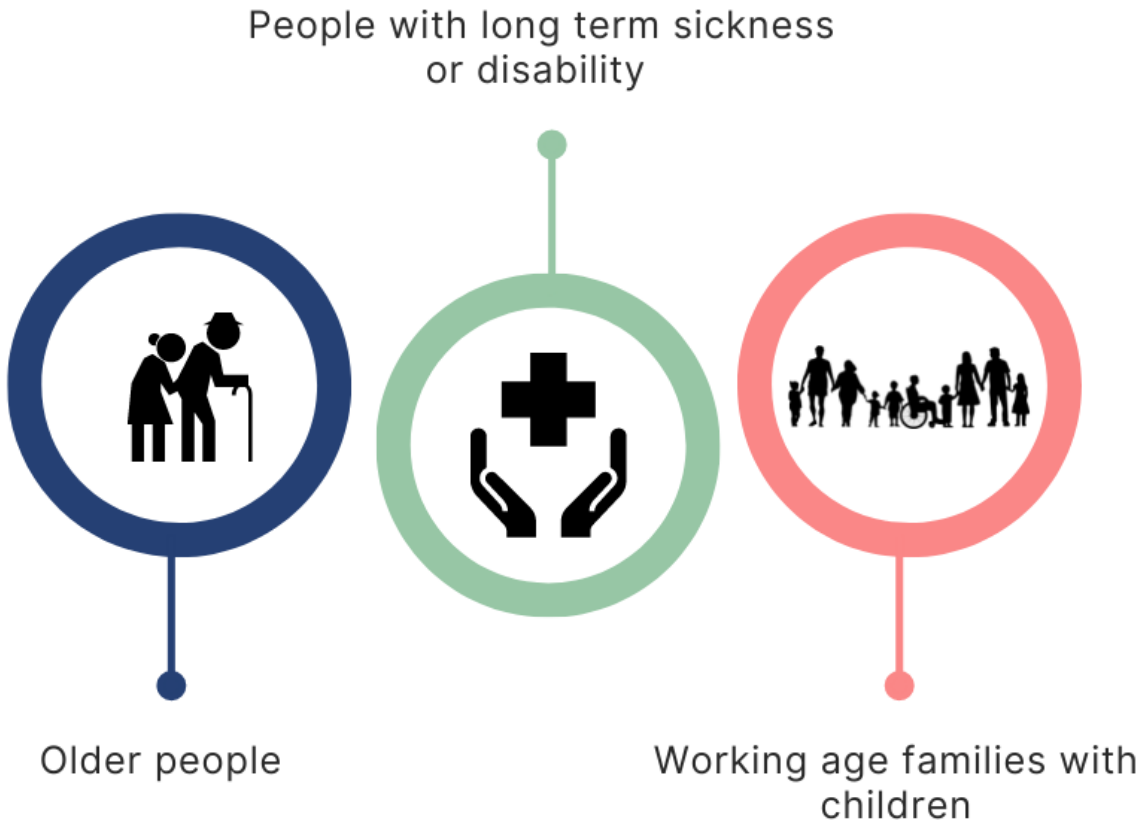


The lowest paid increasingly have nothing left or are in negative budgets





Key Groups likely to be Impacted



People with long term sickness or disability

HIGHER ENERGY BILLS

For some disabled people, energy is needed to run health, medical or mobility equipment

DISABILITY PREMIUM

Disabled people face extra costs of £583 per month

INCREASED RISK OF POVERTY

Nearly half of all people living in poverty live in a household where someone is disabled

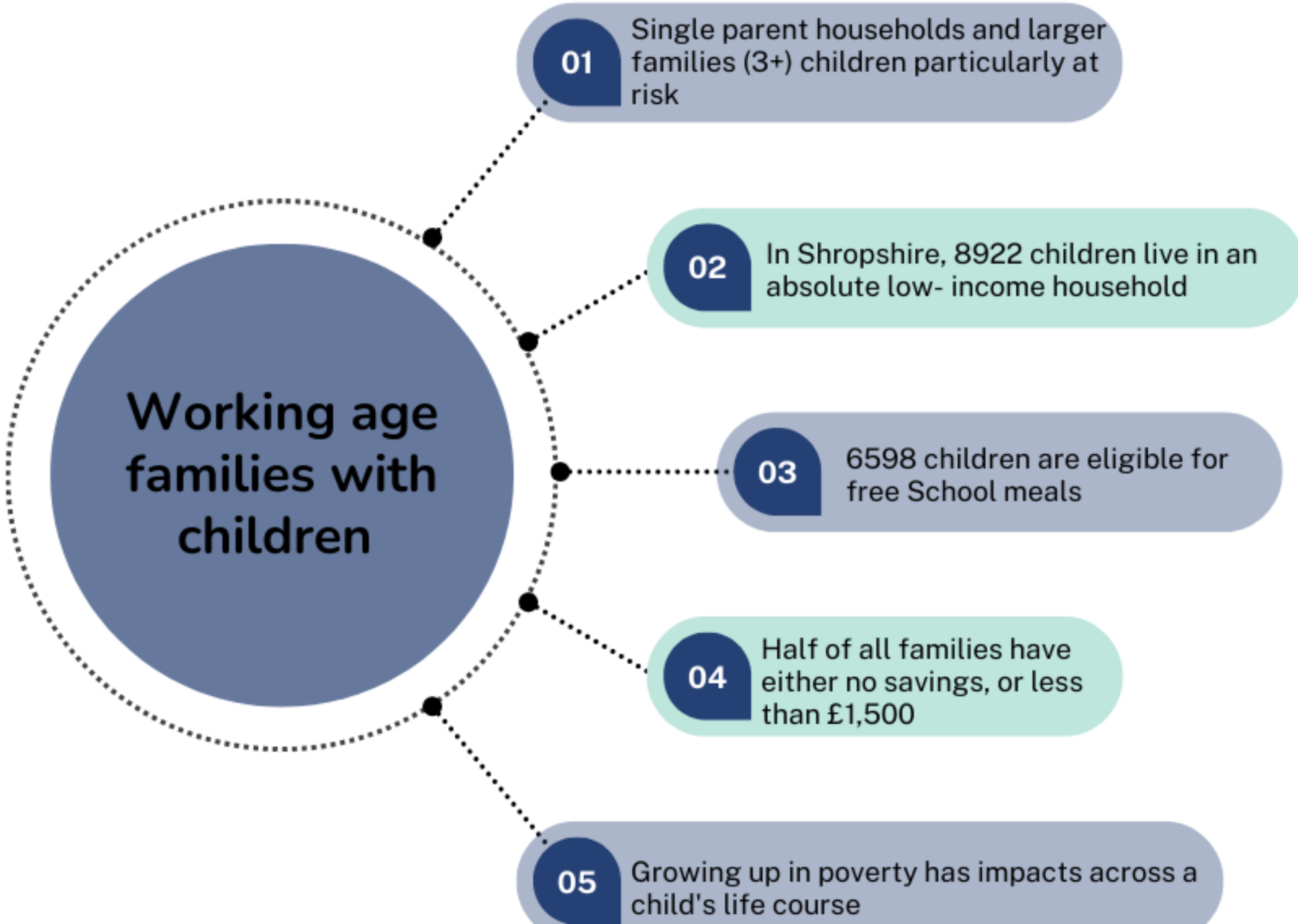
IN SHROPSHIRE

12,561 claim Personal Independence Payments to pay for help with daily living or mobility costs

12,561

Older People Key Challenges

Higher proportion of older people than other areas This number is increasing	82,000 people aged 65 and over. Rising from 63,300 in 2011, a 29.5% rise (compared to a 20.1% rise in England)
Tight budgets	State Pension = £9627 In April 2022 State pension rose by 3.1%, less than inflation
Entitlement going unclaimed	Pension Credit one of the most unclaimed benefits 33% of those eligible in Shropshire are not claiming Costs the local economy £323,673 each year


Working age families with children
01
Single parent households and larger families (3+) children particularly at risk
02
In Shropshire, 8922 children live in an absolute low- income household
03
6598 children are eligible for free School meals
04
Half of all families have either no savings, or less than £1,500
05
Growing up in poverty has impacts across a child's life course

Money and resources

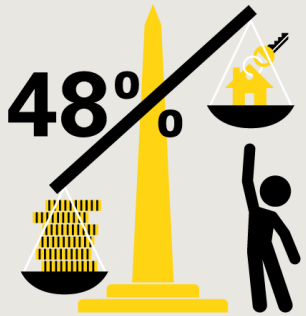
1 IN 5 of the UK population live in poverty. Over half of these people live in working households. Poverty damages health and poor health increases the risk of poverty.

An inadequate income can cause poor health because it is more difficult to:

Avoid stress and feel in control

Living with the day-to-day stresses of poverty in early childhood can have damaging consequences for long-term health

Access experiences and material resources

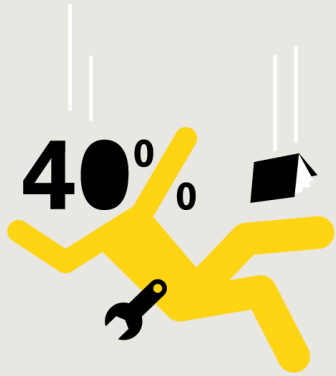


Money can allow people to access the basics they need to fully participate in society. Yet, 48% of 21-24 year-olds earn less than the living wage

Adopt and maintain healthy behaviours

Healthy behaviours can feel unattainable. It is 3 times more expensive to get the energy we need from healthy foods than unhealthy foods

Feel supported by a financial safety net



A safety net enables people to invest in their future. In a recent study, 40% of people with unmanageable debt said they were less likely to study or retrain

The Health Foundation

References available at www.health.org.uk/healthy-lives-infographics

A NOTE ON STIGMA

PEOPLE OFTEN FIND IT DIFFICULT TO COME FORWARD FOR SUPPORT

A LOT OF THE COMMON NARRATIVES AROUND THOSE ON A LOW-INCOME DO NOT HAVE AN EVIDENCE BASE TO SUPPORT THEM

NOT ALL PEOPLE CLAIMING BENEFITS ARE OUT OF WORK

IN SHROPSHIRE IN JULY 2022 19,461 PEOPLE WERE IN RECEIPT OF UC, 8,742 ARE IN WORK (45%)

