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Shropshire Council

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

Date: 11 September 2024

Committee:
Health and Wellbeing Board

Date:	**Thursday, 19 September 2024**
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

Kirstie Hurst-Knight – PFH Children & Education
Cecelia Motley – PFH Adult Social Care and Public Health (Co-Chair)
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention
Tanya Miles – Executive Director for People
Laura Fisher – Housing Services Manager, Shropshire Council
Simon Whitehouse – ICB Chief Executive Officer, NHS Shropshire, Telford and Wrekin (Co-Chair)
Claire Parker – Director of Partnerships, NHS Shropshire, Telford and Wrekin
Patricia Davies - Chief Executive, Shropshire Community Health Trust
Ben Hollands – Health and Wellbeing Strategy Implementation Manager, MPFT
Nigel Lee - Director of Strategy & Partnerships SATH and Chief Strategy Officer NHS STW (ICB)
Paul Kavanagh-Fields – Chief Nurse and Patient Safety Officer, RJAH
Nick Henry – Paramedic & Patient Safety Director WMAS
Lynn Cawley - Chief Officer, Shropshire Healthwatch
Jackie Jeffrey - VCSA
David Crosby - Chief Officer, Partners in Care
Stuart Bill - Superintendent, West Mercia Police

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 - 6)

To confirm as a correct record the minutes of the meeting held on 16 July 2024 (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 12noon on Friday 13 September 2024.

5 **Suicide Prevention Strategy Update** (Pages 7 - 16)

Gordon Kochane, Public Health Consultant, Shropshire Council

6 **Inequalities Plan, Progress update** (Pages 17 - 28)

Mel France, Public Health Principal, Integration & Health Inequalities, Shropshire Council
Tracey Jones, Head of Health Inequalities, STW ICB

7 **Rural Proofing - approval and progress** (Pages 29 - 58)

Cllr Heather Kidd, Chair of Rural Proofing in Health and Care Task and Finish Group, Shropshire Council
Cllr Geoff Elner, Chair of Health Overview and Scrutiny Committee, Shropshire

Council

8 **CYP JSNA update** (Pages 59 - 308)

Jess Edwards, Public Health Intelligence Manager, Shropshire Council

9 **Cost of Living Dashboard update** (Pages 309 - 312)

Jess Edwards, Public Health Intelligence Manager, Shropshire Council

10 **ICP Dashboard update** (Pages 313 - 326)

Jess Edwards, Public Health Intelligence Manager, Shropshire Council

11 **Women's Health Hub Progress report** (Pages 327 - 340)

Naomi Roche, Public Health Principal - Healthy Population Lead & Women's Health Hubs Lead, Shropshire Council

12 **Chairman's Report**

Cllr Cecilia Motley, Portfolio Holder for Adult Social Care and Public Health, Shropshire Council

13 **ShIPP Update** (Pages 341 - 344)

Penny Bason, Head of Joint Partnerships, STW ICB & Shropshire Council

Committee and Date

Health and Wellbeing Board

19th September 2024

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 16 JULY 2024
9.30 - 11.23 AM

Responsible Officer: **Shelley Davies**
Email: **shelley.davies@shropshire.gov.uk** **Tel:** **01743 257718**

Present
Councillor Cecilia Motley – PFH Adult Social Care and Public Health (Co-Chair)
Rachel Robinson - Executive Director of Health, Wellbeing and Prevention, Shropshire Council
Claire Parker - Director of Strategy & Development, NHS Shropshire, Telford and Wrekin
Nigel Lee - Director of Strategy & Partnership SaTH/Chief Strategy Officer, STW ICB
David Crosby - Chief Officer, Shropshire Partners in Care (Remote)
Ben Holland – Health and Wellbeing Strategy Implementation Manager, MPFT (Remote)

1 **Apologies for Absence and Substitutions**

Apologies had been received from:

Simon Whitehouse – ICB Chief Executive Officer, NHS Shropshire, Telford & Wrekin (Co-Chair)
Lynn Cawley - Chief Officer, Shropshire Healthwatch
Patricia Davies, Chief Executive, Shropshire Community Health NHS Trust
Laura Fisher - Housing Services Manager, Shropshire Council
Kirstie Hurst-Knight – PFH Children & Education, Shropshire Council
Jackie Jeffrey - Chief Officer, Citizens Advice, Shropshire
Tanya Miles – Executive Director for People, Shropshire Council

2 **Disclosable Interests**

None received.

3 **Minutes of the previous meeting**

RESOLVED:

That the minutes of the previous meeting held on 18 April 2024 by agreed and signed by the Chairman as a correct record.

4 **Public Question Time**

None received.

5 Shropshire Integrated Place Partnership Strategic Plan & Local Care Neighbourhood Working Update

Members received a report and presentation from Penny Bason, Head of Joint Partnerships, STW ICB & Shropshire Council and Claire Parker, Director of Strategy & Development, NHS Shropshire, Telford and Wrekin which provided an update on Shropshire's Integrated Place Partnership Strategic Plan and Local Care Neighbourhood Working.

Rachel Robinson, Executive Director of Health, Wellbeing and Prevention thanked all involved in this work on behalf of the Health and Wellbeing Board and stressed that the alignment of services was key to ensure resources were best used for communities. She noted that the next stage was to consider how best to share this work more widely.

In response to queries regarding the promotion of the work Claire Parker agreed with the suggestions made to do this through Parish Councils or WI meetings to ensure rural areas were included. Penny Bason added that a comprehensive communication plan was in progress and explained that the work would complement the Making Every Contact Count (MECC) programme.

In response to suggestions the Chairman agreed that the item be brought back to a future meeting and be promoted outside of Shropshire.

After further discussion it was **RESOLVED:**

1) That the progress of ShIPP in 2023/24 be noted;
2) That the ShIPP Strategic Plan for 2024/25 be approved;
3) That the system descriptor pack for Local Care be noted; and
4) That the communications plan includes promotion of the work outside of Shropshire.

6 Primary Care Update

Members received a report and presentation from Nicola Williams, Associate Director of Primary Care, NHS Shropshire Telford & Wrekin which provided an update on Primary Care including Community Pharmacy, Dentistry and Optometry.

Nicola Williams outlined the expansion of primary care services to enhance patient care and access and noted the efforts to improve appointment accessibility through digital telephony systems and online consultations. Preventative Programs such as Pharmacy First which allow pharmacists to prescribe medications for common conditions were highlighted.

In response to questions Nicola Williams explained that the service was trying to improve access to dentistry services to pre-covid levels and noted that she would be happy to link up with colleagues after the meeting in the relation to the following areas:

- Pharmacies
- Dental communication/education
- Dentistry Development session
- The promotion of sight loss training within the voluntary sector

RESOLVED:

That the Health and Wellbeing Board note the contents of the update.

7 Better Care Fund - End of Year Report

Members received a report from Laura Tyler, Assistant Director of Joint Commissioning, Adult Services, Shropshire Council & the Service Manager Commissioning & Governance, Shropshire Council which provided a summary of both the Better Care Fund End of year plan for 2023-24 and the Better Care Fund Annual plan for 2024-25.

Laura Tyler discussed the Better Care Fund's progress and future plans, emphasizing the importance of continued partnership and collaboration across the health and social care sectors to improve patient outcomes. It was noted that a number of workshops had been arranged which were aimed at reviewing the Better Care Fund and aligning it with system-wide health priorities and strategies. David Crosby requested an invite to the workshops.

RESOLVED:

That the Health and Wellbeing Board approve the Better Care Fund End of Year Report 2023-2024 and the Better Care Fund Annual plan 2024-25 in appendices 1 and 2.

8 Joint Strategic Needs Assessment

Members received a report from Jess Edwards, Public Health Intelligence Manager, Shropshire Council which gave an update on the Joint Strategic Needs Assessment (JSNA).

Jess Edwards highlighted the progress on the Joint Strategic Needs Assessment (JSNA), including the development of place-based JSNAs and the upcoming mental health needs assessment. It was noted that several place-based assessments had been published and others were underway.

Laura Tyler requested to be involved in the mental health needs assessment.

The Chairman felt that promotion of the JSNA process was important, Rachel Robinson agreed to look at this with colleagues from the Communications Team.

RESOLVED

That the Health and Wellbeing Board note the update to work programmes and timescales.

9 **Joint Forward Plan**

Members received a report from Claire Parker, Director of Strategy & Development, NHS Shropshire, Telford and Wrekin.

Claire Parker provided an update on the Joint Forward Plan, outlining the progress made and the alignment with the ICB's operating model for strategic healthcare planning. The alignment of the plan with broader healthcare strategies was emphasised and the commissioning intentions were detailed.

RESOLVED:

That the Health and Wellbeing Board note the contents of the report.

10 **Chairman's Report**

The Chairman read out the following statement:

As a health and wellbeing board, we naturally have a focus on the best interests and the health and wellbeing of our local communities, which lies at the very heart of what we do.

We are therefore mindful of the recent national coverage in Channel Four Dispatches programme on the Royal Shrewsbury Hospital, which came to light following the recent Care and Quality Commission's (CQC) report published in May on the area's two acute hospitals, the Royal Shrewsbury and Princess Royal in Telford.

As a board we recognise the serious concerns and issues these have raised among our communities.

We want to acknowledge this, and I know the concerns raised following the media attention and the publication of the CQC report will be examined at the next Joint Health Overview Scrutiny Committee (JHoSC) where the committee members will meet with our health colleagues to review the challenges and actions required to improve patient care and outcomes.

As a board we will monitor these discussions and will review and support the work undertaken by SaTH and as a system, to help improve the outcomes for our patients.

11 **ShIPP Update**

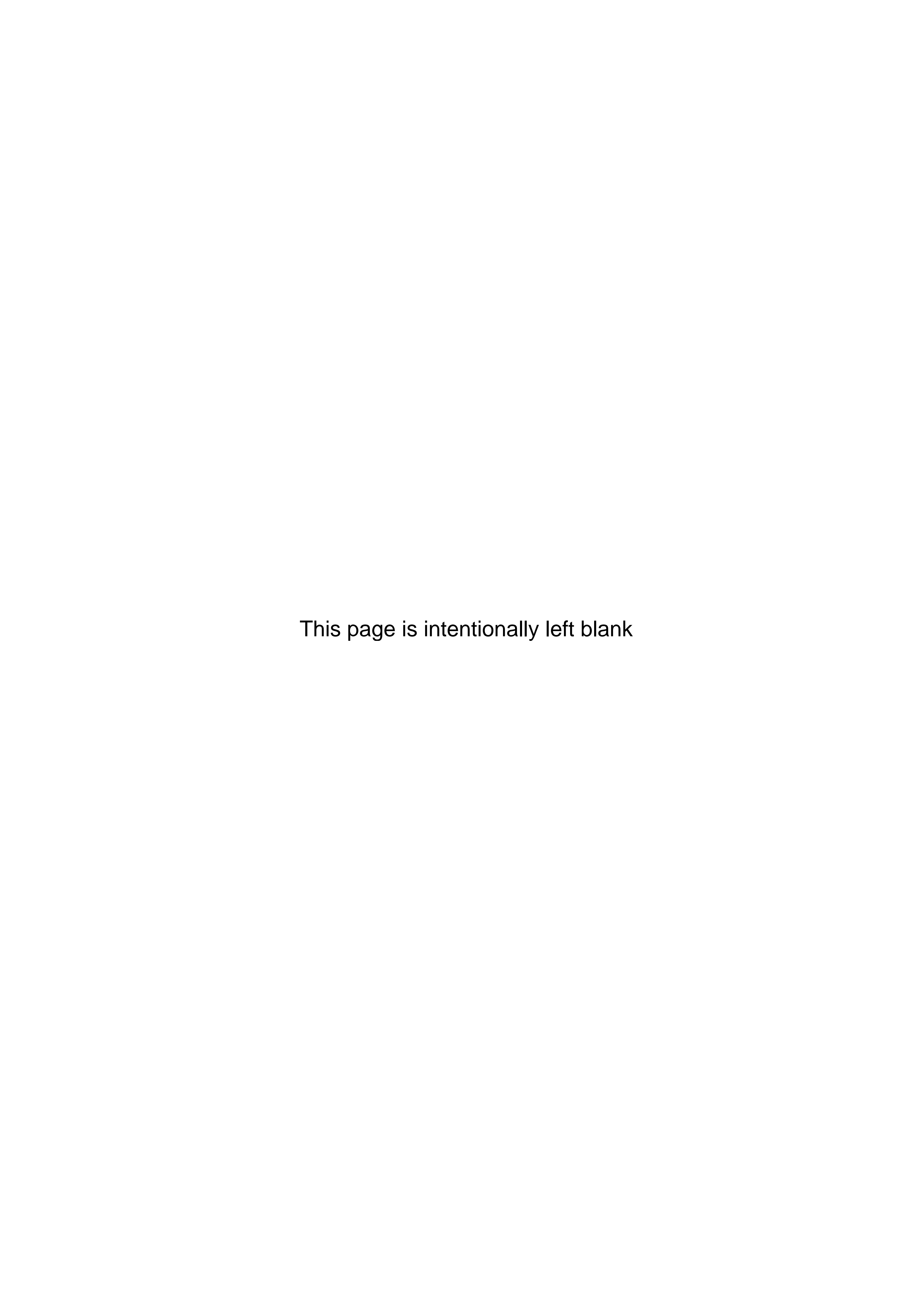
Members had before them a report which gave an update on the work of ShIPP.

RESOLVED:

That the Health and Wellbeing Board note the contents of the report.

Signed ………………………………………………………… (Chair)

Date: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SHROPSHIRE HEALTH AND WELLBEING BOARD Report							
Meeting Date	**19th September 2024**						
Title of report	**Shropshire Suicide Prevention Update**						
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendation s (With discussion by exception)		Information only (No recommendations)		
Reporting Officer & email	Gordon Kochane Gordon.kochane@shropshire.gov.uk						
Which Joint Health & Wellbeing Strategy priorities does this report 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 report address?	People at greater risk of suicide and those who have been impacted or bereaved by suicide.						

1.0 Executive Summary

1.1 Purpose

To update the HWBB on the local response to the recently published data indicating an increase in the local suicide rate and progress with delivery of the objectives within the Shropshire Suicide Prevention Strategy.

1.1.2 Latest Shropshire Suicide Rate and Response

Latest national data indicates the suicide rate for Shropshire has increased. During the reporting period 2020-2022 the Shropshire rate was higher than the England average. However, recently published data in September 2024 covering the period 2021-2023 indicates the Shropshire rate has reduced slightly and is now statistically similar to the England average rate. It is noted, that although the Shropshire suicide rate is no longer higher than the national average, the local rate of 12.8 per 100,000 population is still high compared to previous years and above many other local areas in the West Midlands region, so is therefore important suicide prevention continues to be a system priority.

Following the published suicide data for 2020-22 earlier this year which indicated an increase in the suicide rate, an exceptional meeting of the Action Group agreed a number of actions as an immediate response and focused around improving local knowledge around these deaths. Activities have included:

- An audit of Coroner inquest reports for suicide deaths during this period – to review patterns, trends or commonalities that may indicate differing circumstances for deaths during this period. This has been led by Public Health with key messages to follow.
- Progression with enhancing the local real time suspected suicide real time surveillance model – expanding the partners who contribute towards the system to record which services individuals accessed in the 12 months prior to death and to facilitate conversations on possible targeted earlier interventions. Partners have been trained and due to start contributing by September 2024 (following information sharing agreements being finalised).
- Recruitment of a data co-ordinator operating across Shropshire, Telford & Wrekin to support the above process.

- Escalation of progress to design a suicide death review panel utilising a similar methodology as the drug alcohol death review panel. A test and learn first panel is being planned prior to end of calendar year.

1.1.3 Updates and Progress with delivery of the Strategy

- Review of multi-agency Suicide Prevention Action Group to ensure the right representation from partners and review of priority action plans
- Confirmation to continue delivery of the suicide bereavement service across Shropshire, Telford & Wrekin. Working with Support After Suicide to evaluate the suicide bereavement service
- Establishment of two survivors of bereavement by suicide (SOBS) peer led support groups for adults impacted by suicide loss
- Continued delivery of subsidised and free to access suicide prevention training across the system
- Introduction of suicide risk awareness as part of the safeguarding session for taxi drivers applying for a taxi license
- Continuation of implementing dedicated workstreams for addressing needs for high-risk cohorts and integration with partners including (but not limited to) men, rural communities, substance use, domestic abuse, housing & homelessness, and military veterans
- Currently finalising a suicide prevention toolkit for GPs and Primary Care practitioners to support conversations where concerns of suicide are raised, including involvement of family and carers as well as support for professionals impacted by suicide or other traumatic events.

2.0 Recommendations (Not required for 'information only' reports)

That the Board

i. Considers endorsement of the activities presented within this update
ii. Contribute and support the continued delivery of the Suicide Prevention Strategy and evolution and delivery of the Action Plan
iii. Support the recommendation that system partners continue to prioritise suicide prevention actions and promote the workforce to access suicide prevention training to help contribute towards efforts in reducing local deaths
iv. Will receive regular updates on progress with suicide prevention activity

3.0 Report

3.1 Introduction

Every death by suicide is a tragedy for the individual, their families and friends, and for their local communities. Whilst there is much activity happening nationally to help prevent suicide, local action is critical to save lives and this requires strong multiagency groups, partnership working and excellent local leadership to develop and deliver robust suicide prevention plans specific and tailored for the local population.

In Shropshire, we believe that suicide is preventable; but it requires all of us to seek every opportunity to achieve this. A refreshed Suicide Prevention Strategy for Shropshire was launched in September 2023 with ambition to build upon the foundations laid by the previous strategy with recognition of new presenting challenges over the past years that can be associated with increased suicide risk (including impact of COVID, economic and social uncertainty related to world events and rising costs of living).

The agreed objectives from the 2023 Suicide Prevention Strategy are displayed in the following diagram.

Objectives

This strategy intends to reduce the number and rates of suicides across Shropshire through the following commitments;

Objective one

Improve the quality of data and intelligence on suicide and suicide risk, utilising tools such as Real Time Surveillance to better understand and respond to demographic need and emerging trends. Implement learning reviews and audits with partners to ensure recommendations are implemented.

Objective two

Improve the mental wellbeing and social outcomes for people bereaved by suicide through timely connection and support. This includes bereavement and practical support as well as ongoing opportunities to access postvention services as required. This will include review of the sustainability and evolution of existing models for long-term investment.

Objective three

Ensure that all professionals, partners and volunteers across Shropshire are suicide risk aware, and have the knowledge, skills and confidence appropriate to their role.

Objective four

Enhance the universal offers to mitigate suicide and self-harm risk to raise awareness of suicide. This builds upon the previous Strategy and involves close partnership with representatives from high risk cohorts to co-produce targeted offers and messages for suicide risk mitigation.

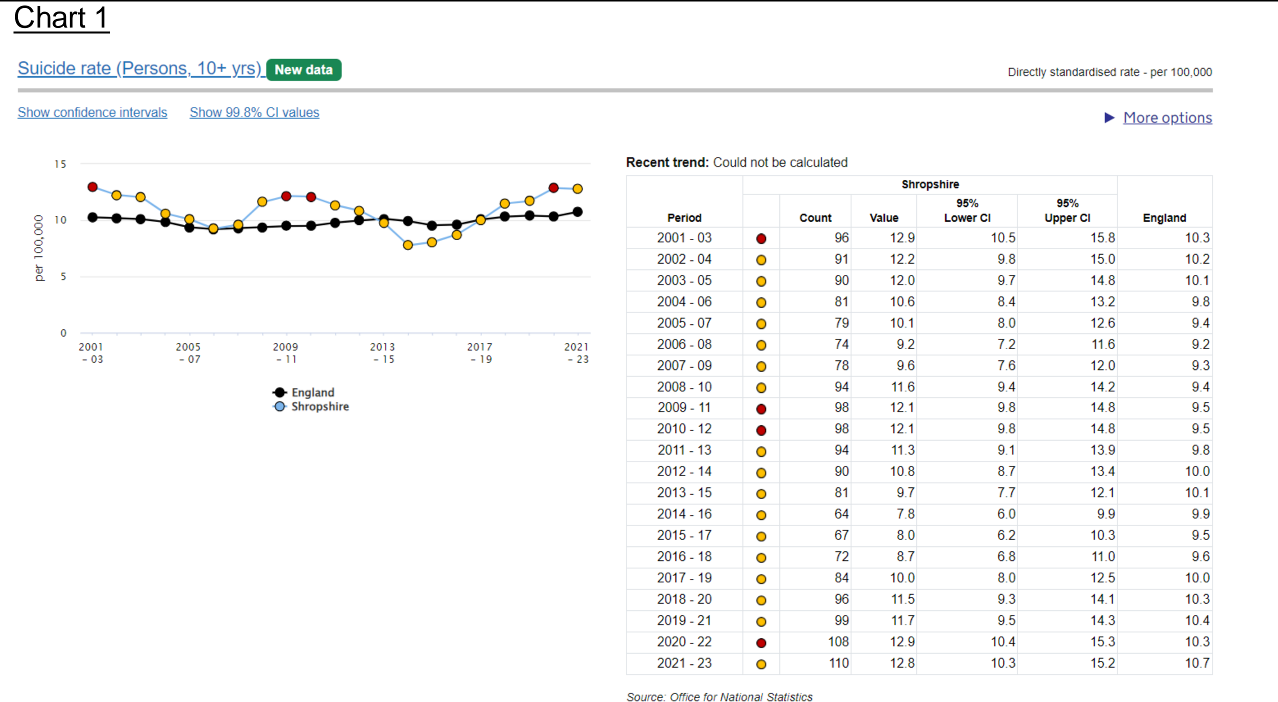
3.2 Data Intelligence and Latest Position

Data from the Office for Health Improvement and Disparities (OHID) covering the 3-year period 2020-2022, has identified an increase of the suicide rate for Shropshire. Although this moved Shropshire to having a higher than England average suicide rate, latest data published in September 2024 reports the rate has slightly reduced and is now considered statistically similar to the national average rate.

As is displayed in Chart 1 below, the rate of suicide in Shropshire for 2020-22 was 12.9 per 100,000, compared to the England average rate at 10.3 per 100,000. This related to 108 suicide deaths in this period and 9 additional suicide deaths compared to the previous reporting period. In 2021-23 the Shropshire suicide rate was 12.8 per 100,000 compared to the England average rate of 10.7 per 100,000. This related to 110 suicide deaths during this period and 2 additional suicide deaths compared to the previous reporting period.

It should be noted that statistical modelling has been used by OHID to take into account low numbers (as a small change in number can have a significant impact on rate).

Chart 1



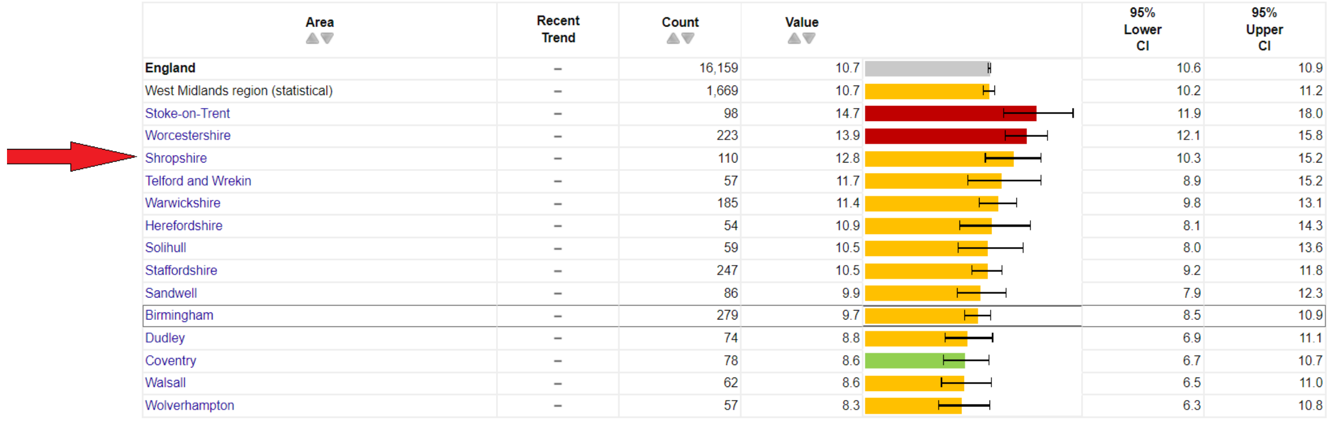
Recent trend: Could not be calculated

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	England
2001 - 03	●	96	12.9	10.5	15.8	10.3
2002 - 04	○	91	12.2	9.8	15.0	10.2
2003 - 05	○	90	12.0	9.7	14.8	10.1
2004 - 06	○	81	10.6	8.4	13.2	9.8
2005 - 07	○	79	10.1	8.0	12.6	9.4
2006 - 08	○	74	9.2	7.2	11.6	9.2
2007 - 09	○	78	9.6	7.6	12.0	9.3
2008 - 10	○	94	11.6	9.4	14.2	9.4
2009 - 11	●	98	12.1	9.8	14.8	9.5
2010 - 12	●	98	12.1	9.8	14.8	9.5
2011 - 13	○	94	11.3	9.1	13.9	9.8
2012 - 14	○	90	10.8	8.7	13.4	10.0
2013 - 15	○	81	9.7	7.7	12.1	10.1
2014 - 16	○	64	7.8	6.0	9.9	9.9
2015 - 17	○	67	8.0	6.2	10.3	9.5
2016 - 18	○	72	8.7	6.8	11.0	9.6
2017 - 19	○	84	10.0	8.0	12.5	10.0
2018 - 20	○	96	11.5	9.3	14.1	10.3
2019 - 21	○	99	11.7	9.5	14.3	10.4
2020 - 22	●	108	12.9	10.4	15.3	10.3
2021 - 23	○	110	12.8	10.3	15.2	10.7

Source: Office for National Statistics

Chart 2 compares the Shropshire suicide rate to other LAs in the West Midlands, with a regional average rate of 10.7 suicide deaths per 100,000 population. It can be seen during the 2021-2023 reporting period the Shropshire rate was the 3rd highest in this cohort. During this period, it is also noted that 6 local areas in the West Midlands experienced an increase in suicide rate and 8 reported a decrease to varying degrees. It is noted that in addition to Shropshire, Worcestershire is the only other LA in the region that has moved to a rate higher than the national average during 2020-2022.

Chart 2



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	16,159	10.7	10.6	10.9
West Midlands region (statistical)	–	1,669	10.7	10.2	11.2
Stoke-on-Trent	–	98	14.7	11.9	18.0
Worcestershire	–	223	13.9	12.1	15.8
Shropshire	–	110	12.8	10.3	15.2
Telford and Wrekin	–	57	11.7	8.9	15.2
Warwickshire	–	185	11.4	9.8	13.1
Herefordshire	–	54	10.9	8.1	14.3
Solihull	–	59	10.5	8.0	13.6
Staffordshire	–	247	10.5	9.2	11.8
Sandwell	–	86	9.9	7.9	12.3
Birmingham	–	279	9.7	8.5	10.9
Dudley	–	74	8.8	6.9	11.1
Coventry	–	78	8.6	6.7	10.7
Walsall	–	62	8.6	6.5	11.0
Wolverhampton	–	57	8.3	6.3	10.8

Chart 3 compares the Shropshire suicide rate to nearest statistical neighbours as defined by NHS England (local authority areas with similar characteristics, geography and demography). It can be seen during the 2021-2023 reporting period; the Shropshire rate was the 7th highest in this cohort. Similar to the regional position, there is variation of trends from the previous reporting period with 7 statistical neighbour areas reporting an increase in suicide rate and 7 reporting a decrease.

Chart 3

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	16,159	10.7	10.6	10.9
Neighbours average	–	-	-	-	-	-
Cumberland	–	7	133	19.0	15.7	22.2
Cornwall	–	11	244	16.1	14.1	18.2
Westmorland and Furness	–	5	93	15.5	12.4	19.1
Northumberland	–	10	122	14.9	12.2	17.6
Devon	–	14	293	13.7	12.1	15.3
Dorset	–	12	132	13.5	11.1	15.9
Shropshire	–	-	110	12.8	10.3	15.2
Somerset UA	–	4	189	12.6	10.8	14.5
Cheshire East	–	15	133	12.5	10.3	14.6
East Riding of Yorkshire	–	6	117	12.4	10.1	14.7
North Yorkshire UA	–	1	202	12.2	10.5	13.9
Herefordshire	–	3	54	10.9	8.1	14.3
Suffolk	–	8	217	10.8	9.4	12.3
Gloucestershire	–	9	183	10.6	9.0	12.1
Wiltshire	–	2	142	10.6	8.8	12.3
West Berkshire	–	13	29	6.8	4.5	9.7

Source: Office for National Statistics

Considerations for the Health and Wellbeing Board to be aware of regarding the increased suicide rate:

- Our local Suicide Prevention Strategy was published in September 2023 which is outside of the reporting period for the higher suicide rate.
- It is recognised that the latest reporting period includes the period during the COVID pandemic and lockdown period and is acknowledged there may have been delays in completion of some inquests within the year of death due to disruption of usual services which may have an impact on data.

Initial Response to increasing rates

A briefing paper was shared with the Suicide Prevention Action Group and exception meeting called to agree a co-ordinated response. A key outcome was the need to improve understanding of circumstances surrounding suicide deaths during this period and if there have been any thematic changes that may have contributed towards this increase. This also links with the Strategy ambition to improve data and intelligence on suicide death and suicide risk.

The recommendations for initial response included:

- Audit of Coroner inquests where a verdict of death by suicide has been recorded to better understand nature of circumstances around suicide deaths during this period
- Enhancement of Real Time Surveillance to include additional partners to record if the individual was known to services (supporting opportunities for earlier intervention as appropriate)
- Escalation of design and implementation of a multi-agency suicide death review panel where the individual was known to service, to review any gaps, missed opportunities and consider recommendations to mitigate similar future risk

Audit of Suicide Deaths

The audit of Coroner inquests where suicide was recorded as verdict has been led by Public Health and is to complete soon. Outcomes from the audit will be used to inform further priority actions for the Suicide Prevention Action group. Detailed findings will be restricted given the sensitive nature of the information.

A real time suspected suicide surveillance system has been introduced across Shropshire, Telford & Wrekin which provides function to capture primary detail related to recent probable and possible suicide deaths. The purpose is to enable multi-agency collaboration to provide ability to learn from, and react to, emerging patterns and trends in local suicide. Key partners have included West Mercia Police, Midlands Partnership Foundation University Trust and Public Health.

A new dedicated Real Time Surveillance Co-ordinator post has now been recruited, to ensure enhanced use of real time surveillance and to work collaboratively with a broader range of partners to provide greater understanding as to the social circumstances and services contacted in the period prior to death, providing further insights for prevention planning. Expanded partners who will be included within the

real time surveillance process include drug and alcohol services, domestic abuse services, representatives from the local mental health voluntary sector as well as Local Authority Adult Social Care and Housing teams. Further partners that could support are also being explored.

Suicide Death Review Panel

A new process for thematic review of suicide deaths is currently being designed, with intention to create a multi-agency suicide death review panel. The purpose of this panel is to invite system partners to thematically review whether there may have been any additional opportunity for prevention and consideration of any gaps that could have reduced risk that need to be addressed. Learning and recommendations from these reviews will be shared with appropriate partners or escalated as necessary to mitigate similar future risk in others. Outcomes from the panel will also be used to influence Suicide Prevention Action Group activities.

An initial test and learn approach to the new suicide death review panel is being planned before end of calendar year.

3.3 Updates for delivery of the Shropshire Suicide Prevention Strategy

This section provides an update of activity against the 4 Suicide Prevention Strategy objectives

Objective 1: Improve data quality and intelligence on suicide and suicide risk

Access to meaningful data and intelligence is essential for effective suicide prevention planning and to ensure the right offers are available and accessible to those impacted by suicide and thoughts of suicide.

The Real Time Suicide Surveillance system now has a dedicated Co-ordinator with purpose to manage the surveillance system, ensure data completeness through developing relationships with multi-agency partners and support both Action Groups with data reports and flagging emerging trends and risks. A real time surveillance approach provides a more timely opportunity to review risk in the community, as it is recognised Coroner inquest may take a longer time due to the additional detail collated.

Both Action Groups continue to invest in the surveillance system and are keen to expand the information captured from both existing partners (providing further insights about the individual that could establish further patterns of risk) and to explore working with additional system partners.

We are continuing to explore opportunities to collect intelligence from partners agencies who respond to suicide (or suspected suicide) attempts, which will assist in using an evidence-based approach to targeted intervention planning. It is recognised there are challenges in collecting this (including challenges around subjectivity and formats of how databases store information). A new "Improving data and intelligence" subgroup of the Action Group is being created to support these conversations.

Objective 2: Improved outcomes for people bereaved by suicide

It is estimated that for every person who dies as a result of suicide, at least 115 people are affected. There is much evidence that people bereaved by suicide are at greater risk themselves of suicide or poor health, social and economic outcomes and greater risk of trauma.

The suicide bereavement service operating across STW was one of the first systems to implement a suicide bereavement service and is now well established. It is delivered in partnership by Shropshire MHS and Telford Mind, with a focus on practical, therapeutic and advocacy support. There were 75 referrals into the service from Shropshire residents during 2023-24. Feedback is collected from clients who have accessed the service and has been very positive. Example comments collected from recent reports include;

- *"Being able to see you and talk things through before I feel worse helps me so much"*

- *“You were able to help me plan for how I was going to get through the funeral, it helped me to get through it and reassured me I can reach out to ask for help”*
- *“I wouldn't be here today if it hadn't been for you seeing me and spending time with me. My family don't understand”*
- *“Thank you so much for listening without judging me”*
- *“Knowing that the support is here is great, it makes such a difference”*
- *“Talking to you relieves so much”*

Referrals into the suicide bereavement service can be inconsistent so there is ongoing discussion to promote opportunity for our suicide bereavement officers to meet with agencies and teams across Shropshire, Telford & Wrekin to promote the service, what the offer includes and how to access. Plans are also in place for a refresh of the communications to promote the service across STW which will include updated printed materials to be made available.

Although the suicide bereavement service is not a counselling offer, there are alternative pathways for people needing these offers. This includes strong links with local bereavement voluntary sector providers where supported signposting and connections are in place via the Council customer services team where people are impacted by bereavement, grief or loss for any reason including suicide bereavement.

Shropshire now has two peer led support groups for adults impacted by suicide loss. This is delivered by trained volunteers from Survivors of Bereavement by Suicide (SoBS) and currently has regular groups in Shrewsbury in Oswestry.

Objective 3: Promoting a suicide risk aware workforce with skills and confidence to respond to concerns of suicide

Subsidised access to suicide prevention training continues to be provided for some teams and agencies (including voluntary, community sector). This is to support the ambition of creating a suicide aware Shropshire and developing a culture free of stigma to encourage more open discussion about suicide and raise awareness of the range of offers and support that can help those impacted by suicide or thoughts of suicide.

The Action Group continues to work with system partners to promote the range of suicide prevention training available (both locally subsidised, self-funded and broader peer reviewed suicide prevention training). This includes ongoing discussion on how to ensure time to train where services may be facing capacity issues due to high service demands.

During 2023/24 subsidised training was provided to almost 200 representatives from across Shropshire. These include (but are not limited to) faith groups, VCSE counselling services/mental health agencies, sexual and domestic abuse support services, Fire & Rescue workforce, carer support services, community hospitals, NHS (including NHS Mental Health services), the Shropshire RESET team (supporting rough sleepers), the Shrewsbury Ark, refugee support services, Shrewsbury Colleges, foodbanks, Healthy Lives Social Prescribers, Community Hub staff, drug and alcohol services, Local Authority housing team and social care staff.