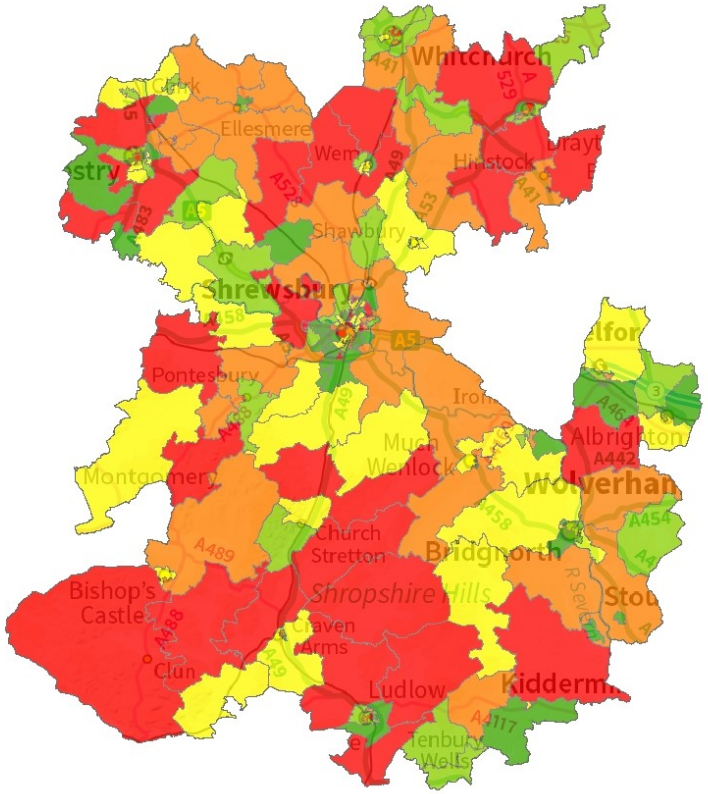
FOOD BANKS ARE INCREASINGLY SUPPORTING PEOPLE WHO ARE IN WORK

THERE ARE A WIDE RANGE OF BENEFITS THAT SUPPORT PEOPLE IN VARYING SITUATIONS- BENEFITS PROVIDE A LIFELINE, HELPING PEOPLE MAINTAIN A REASONABLE QUALITY OF LIFE IN DIFFICULT CIRCUMSTANCES

THE LANGUAGE WE USE AND THE PRECONCEPTIONS WE BRING TO THESE DISCUSSIONS ARE HUGELY IMPORTANT

Social Taskforce: Supporting Shropshire residents through the cost-of-living crisis

Index of Potential Risk



Household Fuel Risk	Proportion of households in fuel poverty based on "Low Income Low Energy Efficiency" (LILEE) methodology
	Median gas consumption (kWh per meter)
	Median elec consumption (kWh per meter)
	Housing in poor condition indicator
	Houses without central heating indicator
Cohort Risk	Years of potential life lost indicator
	Comparative illness and disability ratio indicator
	Acute morbidity indicator
	Mood and anxiety disorders indicator
	Household overcrowding indicator
Travel Fuel Risk	Road distance to a post office indicator (km)
	Road distance to a primary school indicator (km)
	Road distance to general store or supermarket indicator (km)
	Road distance to a GP surgery indicator (km)
Economic Risk	Income Score (rate)

Cost of living group Key Messages

- If you or someone you know is worried about money or is struggling right now, **you are not alone**.
- There may be **simple steps** you can take to cut costs or maximise your income.
- If you are getting into debt or your mental health is suffering, **do not wait to get help**.

16 things

that could help if you or someone you know is struggling with day to day living costs

COST OF LIVING HELP

Scan this QR code or visit:
shropshire.gov.uk/cost-of-living-help

Shropshire Council

Step 1

Can you maximise your income?

7 million people are missing out on benefits

Step 2

Can you cut your costs?

Many people have already cut back in key areas, but there may be things you haven't thought of

Step 3

Borrow money safely and get support with debt

Seek advice early and don't let things spiral out of control

Step 4

Talk to someone if you are worried about your mental health

There are organizations which can help

£15 billion benefits unclaimed each year

Worrying About Money?

Follow these steps to find available financial advice and support in Shropshire

View full information online

Step 1: What's the Problem?

I suddenly have no money

- Lost job/reduced hours
- Lost money/unexpected expense
- Disaster (e.g. flood or fire)
- Relationship breakdown
- Money stopped (e.g. failed a medical)
- Sanctioned - see option 5

See options 1 2 5 6

I am waiting on a benefit payment/decision

- Made a new claim for benefit
- Benefit payment is delayed
- Waiting for a benefit decision

See options 1 4

My money doesn't stretch far enough

- Deciding between food/fuel/mobile credit
- Low income or zero hours contract
- Statutory Sick Pay too low to cover costs
- Not sure if eligible for support
- Change of circumstance (e.g. new baby/ bereavement/illness/left partner)

See options 1 2

I have debt

- Rent or Council Tax arrears
- Gas or electricity
- Credit or store cards
- Personal loans and overdrafts
- Owe friends and family
- Benefit repayments

See option 3

Step 2: What are some options?

1 Council Support Schemes

People on low incomes may be eligible for Housing Benefit, Council Tax Support and Discretionary Housing Payments. Find out more at: **www.shropshire.gov.uk/benefits**

Local Welfare Provision support is also available for anyone struggling to meet their essential living costs or facing an unexpected crisis. Find out more at: **www.shropshire.gov.uk/local-welfare-team**

2 Maximise Your Income

Anyone who is struggling financially can get a benefit check and speak to an advisor for free and confidential advice.

A **benefit check** can ensure that you are receiving all the money you're entitled to, especially if your circumstances have changed recently. Speaking to an advisor could also help you **find cheaper deals** on things like gas and electricity and **make sure you're not missing out** on things like school clothing grants or free school meals.

3 Debt Advice

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

4 Benefit Advance

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

5 Hardship Payment

If you have been sanctioned, you may be able to request a hardship payment from the Jobcentre. Hardship payments are not always paid immediately, and they're not available to everyone. Hardship payments of Universal Credit need to be paid back (a loan), but hardship payments of Job Seekers Allowance or Employment Support Allowance do not (not a loan).

6 Challenge a Decision

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

Step 3: Where can I get help?

Each of these services offer free and confidential advice

Shropshire Council

Advice on Housing Benefit, Council Tax Support and Discretionary Housing Payments
0345 678 9002 (Benefit Service)
benefits@shropshire.gov.uk
www.shropshire.gov.uk/benefits

Advice on local welfare provision
0345 678 9078 (WelfareSupport Team)
localsupport@shropshire.gov.uk
www.shropshire.gov.uk/shropshire-council/welfare-support-team-local-welfare-provision
Help with options: 1

Citizens Advice Shropshire

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

A4U

Information, legal advice and advocacy for those with a disability and their families and carers
01743 539 201 | advice@a4u.org.uk
www.a4u.org.uk
Help with option: 2 4 6

Age UK Shropshire Telford & Wrekin

Support and advice for older people, their families and carers
01743 233 123
www.ageuk.org.uk/shropshireandtelford
Help with option: 2 4 6

Other Support

Keep Shropshire Warm
Energy advice service
0800 112 3743
www.mea.org.uk

The Shropshire Larder
Money advice and more
www.shropshirelarder.org.uk

The Shrewsbury Ark
Support, hardship funds and more for people in need
01743 363 305
www.shrewsburyark.co.uk

Shelter
Free housing advice
0808 800 4444
england.shelter.org.uk

Healthy Start Vouchers
To help buy fruit, vegetables and milk if you're on a low income, pregnant or have a child under 4
www.healthystart.nhs.uk

Step Change
Free debt advice
0800 138 1111
www.stepchange.org

Turn2Us
Information and financial support
0808 802 2000
www.turn2us.org.uk

Updated on 30/08/22

SHROPSHIRE LARDER

Home Food Finding Help Covid Directory About Us News

The Shropshire Larder is a community information resource, bringing together the support av
Shropshire for people on low incomes

Find help quickly

Have you seen the new 'Worrying About Money?' leaflet for Shropshire?

The leaflets are straightforward resources for people facing financial crisis, and anyone supporting them, to quickly see available advice and cash first support options and which agencies are best placed to help.

You can access the leaflet here.

Emergency financial support

Shropshire or Telford & Wrekin Council may be able to help with food, bills and other essentials

Shropshire: Call 0345 678 9078 or apply online

Find the support you need

Emergency Food

Find out where to access emergency food in Shropshire.

Household bills

Help with council tax, energy bills, water bills and TV licensing

Maximising I

Support with benefits, employmen

Community food projects

Low cost or free food provided by the community for the community

Covid-19 Advice & Support

Find mutual aid groups, council services and specific initiatives to help you during this time

Budgeting and

Debt advice and resou you manage your

Cost of living
support in Shropshire

COST OF LIVING HELP

Scan this QR code or visit:
shropshire.gov.uk/cost-of-living-help

On our website you can:

- check you are getting the right income
- use the free benefits calculator
- check if you are eligible for council tax support
- find out how you could reduce your energy costs
- access mental health support
- plus lots more help and advice

Shropshire Council

Cost of living
support in Shropshire

COST OF LIVING HELP

- If you or someone you know is worried about money or is struggling right now, **you are not alone.**
- There may be **simple steps** you can take to cut costs or maximise your income.
- If you are getting into debt or your mental health is suffering, **do not wait to get help.**

We are working with our partners to bring together key resources so that everyone is signposted to the best place to get support in Shropshire.

Scan this QR code or visit:
shropshire.gov.uk/cost-of-living-help

citizens advice Shropshire

Keep Shropshire Warm

Shropshire Telford & Wrekin age UK

SFPA Shropshire Food Poverty Alliance

Shropshire MHS

COMMUNITY RESOURCE

marches energy agency

Shropshire Council

Support

Face to face conversations	Trained staff/volunteers Shropshire Local Libraries Warm Welcome
Telephone	SC Cost of living line Citizen's Advice Shropshire Advice Line Age UK STW Benefits team Keep Shropshire Warm/ Marches Energy Agency Community Resource
Financial Support	Household Support Fund – Targeted to support vulnerable families SC Welfare Team Energy grants Food banks

SHROPSHIRE HEALTH AND WELLBEING BOARD Report				
Meeting Date	**17.11.22**			
Title of Paper	**Social Task Force – Cost of Living Update**			
Reporting Officer and email	Emily Fay Emily.fay@shropshire.gov.uk			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	x	Joined up working	x
	Mental Health	x	Improving Population Health	x
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	x
	Workforce	x	Reduce inequalities (see below)	x
What inequalities does this paper address?	This work is seeking to raise awareness of the cost-of-living crisis and the detrimental impact on health and wellbeing and the wider determinants of health for people living in Shropshire.			

1. Executive Summary

The Social Taskforce has been meeting since March 2022. Chaired by Executive Director for Public Health Rachel Robinson, the taskforce brings together organisations to work in partnership to create a joint response to the cost-of-living crisis. Our partners include Citizens Advice Shropshire, Age UK, Marches Energy Agency, Community Resource, Shropshire Food Poverty Alliance, and many other key organisations who have been contributing via the taskforce and its subgroups.

This report provides a brief overview of the current situation in regard to the Cost-of-living crisis, and a description of the key areas of work to date.

2. Recommendations

The Health and Wellbeing Board is asked to note the work underway to mitigate the impact of the cost-of-living crisis on our residents and to make any comments as appropriate.

Members undertake to take this information on the cost-of-living back to their organisations and consider how the cost-of-living crisis is impacting both their own workforces and the residents they support.

3. Report

The cost-of-living situation

Inflation rose to 10.1% in the year to September 2022, a 40-year high, leading to significant rises in retail prices. Some of the largest increases have been seen in our supermarkets, with the ONS reporting that some of the lowest priced food items rising 40% since September 2021. Residents have seen an increase in average household energy prices from £1277 at the beginning of the year, to £2500 in October. The FCA has reported that one in four adults are now in financial trouble or at the brink of difficulty. The Food Foundation reports that 9.7 million adults (18.4% of households) and one in four households with children have experienced food insecurity in September. Food Standards Agency research from September found that 40% of participants were worried about being able to afford food in the next month, 30% had skipped a meal or cut down the size of their meals because they did not have enough money and 18% had turned off a fridge and/or freezer containing food, at least once in the last month, to reduce energy bills.

Citizen's Advice are producing monthly reports on the Cost of living. In September they reported:

- In the year to date they have seen more people unable to top up their pre-payment meter than the previous three years combined.
- They have never seen a higher proportion of people in a negative budget (meaning they have more essential spending going out than they have coming in).
- They are helping two people every minute with crisis support, such as referrals to food banks and fuel vouchers. They have supported more people this year than 2019 and 2020 combined.
- They are seeing more disabled people with issues around the cost of living than other issues.

Shropshire's Social Taskforce

Organisations in Shropshire have been working together to support residents through the cost-of-living crisis through a social taskforce, chaired by Executive Director for Public Health Rachel Robinson. This taskforce brings together organisations to work in partnership to create a joint response to the cost-of-living crisis. Our partners include Citizens Advice Shropshire, Age UK, Marches Energy Agency, Community Resource, Shropshire Food Poverty Alliance, and many other key organisations who have been contributing via the taskforce and its subgroups.

Cost of living Data

Working with partners we have developed a preliminary index of vulnerability to the cost-of-living crisis. We will be using this mapping to help with the targeting of communications and support across the County.

Cost of Living Communications

With our partners we have developed three key messages we want all Shropshire residents to know:

- If you or someone you know is worried about money or is struggling right now, **you are not alone**.
- There may be **simple steps** you can take to cut costs or maximise your income.
- If you are getting into debt or your mental health is suffering, **do not wait to get help.**

We are encouraging residents worried about money to:

- Visit the **cost of living help page** for information on what support is available in Shropshire.
- Use our **checklist** to see if there are any steps they can take which may help them to cope with rising costs. Recommended steps include using a benefits calculator to check they are not missing out on income, exploring schemes which help with household bills, getting support with debt, and reaching out for mental health support.
- Use the **'Worrying About Money' leaflet** to identify which organisation in Shropshire can offer support.

Warm Welcome

More than 50 community spaces and council buildings will be offering a Warm Welcome to Shropshire residents this autumn and winter.

The colder months can be a lonely and challenging time for many people, especially those who may be worried about the cost of energy bills.

The Warm Welcome project is a collaboration between Shropshire Council and partners which highlights community venues where people can go for free to socialise, meet friends and take part in activities while also keeping warm.

Visit www.shropshire.gov.uk/cost-of-living-help/

Cost of living helpline

The Social Taskforce has worked with partners to develop a helpline for residents. Based within Shropshire Customer Services, the line provides residents with signposting information about the support which is available. Call centre staff will be making targeted outbound calls to the most vulnerable households, alongside dealing with incoming enquiries.

Shropshire Local

The Shropshire Local team will be available in the Local Hubs in Shrewsbury and Ludlow and visiting libraries over the winter to support residents.

Financial Support for households (2021-22)

Shropshire Council have been administering funds from Central Government to support households. Teams have been taking a targeted, cash first approach, to ensure that the funds reached the most vulnerable households. Since 2021 Shropshire Council has delivered more than £30 million in support to residents with rising living costs:

- £6.266m Household Support Fund to support low-income families, single parents, pensioners in receipt of council tax support and has also provided around 7,500 children meal vouchers for the school holidays.
- £789,000 via the Welfare Support team to support Shropshire households in crisis.
- £16m Energy bills rebate scheme.
- 3,500 children and young people have accessed free food and activities during the school holidays via the Holiday Activities and Food scheme.
- The council's Affordable Warm and Energy Efficiency team has delivered a huge range of support to residents throughout the ongoing cost of living crisis. 300 households have received grants of up to £90,000 to carry out energy efficiency works totalling £1.65m.

Household Support Fund (October 22-March 23)

Shropshire Council have received a £2.1 million Household Support Grant to support residents most impacted by the cost-of-living crisis. The funding is being allocated:

- £1m to fund a one off £180 payment to around 5,250 households on low incomes in receipt of Housing Benefit who have not previously received support through the Council's Household Support Fund.
- £450,000 to support 7500 children entitled to Free School Meals with meal vouchers in the 4 weeks of school holidays.
- £300,000 funding for the Welfare Support Fund to provide support to low-income households who are most in need of help with food, energy and water bills and with other wider essential costs.
- £220,000 Keeping Warm at Home funding for a range of initiatives to help low-income households in debt with energy costs and grants to help reduce energy costs.
- £75,000 is helping to support a range of partners' hardship grants.

Cost of living training

This session was developed in partnership with Community Resource, the Shropshire Food Poverty Alliance, Age UK, Marches Energy Agency, and Shropshire Citizens' Advice.

The training video will help you understand the key issues faced by residents, the key groups likely to be impacted and the likely impact on health inequalities.

It will also take you through the key resources you can use to support residents and outlines the support available both nationally and from local organisations. Over 500 frontline staff and volunteers have watched the session so far.

You can watch the session here: https://youtu.be/oDQaCScx5p4

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The work of the Task Force aims to mitigate the impact of the cost-of-living crisis on the population of Shropshire through supporting people to access the help available.
Financial implications (Any financial implications of note)	There are no direct financial implications as a result of this report. However, increases to energy costs, fuel and the price of goods will impact on the cost of delivery of services across the county.

Climate Change Appraisal as applicable	Working to support people in local communities to improve energy efficiency is an important part of the programme.	
Where else has the paper been presented?	**System Partnership Boards**	
	Voluntary Sector	
	Other	
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)		
Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130) Cllr. Gwilym Butler Finance and Corporate Resources Cllr. Simon Jones Adult Social Care and Public Health		
Appendices Cost of living Presentation		

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD Report				
Meeting Date	**17th November 2022**			
Title of Paper	Joint Strategic Needs Assessment **(**JSNA) Update			
Reporting Officer and email	Rachel.robinson@shropshire.gov.uk			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	x	Joined up working	x
	Mental Health	x	Improving Population Health	x
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x
	Workforce		Reduce inequalities (see below)	x
What inequalities does this paper address?	Inequalities in health outcomes, service provision/access,			

1. Executive Summary

This report presents to the Health and Wellbeing Board an update on Shropshire's JSNA; progress to date, future direction of the JSNA and timescales.

2. Recommendations

The Health and Wellbeing Board:

- Note the update to work programmes and timescales
- Provide comment on the contents and format of first Place Plan Profile (attached as Appendix A)

3. Report

Joint Strategic Needs Assessment (JSNA)

Work continues on the JSNA development programme subsequent to standing down of parts of Omicron reporting. The JSNA has been managed as separate workstreams – a place-based approach and development of web-based media (in particular Power BI interactive reports) to present needs assessments. We are about to draw these two workstreams together to create web-based interactive profiles for Place Plan areas in Shropshire.

- **Place-Based Needs Assessment (PBNA)**

Profiles for Highley and Oswestry, the first of the "Wave 1" priority Place Plan areas have been produced. They have been developed concurrently with preliminary engagement in the respective areas, the results of which are being analysed and taken to local community events for engagement. The Oswestry profile had specific and additional content on measures relating to children and young people to aid focused work in this geography.

The work on high level profiles spanning a multitude of health and wellbeing outcomes and causal factors for the 18 Place Plan areas in Shropshire has begun, and we report to this HWBB meeting with the first of these profiles for Highley. This work integrates quantitative and qualitative data, for public health and clinical sources, but also citizens and stakeholders for Highley, asset mapping, and

focus themes relating to place-specific needs. These profiles will be used to inform local stakeholder group discussions around recommendations, next steps and system-wide ways to address these focus areas.

The first profile (attached as **Appendix A**) for Highley has been used to discuss with stakeholder the key issues facing citizens in the Highley area, with a view to creating an action plan to address the main themes or areas of focus. For Highley the areas of focus are:

- Children and Young People
- Mental Health and Social Isolation
- Access to Services
- Cost of Living

The notes from the stakeholder meeting and subsequent action plan will be produced in due course, with an ongoing dialogue and partnership approach to addressing the issues.

- **Web-Based Needs Assessment (WBNA)**

Substantial content has been added to WBNA. As well as the overview of key demographic data for Shropshire overall and (where available) its communities, a number of sections have been added taking a life-course approach focusing on particular cohorts and wider determinants of health. To date the following sections have been added:

Starting Right - conception, perinatal measures, and family environment/vulnerability at birth
School Years - educational attainment, provision, SEND, Free School meals (FSM)
Adult Wellbeing - currently predominantly behavioural measures; obesity, physical activity, drug and alcohol
Ageing Well – Health checks, outcomes associated with older populations
IMD – Deprivation indices
Cost of Living – Poverty, employment, benefits
Employment and Economy – Activity, occupations, qualifications, business health, earnings.
Quality of Life – Crime, measures of social fabric communities, franchise etc.

Further content and narrative sections have now been added, and the tool will "go live" shortly before the HWBB meeting where the Board will be given a demo of this live version of the JSNA.

- **Pharmaceutical Needs Assessment (PNA)**

This consultation period for the draft PNA closed on 30th September and the final PNA was published on 1st October. Any substantial changes to the provision or need for pharmacy services will be brought to the Board and supplementary publications to reflect said changes considered.

Summary of key milestones completed and forthcoming in Public Health Intelligence

October 2022 – Closure of consultation and publication of Pharmaceutical Needs Assessment.
October 2022 – Profiling to support Dental Programme Targeting.
October 2022 – Alignment of WBNA and PBNA through initial high-level profile for Highley Place Plan Area.
November 2022 – Refinement and initial publication of Web-Based Needs Assessment tool.
November 2022 – Production of Drug and Alcohol Needs Assessment (currently in review stage for publication this month).
December 2022 – First stages of APHR initial development.
Winter 2022 - Ongoing refinement, data acquisition and analysis in relation to Place Plan indices for Place-Based Needs Assessments.
February 2023 – Autism strategy evidence
Spring 2023 – Comprehensive Children and Young's People's Needs Assessment

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	A single, coordinated approach continues to be supported in the development of place-based profiles and needs assessments which in turn support place-based working. This will take time to develop and is intrinsically linked to the refresh of the HWB Strategy. Therefore, this report seeks agreement to the approach and ongoing work programme in terms of the development of a coordinated evidence base for the whole system, delivered under the JSNA umbrella.	
Financial implications (Any financial implications of note)		
Climate Change Appraisal as applicable		
Where else has the paper been presented?	**System Partnership Boards**	
	Voluntary Sector	
	Other	
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)		
Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130) Cllr. Simon P Jones, Portfolio holder for Adult Social Care and Public Health		
Appendices Highley Profile Presentation.pdf (Link to Web-Based JSNA to be provided on publication).		