The training courses provided during 2023/24 include:

- Suicide prevention awareness training
- Suicide First Aid (understanding suicide interventions)
- Suicide First Aid lite
- Suicide First Aid CYP (trial)

Feedback is collected from all who undertake subsidised training to influence future delivery and has been mostly positive in terms of participants demonstrating how they will/have been able to utilise the learning within their usual roles. Example of recent feedback is highlighted below;

- *“I am utilising this learning already, fully informed and confident in asking correct questions at right time”.*
- *“It is a heavy subject to talk about, but the course was presented in a way to enable free and open discussion, which made it an excellent learning environment. I now feel better equipped to offer help and support to someone in crisis until professional help can be sought”.*
- *“I was pleased I took the course as it has helped me so much in my job. on some of the courses I have been on I have found some of them very boring and I start to lose interest”.*
- *“A good course that has definitely helped me with my role and has increased my confidence when dealing with people with suicidal thoughts and intentions”*

In addition, roughly 45 individuals that work within Shropshire were able to access 3 jointly funded ASIST 2-day suicide prevention workshops, which provide a more in-depth opportunity to both learn and practice suicide prevention skills using role play.

The free to access Zero Suicide Alliance training continues to be promoted and is now embedded into the Leap into Learning platform. Specialist categories linked to the Zero Suicide Alliance free training also continue to be promoted, specifically for:

- Taxi drivers – connections have been made with the licensing team to include a suicide risk awareness element is built into safeguarding awareness sessions for taxi license applications. This includes provision of the ‘Pick up the phone you are not alone’ z-card and details of the free online suicide awareness training aimed at taxi drivers
- Veterans – shared with the Armed Forces covenant
- Prisons
- Probation

It is also recognised that Shropshire Council has invested in a STORM train the trainer model to address suicide and self-harm risk for people working with children and young people.

A new training offer from Papyrus has been made available for Shropshire, Telford & Wrekin until end of 2024 with funded spaces to access SP-OT and SPEAK suicide awareness sessions as well as further ASIST 2-day workshops. Please contact Gordon Kochane at Gordon.kochane@shropshire.gov.uk for further details and expressions of interest.

Objective 4: Enhance offers that mitigate suicide risk and target higher risk groups

The Strategy identified a number of groups which based on national evidence have a higher risk of suicide compared to the general population. These higher risk groups include men, people who self-harm, people in contact with services where suicide risk is identified, farming and rural communities, military veterans and people with protected characteristics. Additional groups of focus include children, young people and young adults as well as those impacted by wider social risk (including but not limited to financial insecurity, domestic abuse, problem gambling, housing insecurity, criminal justice contact, substance use dependency and relationship breakdown).

There are already existing links with many programmes of work across the system to ensure suicide prevention is embedded or opportunity to identify and respond to risk considered. To date, there has been focus on promoting access to suicide prevention training and sharing of resources that can be used by services and teams to support conversations about suicide, support for suicide and support for bereavement by suicide. This includes distribution to GPs, libraries and a range of other partners in the community of the Pick up the Phone You Are Not Alone zcard, bereavement support materials and TogetherAll leaflets (promoting the online emotional wellbeing peer support platform for adults in Shropshire). It is recognised however, that although it is important to have universal access to support, there may be different approaches and messaging required to have best impact when supporting different groups. To help identify priority actions for targeted offers, a number of new workstream subgroups of the Suicide Prevention Action Group have been formed. Although still being established, these subgroups provide a more focused space to invite people with lived experience along with stakeholders who actively work (or have interest) with the target group, to consider the challenges and potential opportunities that could mitigate and manage risk.

To date these groups, include; people known to services, men, rural communities, wider determinant risks and a children and young people workstream planned for end of August. Additional focused workstream discussions have included improving data and intelligence and training.

The purpose is to encourage integrated approaches to addressing shared ambitions, with workstream outputs influencing priorities within the suicide prevention action plan. It also provides opportunity to take recommendations from the Action Group to other system Boards and working groups to work in partnership (recognising their may be instances where others expertise may be better placed to influence).

If there is interest in supporting any of the workstreams please contact Gordon.kochane@shropshire.gov.uk for further information.

Examples of local enhanced offers to date

Farming and rural community:

- Connected with the rural health check programme delivered at livestock markets, whereby representatives from the Outreach team have been trained in suicide first aid to support anyone impacted by suicide or thoughts of suicide.
- Close working connections with Shropshire Rural Support as key partners of the Action Group.
- Continue to explore opportunities to connect with those that work closely with the farming community (such as suppliers and animal veterinarians) to promote subsidised access to suicide awareness training and information on signposting for support

People known to services

- A new toolkit aimed at supporting GPs and Primary Care with suicide prevention is currently being finalised. This has been designed in collaboration with the Shropshire, Telford & Wrekin named GPs for Safeguarding and provides details on how to identify risk, consideration of engaging language and example conversation openers taking a trauma informed approach, safety planning materials and detailing the specific role that GPs and primary care practitioners could undertake to help keep people safe and well and/or appropriately involve and support family or carers. The toolkit also includes information for practitioners to look after themselves. The toolkit is due to launch before end of calendar year.
- Funded 2-day ASIST workshop suicide prevention training for Shropshire Recovery Partnership staff to provide additional practitioner knowledge for supporting substance use clients with thoughts of suicide

Military Veterans

- Targeted subsidised training provided to services supporting military veterans with a spotlight focus as part of the 2023 World Suicide Prevention Day promotions

Communications and Messaging

- A communications plan to promote messages of suicide prevention and appropriate signposting has been agreed by the Action Group.
- A Christmas and New Year poster campaign was launched in December 2023 to promote offers of support available during a period where many usual services may be closed and recognising this can be a challenging time for some. This was widely promoted throughout Shropshire, Telford & Wrekin with positive feedback.

Although the Suicide Prevention Action Group is responsible for delivery of the Strategy, it is recognised suicide prevention is everyone's role. There is reliance on system partners to understand their role and promote messages and signposting information to people who they support. The Action Group welcome ideas and suggestions for further integration with wider strategies and programmes that work with similar cohorts.

Risk Assessment and Opportunities Appraisal	Partner agencies are asked to continue to prioritise suicide prevention, related actions and opportunity to release staff as

	appropriate to access suicide prevention training in order to support reduction in the higher rate of deaths	
Financial implications (Any financial implications of note)	No financial decisions are explicitly required for this report.	
Climate Change Appraisal as applicable	Not applicable for this report	
Where else has the paper been presented?	System Partnership Boards	MH, LD &A 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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead –** Cllr. Cecilia Motley, Portfolio holder for Adult Social care, Public Health, and Communities		
Appendices (Please include as appropriate)		

SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**19th September 2024**
Title of report	**Inequalities Plan, Progress Update**

This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	X	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	

Reporting Officer & email	Melanie France, Public Health Principal (Melanie.France@shropshire.gov.uk) Phillip Northfield, Public Health Development Officer (Phillip.Northfield@shropshire.gov.uk)

Which Joint Health & Wellbeing Strategy priorities does this report 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 report address?	The Inequalities Plan for Shropshire focuses on the main types of inequalities, including health and wider determinants, using a population health model approach. The plan is particularly focused at those most in need of additional support. This report presents an update on the Plan's delivery which was endorsed by the HWBB in November 2022.

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

1. Executive Summary

Purpose: To update the Health & Wellbeing Board (HWBB) on the ongoing work undertaken by health, local authority and voluntary and community sector agencies to reduce inequalities within the County, as outlined in the Shropshire Inequalities Plan (2022-2027) and the delivery of the plan to date.

Introduction: Health inequalities are "avoidable, unfair, systematic differences between population group that stem from wider societal inequalities." These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as determinants of health.

Determinants of health are often interlinked. For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population.

The Inequalities Plan: Endorsed by the HWBB in November 2022, the Plan aims to improve the lives of those with the worst health fastest and break the link between people's background and healthy life prospects.

Across the County, Health, the Voluntary, Community & Social Enterprise sector (VCSE) and Local Authority partners and organisations spanning Shropshire have, and continue to, deliver work aimed at reducing and tackling inequalities – this report outlines the progress and success of these activities, as well as looking forward to future priorities, and how best to build on the excellent work already completed to date.

The Inequalities Plan presented areas of work across 6 categories, these being:

1. Wider Determinants
2. Healthy Lifestyles
3. Healthy Places
4. Integrated Care System (ICS)
5. Social Inclusion Groups
6. Primary Care Network (PCN) Inequality Plans.

This report outlines some of the key work completed to progress and reduce inequalities within Shropshire. Delivery of the inequalities plan involved close working with ICS colleagues and inequalities leads, as the plan is also aligned to the Shropshire, Telford and Wrekin ICS Inequalities Implementation Plan. Moving forward, the full Plan will be updated and reporting to Board on an annual basis. Alongside this, a bi-annual Inequalities Report will be prepared which will focus on emerging issues and trends, or deep dive into a part of the Plan delivery in more detail. These reports will be monitored via Shropshire Integrated Place Partnership (SHIPP) and the ICS Prevention and Inequalities Group.

Please note, in addition to the originally outlined objectives included in the Plan, work to support reduction in further identified local needs has taken place, and this is also highlighted within this report.

The report demonstrates progress against **54** of the **70** actions expected to be taken forward during the reporting period, **12** remain under review for refresh with the service leads and **4** projects were reviewed and replaced with new actions.

2. Recommendations

For members of the Health & Wellbeing board to:

- Note the progress made in delivery of the Shropshire Inequalities plan to date, and for the HWBB partner agencies to continue to work together to deliver the Plan commitments.
- Approve the forward plan and priorities outlined for the next 12-month period listed in this report.
- Receive yearly updates on the continued progress of the Inequalities plan.

3. Report

High Level Indicators - Indicators of Inequality Across Shropshire

Since the Inequalities plan was written, the UK has faced unprecedented circumstances in the form of both the aftermath of the COVID-19 Pandemic, and the subsequent, and ongoing, cost-of-living crisis and their impact on inequalities. Whilst we cannot say what the situation would have been without these events; it is clear that the steps taken by partners in various sectors during the 2 years since the original plan have undoubtedly focused on, and have, mitigated some of the impacts and severity of these events on the residents of the county. At this time, we cannot measure the extent of these measures on mitigating any further inequalities. It should be noted however that the issues relating to these factors facing Shropshire represent national trends, and the County is not unique in this regard.
Rurality continues to be a significant driver of inequalities within Shropshire, and these impacts are well known – having been noted within the original plan and more recently becoming a key focus within Shropshire via the deployment and adoption of the Rural Proofing for Health Toolkit.

Healthy Life Expectancy in Shropshire and Inequality in Life Expectancy

The Inequalities Plan provided key measures for capturing the impact of inequalities on our population's health. These included performance on:

- Healthy Life Expectancy - a measure of the average number of years a person would expect to live in good health, rather than with a disability or in poor health.
- Inequality in life expectancy – a measure indicating the number of years people living in the least deprived areas of Shropshire live longer compared to those living in the most deprived areas.

Indicator	England	Shropshire
HLE Males (2018-20) (Years)	63.1	62.8
Inequality in life expectancy at birth Males (2018-20) (Years)	9.7	5.5
HLE Females (2018-20) (Years)	63.9	67.1
Inequality in life expectancy at birth Females (2018-20) (Years)	7.9	3.5

This data indicates that healthy life expectancy for males in Shropshire is similar to the national position, and for females, better than the national position – however, this data has not been updated by OHID (Office of Health Improvement and Disparity) since the publication of the Inequalities Plan. Public health will therefore continue to monitor data updates as they are produced and alongside seek to develop proxy measures to support tracking of the Inequalities Plan delivery and impact, and will be included within the system Inequalities dashboard, currently under development.

Inequalities Plan Delivery

The next section of the report provides an overview of the key delivered actions and outcomes from the Inequalities Plan to present day, broken down into the 6 original categories within the report.

Wider Determinants

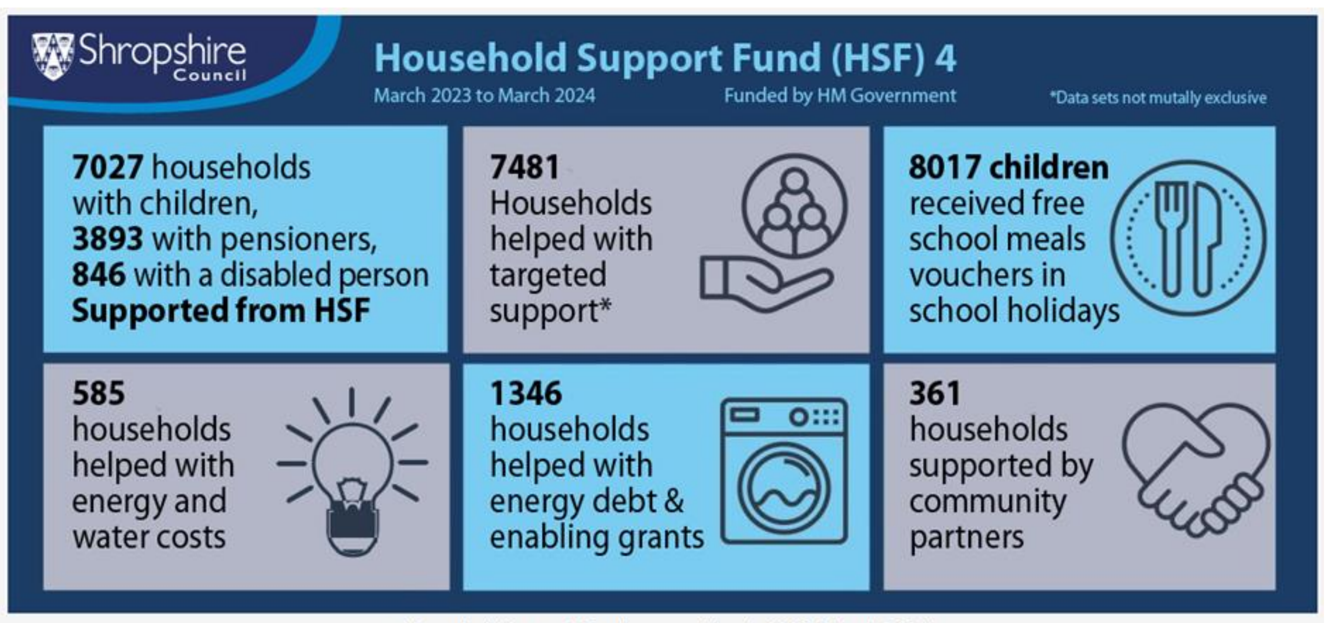
The wider determinants of health are a diverse range of social, economic, and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of the health inequalities. They account for up to 90% of health-related issues outside of the healthcare environment, and can include items such as education, housing, transport, and leisure amongst others.

Of the **11** priorities related to Wider Determinants that were assigned/in progress at the time of the report, **9** have been initiated and are ongoing. The final **2** remain planned for delivery and updates on these will be provided for the next report.

Key developments and areas of focus for this section that have been delivered to date include but are not limited to:

- The introduction of Equality, Social Inclusion and Health Impact Assessments (**ESHIA**) across the council, to be completed by all service areas upon submission to cabinet. These are reviewed/amended as required to mitigate negative health impacts of any service changes.
- The embedding of Supplementary Policy 6 (**SP6** – *Health & Wellbeing*) within the adopted Local Development Plan (**LDP**) – with an agreement in principle to include developer-completed Health Impact Assessments within the next version of the plan, which is currently under development.
- Delivering of the Talk Boost programme in early year's settings across Shropshire to support speech and language development in 3–4-year-olds. Talk Boost - Speech and Language UK: Changing young lives
- The publishing of the Affordable Warmth Strategy, and support given via the Warm Welcome initiative launched by the Social Task Force. Over **80** Warm Welcome Hub venues were provided by Shropshire Council & Partners including Libraries, Community Hubs and more.
- The completion of a Health Impact Assessment (**HIA**) for the next version of the Local Transport Plan (**LTP4**) – which was shared with the external consultants and provides a framework to ensure that all health impacts are appropriately considered and mitigated or enhanced as appropriate.

- Shropshire Council is on track to complete its Bronze level submission to the 'Thrive to Work' West Midlands Award – and will pick this work up again next spring.
- Joint Communications campaign developed with partners, including key Cost-of-living messages, a self-help checklist, leaflets, Cost-of-living help page https://www.shropshire.gov.uk/cost-of-living-help/ and suite of cost-of-living locally themed videos. Targeted leaflet distribution to households identified as vulnerable via our Revenues and Benefits team. To ensure inclusivity and accessibility, communications were available in a variety of languages and accessibility formats.
    - Cost-of-living helpline delivered by Customer Services team. Targeted outbound calls to the most vulnerable households, alongside dealing with incoming enquiries. 25,000 people were contacted between October 2022 and March 2023.
- Partnership development and oversight of principles to ensure the Household Support Fund allocated proactively to the most vulnerable households. Distribution of the Household Support Fund was via both targeted and application-based approaches. Allocations included targeted payments to households identified as being at high risk; holiday meal support for 8000 children entitled to free school meals; a Welfare Support Fund to provide support to low-income households who are most in need of help with food, energy and water bills and other wider essential costs; and funding for support with energy costs administered by partner agencies.



Household Support Fund success March 2023-March 2024

- HSF 2 - April-30th Sept 2022 - £2.1 million
- HSF 3 - Oct 2022- March 2023 - £2.1 million
- HSF 4 - April 2023 – March 2024 - £4.2 million
- HSF 5 - April – Sept 2024 - £2.1 million

Actions remaining to be progressed include the completion of the next iteration of the Local Transport Plan (**LTP4**) – following the guidance and advice set out within the Health Impact Assessment (HIA) that was shared with the external consultants leading on this project, this work remains ongoing, with regular attendance at the steering groups. The household support fund has recently been extended/additional funding will be provided; funding allocation is yet to be agreed by partners but remains on track for delivery.

Healthy Lifestyles

Our health behaviours and lifestyles are the second greatest influence on our health. They include behaviours such as smoking, drinking, diet and exercise or physical activity. Improved lifestyle approaches will lead to a reduction in avoidable diseases and issues, and an increase in healthy life expectancy.

Of the **3** priorities related to Healthy Lifestyles/Behaviours that were assigned/in progress at the time of the report, **all** have been initiated and are ongoing, and subsequently have associated action plans that are currently in the process of being delivered upon. These are large scale significant programmes, aiming to deliver improved health outcomes across the county.

Key developments and areas of focus for this section that have been delivered to date include but are not limited to.

- Healthy Lives Stop Smoking Service has been enhanced with an expanded offer launching in September 2024. This is enhancement/expansion of existing behavioural stop smoking support using 'Local Stop Smoking Services and Support' (LSSSS) grant funding. This is delivered by dedicated stop smoking advisors and aims to support an increase in both the number of smokers in Shropshire who set a quit date and the number of successful quits.
    - This complements existing support provided by NHS LTP tobacco dependency treatment services. A business case and comms plan have been developed, and a multi-agency stop smoking planning group is in place chaired by a Shropshire Council Public Health Consultant.
    - There has been identification of key target groups, including those eligible for Targeted Lung Health Checks, and 'With You' clients who smoke and would like support to quit.
    - There is planned data recording using PharmOutcomes, with quarterly reporting against annually set targets sent to the Office for Health Improvement and Disparities (**OHID**) in line with grant conditions.
- The Shropshire Healthier Weight Strategy 2023-2028 (**HWS**) including high-level action plan was published in January 2024 following endorsement by the HWBB.
    - There is ongoing sharing of the HWS with system partners via strategic meetings and boards, including activity to develop the high-level action plan with key partners. The focus of Year 1 (2024) delivery is developing training to upskill front-line workers with appropriate training to enable them to have sensitive conversations with residents about healthy weight and resources and support available to them. A particular focus on pre-conception advice, including health weight, to pregnant women through the emerging Women's Health Hubs is also being prioritised.
- The Holiday Activities and Food Programme, funded by the Department for Education, has provided eligible children and young people free access to holiday activity during the three main school holidays since 2021. The programme is aimed primarily at children and young people aged 4 to 16, in receipt of benefits related free school meals (FSM). Children meeting wider eligibility criteria can also access the programme. The programme is delivered in partnership with organisations from across the county in the private, voluntary, and public sectors. In 2023 - **3,484** HAF eligible Children and Young People took part in the programme, with over **18,494** meals provided.
- Energize have established #TogetherWeMove, a social movement to promote physical activity. Over **900** people have benefitted from an active lifestyle as a result of activities created by the movement, with **10** champions all busy helping people to participate.

The above Smoking Cessation and Healthier Weight programmes are ongoing, and delivery is due to commence imminently.

Healthy Places

The places and communities we live in, and with are represented by our local environment, which is a key influence on our health, and our behaviours. Additionally, there is a strong link between mental health, and our social and community relationships.

Of the **5** priorities related to Healthy Places that were assigned/in progress at the time of the report, **all** have been initiated and are ongoing.

Key developments and areas of focus for this section that have been delivered to date include but are not limited to.

- The two Air Quality Action Plans (AQAP), covering the two statutory Air Quality Management Areas (AQMA) within Shropshire (Shrewsbury & Bridgnorth) have been written, with an ESHIA completed, and are due to be reviewed at the November cabinet. These aim to reduce the levels of NO_2 to acceptable levels. At the time of writing, they are out for public consultation.
- Health Impact Assessments (HIA) have been agreed in principle with planning colleagues to be included within developer submissions as a matter of course for all new applications. These submissions will include considerations on access to services, green space, and other health considerations.
- The Shaping Places for Healthier Lives programme (funded by the Health Foundation in partnership with the Local Government Association) will reach completion in September 2024.
    - Taking a complex systems change approach, the programme has brought communities and organisations together to focus on actions which prevent food insecurity with the aim of increasing health and wellbeing and reducing inequalities including:
    - Partnership working, community engagement and the development of system-wide communications.
    - Actions to support residents maximise household income (Maximising income communications including 'Worrying about money' leaflet & Healthy Start campaign), Training for frontline staff and volunteers to support residents to navigate local support system (Advice First Aid pilot and development of Ask, Assist and Act toolkit and training), funding for Citizens Advice advisor in SW Shropshire foodbanks.
    - Actions to increase understanding of the causes of and experience of food insecurity with the aim of reframing food insecurity and reducing stigma (including Food basket research, stigma video).
    - Grant funding for co-produced community-led solutions in S/W Shropshire.
- Within the library service, the Early-Years targeted offer 'Bookstart' packs are delivered directly to pre-school settings in specifically targeted disadvantaged areas.
    - Additionally, Bookstart baby packs are delivered to health visitors for distribution.
    - Libraries also offer regular rhyme/story times to support Speech, Language and Communication (SLC) and Home Learning Environments (HLE).

Actions remaining to be progressed include implementation of the agreed HIA developer submission documents (a tool has been completed for review) and continued joint working with the Internal Infrastructure Group (IIG) to promote health-positive outcomes in Community Infrastructure Levy (CIL) funded projects across the county. The recently built Highley Medical Centre being a prominent example of JSNA data being utilised to meet required need and being part-funded by the IIG and CIL monies in conjunction with additional funding streams including the UK Shared Prosperity Fund (UKSPF), NHS funding and support from Halo Leisure.

NHSE Healthcare Inequalities within the Integrated Care System

Work within this category is being led by the systemwide ICS Prevention and Inequalities Group and includes the NHSE 5 nationally agreed key lines of enquiry (KLOE). Reporting from Q4 of 2023-24 noted there were 20 priority areas with 37 programmes or projects to be delivered. 13 of these are making good progress and are on a green rating, 15 programmes are currently amber, and progress is red on 5 programmes, with these requiring more focus. 4 areas from the original healthcare inequalities plan are no longer applicable for delivery.

Restore NHS Services Inclusively

- A new System IIA (Integrated Impact Assessment) template is now in place that builds in enhanced screening of inequalities and inequity impact.

Leadership & Accountability

- Senior Reporting Officers (SROs) have been appointed for each health organisation and form the membership for the newly established Prevention and Health Inequalities Group.

Obesity

- 47/52 GP Practices (Across ICS, STW) made referrals to the NHS Digital Weight Management Programme in 2023-24. **1536** eligible referrals were made this year achieving **81%** of our total target. Increases in referrals can be seen throughout April – June and December – March with declines in activity over Summer and the lead up to Christmas.

Vaccinations (COVID-19 & Influenza)

- There was a completion of Equity Audits on Campaign uptake. Additionally, there was utilisation of national communications material including in other languages and easy-read.
- Vaccination sites offering walk-ins are made available in areas of highest deprivation. Clinics are offered 7 days a week including evenings and weekends to support access.
- There has been reviewing of historical uptake in areas of highest need and using this insight to inform future targeted plans, as well as utilising existing resource, contacts, and partner relationships to promote uptake to target groups.
- Satellite clinics and pop-ups in target areas (using fire stations, community, and cultural centres) have also been set up as needed.
- Data and information on vaccinations & immunisations are regularly included within updates to both the HWBB and the STW Health Protection Quality Assurance (HPQA) Board.

ICS Action Plan Monitoring

The Inequalities Plan will now be updated to include the NHSE Healthcare Inequalities Plan. Updates and progress will be included in reports to the board.

Collaborative Projects

Community & Family Hubs, including Integrated Multi-Disciplinary Teams

The community and family hubs are a cornerstone for tackling inequalities within our communities. This means an integrated approach to delivering services closer to peoples' homes, in local communities, working across health, care and the voluntary and community sector. The hubs are there to offer face-to-face assistance and supporting people to help themselves through the digital and other community offers. Governance & reporting for this programme involves updates to the HWBB, SHIPP and its own internal Community & Family Hub board.

- Community and Family Hubs will be for all-ages providing a single access point – a 'front door' – to universal services for families with children of all ages (0-19) or up to 25 with special educational needs and disabilities (SEND), with a Start for Life offer at their core.
- Beyond Children and Families, the hubs aim to support adults and older people to access the support and activities they need to keep themselves as well as possible, including being able to connect with preventative health services, carer support and other social support.
- Hubs provide services and professionals with a shared space to make it easier for people of all ages to access the services they need, and these include physical locations, but also outreach support.

Development of Community and Family Hubs, includes:

- Integration CYP Multi-Disciplinary Teams
- Health and wellbeing Drop-Ins – led by ShropCom
- Proactive Care
- Women's Health and Wellbeing Hubs
- ASC Multi-disciplinary Teams
- Library Transformation/ Shropshire Local
- Open Access Clinics (Health Visitor and Family Support Workers)

Currently, there are 5 multi-agency integrated community and family hubs in operation, covering Southeast, Southwest, Central, Northeast and Northwest Shropshire, which will be further developed in line with local needs.

Digital Exclusion - Digital Skills Programme (DSP) (2023 to 2026)

The DSP is an inclusive service, aimed at providing support for our most vulnerable citizens. Access to free digital support is across the whole of Shropshire, with more providers than ever before. There are 25 learning locations, 13 of which are in local Libraries. Specialist provision is available for people seeking work through the Council's Enable service, for people with visual impairment through Sight Loss Shropshire, and for people with learning difficulties through Taking Part. We are delighted that in addition, 10 voluntary and community groups are delivering the programme, including one Food Bank. Many providers work closely with their local Food Banks and GP surgeries.

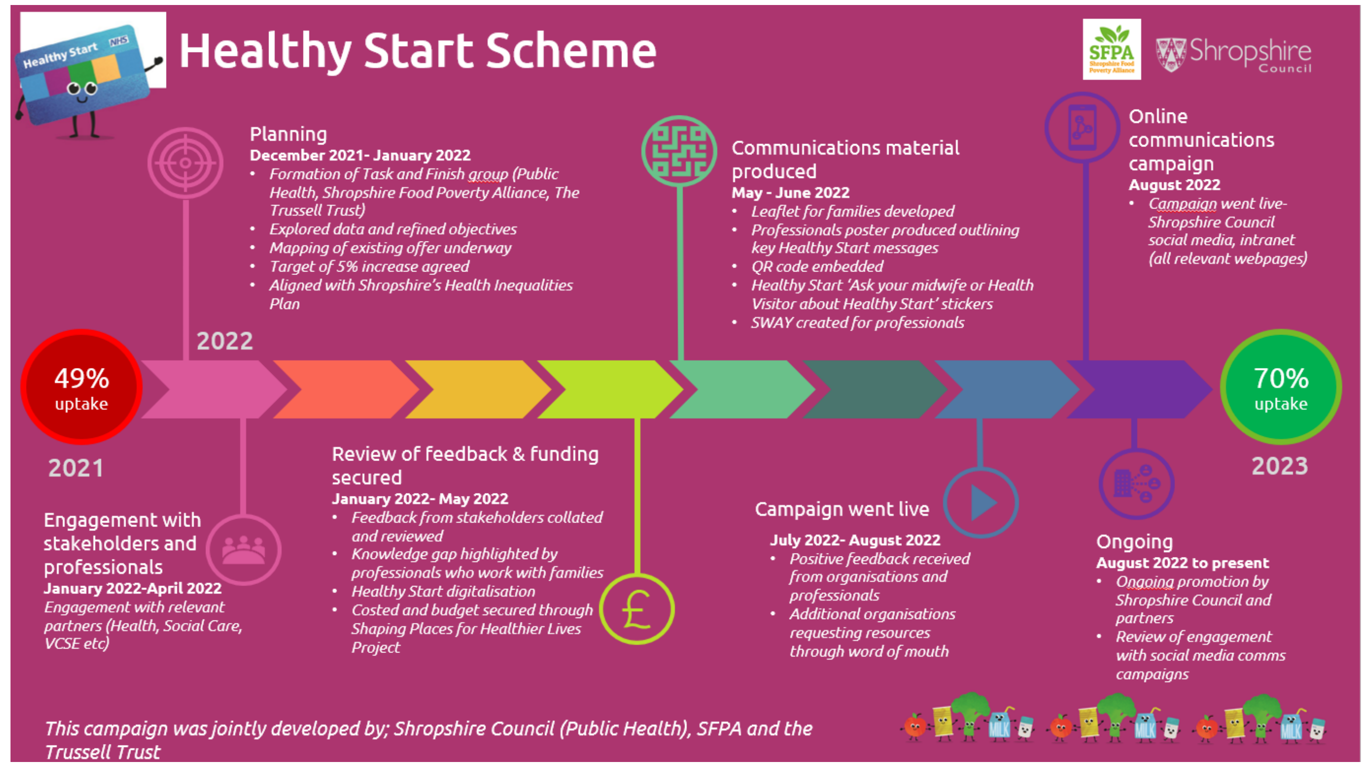
Free devices and SIM cards with 6 months of free data are available from all DSP providers for people in need. The programme works closely with the Good Things Foundation, the biggest national digital inclusion charity, that provides the free SIM cards. Most participants learn on their own device, at their own pace.
update:

DSP performance info to 30 June 2024:

- **855** people have participated in the Digital Skills Programme to date.
- **321** people have completed an 8-week volunteer-led programme of free digital support.
- **534** people have participated in a free Digital Drop In.
- Learner average hours of digital support: 7.85 hours
- Learner digital skills average start score: **28%.**
- Learner digital skills average completion score **59%.**
- Learner average increase in digital skills **31%**
- **78** Digital Volunteers are currently engaged with the programme.

Healthy Start

Healthy start is an NHS Scheme that supports families on low incomes to buy fruit, vegetables, milk and access free vitamins. At Shropshire Council we have encouraged eligible families to apply for Healthy Start. Public Health have been working with partners including the Shropshire Food Poverty Alliance and the Trussell Trust to improve awareness and uptake of the NHS Healthy Start Scheme. All professionals across the ICS working with pregnant people and young families have been playing a key role by talking about Healthy Start and promoting the offer. The scheme is digital, making the application process easier.



Social Inclusion Groups

Above and beyond the areas listed above, the original Inequalities plan specifically targeted groups who require additional support and looked to include plans/projects and actions that would reduce the inequalities faced by these cohorts in particular.

Of the **15** priorities related to the additional Social Inclusion Groups that were assigned/in progress at the time of the report, **10** have been initiated and are ongoing. **5** remain on the plan for delivery, with updates pending at the publication of this report.

Key developments and areas of focus for this section that have been delivered include but are not limited to.

- The Domestic Abuse Needs Assessment is in the in process of being reviewed/updated, with the subsequent Strategy to be updated imminently during Autumn 24.
- The ICS are supporting the Local Authorities with the Education, Health, and Care Plan (EHCP) process to support Children and Young People (CYP) with Learning Disabilities & Autism (LD&A) to reach their potential.
- Publishing of Homeless and Rough sleeping strategy – ESHIA completed with additional health protection advocacy included for those unable to support themselves through infectious disease incidents.
- Farmers Health Check's programme rolled out by Shropshire Council's Public Health Community Outreach Team. Additionally, this team provides support to Bulgarian & other Eastern European communities including advice, support, and translation assistance.
- Shropshire Council's Housing team continues to support Syrian, Afghan and Ukrainian households/refugees, including registration support with local GP's where required.
- Early adoption through the Home Adaptation Policy pilot shows an improvement and reduction in time spent waiting for grants. This is due to be rolled out after approval by cabinet.
    - The new Community Equipment Service has been in place since 1st April 2024 – and is shared with the ICS/T&W.
- The planned Human Library Pilot working alongside Stoke Heath Prison took place, but this initiative will not be moving forward beyond pilot stage.

Actions remaining to be progressed include the continuation of the Outreach work, implementation of the relevant housing strategies and the proposed inclusion of Autism support sessions within the Children and Family Hubs.

PCN Inequality Plans

Delivery of PCN Inequality plans was funded for a fixed period of 6 months during 2022. This funding is no longer provided and so this work is currently not being progressed. Various aspects of these priorities, however, are incorporated within the ICS Inequalities plan, and there is an intention for greater engagement with PCN's moving forward within the next 12 months.

Forward Plan

Reflecting on the work completed on this plan previously, there has been a huge investment from partners across Local authorities, Health and VCSE partners. Looking forward to the future, and considering the evidence obtained from the review, we propose the following priorities over the next 12 months for approval by members of the Health and Wellbeing board.

Strategic

- Refresh of the Inequalities plan to focus on key objectives that deliver the greatest change in inequalities - to include a focus on health and wider inequalities and to support improved tracking of key deliverables.
- Collaborative working across the system, to enable joint reporting with the ICS Inequality group.
- Continued need to focus on rurality and inequalities - to include the implementation of the Rural Toolkit.