This page is intentionally left blank

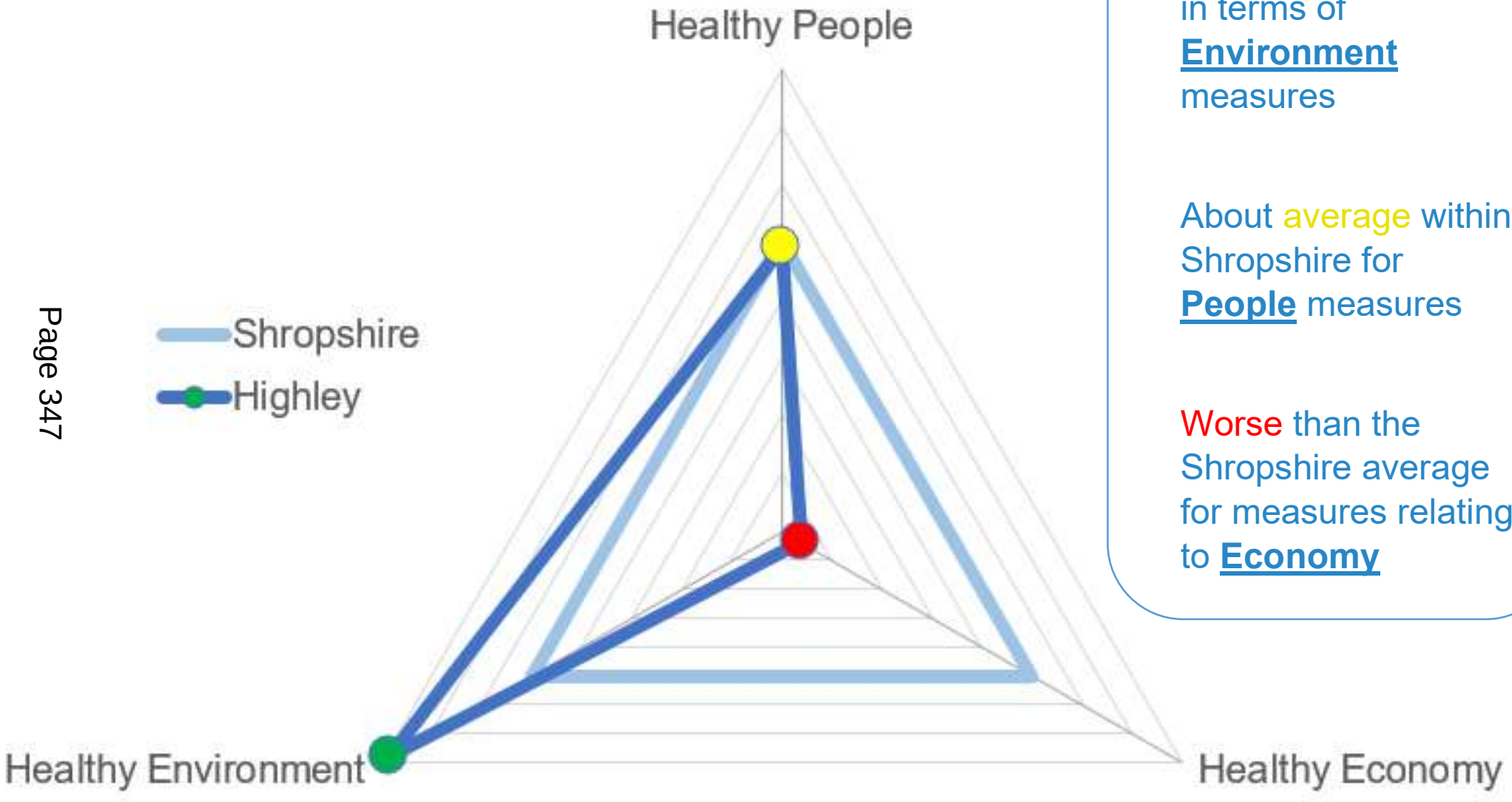
Shropshire Council

Highley Place Plan Area

Highley Key Facts

- Highley is in the Southeast of Shropshire and is one of the smallest communities in terms of area at under 2,000 hectares and in terms of a population of around 4,400 citizens. Despite this, Highley actually has a population density of 2.2 persons per hectare – only the Shrewsbury place plan area has a higher ratio.
- Between 2001 and 2020, the population grew by 15.6%. The average age of residents is 46.
- In the 2020 population estimates, 16.9% of Highley PPA were aged 0-15, compared to 17.5% in Shropshire, whilst 27.5% of Highley PPA were aged 65+, which is higher than the 25% in Shropshire, compared to the 55.6% who are aged 16-64 (58.7% in Shropshire).This gives a ratio of 0.8 in Highley for those dependent (0-15 and 65+) on those considered independent (16-64) and this is above Shropshire (0.7).
- Based on data between 2013 and 2017, Highley has the lowest life expectancy for both males (78.7) and females (82.6) of the 18 place plan areas, compared to Shropshire (80.5 and 84.1 respectively)
- Of the 18 place plan areas, Highley has the 7th highest overall deprivation score,
- According to Household income data for 2020, Highley has a significantly higher percentage of households in the lower income bands (up to £30,000) compared to both Shropshire and England. The data also shows that Highley has the lowest median gross household income levels and median affordability ratios.
- Between 2001 and 2019, there were 900 births in the Highley place plan area.
- While the majority of Highley place plan area's residents are registered at the Highley Medical Practice (56%), there are a large number who are registered practices that are based in other place plan areas. For this reason a calculation was devised to aggregate out practice based information to place plan areas.

Highley Health and Wellbeing Index Overview



Better than the Shropshire average in terms of **Environment** measures

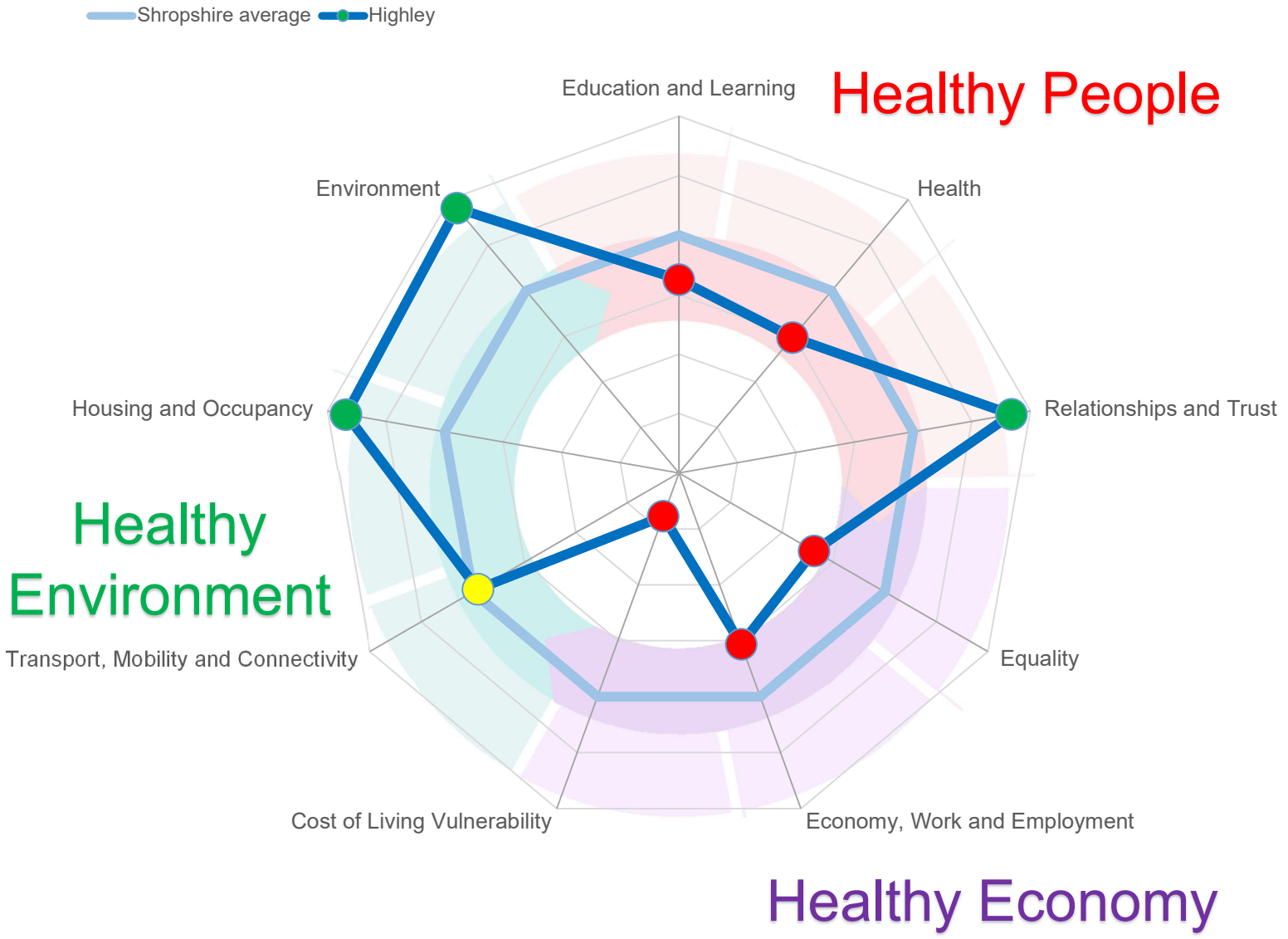
About average within Shropshire for **People** measures

Worse than the Shropshire average for measures relating to **Economy**

This graph provides more detail to the previous slide.

This shows where Highley is stronger or weaker in terms of specific themes within the high level categories.

For example, whilst overall Highley is around average for measures of Healthy People, it is weaker specifically in terms of **education and learning**, and **health**, and stronger in measures of **relationships and trust**.