Projects/Programmes

- **Healthier Weight -** To progress the implementation of the Healthier Weight Strategy (HWS) via the assigned action plan.
    - **ICS - NHS Digital Weight Management -** Targeted plan to check in with lower referring practices, focusing especially on those in higher areas of deprivation and rurality to be developed.
- **Children & Family Hubs –** focused development with system partners of hubs and spokes based on local needs.
- **Stop Smoking & Vaping –** Continuation and promotion of the smoking cessation work as outlined above, including a Vaping plan within the refreshed strategy.
    - **ICS - Tobacco Dependency Teams (TDT) -** Continued close working with Community Pharmacies to increase the number of pharmacies signed up to and delivering smoking cessation services.
        - Smoking is a leading cause of preventable mortality and a leading modifiable cause of health inequalities amongst Core20PLUS communities. Smoking cessation is therefore highlighted in the Core20PLUS5 as a key area of improvement which, if addressed, can lead to a positive impact across all 5 key clinical areas of the Core20PLUS5 in adults.
- **Suicide Prevention Strategy –** deliver on the actions and deliverables in the refreshed strategy.
- **ICS - Severe Mental Illness (SMI) -** Improving lifestyles - Greater focus on engagement with the third sector to support educational and practical advice on healthy eating, weight management and other lifestyle choices. Greater engagement with Public Health network including joint offer.
- **InHIP –** Continued implementation of the InHIP programme supported and delivered by a system partnership. Year 2 is currently in delivery.
- **ESHIA –** Updating and improving of internal ESHIA processes via the inclusion of supplementary documents such as the **HEAT** (Health Equality Assessment Tool).
- **Housing –** Continue to work closely with both planning and regulatory service colleagues on possible future involvement in infrastructure and housing projects to support a reduction in inequalities.
    - Explore the potential for Health Impact Assessments to be included as part of developer submissions for planning application, to be reviewed by council planning officers as part of due process.
    - Submit the Housing and Health action plan to the November 2024 HWBB for endorsement and implementation following system workshops commissioned by the Board.
- **Drugs & Alcohol -** To develop and implement the 2024/25 Drug & Alcohol Strategy.
    - Roll out and pilot the M-Pact programme.
    - Continue delivery of RESET, multidisciplinary team to support people who are rough sleeping or at risk of rough sleeping with drug and alcohol needs.
    - Publish the Schools Drug, Alcohol & Vaping Toolkit (Autumn 24)

Risk Assessment and Opportunities Appraisal	Due to the continued cost pressures on families, as well as financial pressures on the local authority and system partners as a whole, there is the potential for increasingly adverse impacts on the population, particularly those who are most vulnerable. Tracking of inequalities and delivery of the above programmes is therefore crucial to ensure or mitigate against avoidable outcomes.	
Financial implications (Any financial implications of note)	• There are no financial implications.	
Climate Change Appraisal as applicable	• *Not applicable, associated Climate Change project (LTP4) has had appropriate climate change involvement.*	
	System Partnership Boards	N/A

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<tr><td rowspan="2">Where else has the paper been presented?</td><td>Voluntary Sector</td><td>N/A</td></tr>
<tr><td>Other</td><td>N/A</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)
N/A</td></tr>
<tr><td colspan="3">Cabinet Member (Portfolio Holder) Portfolio holders can be found here or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead

• Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities
• Rachel Robinson – Executive Director, Health, Wellbeing and Prevention</td></tr>
<tr><td colspan="3">Appendices
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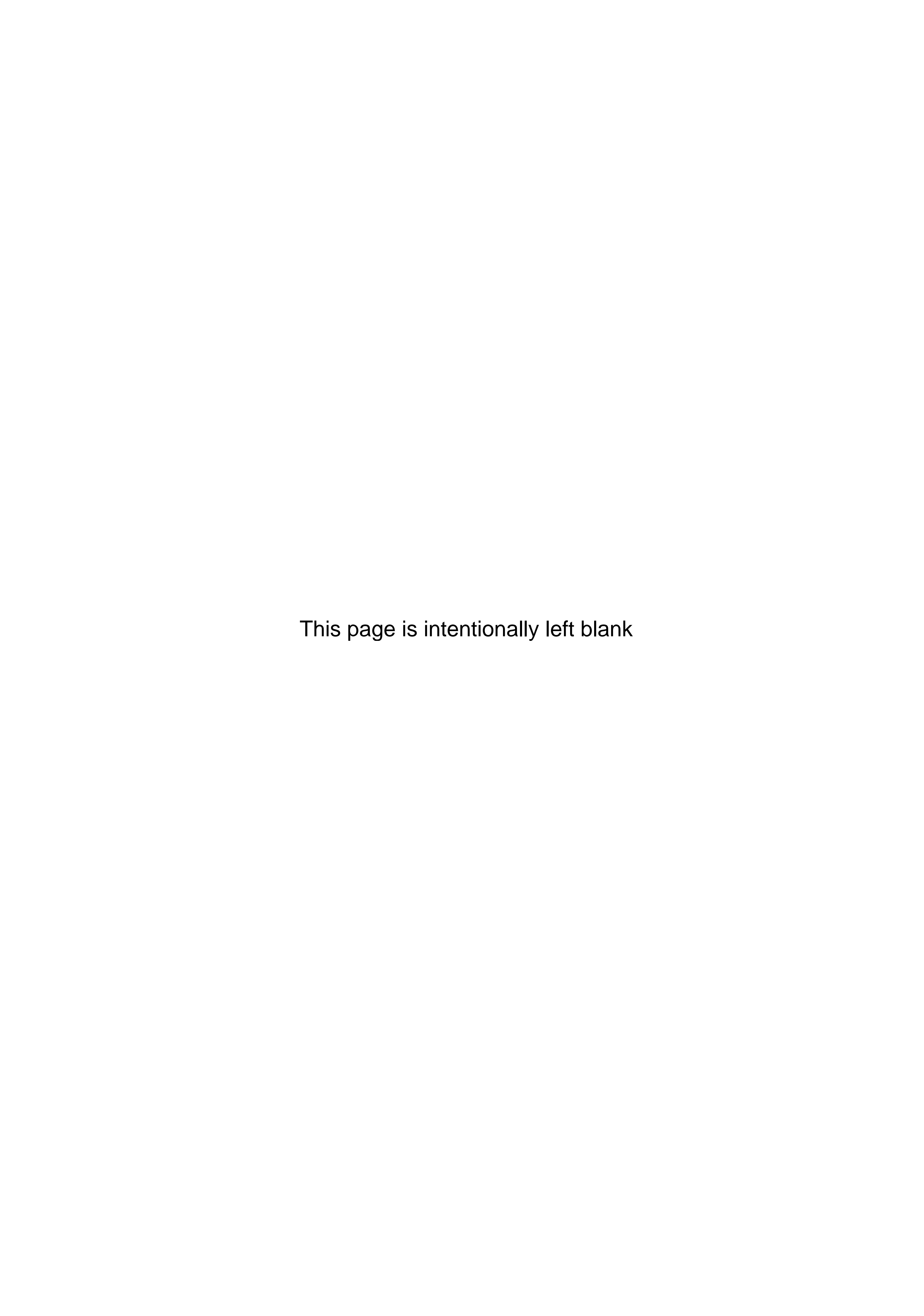
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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**19/09/2024**
Title of report	**Report of the Health Overview and Scrutiny Committee- Rural Proofing in health and Care**

This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	

Reporting Officer & email	Sophie Foster Sophie.foster@shropshire.gov.uk

Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply	Children & Young People		Joined up working	
	Mental Health		Improving Population Health	
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	
	Workforce		Reduce inequalities (see below)	X

What inequalities does this report address?	The report has rural health and care inequalities at its focus

Report content:

1. **Executive Summary**
This paper reports the findings and recommendations of the Rural Proofing in Health and Care Task and Finish Group following their investigation looking at the options to effectively 'rural proof' the amendment or introduction of strategies, plans, policies and service design and provision in health and care in Shropshire which have been adopted by the Health Overview and Scrutiny Committee

2. **Recommendations**
Note the report and recommendations of the Task and Finish Group attached at appendix A.
From the 14 recommendations that were outlined in the report, the HWBB are asked to endorse those which relate to the Board which are included in section 7 of the report.

3. **Report**- For full report see Appendix A

This is the report of the Health Overview and Scrutiny Committee which adopted the report of the Rural Proofing in Health and Care Task and Finish Group. It sets out key findings, conclusions and recommendations of their work considering delivering health and care services to rural communities.

The members of the Task and Finish Group have been clear from their first meeting about the topic, that addressing any inequalities of service provision between rural and urban areas requires a system wide understanding of the opportunities and challenges. Having this will help to identify the most suitable and effective options that need to be explored and implemented to effectively 'rural proof' the amendment or introduction of strategies, plans, policies and service design and provision in health and care in Shropshire.

This work arose from Members of the Health and Adult Social Care Overview and Scrutiny Committee (now Health Overview and Scrutiny Committee) frequently highlighting concerns about rurality and access to health and care services through their work. This Task and Finish Group was therefore commissioned to draw together the key

points and observations that have arisen through the work of the committee during 2022/2023, to review the latest local and national evidence on rural proofing, hear from local system providers and take the opportunity to learn from other areas of the country.

Against this context, the Task and Finish Group has looked in detail at the available data and information, carrying out a desk top review of the available research and case studies into rural proofing and the impact of living rurally on access to health and care services. Hearing from customers, service users, and patients about their experiences of accessing health and care when living rurally. Hearing from providers of health and care services about current approaches to delivering to/serving rural communities and sought evidence and learning from other areas of the country.

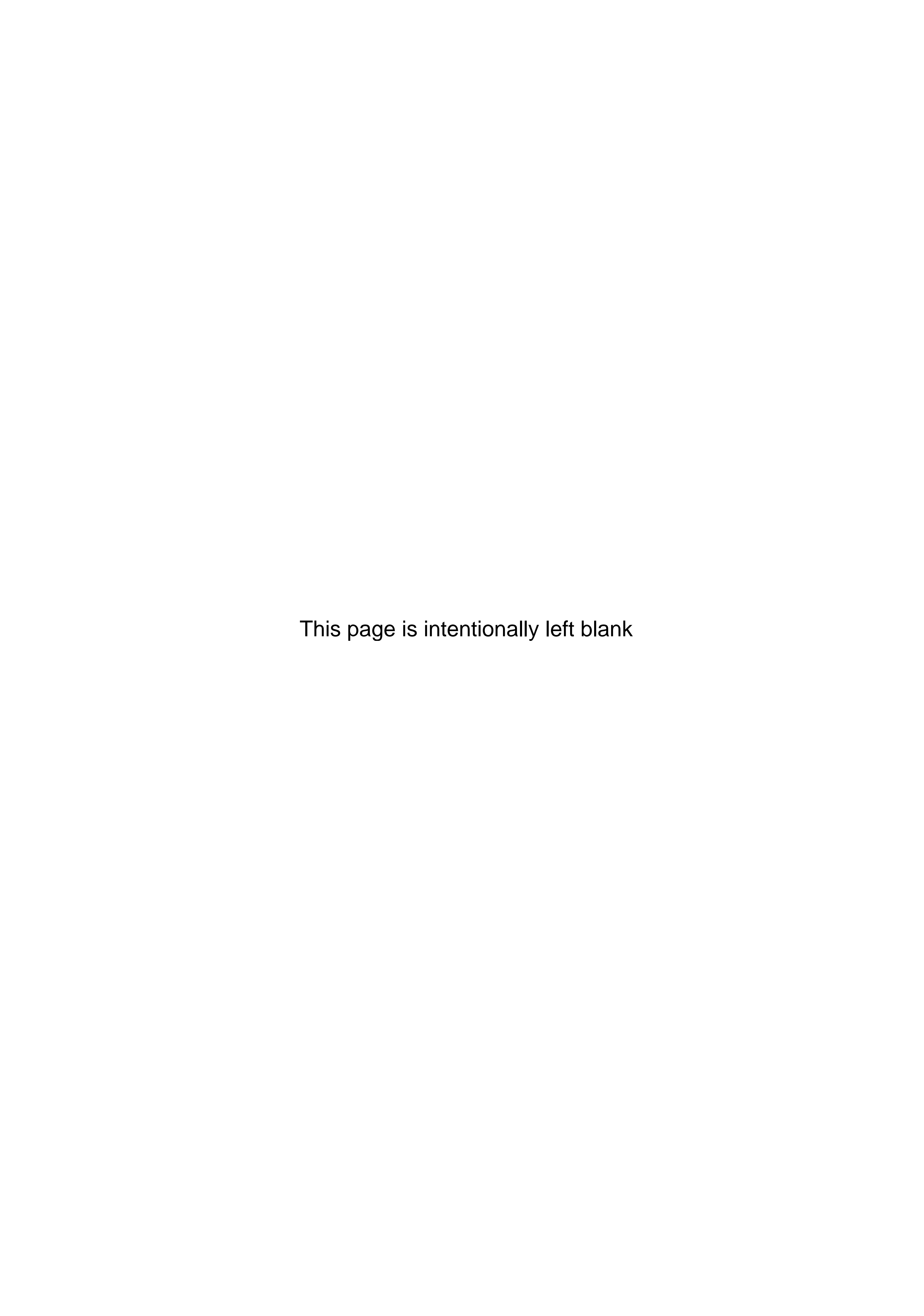
The system and organisations that have fallen within the scope of this work are complex, multi-dimensional and dynamic. With national, regional and local actions and activity being identified and reviewed whilst the Task and Finish Group has been in operation.

The Group made 14 recommendations which they believe will contribute to addressing inequalities of service provision between rural and urban areas.

These recommendations were unanimously adopted by the Health Overview and Scrutiny Committee and included recommendations: to Shropshire Council and to the Integrated Care Board, promoting a system working approach across all Integrated Care System stakeholders promoting a consistency of approach with local and regional partner Councils

<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">See Appendix A</td></tr>
<tr><td>Financial implications
(Any financial implications of note)</td><td colspan="2">Whilst there are no direct financial implications from this report, should the HWBB partners wish to adopt any of these recommendations then appropriate financial advice on the costs involved should be sought.</td></tr>
<tr><td>Climate Change Appraisal as applicable</td><td colspan="2">Work completed by the Task and Finish Group has identified the following points related to their work which could have benefits for climate change and the environment:
By undertaking an end-to-end evaluation of the travel and transport infrastructure which supports the Shropshire health and care system the Groups recommendation has the potential to benefit the climate by reducing the number of individual car journeys made by residents and so reducing carbon emissions and improving air quality.</td></tr>
<tr><td rowspan="2">Where else has the paper been presented?</td><td>System Partnership Boards</td><td>ShIPP</td></tr>
<tr><td>Voluntary Sector</td><td></td></tr>
</table>

	Other	HOSC, People Overview and Scrutiny Committee, JHOSC, Integrated Care Board, Shropshire Council Cabinet
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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** **Cllr Cecilia Motley**		
Appendices Appendix A- Report of the Health Overview and Scrutiny Committee- Rural Proofing in Health and Care		



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Appendix 1

Health Overview and Scrutiny Committee

Report of the Rural Proofing in Health and Care Task and Finish Group

20 November 2023

Acknowledgments

The Task and Finish Group would like to thank the officers, partners and witnesses who have given up their time to share their knowledge, experience, and perspectives on the challenges and opportunities associated with delivering health and care services to rural populations. The Group were very appreciative of the positive levels of engagement from all parts of the health and care system and have used the evidence collected to propose a consistent set of criteria to be recommended for use to evaluate rural proofing in strategies, plans, policies and service design and provision in health and care in Shropshire.

Members of the Task and Finish Group

- Cllr Heather Kidd (Chair)
- Cllr Geoff Elner
- Cllr Roger Evans
- Cllr Julia Evans
- Cllr Julia Buckley
- Cllr Edward Towers
- Cllr Ruth Houghton
- Cllr Roy Aldcroft

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Report

Introduction

Context
Ensuring access to health and care services is a complex, multi-dimensional challenge which has become more pressing with the impact of wider societal factors such as the coronavirus pandemic and the cost-of-living crisis. Dimensions of access are particularly evident in rural health and care systems such as Shropshire where additional structural barriers make access more challenging.

Members of the Health and Adult Social Care Overview and Scrutiny Committee (now Health Overview and Scrutiny Committee) frequently highlight concerns about rurality and access to health and care services through their work. This Task and Finish Group was therefore commissioned to draw together the key points and observations that have arisen through the work of the committee during 2022/2023, to review the latest local and national evidence on rural proofing, hear from local system providers and take the opportunity to learn from other areas of the country.

The members of the task and finish group have been clear from their first meeting about the topic, that addressing any inequalities of service provision between rural and urban areas requires a system wide understanding of the opportunities and challenges. Having this will help to identify the most suitable and effective options that need to be explored and implemented to effectively 'rural proof' the amendment or introduction of strategies, plans, policies and service design and provision in health and care in Shropshire.

With this clarity, the Task and Finish Group scoped their work around three key stages:

- A desk top review of the available research and case studies into rural proofing and the impact of living rurally on access to health and care services.
- Hearing from customers, service users, and patients about their experiences of accessing health and care when living rurally.
- Hearing from providers of health and care services about current approaches to delivering to/serving rural communities.

The view from the national perspective
The challenges of delivering health and care services to rural communities have been identified nationally by several organisations and observers, including the House of Lords Select Committee on the Rural Economy, which considered rural health services as part of its 2019 inquiry into the rural economy. Amongst its findings, the committee's report, 'Time for a strategy for the rural economy'[1], published on 27 April 2019, said challenges included:

- Older populations
- Funding challenges
- Access to services
- Poor connectivity
- Issues of isolation and loneliness

The House of Lords reaffirmed their concerns over how health care was being delivered to rural populations nationally in the 'In Focus' article published on 17 February 2023[2], which included recommendations from the Royal College of Nursing, Nuffield Trust, Organisation for Economic Co-operation and Development (OECD) and the All-Party Parliamentary Group on Rural Health and Care which was published February 2022. With the government currently

reviewing the issue of health and care in rural areas as part of its wider 'Levelling Up' agenda which incorporates twelve 'missions', including health.

In March 2021, the Department for Environment, Food and Rural Affairs (Defra) published its report 'Rural proofing in England 2020'[3]. The term 'rural proofing' describes when policy makers and analysts consider how to achieve their policy objectives in rural areas. The report was published in response to recommendations made in the House of Lords Select Committee on the Rural Economy's report, 'Time for a strategy for the rural economy 2019[4]'.

The foreword to 'Rural proofing in England 2020' said that it aimed to "improve transparency and accountability by illustrating how rural proofing is planned and coordinated across government, and by demonstrating the various innovative ways in which rural needs are being successfully identified and met".

Defra's second report on rural proofing published in September 2022 'Delivering for rural England'[5] sets out the national 'rural position' as follows, which reflects the findings of other organisations:

- In 2018 in England, the average life expectancy was 79.6 years for men and 83.2 years for women. Life expectancy is slightly higher in rural than in urban areas.
- The rural population is older than the urban population and its average age is increasing faster with implications for health and social care needs.
- Distance can mean that some health services are less accessible. The average minimum travel time to a hospital is approximately one hour in rural areas, compared with approximately half an hour in urban areas, with difficult road conditions meaning that emergency transfers can take longer for rural residents.
- Delivering community-based care can be more expensive in more sparsely populated rural areas.
- It can be more difficult to recruit health care professionals to rural areas.