Highley Health and Wellbeing Index Detail

Rank of Highley compared to Shropshire's 18 Place Plan Areas (1 = best, 18 = worst)

Healthy People	Healthy Economy	Healthy Environment
11 Education and Learning	17 Equality	9 Transport, Mobility and Connectivity
15 Health	13 Economy, Work and Employment	2 Housing and Occupancy
2 Relationships and Trust	18 Cost of Living Vulnerability	5 Environment

Top Strengths:

Housing and Occupancy
e.g. Affordability

Relationships and Trust
e.g Crime Rate

Environment
e.g Air Quality

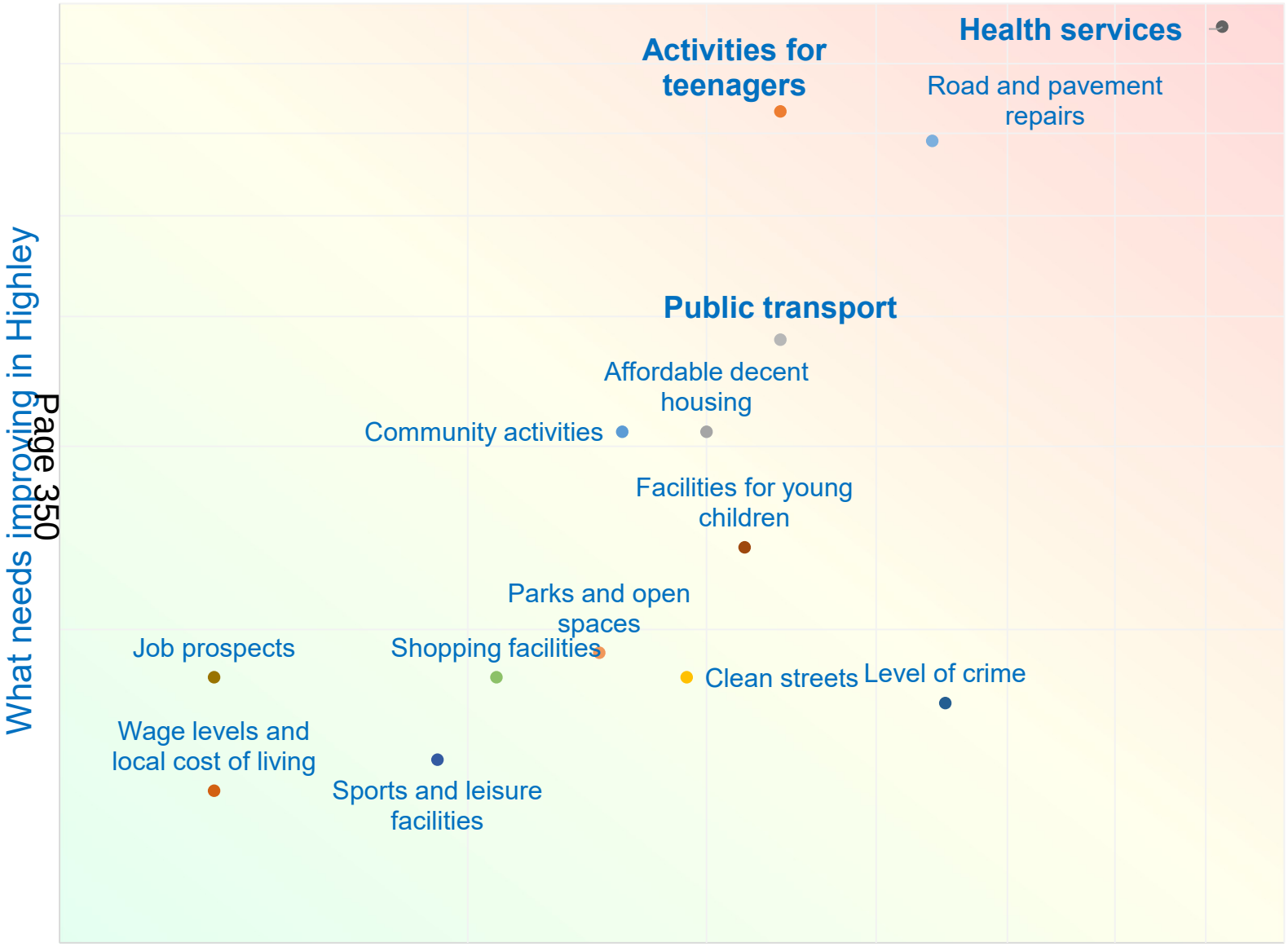
Top Challenges:

Cost of Living Vulnerability
e.g. Fuel Poverty

Equality
e.g Ratio in earning of top/botto 10%

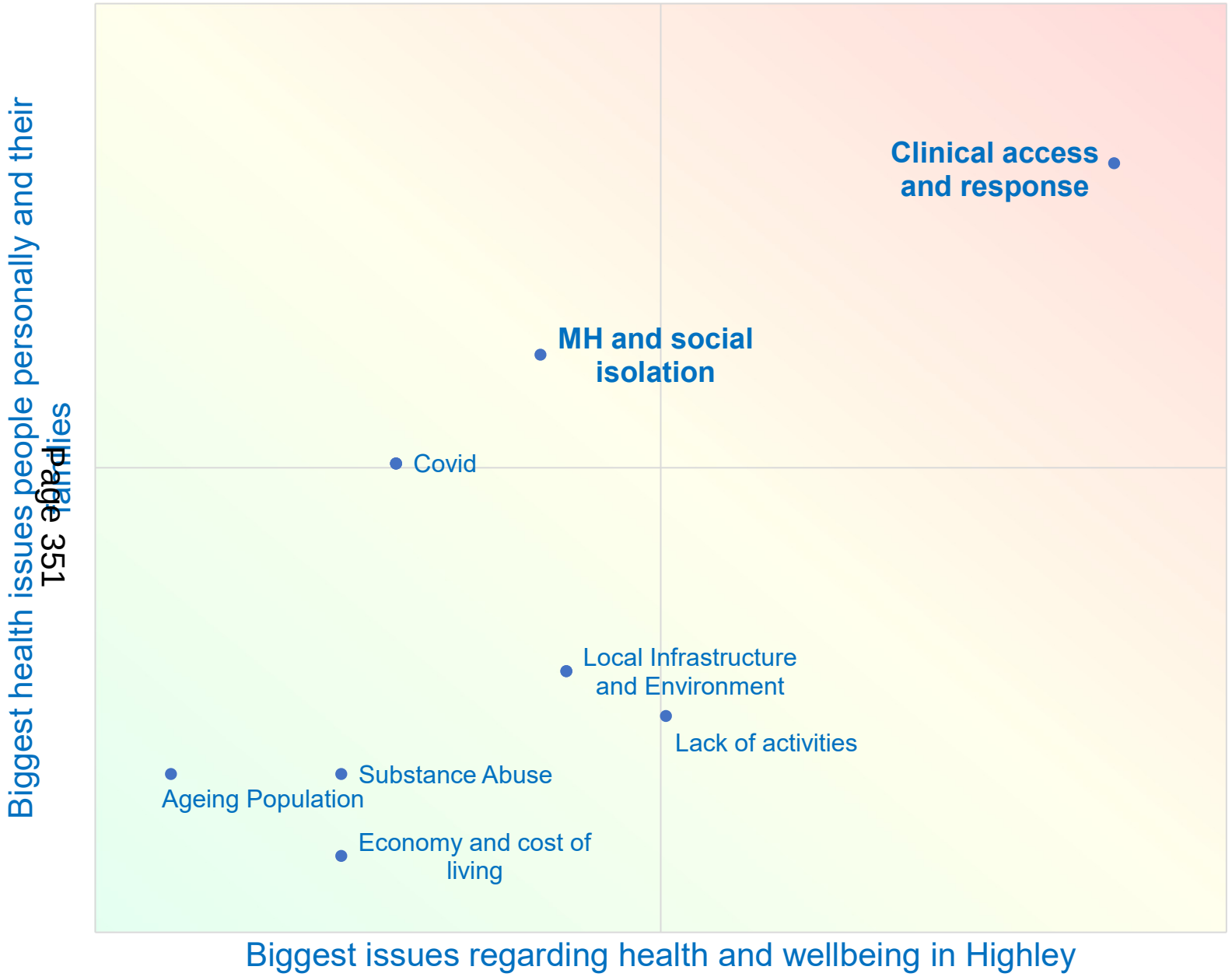
Health
e.g. Life Expectancy

What makes a good place to live vs What needs improving in Highley



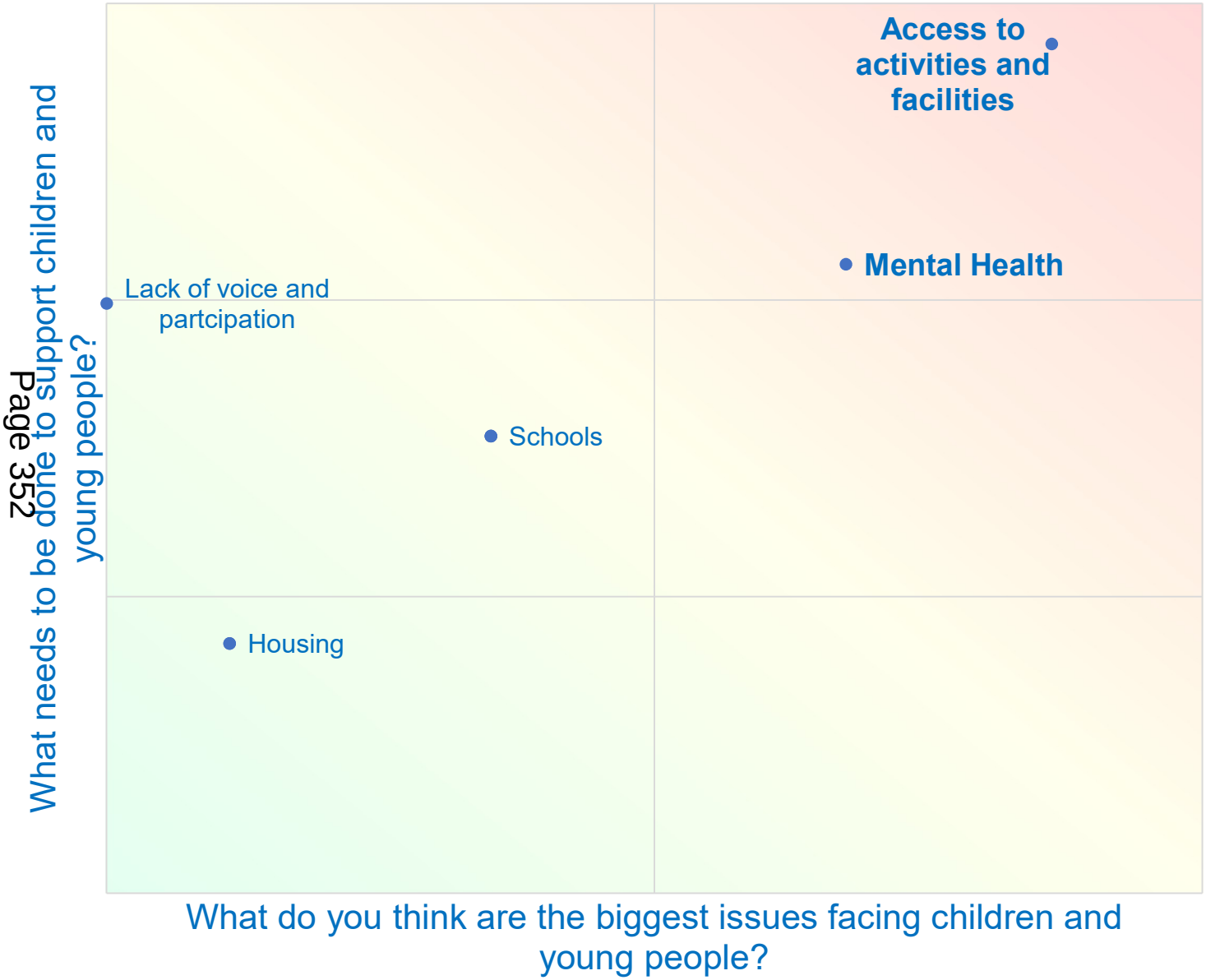
HIGHLEY FOCUS THEMES IN **BOLD**

Biggest health and wellbeing issues – Highley area vs personally and for family



HIGHLEY FOCUS THEMES IN **BOLD**

Biggest issues facing Children and Young People vs What needs to be done



HIGHLEY FOCUS THEMES IN **BOLD**

Focus Theme 1 - Access to services and capacity

- The top theme of what is important to Highley residents in terms of making an area a good place to love in, and in term of what can be improved in Highley was “Health Services”.
- Also, overwhelmingly the consistent issue raised around needs at both a community and personal/family level was access to health services (GP & Specialist Care).
- Whilst Highley has above average geographical access to a GP via public transport/walking, cycling and car, it has below average access to a major town centre, with associated limitation in terms of employment and shopping (something mentioned as a characteristic of a “good place to live” by Highley survey respondents).
- While the majority of Highley place plan area’s residents are registered at the Highley Medical Practice (56%), there are a large number who are registered practices that are based in other place plan areas.

“Many patients go to Cleobury. The main hubs for Highley residents are Bridgenorth and Kidderminster due to where children and young people attend school.”

– the Place Plan Team

“Health services should come first; particularly the capacity of the system in Highley.

Shrewsbury is 20 mile away and there is no direct service to this location – Highley is served by Diamond Buses which are based in the West Midlands – it is easier for residents to travel out of the county than it is to travel within Shropshire for healthcare, education and employment.”

- Cllr Williams

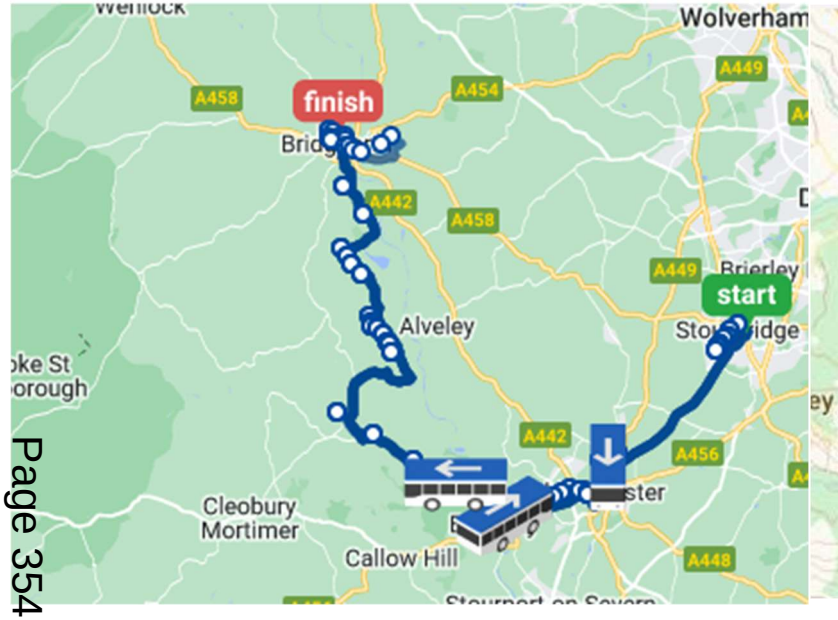
“Access to Emergency services when needed needs improvement.”

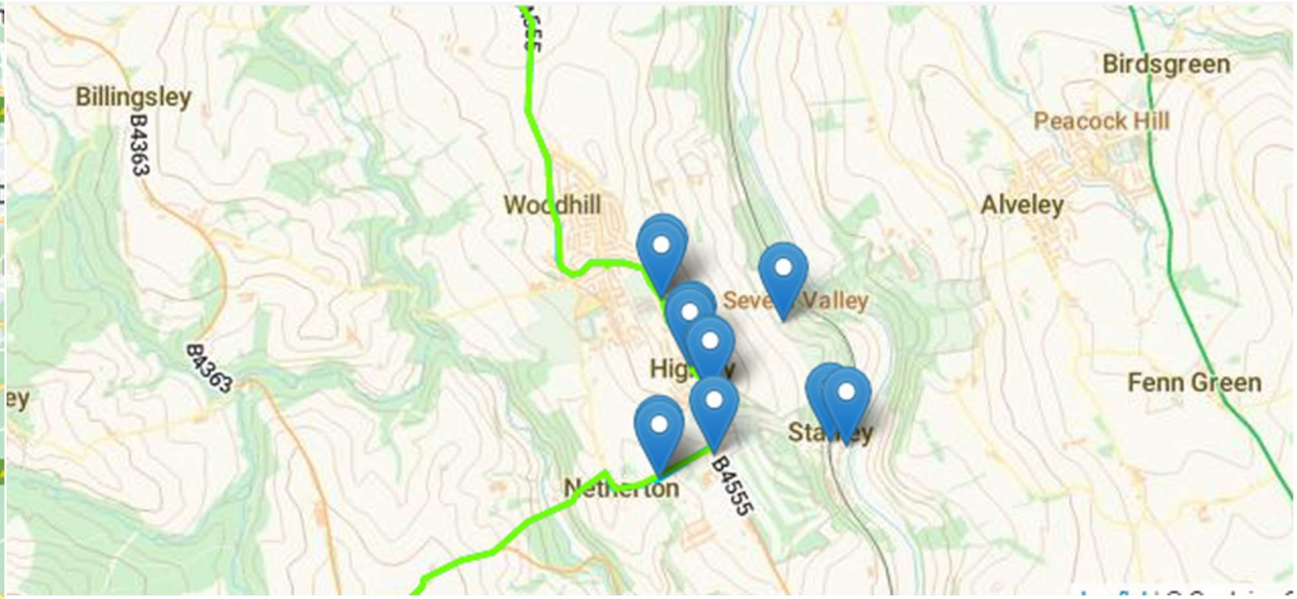
“Doctors’ surgery with adequate parking“

"Believe we could do with a larger Doctor's surgery as the village has grown so big and the one we have does not suffice "

"The surgery is too small for the village with poor access for wheelchair users, other nearby practices will not take on Highley residents."

- Highley has one bus route, the 125, which goes between Bridgnorth and Stourbridge. This is about an hourly service, finishing at 6.30pm.





Monday to Friday

Stourbridge to Bridgnorth

Show all stops

Stourbridge Interchange (Stand A)		08:05	09:10		15:10	16:20	17:20	18:25
Broadwaters Drive (adj)		08:23	09:25		15:25	16:35	17:35	18:40
Kidderminster Bus Station (Stand 6)		08:33	09:35		15:35	16:45	17:45	18:50
	07:27	08:37	09:37		15:37	16:47	17:47	
Kidderminster, adj General Hospital	07:34	08:44	09:44		15:44	16:54	17:54	
Bewdley Load Street (Westbound)	06:30	07:45	08:55	09:55	15:55	17:05	18:05	
Buttonoak, adj Wyre Cottage	06:36	07:51	09:01	10:01	16:01	17:11	18:11	
Kinlet, adj Hall	06:43	07:58	09:08	10:08	then hourly until	16:08	17:18	18:18
Highley, adj Bache Arms	06:53	08:08	09:18	10:18		16:18	17:28	18:28

Bridgnorth to Stourbridge

Show all stops

Stanmore Industrial Estate (adj)	07:24							
High Town, adj Sainsbury's		08:40			14:40	15:45	16:45	18:05
Low Town, adj Falcon Hotel	07:32							
Eardington, adj Post Office	07:37	08:49			14:49	15:50	16:50	18:10
Chelmarsh, adj Church	07:42	08:54			14:54	15:55	16:55	18:15
Woodhill, opp Castle Inn	07:47	08:58			14:58	16:00	17:00	18:20
Highley, opp Bache Arms	07:51	09:01			15:01	16:04	17:04	18:24
Kinlet, adj Eagle & Serpent Inn	08:01	09:11	then hourly until		15:11	16:14	17:14	18:34

Focus Theme 2 – Mental Health

- The next highest issue in Highley was Mental Health, at both community and personal level.y
- In our engagement survey mental health was mentioned as one of the top 3 issues raised by respondents. The other 2 were social media influence and lack of groups and things to do, themselves being upstream factors for mental health issues.
- Highley has a prevalence rate for depression amongst over 18's of 15.8% - the 4th highest of communities in Shropshire and significantly higher than the county average.

"Social Media issues and Mental Health for C&YP go hand in hand – many YP's mental health is impacted by their engagement with social media, however they are more likely to become dependent on social media if the provision of alternative activities is inadequate."

- *Cllr Williams*

"For the past 2 years the school has bought into external services that offer mental health help & advice and can fast track some issues to be able to access specialist services. We also have a trained mental health lead that deals with low level mental health issues. We feel that this is very important, especially in the teaching sector where stress is the highest factor for absence."

- *Highley Primary School*

"WMP are aware of the increased need to support our community with MH related issues and are aware that this demand puts a strain on agencies in Shropshire."

- *Highley Safer Neighbourhood Team*

Focus Theme 3 – Children and Young People

- The second highest theme when citizens where asked where Highley can improve “Activities for Teenagers”

Areas of concern were split into some key themes

Lack of groups & things to do

- Overwhelming response identified a need for more affordable activities.
- Whilst 64% of respondents do not face challenges to being active in their daily life, Highley Primary School said that “Children need to get outside more, but there needs to be activities & facilities available to them to allow this”.

> *“We have a big leisure centre that isn't used to its full potential. After school clubs could be held here in the same way the nursery walks the kids round for after school club. More clubs could be offered to school children and they could work closer with the school”*
>
> *“Teenage boredom can lead to disruptive behaviour… …though those responsible are a very small minority. Highley lacks safe places for young people to relax, be themselves and just hang out”*
>
> - *Cllr Williams*

Improving Public Transport

- Highley has the 3rd highest average journey time (19.5 minutes) to a primary school in Shropshire and the 4th highest (36.5 minutes) to a secondary school.

> *“The main hubs for Highley residents are Bridgenorth and Kidderminster due to where C&YP attend school”*
>
> - *The Place Plan Team*

Social Media Influence and Mental Health

“Youth ASB issues can be perceived issues, based on the mere presence of youths rather than their behaviour.”

- *Highley Safer Neighbourhood Team*

“Services for young children are overwhelmed and it is difficult to get immediate advice. Waiting lists are getting longer & longer & therefore the children & parents are not getting the help they need.”

- *Highley primary School, regarding Mental Health*

"There is a lack of parenting and family support, with little Health Visitor time and no support for the Children's Centre initiative"

“(we need) Help and guidance towards children’s stages of developments to prevent issues. Who to go to for help in different situations."