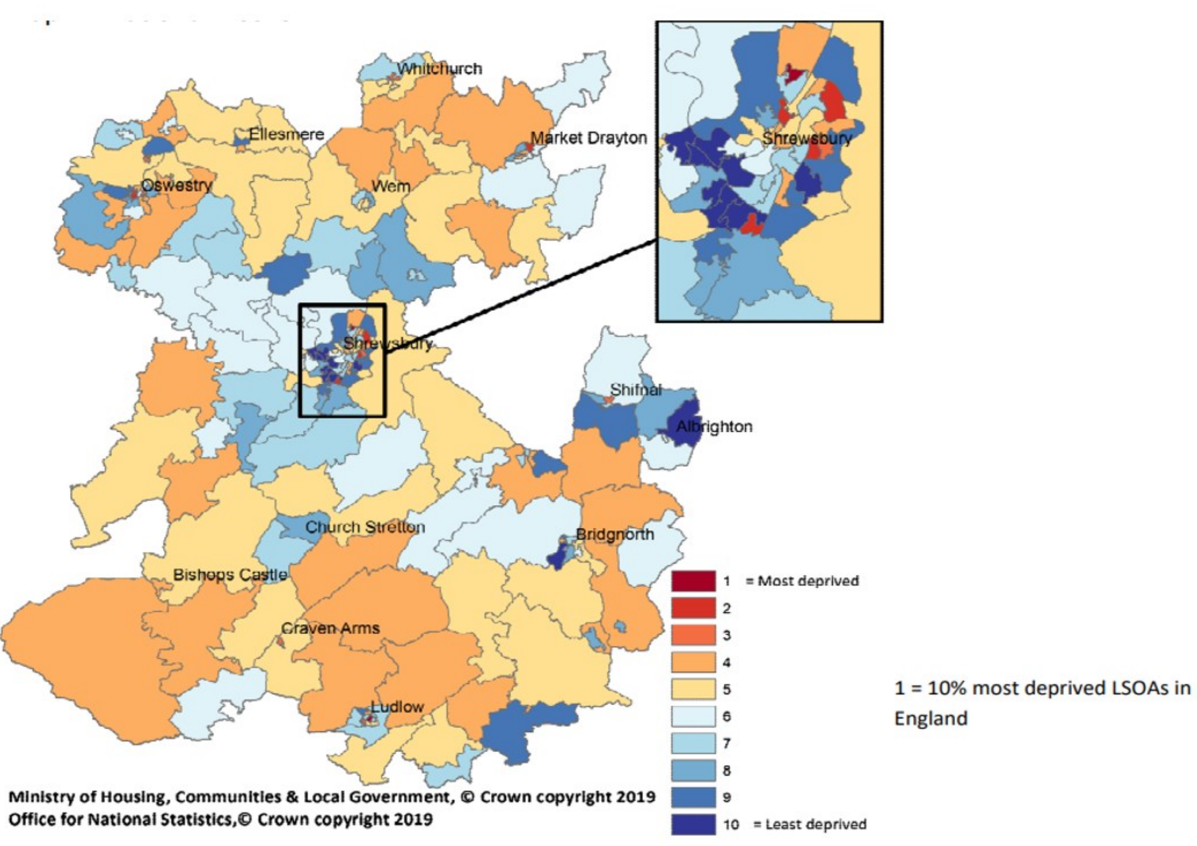
The report, noted that the government had a number of measures in place to address challenges of delivering health care in a rural setting:

- Pharmacy access scheme. This £20mn scheme provides funding to support pharmacies to stay open to provide accessible primary care. The government has said that there are 1,230 rural pharmacies in England and 46% of these qualify for support under the scheme. The scheme will remain in place "until at least the end of 2023".
- NHS community pharmacist consultation service. This scheme, launched by NHS England in October 2019, enables patients to get same-day appointments with a community pharmacist for minor illnesses or the urgent supply of a regular medicine. The government has said that this improves access to services and provides convenient treatment closer to a patient's home. The service includes referrals from general practice and the government has said that it is looking at whether the approach could be further expanded.
- Targeted enhanced recruitment scheme. This scheme funds a £20,000 salary supplement to encourage trainee GPs to work in areas where training places have been unfilled for a number of years. The government has said this includes rural communities. The government has been increasing the number of places on the scheme. There were 550 in 2021 and 'Delivering for rural England' said the government would fund 800 places in 2022. The government has also said that trainees on the scheme "usually stay after training, helping to sustain the GP workforce in rural areas".
- 'Delivering for rural England' also considered health care in rural areas as it is impacted by other factors. On transport, Defra said that rural areas typically suffered

from poor connectivity. It said that the Department for Transport's forthcoming 'Future of transport: Rural strategy' would "guide local authorities, transport operators, and the private sector towards a future transport system which maximises the benefits of new technologies and business models for rural and remote communities". The report said this would make it easier for people to access health care. A written answer given on 9 February 2023 said that the 'Future of transport: Rural strategy' was "soon to be published".

In a November 2022 written answer[6], the government stated that integrated care boards (ICBs) are responsible for making appropriate provisions to meet the health and care needs of local populations. It has said that the core ICB allocations formula is adjusted to allow for differences in the costs of providing health care between rural and urban areas. P5-10

The local perspective
Shropshire is the second largest inland county in the country and whilst there are eighteen market towns, the remainder of the county is more rural and sparsely inhabited. Although there are no stark levels of deprivation across the county, there are pockets of deprivation in market towns and rural areas, particularly with issues of low pay and poor physical and digital access to services and facilities.



The Task and Finish Group found that the rural nature of Shropshire and the opportunities and challenges this can pose are acknowledged in local health and care systems policy development and strategic planning. The Shropshire, Telford & Wrekin Integrated Care System Priorities include deprivation and rural exclusion. There is also an acknowledgement within the Joint Forward Plan 2023[7] that "a largely rural Shropshire in contrast with a relatively urban, deprived Telford & Wrekin provides challenges to developing consistent, sustainable services with equity of access and long drive times to access acute services." P27

Within Shropshire Council's strategic 'Shropshire Plan 2022-2025'[8] there is a commitment to "tackle inequalities, including rural inequalities, and poverty in all its forms; providing early support and interventions that reduce risk and enable children, young people, adults and families to achieve their full potential and enjoy life" P1

Within Shropshire Council's Health and Wellbeing Strategy 2022-2027[9] it is recognised that "Shropshire has many strong and vibrant rural and town communities. We will work with our communities to engage and find out what matters, 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." P9

The Group was able to find the beginnings of these priorities translating into collective action form the Local Authority and Integrated Care Board. The Joint Strategic Needs Assessments data being identified by system partners as providing opportunities to further develop effective joined up working by identifying the strategic priorities which will inform the commissioning of services and activities by the Integrated Care System going forward.

On the wider issue of funding for rural residents, the Rural Services Network (RSN) has argued that rural local authorities such as Shropshire are not getting enough funding. Referencing the 2024 local government finance settlement[10], the RSN stated that:

- Rural areas in 23/24 will still receive some 38% (£135) less per head in Government Funded Spending Power (which excludes Council Tax) than their urban counterparts.
- Rural residents will pay, on average, 17% (£1040) per head more in council tax than their urban counterparts due to receiving less government grant.
- Rural residents will get 13% per head less in social care support overall.

The RSN said that "rural residents pay more, receive fewer services and, on average, earn less than those in urban areas and that is inequitable". They state that "closing the gap between the Government grant to the urban dweller and the rural dweller by only 10% over 5 years (for instance) would make a massive difference to rural services. In Shropshire it would provide an extra £13,000,000 per annum at the end of this five-year period."[11]

The RSN also states that in respect of Public Health Grant allocations for 2023/24 predominantly rural councils receive £45.70 per head of population compared to £73.85 for those councils serving predominately urban areas.

Scope and focus of the work
The task and finish group sought to:

- Set out/define what 'rural' and 'rurality' means for the Shropshire Council area, including inequalities and access to services
- Understand what rural proofing means for Shropshire
- Identify a view/position on rural proofing affecting Shropshire communities and services (based on work during the year), and through additional research
- Use the evidence collected to propose a consistent set of criteria to be recommended for use to evaluate rural proofing in strategies, plans, policies and service design and provision in health and care in Shropshire

What has the task and finish group done?
To conduct this review the group:

- Carried out an initial scope of the issues that it wanted to investigate and to determine the evidence that it would need to conduct the review.
- Conducted desktop research and analysis to inform the consideration of rural proofing in health and care services.
- Undertook desk top research to identify best practice from other parts of the country.
- Heard from a range of different witnesses across the voluntary, health, care, and public sectors.
- Heard from service users, customers, and patients about their experiences of accessing health and social care when living in a rural community.
- Members considered the findings of the work completed by the National Centre for Rural Health and Care and Rural England C.I.C to produce the Rural proofing for Health Toolkit.

Who the Task and Finish Group Heard From?
The Task and Finish Group heard from a wide range of people and organisations via written submissions and through attending their meetings; providing the opportunity to share their knowledge and experience of receiving or delivering health and care services in rural communities. Please see Appendix 1 for the full list of whom the group heard from during their considerations and meetings. Appendix 1

Key Findings
Rural living is often thought of and portrayed as idyllic and can have a huge appeal. For example, rural areas are perceived as offering more peace and quiet, a slower pace of life and access to beautiful countryside. Rural living is seen to offer opportunities to stay active and as having a greater sense of community spirit. Yet, as the findings of this report shows, for many of those living in rural areas, especially those with additional needs or vulnerabilities rural life can be very different. The Group found that the situation in Shropshire is reflective of what this report described in the national context for rural communities.

Shropshire contains significant areas which are sparsely populated, with scattered dwellings and settlements further apart from each other than in urban areas and with poorer transport infrastructure, making it harder to access vital services, get to work and maintain social connections. The evidence reviewed has shown that on average people living in rural areas have higher life expectancies and report slightly better wellbeing (Annual Population Survey, 2018[12]). There are higher levels of home ownership and evidence of stronger social capital compared to their urban counterparts; with 78% believing people in their neighbourhood could be trusted, compared to 61% of urban dwellers (Understanding Society, 2012[13]). National Statistics often mask the rural situation in local areas. Look beneath these figures and you can see that there are inequalities. The When the Safety net Fails 2023[14] report produced by Citizens Advice Shropshire outlined that those higher levels of home ownership disguise higher levels of fuel poverty, with many homeowners ‘asset rich’ but ‘cash poor’. The people they spoke to told them they must make tough choices with their money all day, every day, with no room for errors. For those they spoke to, this balancing act was often impossible. It was common for people they interviewed to have gone without essentials such as adequate shelter and food.

Strong community spirit and social capital mask pockets of social isolation. Higher than average life expectancies overall hide some communities with much poorer health outcomes. The geography of rural areas can prove problematic for delivery of and access to health and care. The Task and Finish Group sessions have identified a range of the issues and

challenges, as well as potential solutions and possible action areas for rural proofing of health and care services.

The general themes identified by Members from the evidence reviewed in relation to which areas needed to be considered when thinking about rural proofing health and care services were:

Geography

The largest population centres in Shropshire are located in the market towns, the remainder of the county is more rural and sparsely inhabited. There are communities living across the wonderful landscape unlike authorities such as Cumbria where there are areas which are uninhabited. The Group therefore recognised that their recommendations must be based on an understanding of Place that embraced the fact that different communities had different needs and therefore ways to meet them.

Shropshire's beautiful landscape whilst an undeniable asset can also pose issues. The Task and Finish Group heard from community transport voluntary sector organisations, care providers and service user case studies that some rural areas in Shropshire comprise such steep valley topography that it presents an accessibility challenge. The issue of the remoteness of some homes was also highlighted with them being described as very difficult to access safely as they are up steep roads with no pavements, no public transport which serves them and poor road conditions meaning that physical and social isolation is a real risk, especially in adverse weather conditions. The Group heard from voluntary sector organisations, service user testimonies and Shropshire Council Officers how it is very difficult to receive and provide care especially domiciliary care in these circumstances.

Provision

Comparison of geographic provision
(Locations identified as geographic neighbours/sharing services, and family group local authorities)

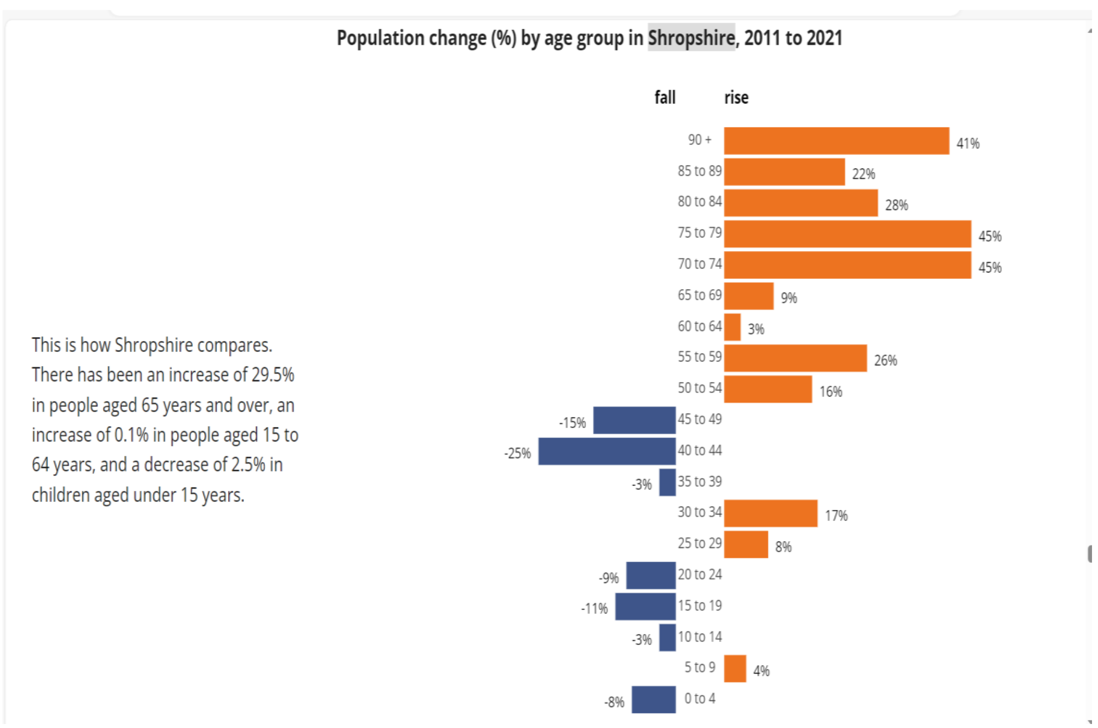
Local Authority	Area (sq. miles)	Population (Census 2021)	Population increase	65+ population	Population density (per hectare)	Additional comments	Hospitals in the area (Acute and Community)
Shropshire	1,235	323,600	5.7%	25%	circa 1 person per hectare	Households are spread across all areas of the geography.	1x Acute Hospital (RSH) 3x Community Hospitals (providing MIU) 1x Health Centre (providing MIU)
Telford and Wrekin	112.1	185,600	11.4%	17.6%	5.7		1x Acute Hospital (PRH)
Powys	2,008	133,200	0.2%	27.7%	0.26	Large areas are not inhabited due to landscape/ geography	9x Community Hospitals (4 providing MIU)
Northumberland	1,936	320,600	1.4%	24%	0.6	97% rural 50% live in 3% of urban land in the SE of county Large areas are not inhabited due to landscape/ geography	1x Specialist Emergency Care 3x General Hospitals (Urgent Care Centres) 5x Community Hospitals (3 providing MIU) 1x new integrated health and social care scheme for patients requiring inpatient support for people following illness, injury or time in hospital) 1x NHS Centre
Cornwall	1,376	570,300	7.1%	25%	1.4	40% live in communities of less than 3000 people 4m tourists per year	1x Acute Hospital 1x Hospital with 24hr Urgent Care Centre 10x Community Hospitals (9 providing MIU)

15

The Group observed that Northumberland having a similar sized population and specifically older population to Shropshire provides health services through a model which included a larger amount of local provision community hospitals. The Group did note that the distribution of the population within the two areas was very different with Shropshire seeing households spread across the whole county whilst in Northumberland most were clustered around a particular urban area in the Southeast.

Demography

The geography of rural Shropshire has huge appeal for many, including to those in later life who look to retire to the countryside. The table below [16] outlines the growth in the 50+ population and this is predicted to continue to grow in the future.



The Centre for Ageing Better summarises the findings of the Group in its Ageing in a Rural Place 2021 report.[17] Shropshire like society more widely, is undergoing an age shift with Shropshire showing a 29.5% increase in the number of people aged 65 and over between 2011 and 2021. The rapid demographic change in rural areas is often driven by inward migration of older people seeking to retire and the outward migration of young people heading to towns and cities for education and work opportunities. The increase in the older population presents a specific challenge to the delivery of health services owing to greater incidences of chronic illness, disability and mortality within this demographic. Those aged 85+ are, on average, likely to have more complex (and expensive to meet) needs. This all highlights the need for rural areas to focus on a preventative approach to ensure that those in mid-life now reach later life in good health, whilst staying financially secure and socially connected.

Transport

For most people the Group spoke to, transport was a big issue. Bus routes have been cut over many years, leaving a fractured public transport system and rural residents more dependent on cars. We know from 2021 Census Data that in Shropshire 28.5% of people in employment aged 16 years and over travel 10km or more to work. Of those, 54.8% travel to work by driving a car or van. There is therefore a reliance on private motor vehicles which can impact on those not old enough to drive, who can no longer drive or who don't have access to a vehicle. The Group heard that essentials such as fuel are more expensive in rural places with the Rural Services Network reporting that it is on average 1.2 p per litre more expensive. The cost-of-living crisis has intensified these pressures making affording a car or fuel for it more challenging than ever for some.

The RSN has produced figures for 2022/2023 which show that in respect of public transport, predominantly urban authorities budgeted to spend £76.3 per head of population being some

74% more than predominantly rural councils (at £20.1 per head.) Public transport is a discretionary service and overall RSN figures show for 2022/2023 that predominantly urban councils budgeted to spend almost double the amount on discretionary services per head compared to predominantly rural authorities (£131.3 compared to £67.0.)