“More training for teachers and official councils and government staff is needed in all aspects of mental health and physical disabilities to help them understand and to give dignity in all aspects of everyday life"

Opportunities for engagement

Focus Theme 4 - Cost of Living

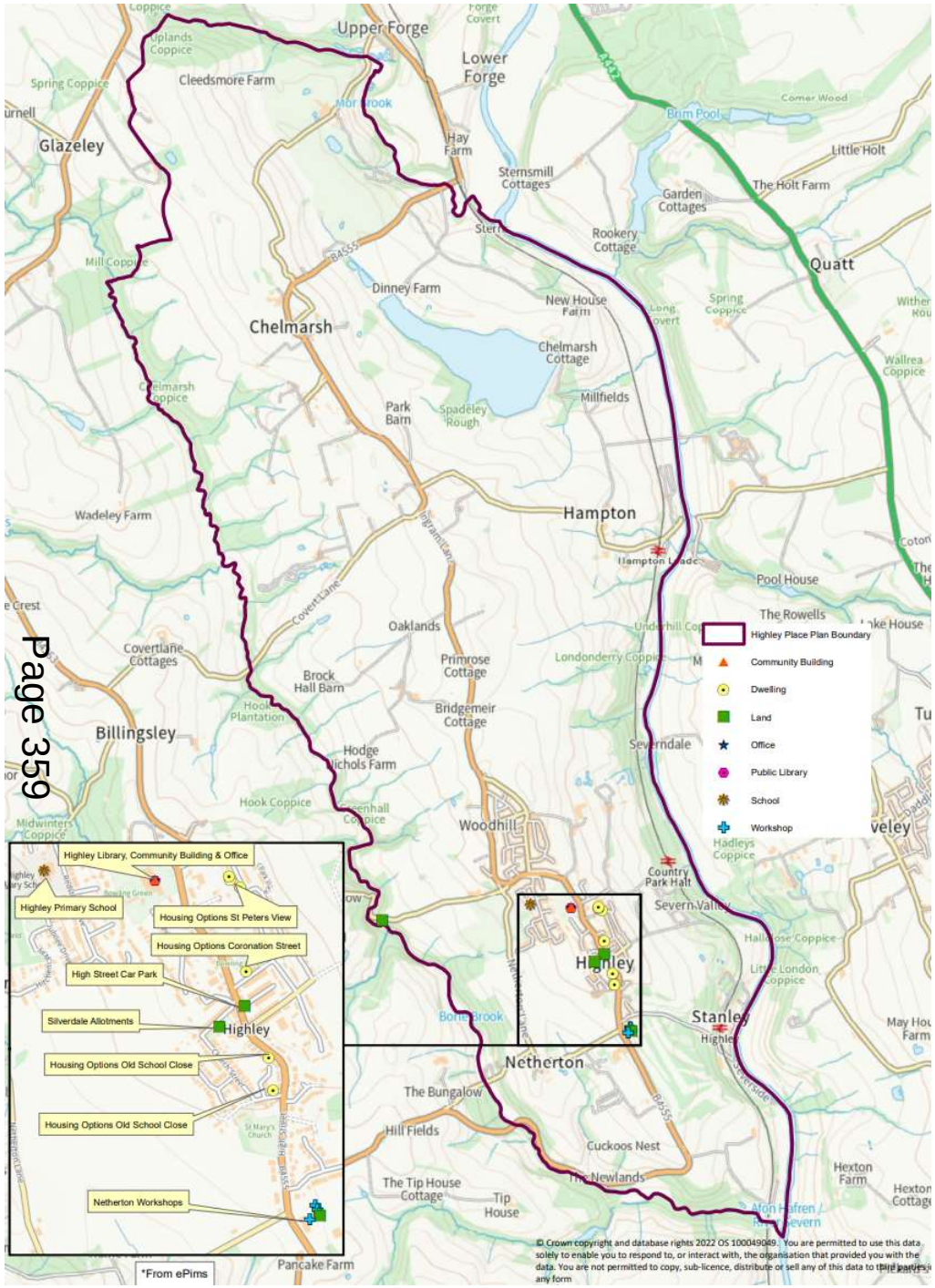
- Highley has the lowest median and lower-quartile household income level of all Shropshire's communities (£29,679 and £17,186 respectively).
- The community also has the highest proportionate claimant in Shropshire, with 4.8% in receipt of benefits principally for the reason of being unemployed, based on administrative data from the benefits system. This is primarily Jobseeker's Allowance but will also include certain Universal Credit claimants as the new benefit is introduced.
- Highley has the 5th highest proportions of households who are fuel poor, based upon data from the Department for Business, Energy and Industrial Strategy. These are households with an energy efficiency rating of D or lower and who are left with an income below the poverty line after spending the amount required to heat their home.
- Highley has the highest proportion of its children and the second highest proportion of its older people in income deprivation.
- Whilst our engagement work showed little difficulty for people eating healthily, local pressures in terms of access to cheaper food and special dietary requirements maybe compounded by cost of living pressures – in our survey the overwhelming reasons for not eating healthily were access and lack of choice, and cost.

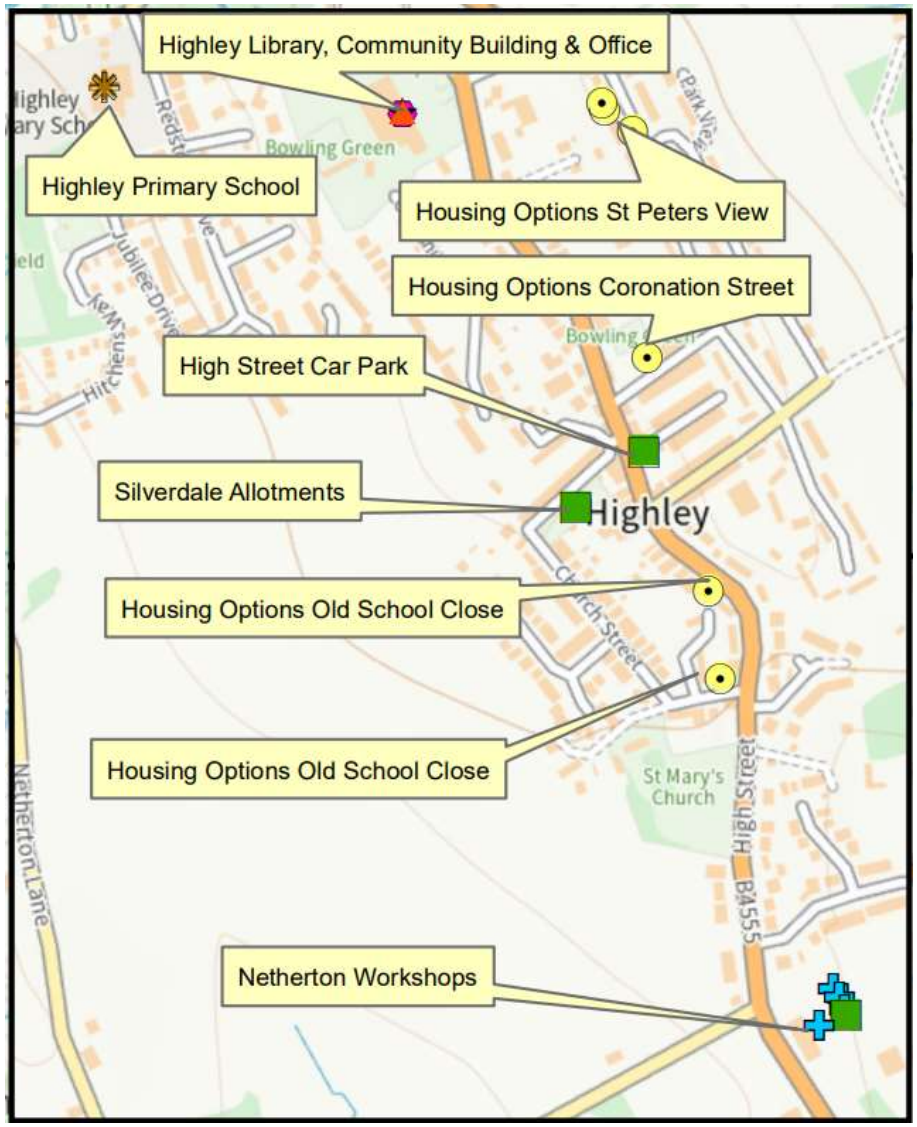
"Being vegan, I have to travel all the time to buy my supplies "

"Cost of healthy food has always been far too expensive. Junk food has been cheap and easily accessible for low-income families "

"Fruit goes off quickly, easier to purchase the not so healthy items that keep longer"

HIGHLEY ASSET MAP





NEXT STEPS……

SHROPSHIRE HEALTH AND WELLBEING BOARD **Cover Sheet for submissions**				
Meeting Date	**17th November 2022**			
Title of Paper	**Health Protection Report**			
Reporting Officer	**Susan Lloyd, Consultant in Public Health** **Report Author Anne-Marie Speke Health Protection Cell Operational Lead**			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People	X	Joined up working	X
	Mental Health		Improving Population Health	X
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	
	Workforce		Reduce inequalities (see below)	X
What inequalities does this paper address?	**Health inequalities specific to screening and vaccination.**			
Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	The report identifies risks to the population health groups if vaccination rates remain below target, and identifies measures being taken to mitigate this.			
Financial implications (Any financial implications of note)	**There are no financial implications**			
Climate Change Appraisal as applicable	**Not applicable**			
Where else has the paper been presented?	**System Partnership Boards**			
	Voluntary Sector			
	Other		**Health Protection Assurance Board**	
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)				
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130) Cllr Simon Jones Portfolio holder for Adult Social Care and Public Health Rachel Robinson – Executive Director, Health, Wellbeing and Prevention				
Appendices Appendix 1 MMR Uptake January- March 2022				

Report to Health and Wellbeing Board - Health Protection Report

Recommendation: That the Board note the contents of this report

Introduction

This health protection report to the Health and Wellbeing Board provides an overview of the health protection status of the population of Shropshire. It provides an overview of the status of communicable, waterborne and foodborne disease.

Part one is an overview of health protection data and a summary of new risks, part two is an overview of new health protection developments relevant to the system.

Part one

Immunisation Cover Shropshire

Flu vaccination is being offered to eligible cohorts through a variety of settings including GP practices, pharmacies and maternity services. They are also available alongside Covid vaccinations in some clinics.

Shingles - uptake remains low. UKHSA have cascaded a toolkit to GP practices to try to increase uptake.

Childhood immunisations - these remain above the England average but are still below previous years figures for some immunisations. Communications are on-going to encourage uptake and utilising opportunities to promote these during contacts with families.

MMR Update

Following the implementation of the measles vaccine and the Measles, Mumps and Rubella (MMR) immunisation programme, the UK reached elimination status in 2016. However, since this time the number of children receiving two doses of MMR has declined and no longer meets elimination status requirements. The Covid-19 pandemic has led to a further decline in the number of parents and carers taking their children to receive the MMR vaccines. Furthermore, there are high numbers of children who have received just one dose of the MMR vaccine meaning they are only partially vaccinated against MMR. There is a call-to-action to encourage parents and carers to contact their GPs and make an appointment, where their child has missed their first or second vaccine. The England target for coverage of both MMR doses by the age of five years is 95%.

A full report was presented to the Health and Wellbeing Board in March 2022, where MMR % uptake data for Quarter 2 (2020-21) was discussed. Quarter 2 data identified that Shropshire were exceeding the England national average % overall uptake to the MMR vaccine at 91.2%, in comparison to 86.6% England average. The data identified that a small percentage of children had received MMR1 and not MMR2 by age 5, and the Board requested a review to the MMR action plan to explore how uptake of MMR2 could be increased.

The most recent available data for the period of January-March 2022 **(See appendix 1)** shows an increase in uptake to MMR1 and MMR2 which continue to exceed both regional and National averages. The % uptake at 5 years for MMR2 has increased during this period to 92.6%, however still falls below the England target of 95%.