Transport for young people in rural areas, in particular came through, with high costs and reductions in services causing anxiety for young rural residents and their families. Although not directly a health or care issue the Group felt it was important to highlight these concerns as it was likely to have an impact on their wellbeing, access to opportunities and may be a contributing factor to the changes explored in the demographics section of this report.

Challenges for people to access health and care appointments in rural areas, came through very strongly. Patient Travel Support which provides free transport to and from hospital for eligible people including:

- those whose condition means they need additional medical support during their journey
- those who find it difficult to walk
- parents or guardians of children who are being transported

was identified as posing several challenges. Patient and service user experiences laid out that the criteria for eligibility was complex and unclear with many rural residents being signposted to community transport groups to provide support with travel to hospital even though they were not within their delivery area. The Group heard that transport provision overall for health and care services was confusing for service users to navigate.

The Group heard from community transport providers who work across the England and Wales border that Powys has an effective Patient Transport System and could be investigated to identify best practice**.**

Community transport was identified as an essential feature of community life where volunteer drivers help people access social events, shops and services including health appointments. The Group identified some areas of the county where there is no public or community provision available, and people rely on expensive taxies or family and friends to support them. This is feasible for a one-off appointment, however the group heard that for patients requiring regular ongoing treatment that costs and pressures can make attending their appointments impossible. Several risks and issues were shared which prevent current schemes expanding or new ones being created to support those in need including barriers such as:

- Fuel
- Parking
- Rising costs
- Reduction in the numbers volunteering
- Growth in demand
- Increased legislation

It was highlighted by voluntary groups who co-ordinate and organise health and social support for those living rurally how vital community transport is to their service users. Many would not be able to access their services without it and highlighted that transport is a major potential barrier to access and more specifically to prevention initiatives being successful.

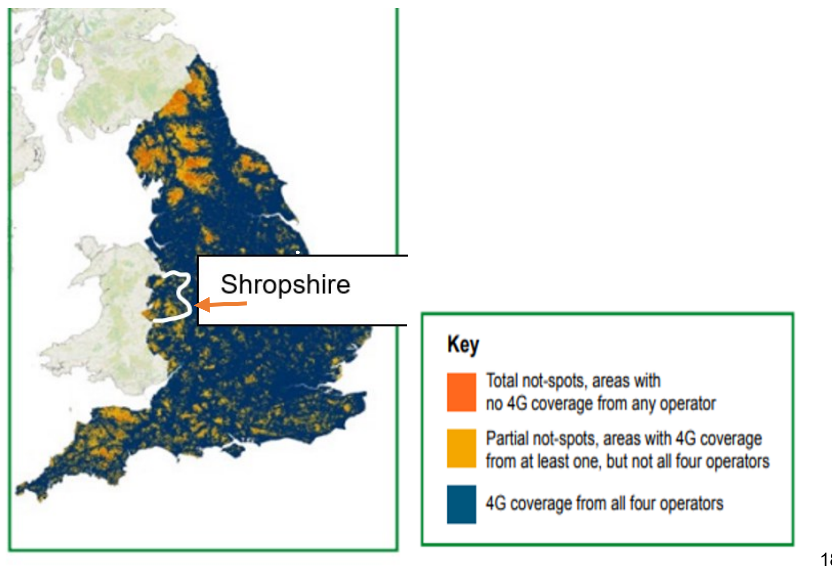
Concerns about the physical infrastructure of the road network in rural areas came through, as did safety whilst on the roads. This was highlighted by care workers and community transport volunteers who stated that with poor road surfaces, no pathways, lack of streetlighting and narrow roads that they often feared for their vehicles and at times themselves. Thus, making reaching some rural residents very challenging.

Digital Connectivity
Improving digital connectivity was highlighted as a national as well as local issue. In the government report Delivering for rural England – the second report on rural proofing [5] connectivity is described as "arguably the single most important way to support levelling up in rural areas. Digital connectivity is an important driver of productivity, enabling businesses and individuals to take full advantage of the growing opportunities available online, but it is more than just an economic necessity. It is also a matter of social justice. As more and more services, both public and private, are delivered electronically, the government does not want those who live in rural areas to be denied access to them simply because their broadband is not good enough or there is no mobile signal." P15 The government has therefore introduced two initiatives to improve rural connectivity - Project Gigabit and the Shared Rural Network.

Project Gigabit is a national initiative to provide funding to support gigabit-capable infrastructure in hard-to-reach, rural areas. The government received over 3,300 responses to its call for evidence on 'Improving Broadband for Very Hard to Reach Premises'. These responses highlighted the challenges faced by, and potential opportunities available to, rural and remote communities. The government will use this evidence to assess policy options to support those unable to access a gigabit-capable connection through either a commercial or government-funded roll-out. The government will publish further information later in 2023.

The Shared Rural Network is the second government initiative which aims to provide people with high-quality and reliable mobile coverage wherever they live in the UK. Typically, rural areas have tended to be less commercially attractive to mobile network operators and as a result some rural areas are underserved, lacking good quality reliable mobile coverage. The table below shows the 2022 levels of 4G coverage and areas with unreliable or no coverage.

In 2025 analogue copper phone services are planned to be withdrawn nationally. The Local Government Association (LGA) and National Farmers Union (NFU) have both identified potential risks with this approach. The LGA are concerned that there is a huge lack of awareness among residents about the coming changes and that there is a need for government to spread the message through communications campaigns, including adequate funding to support the above. The NFU highlights the risks to rural communities if they have to rely on a broadband connection for calling as it creates a vulnerability to power outages.
In most cases, mobile signal provides a backup in case of emergency, however, in areas of poor mobile signal, a battery back-up is expected be offered to customers so that during a power outage, emergency calls can still be made on the household phone.
The NFU and RSN are also working with BT and other providers to ensure that rural communities are not left without sufficient support and access to working home phones in any emergency situations and continue to press the importance of rural mobile access to industry and government. Members of the Group were able to provide their own experiences of vulnerable members of their communities who have been left without landline access due to analogue lines being downed in adverse weather and how it has taken up to six weeks to have these repaired, leaving residents without their emergency call buttons if they fall.



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In Shropshire health and care system too, the local digital strategies all acknowledge the vital role played by online and digital services. They also highlight that Shropshire's geography poses challenges to providing equitable access to online and digital services, but not all are explicit about how to address these. [18, 19, 20].

The Shropshire Council ICT and Digital Strategy [18] sets out how it plans to deliver equitable service access to all citizens and acknowledges that "users need more than just encouragement and education, they need affordable connectivity, they need devices, and in some instances, they will also need specialist software that supports those with disabilities." P15-16 The Strategy proposes to support citizens who don't have a computer at home, by enabling them to use public access computers at a council face to face service point. The Strategy also suggests that if someone does not have their own device that councils elsewhere have participated in schemes to redistribute unwanted but serviceable laptops, tablets and smartphones from organisations which regularly replace their devices. The Group welcomed the ideas laid out in the plan. However, from the evidence they had heard from people living very remotely with little access to transport; the Group felt that there needed to be a more proactive element to the support on offer and recommended the investigation of the feasibility of utilising mobile vehicles such as library vans where the staff are already well known to the local population and have a transferable skill set.

Whilst the Group welcomed the national and local strategies; the evidence heard demonstrated that online and digital services and products whilst offering innovative and efficient methods of delivery can also act as a significant barrier to access for some. The service user case studies highlighted the risks of creating significant inequalities for rural service users, especially the elderly and other vulnerable groups who find the move towards digital becoming an increasing barrier to accessing services. The findings of the group were summarised in the report by the Greater Manchester Digital Inclusion Network, 'Issues of wider digital and technological exclusion for older people[21]' which identified the following as barriers to access to online and digital services:

- Finance
- Impairments
- Knowledge
- Connection

These experiences were echoed by the Group themselves who were able to provide several examples where the use of online/digital access as the only method to interact with a service had caused vulnerable people to be negatively affected.

The impact of wider digital and technology exclusion was also highlighted through the evidence, identified as including:

- Reduced independence and autonomy
- Limited mobility
- Negative impact on health and wellbeing
- Anxiety inducing
- Leading to people paying more than necessary

The evidence heard by the Group bore out the findings of the LGA report Health and Wellbeing in rural areas[21] that to provide services in rural geographies an innovative mixed delivery approach is required. Including multiple points of entry to access into health and care services, multi-channel options for the use of these services including the use of mobile or outreach vehicles. This approach has been shown to provide meaningful alternatives to digital, with some face-to-face support available within accessible locations or being taken to the most vulnerable.

The direction of travel for many organisations is to online, with digital application processes as default. Whilst the Group acknowledges there are many benefits to this way of working, they were presented with robust evidence that many rural areas in Shropshire still lack the infrastructure to deliver a consistent phone signal or allow people to get online. The Group also identified the fact that there will always be individuals who need alternative ways to access services. With these individuals often being some of the most vulnerable.

Recruitment and Retention

The Group heard that there are nationally recognised challenges to recruit into both the health and care sector. The national NHS Long Term Workforce Plan 2023[23] seeks to put staffing on a sustainable footing and improve patient care. It is focussed on retaining existing talent and making the best use of technology alongside a large recruitment drive. This includes creating skills to work in multidisciplinary teams and to enable more digital adoption especially in helping to address geographical inequity. The approach is described in the plan as addressing "[I]mbalances in geographical distribution of training posts and is not confined to medical training. Other professional groups also require a more equitable spread of training opportunities, based on current and future patient need. ICS's will be able to consider local needs and respond to geographical inequity, via reform of education funding policy, and increased use of apprenticeships and blended learning opportunities. Work is already underway within pilot ICS's as part of the rural and coastal workforce transformation programme to implement education, training and workforce transformation solutions, aimed at improving attractiveness of jobs and retention of the healthcare workforce in these locations." P85

Locally the Group heard lots of anecdotal evidence from service users, voluntary sector organisations and Members that the Shropshire health system is finding it hard to recruit in rural areas. This was confirmed by the Integrated Care Board and the Shropshire Community Health Trust and that both were investigating new ways of attracting and retaining staff in rural areas.

The Rural Services Network has drawn together some options for addressing these issues in their article 'Working with Rural Communities; Promoting Rural Best Practice[24].' Which outlines the headline findings from a lecture by Professor Roger Strasser on his widely appraised rural workforce research. Professor Strasser is a leader in the global reform of health professional

education and has become one of the world's foremost authorities in rural, socially accountable medical education. His lecture included examples of available strategies which health organisations can employ to attract their workforce to rural areas:

- The NHS England's **programme to help tackle health inequalities in rural and coastal areas**;
- The importance of, "access to digital online resources [as being] key to reaching out to rural communities."
- The **knowledge and library services** gives all NHS staff the right knowledge and evidence to achieve high-quality, safe healthcare and health improvement;
- Highlighted the retaining of staff is as important as recruitment, stating, "It's important to recruit but also to ensure we keep the people we've got." The **RePAIR**(Reducing Pre-registration Attrition and Improving Retention) project has enabled us to gain an in-depth understanding of the factors impacting on healthcare student attrition and the retention of the newly qualified workforce in the early stages of their careers; and also said, "The first step to a facilitated rural career pathway is the promotion of health careers," whereas our **Health Careers website** offers information of over 350 career choices in the NHS.
- In addition to these programmes, through **the Enhance Generalism Leadership and Social Medicine Programme**, we are training healthcare professionals to fully understand the needs of rural and coastal communities by working with and for the communities to better healthcare provision.

Within the social care sector, high vacancy and turnover rates are also a notable feature, most obviously in domiciliary care services which has been accelerated through societal factors following the Covid Pandemic and the Cost-of-Living Crisis. However, rural health and care workforce issues are much broader. It was heard that care agencies were not able to accept some rural clients as they could not guarantee being able to provide regular care workers due to:

- Damage to cars from narrow or potted roads
- Distance
- Lack of affordable housing
- Cost of fuel
- No public transport
- Narrow roads with no footways
- Travel time

Shropshire Council Officers agreed that workforce is a significant issue both internally and externally' with 66% of external care providers surveyed by Shropshire Council finding recruitment and retention difficult.

Several local solutions were outlined by Shropshire Council Officers ranging from recruiting bank care staff on casual contracts to reduce the need for agency staff enabling Shropshire Council to maintain a consistent service with their own well-trained staff. To working with the sector to ensure a fair wage, opportunity to training and career progression; supporting managers to create a supportive work environment. The Members were pleased to hear about these developments along with regional work which is taking place to develop an operating model for a social care apprenticeship academy.

System Working
From the evidence heard at the sessions Voluntary, Community and Social Enterprise (VCSE) involvement and leadership has been key to supporting people within the Shropshire health and care system. It is through a system wide approach supported by the VCSE sector that has delivered some progress towards addressing rural health inequalities and supporting people with complex and multiple needs.

However, the Group heard that demand for these services is increasing, and that funding is not keeping pace with this demand. VCSE organisations reported that they were not always included at an early enough stage of planning for the local authority and NHS Trusts to understand the operating realities of their organisations and for meaningful co-production to take place, producing the best outcomes.

The voluntary organisations explained that there are several factors which are making operating more challenging, they are:

- The impact from the cost-of-living crisis
- Increased levels of support required
- Charitable giving is lower
- The emotional and financial costs of the pandemic are still being felt
- Reduction in funding
- Fragility of sector

It was recognised by both the Group and the voluntary sector representatives that the Rural Proofing for Health Toolkit included prompts which addressed considerations regarding the VCSE especially what is already being provided in the community thus, avoiding duplication and an over reliance on the voluntary sector.

Shropshire Council Officers explained that the local Joint Strategic Needs Assessments (JSNA) being carried out by Public Health is a key element of being able to unpick what is happening in local areas with the eventual aim of being able to break that down further to household levels. Working in this way was identified as a national challenge, and that Shropshire Council are working with other rural partners and local authorities who have the same issues to share learning.

The Group identified from the evidence heard that Shropshire Council has a leadership role to play in co-ordinating and commissioning services, providing investment and building trusted relationships across sectors. Clear communication and recognition of the expertise, professionalism and reach of the voluntary sector will help to make sure that all players in the local support system feel like equal partners. The voluntary sector is grounded in communities and understands the nuances of the local context. It acts as an indispensable ally and advocate for local residents. Voluntary organisations and community groups help people to navigate support systems. They piece together information and entitlement from different sources. The voluntary sector does complex work. This needs to be communicated and understood across the local system. Voluntary sector partners will be crucial to meet the challenges we are all currently facing. Funding for the voluntary sector needs to be future-proofed, to ensure the sector is able to recruit and retain the skilled staff it needs as local support services are under a lot of strain. Voluntary and Community Sector Assembly (VCSA) study showed 80% of local voluntary organisations have struggled to recruit in recent months. 68% have concerns about staff leaving their organisations because of low pay. Their demand is growing, and they cannot do what they do without investment.

There were examples provided by the voluntary sector of strategic joined up working between Borderlands Rural Chaplaincy, The Mental Health Trust and Local Authority in Herefordshire

and outlined how this had improved the service being provided to people living rurally. The Group proposed that this could be a case study to learn from.

Mental Health

One of the challenges that were identified for health care providers is how to plan and design child and adult mental health services which are sustainable across larger rural geographies and are accessible to their dispersed communities.

VCSE representatives explained how there could be a real improvement in the strategic leadership and so provision of mental health services in Shropshire including addressing rural health inequalities if there was a dedicated mental health commissioner. They explained that Telford and Wrekin Council have a mental health commissioner and that it helps to provide strategy and direction which assists the system to provide appropriate services.

Officers at Shropshire Council agreed that it would be valuable to have a mental health commissioner for Shropshire in the same way that other local authorities do and explained that to support this a 12-month temporary role had been created but that it was hoped that this could be made permeant due to the expected positive impact it would have.

Role of Members

A frequent theme of the groups discussions was the role Members play in decision making and information sharing. It was agreed that councillors and officers are indispensable to one another and effective communication between both is essential for effective system working. There were numerous instances during the Groups sessions where the Members discovered they were unaware of the services which were on offer to the public and that they felt as elected Members that a real opportunity for them to communicate these to their constituents was being missed.

Another missed opportunity which the Group identified was for councillors to be made aware of planned alterations of or introductions of services across the health and care system so they could represent their communities and inform planning at an early stage.

Equality, social inclusion and health impact assessments (ESHIAs)

In Shropshire Council, the screening tool that is used to give due regard to the impacts of decisions on its citizens is referred to as an Equality, Social Inclusion and Health Impact Assessment (ESHIA). This is a single screening template, usually presented as an appendix to a committee report usually to Cabinet or to Strategic Licensing Committee, which sets out to ensure that “due regard” is being given to equality, equity, social inclusion and health and wellbeing, alongside economic impacts assessment and environmental/climate change impact assessment.

The group heard that social inclusion, health and wellbeing, and economic and climate change impact assessments are not legal requirements under the Equality Act 2010, but that together with the legal requirements in regard to equality, they add value or at least ensure that the council is visibly seeking to take a holistic view of impacts and identify where and how any anticipated positive impacts may be enhanced and where and how any anticipated negative impacts may be minimised.

The ESHIA screening thus sets out to ensure that “due regard” is being given to equality, equity, social inclusion and health and wellbeing, alongside economic and environmental impacts, in line with the local aspirations as set out in the Shropshire Plan as well as national legal obligations. Since 2014, the Shropshire Council equality impact screening assessment has encompassed consideration of social inclusion, including consideration of rurality impacts. These may also be considered within economic impacts.

The Integrated Care System uses an Integrated Impact Assessment Tool which is applied to understand which groups may be impacted by any proposed changes to the way health and care are delivered. This aims to identify whether to engage specific groups or individuals to help reduce inequalities and ensure they are not added to. This is also informed by the Shropshire and Telford & Wrekin Joint Strategic Needs Assessments and evidence on health inequalities. The ICB has an Equalities and Involvement Committee that reviews and scrutinises Integrated Impact Assessments. This is chaired by a Non-Executive Director lead for health inequalities and membership is from within communities.