Following presentation of the full report to the Health and Wellbeing Board, a meeting was held between Shropshire Council's Public Health and Primary Care management, where a number of actions have been agreed:

1. Shropshire Council's Public Health team are preparing a communications paper with the most recent data to be shared with Primary Care partners for information.

2. Assurances are being sought that recall letters are being sent out from General Practices to families who have not presented children for the MMR2.

3. Assurances have been sought that Shropshire's Health visiting service are providing parents with all of the Department of Health information about immunisations and revisit this discussion with those parents whose children have not had their immunisations at each of the key mandated healthy child contacts, currently: New birth visit, 6 – 8 week contact, 12 month development review and the 2 – 2.5 year development review.

4. A communications campaign took place in line with UK government national guidance and resources have been shared widely via Shropshire Council social media platforms and with all partners.

A national recall has also been put in place for children over the age of 5 who have received only one or no MMR vaccinations this commenced in September 2022.

Screening uptake Shropshire

Antenatal and Newborn screening has experienced some staffing challenges which has impacted on some screening. These are being addressed.

Breast screening- an action plan is in place to catch up on backlog of women to be screened. Some mobile screening units have been centralised to accelerate the catch-up programme.

All other screening programmes have now recovered.

Communicable disease

Flu - low and not beyond expected levels, we expect to see increasing numbers of cases as we move into autumn/winter.

Covid - recorded cases are decreasing in Shropshire. Outbreaks are still occurring in care homes and are being risk managed. The numbers of outbreaks had increased over the last two months, and this has created some issues in relation to bed availability within the system, however, this is starting to improve. Asymptomatic testing was paused from August 31st 2022, and currently there is no indication as to whether this will be reinstated.

Covid variants of interest continue to emerge, the situation is being monitored by WHO and includes UK partners.

Tuberculosis - An initial cross ICS TB meeting took place in September 2022 to address local issues linked to the provision of TB services. To develop discussions a TB group will be set up and meet six monthly. Terms of reference have been developed for discussion at the next TB meeting.

Monkeypox (MPX) - Currently the pathway for Monkeypox testing remains via MPFT Sexual Health services, the tests are undertaken in Stafford. A triage call is made to all patients before they travel to Staffordshire to prevent unnecessary travel for residents. The number of new Monkeypox cases nationally appears to have plateaued, with only a small number of new cases being detected although these are still being monitored.

Pre-exposure vaccination pathways are in place and currently being offered to eligible groups through clinics in T&W.

Brucellosis - Brucellosis had been detected in a dog in Shropshire. The health protection team, the Animal Plant Health Authority and UK Health Security Agency have worked jointly to identify any additional cases, and this has now been completed.

Avian Influenza -There has now been a national alert in relation to Avian Infuenza. Mandatory housing measures for all poultry and captive birds are to be introduced to all areas of England from 00:01 on Monday 7 November: these were announced on Monday 31 October. The housing measures legally require all bird keepers to keep their birds indoors and to follow stringent biosecurity measures to help protect their flocks from the disease, regardless of type or size. Outbreaks have been detected in other authority areas including neighbouring authorities.

Foodborne and waterborne disease

Campylobacter - numbers remain largest reported foodborne bacteria. The number of cases has increased in Q2. This is expected and is normal.

Other foodborne and waterborne - case numbers remain low, with the exception of Salmonella. Salmonella cases have risen in the second quarter compared to 2020/21. Numbers of cases remain low.

Part two

Health Protection Developments

In July 2022 the draft Shropshire, Telford and Wrekin (STW) Health Protection Strategy 2022 – 2025 was circulated to Health Protection Assurance Board members, and to stakeholders. Following feedback this has been updated and a final draft is going to the Health Protection Assurance Board later in November. Once agreement and sign off is complete a published version will be available and will be shared with the HWB Board members.

In partnership and in response to learning from emergence of Monkeypox. A decision was made to propose a cross ICB rapid response infectious disease team. This will be stood up in response to emergent diseases in the system, as and when necessary.

Mass antiviral, antibiotic and testing pathways are currently being developed within the ICS to enable STW to respond to any outbreaks or emerging infectious diseases.

Appendices

Appendix 1 MMR Uptake

Quarter 1 (2022-23)

January to March 2022	**24m denominator**	**24m MMR1%**	**5y denominator**	**5y MMR1%**	**5y MMR2%**
Shropshire	649	95.8	780	97.2	92.6
West Midlands	15,833	90.1	17,895	93.8	86.0
England	147,510	89.7	162,668	93.5	85.9

This page is intentionally left blank

SHROPSHIRE HEALTH AND WELLBEING BOARD - Report				
Meeting Date	**17th November 2022**			
Title of Paper	Air Quality Update – November 2022			
Reporting Officer and email	Toby Pierce – Public Protection Officer (Professional), Environmental Protection, Toby.Pierce@shropshire.gov.uk			
Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People		Joined up working	X
	Mental Health		Improving Population Health	X
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	
	Workforce		Reduce inequalities (see below)	X
What inequalities does this paper address?	As detailed in Shropshire Health and Wellbeing Strategy 2022-27.			
Paper content - Please expand content under these headings or attach your report ensuring the three headings are included. Update report attached				
Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	Not Applicable			
Financial implications (Any financial implications of note)	Not Applicable			
Climate Change Appraisal as applicable	Not Applicable			
Where else has the paper been presented?	**System Partnership Boards**	N/A		
	Voluntary Sector	N/A		
	Other	N/A		
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)				
Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130) Cllr Simon Jones, Portfolio Holder for Adult Social Care and Public Health				
Appendices				

Air Quality Update – November 2022

Toby Pierce – Public Protection Officer (Professional)

Environmental Protection, Health, Wellbeing and Prevention Directorate

1. Executive Summary

Environmental Protection have completed and submitted Shropshire Council's 2022 Annual Status Report. Key findings are that both Air Quality Management Areas (AQMA's) in Shrewsbury and Bridgnorth centres are still required. Work continues to review Action Plans (previously referred to as the 2022 Air Quality Action Plan Review Project) for both locations in order to demonstrate how emission exceedances in these areas will be addressed.

2. Recommendations

Further updates to be provided at future Health and Wellbeing Board (HWBB) Meetings.

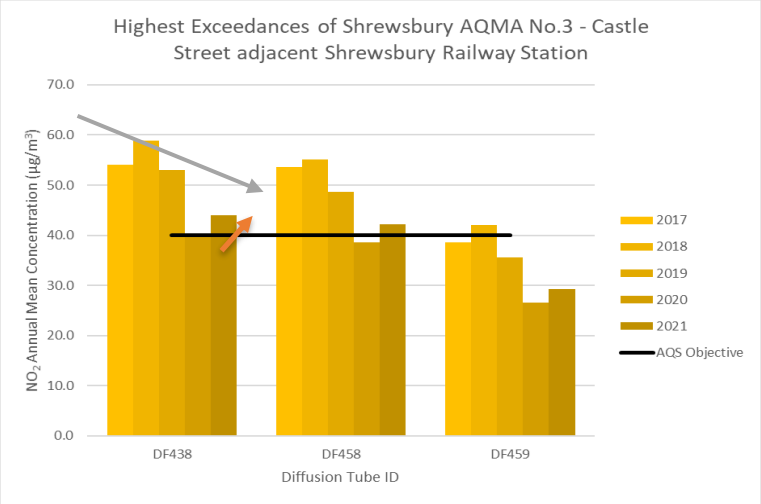
3. Report

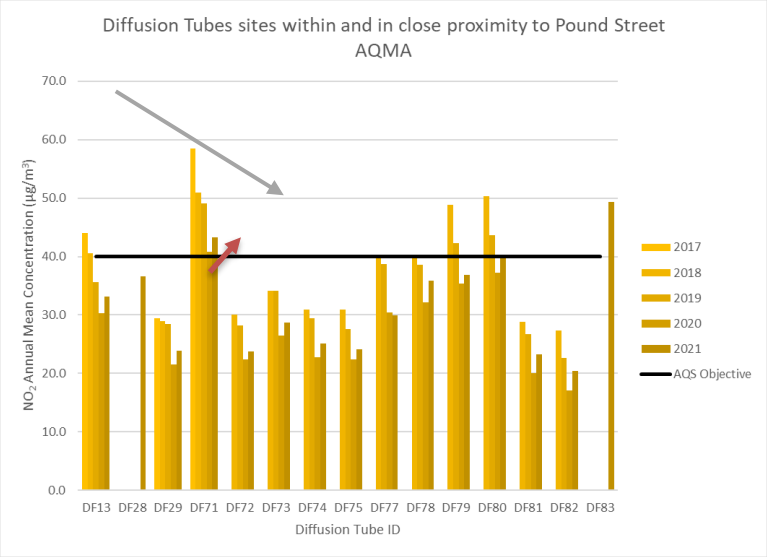
2022 Annual Status Report

Environmental Protection have completed and submitted Shropshire Council's 2022 Annual Status Report (ASR) which reports the work and monitoring undertaken in the 2021 year. The 2022 ASR details that overall trends for nitrogen dioxide (NO_2) appear to be falling, although clear trends are difficult to establish in light of the impact of Covid-19 pandemic on traffic levels and subsequent emissions in 2019/2020. It can be argued that there is an overall downward trend in accordance with national trends, as the public and commercial sector switch to cleaner vehicles such as electric and hybrid vehicles. It must be noted that throughout 2021, traffic was still 'recovering' from lockdown influences and are likely to have been altered by changes in working practices and transport choices i.e., reduced travel due to homeworking, increase in walking and cycling activity post-lockdowns.

2021 data, shown below in Figure A, for both Bridgnorth and Shrewsbury Air Quality Management Area's (AQMA's) show a return to exceedances of the Air Quality Standard (objective level) of 40ug/m^3 – demonstrating the ongoing need for the AQMA at each location. Overall trends have been indicated at one location per AQMA by a green arrow, and recent increases by a red arrow. Close attention shall be paid, through further monitoring, in coming years to assess whether post-pandemic traffic levels impact upon overall emission trends.

Figure A – 5-year trends for Shrewsbury and Bridgnorth AQMA's





No reference particulate monitoring is currently undertaken by the Council given that previous monitoring indicated ongoing trends well below current objective levels. The Council will continue to review available data and undertake further investigation where required.

Further detail and analysis can be found within the full 2022 ASR document which is published on Shropshire Councils website at https://www.shropshire.gov.uk/environmental-health/environmental-protection-and-prevention/air-quality/shropshire-council-air-quality-reports/. The ASR has been submitted to Department of the Environment, Food and Rural Affairs (DEFRA) for review and appraisal, as is required by legislation. Revised versions of the report may be generated, based on DEFRA's appraisal.

2022 Air Quality Action Plan Review Project

The Council's appointed contractor Bureau Veritas are undertaking baseline computer modelling for each AQMA to model the likely concentrations, sources, and movement of emissions at each location. Next steps will be to identify, assess and model a range of interventions that are likely to lead to a reduction in emissions.

Environmental Protection are in discussion with internal colleagues within Highways and Active Travel teams to maximize joint-working and shared agendas in this work. The project continues to be overseen by the internal Air Quality Steering Group with involvement from external stakeholders, and further updates will be provided to the HWBB as the project progresses.