The Group found there was robust evidence of Impact Assessments taking place but were concerned that despite harmful factors being identified in Equality Impact Assessments decisions are still able to proceed, and a course of action may potentially be agreed upon at committee despite negative impacts being identified.

Against this should be set that there are obligations not only to identify likely impacts and risks of proceeding but also to seek to adjust a proposal or service change or clarify why this is not going to be undertaken, and to review and monitor the effectiveness of mitigating actions taken to minimise negative impacts. This equally includes actions to enhance positive impacts.

Public sector equality duty – s49 Equality Act 2010

In summary,

“A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.”

Any decision made in the exercise of any function is potentially open to challenge if the duty under s149 has been disregarded. Not all decisions of a local authority will engage the duty; a decision-taker is obliged to consider an equality issue only where there is some reason to believe that the proposal may raise such an issue and it won’t arise where, on analysis, there has been no change to an existing policy.

There is a substantial body of case law in which the principles have been discussed and applied. The question whether there has been "due regard" has been paid to equality needs is for the court to determine and it will generally be dependent on the facts and circumstances. Some general principles have emerged, however, from the caselaw and they include:

- equality duties are an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.
- The decision-maker must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy and not merely as a "rear-guard action", following a concluded decision.
- *"The concept of 'due regard' requires the court to ensure that there has been a proper and conscientious focus on the statutory criteria, but if that is done, the court cannot interfere with the decision simply because it would have given greater weight to the equality implications of the decision than the decision maker did. In short, the decision maker must be clear precisely what the equality implications are when he puts them in the balance, and he must recognise the desirability of achieving them, but ultimately it is for him to decide what weight they should be given in the light of all relevant factors."*

The undertaking of a formal Equality Impact Assessment is not mandated by the 2010 Act, but the production of an EIA in appropriate form in advance of the decision is usually convincing evidence that due regard has been had to the PSED.

Decisions in a wide range of contexts have been quashed (i.e. ruled as of no effect because they are unlawful) where there has been a failure to pay any or any sufficient attention to the PSED obligation. Conversely, in many cases authorities have been found on the facts to have paid "due regard" to the matters set out in s149.

Where a breach of the PSED is established, the court as a matter of discretion may decide not to quash the decision, but merely to grant a declaration that there has been non-compliance. This will depend on the facts of the case and whether the outcome would have been substantially different if a breach of the PSED had not occurred."

Rural Proofing for Health Toolkit (Appendix 2)
The Group heard from Graham Biggs in his role as Rural Policy Advisor at the Rural Services Network and a Director of the National Centre for Rural Health and Care and Brian Wilson from Rural England C.I.C who is one of the authors of the toolkit. The Group learned that the Toolkit seeks to help those in the health and care sectors to address the needs of their rural populations when they develop strategies, initiatives and service delivery plans.

The Toolkit is based around six main themes:
- Main hospital services
- Primary and community health services
- Mental health services
- Public health and preventative services

- Social care services
- Workforce

The Toolkit defined 'rural proofing' as a "systematic approach which identifies any notable rural differentials likely to impact on service effectiveness and outcomes. It assists service providers by enabling thinking about appropriate solutions, mitigations and opportunities. The objective is to ensure equitable outcomes for service users who live in rural areas."

Rural Proofing can help to:

- Optimise the outcomes achieved by strategies and plans
- Demonstrate a commitment to act equitably and benefit all communities
- Support locality-based approaches to working and services
- Design out any unintended gaps in service provision
- Identify opportunities to innovate or make better use of available resources
- Embed good practice within strategy and plan making" p4

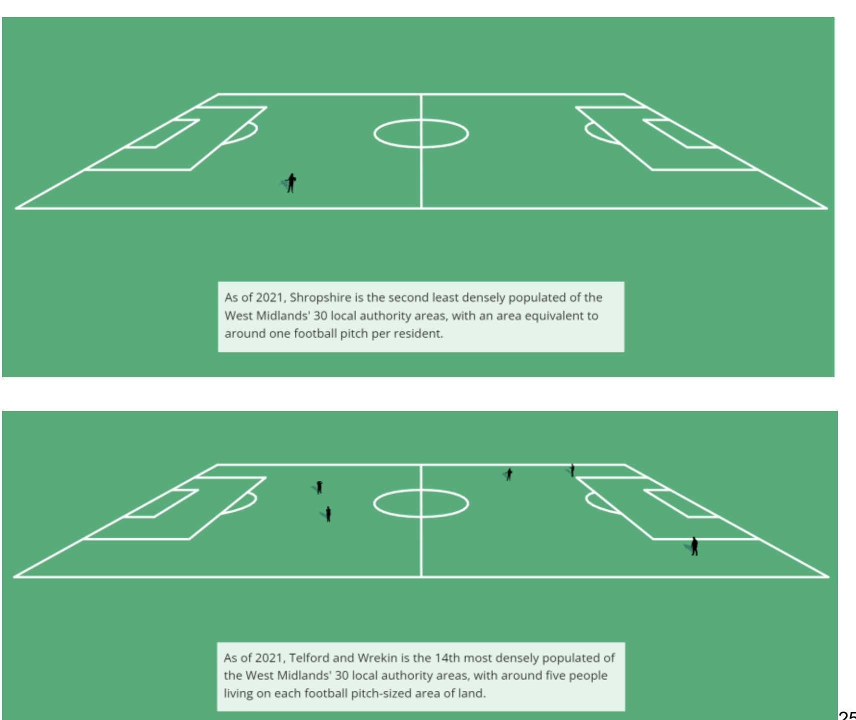
The Toolkit recognises that rural areas have distinct geographies, often characterised by a dispersed population and small settlements and that this presents challenges both for providers who deliver services and residents who use them and is therefore designed to be used across different types of rural geographies, from remoter or sparsely populated areas through to mixed areas, where a rural hinterland adjoins larger urban settlements.

The Group felt from their own review of the Toolkit that through its structure it meant that all of the themes they had identified which needed to be considered when 'rural proofing' a health and care service were covered. This coupled with the evidence presented to them by the speakers and the endorsements for the Toolkit from bodies such as Health Education England and the World Health Organisation led them to feel confident that this Toolkit provides an effective framework for the Shropshire health and care system to work from when amending or developing strategies, initiatives and service delivery plans.

Conclusions

Objective 1: Set out/define what 'rural' and 'rurality' means for the Shropshire Council area, including inequalities and access to services

The official government definition is that urban areas are defined as settlements with populations of 10,000 or more people. Rural areas are those areas outside of these settlements. They make up over 80% of England's land and are home to around a fifth of the English population. In Shropshire around 57% of the population of 323,600 (2021 Census) live in villages, hamlets and dwellings dispersed throughout the countryside[26]. There are 18 market towns and key centres of varying size, including Ludlow and Bridgnorth in the south, Oswestry in the north, and Shrewsbury, the central county town. An additional dynamic is that unlike for example Cumbria, the population is dispersed across the entire county, rather than there being any areas where no one lives at all.



[25]

Therefore, the Task and Finish Group concluded that due to Shropshire's geographical make up; the national definition will in Shropshire include towns (below 10,000 population) as well as villages, hamlets and isolated dwellings. As the rural area types in Shropshire vary from sparsely populated areas through to areas adjacent to larger urban areas it is important that the individual characteristics of these differing areas are considered. The Task and Finish Group saw through their work that the national rural urban classification is often used as the basis for the analysis undertaken when 'rural proofing', but that this is often not sufficient as it lacks granular detail.

The Task and Finish Group have therefore concluded that in Shropshire the official government definition which is used by most organisations should be enhanced through the evidenced consideration of these four characteristics which are taken from the Rural Proofing Practical Guidance to Consider the Outcomes of Policies in Rural Areas 2022[27]:

• **Demographics:** There are proportionately more elderly people and fewer younger people in rural populations compared with urban ones.
• **Access to services**: The combination of distance, transport links and low population density in rural areas can lead to challenges in accessing and providing services.
• **Service infrastructure**: Lower levels of infrastructure such as low broadband speeds and variable mobile coverage can be a barrier for rural businesses and limit the growth in rural productivity.
• **Employment:** The variety of employment opportunities, the availability of people with the right skills, and access to training can be lower in rural areas.

The Group found that these four areas were comprehensively addressed within the Rural proofing for Health Toolkit (Appendix 2)

Objective 2: Understand what rural proofing means for Shropshire

The task and finish group have agreed to adopt the definition of rural proofing from the Rural proofing for Health Toolkit (Appendix 2)

"The term 'rural proofing' is used to define a systematic approach which identifies any notable rural differentials likely to impact on service effectiveness and outcomes. It assists service providers by enabling thinking about appropriate solutions, mitigations and opportunities. The objective is to ensure equitable outcomes for service users who live in rural areas." P4

Objective 3: Identify a view/position on rural proofing affecting Shropshire communities and services (based on work during the year), and through additional research

The group agreed that rural proofing should start at the earliest possible stages of policy development and strategic planning and continue beyond policy evaluation to be included in every development or significant change to policy, planning or service delivery. This does not need to be complicated and can be built into any consultation and policy development process.

Objective 4: Use the evidence collected to propose a consistent set of criteria to be recommended for use to evaluate rural proofing in strategies, plans, policies and service design and provision in health and care in Shropshire.

The group agreed that the use of the Rural Proofing for Health Toolkit be recommended to all partners of Shropshire's Health and Care system. That the Toolkit also be adopted for use by the HOSC and JHOSC to review any changes or new services that are being implemented to ensure they have been 'rural proofed'.

Recommendations

The members of the Task and Finish group are aware that there is ongoing work underway in the Shropshire health and care system, and at a national level, to address how health and care services are delivered equitably in rural areas. If work that would deliver all or part of a recommendation is already planned or underway, please can this be set out in the responses to any accepted recommendations including what is being done, the timelines for action, and how the impact and progress will be evaluated. Please note that the recommendations are ordered chronologically and carry an equal weighting.

1. **Recommendation:** That an end-to-end evaluation of the travel and transport infrastructure which supports the Shropshire health and care system should be completed by the Integrated Care System to understand how effective the current provision is and to identify current and future demand. The evaluation should include:
    - Patient Travel Support
    - Public Transport
    - Concessionary Travel
    - Community Transport
    - A review of how health and care transport is co-ordinated at a system level
    - A mapping exercise to identify community capacity available to deliver voluntary community transport schemes, and whether there are sufficient services available and how best to provide an equitable service closing the gaps overall and in specific locations.

2. **Recommendation:** The group recommends that rurality and the accessibility factors that are associated with it becomes a key consideration for Shropshire's health and care system (including Shropshire Council) when adapting or introducing a new service or policy and recommend the use of the Rural Proofing for Health Toolkit to achieve this.

3. **Recommendation:** That an evaluation be undertaken by Shropshire Council to understand the impact of digitalisation on protected and vulnerable demographics (including those living rurally.) Understanding more about the current and future needs in different communities and investigating alternative delivery models to provide the infrastructure, access to equipment and support to enable all communities to benefit from the advantages which digital services can provide. The evaluation should include:

    - Mapping mobile coverage and broadband access and use across Shropshire.
    - Developing/strengthening partnerships with broadband providers to help identify and support people experiencing digital exclusion?
    - Working with telecoms providers to ensure that vulnerable people are not left without the means to seek help in an emergency through line outages
    - Identifying the impact to vulnerable users of the plans to remove all analogue copper phone services nationally by 2025
    - Working with other council departments, NHS partners, voluntary and/or faith organisations and district councils, to build on the model of an integrated services hub to enable people to access a number of services in one locality

4. **Recommendation:** That an evaluation be undertaken by Shropshire Council in their role as commissioner and Place co-ordinator to understand how the Council's intelligence and data gathering function can contribute to discussions and research on how to identify small pockets of deprivation in rural communities. Testing how ambitious the strategic plans are about strengthening the power of community, leading the way by using robust data to identify the challenges facing different areas, building local capacity, embracing coproduction and community delivery, and devolving power and resources to neighbourhoods.

5. **Recommendation:** The Groups research has shown that local support from the voluntary sector does, and will continue to play, a vital role in supporting residents by providing access to health and care services in rural locations. However, as resources are required to do this; sufficient understanding of the needs of the voluntary organisations and planning time needs to be built into the system. The Group recommends that the Rural Proofing for Health Toolkit be completed alongside the impact assessment process, as in each section it includes prompts to consider the ask being made of the voluntary sector.

6. **Recommendation:** The Group were very pleased to learn that the Rural Proofing for Health Toolkit had been recommended for use within the Integrated Care System (ICS) by Simon Whitehouse (Chief Executive Officer for Shrewsbury Telford and Wrekin Integrated Care Board) and Cllr Cecelia Motley (in her role as Co-Chair of the Health and Wellbeing Board.) The Group recommends that the Toolkit be fully adopted into the Integrated Impact Assessment process of the ICS and all organisations whom it commissions and be accepted as a mandatory document to be completed when making changes to or introducing a new strategy or plan making process, so it can inform thinking from the outset.

7. **Recommendation:** That the Shropshire Health and People Overview and Scrutiny Committees adopt the Rural proofing for Health Toolkit as a part of their own overview and scrutiny processes to support them in maintaining a robust view on the needs of their local rural populations when they review strategies, initiatives and service delivery plans.

8. **Recommendation:** Whilst this Group have focussed on rural proofing specifically in the health and care system their findings have shown that its impact is much wider ranging and relevant to all areas of the Council and the support provided to rural communities. The Group therefore recommends that the Shropshire Council 2020 Community and Rural Strategy be updated and implemented.

9. **Recommendation:** That the Rural Proofing for Health Toolkit be recommended for use to its partner local authorities of Telford and Wrekin to support the work of the Joint Health and Overview Scrutiny Committee. To the Shropshire Association of Local Councils for use in their work as Parish Council's, creating a consistency of approach to rural proofing. Then this be expanded to Herefordshire, Monmouthshire and Powys as with evidenced cross border working through shared interests and the new Marches Forward Partnership, the Group recommends that the adoption of this Toolkit forms part of the Memorandum of Understanding by all the authorities which will contribute towards a shared understanding of the opportunities and challenges of delivering health and care services to rural communities.

10. **Recommendation:** That communication between Council officers, system partners and councillors be reviewed to ensure that the best use of councillor's knowledge of their communities and where there may be previously unidentified health needs. It is recommended that regular briefing updates are provided to councillors from Council officers and system partners so that Members are aware of developments in service delivery and can feed in their local knowledge to the work being developed, sharing new developments and service offers with their communities especially supporting with facilitating communication with historically hard to reach groups.

11. **Recommendation:** That an agreed system approach to 'local' be defined to assist with having comparable data at a local rather than regional level. With Shropshire Council using its role as a public health authority and leader of the Health and Wellbeing Board to ensure that rural communities' travel time to services is an integral factor in the planning of services in the health and care sector.

12. **Recommendation:** That the process and legal obligations for Equality, Social Inclusion and Health Impact Assessment (ESHIA) in terms of responding to impacts identified through the ESHIA be clarified for Officers and Members and until then that this matter be logged on the Shropshire Council strategic risk register.

13. **Recommendation:** That a deep dive be carried out into recruitment and retention policies and practices in the Shropshire health system by the Joint Health Overview and Scrutiny Committee including a review of best practice nationally encompassing the approaches recommended by the Rural Services Network to see if they would work in Shropshire.

14. **Recommendation:** That a permanent Mental health Commissioner role be appointed for Shropshire Council to provide system oversight and strategic leadership.

Appendices

Appendix 1

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

Lois Dale- Performance and Research Specialist: Rurality and Equalities Shropshire Council (in person)
Heather Osborne- Chief Executive Age UK Shropshire Telford and Wrekin (in writing)
Marie Monk-Hawksworth- Chief Executive Officer The Friendly Transport Service (in person)
Nicola Daniels- Chief Officer Mayfair Centre **(**in person)
Graham Biggs-Rural Policy Advisor Rural Services Network and a Director of the National Centre for Rural Health and Care (in person)
Sue Chalk- Head of Service Community Resource (in person)
Brian Wilson-Rural England CIC Author of Rural Proofing for Health Toolkit (in person)
Clive Ireland- Chief Executive of Shropshire Mental Health Support Group (in person)
Nick Henry- WMAS Paramedic Practice and Patient Safety Director (in person)
Jason Evans- WMAS Associate Director, West Midlands 999 and NHS 111 Commissioning Team (in person)
Vivek Khashu – WMAS Strategy and Engagement Director (in person)
Gemma Smith- Director of Strategic Commissioning NHS STW ICB (in person)
Tracey Jones- Director of Mental Health, Learning Disabilities & Autism, and Children & Young People. **ICB Lead Health Inequalities and LTP prevention** (in person)
Heather Bowness - Chief Executive New Dawn Care Agency, Onibury (in person)
Sarah Price - Director, Clinical Lead and Nominated Individual CM Bespoke Care Ltd (in person)
Aston Price (AP)- Care Worker CM Bespoke Care Ltd (in person)
Rachel Wintle- Registered Manager New Dawn Care Agency, Onibury (in person)
Rachel Robinson -Executive Director of Health Shropshire Council (in person)
Bernie Lee- Public-Health Lead Shropshire Council (in person)
Cllr Cecilia Motley -Portfolio Holder Adult Social Care, Public Health and Communities (in person)
Laura Tyler- Assistant Director Joint Commissioning Shropshire Council (in person)
Natalie McFall- Assistant Director Adult Social Care Shropshire Council (in person)
David Shaw - Assistant Director Educations and Achievement Shropshire Council (in person)
Sonya Miller - Assistant Director Children's Social Care Shropshire Council (in person)
Rev'd Nick Read-Borderlands Rural Chaplaincy (in writing)
Jane Latter- Co-ordinator Shropshire Rural Support (in writing)
Andrew Bebb- Chair of Shropshire Rural Support (in writing)
Paul Bowers- Head of Operations MPFT (in person)
Inspector Gordon Kaye- West Mercia Police (in person)
Rabinder Dhami- Prevention Manager Shropshire Fire and Rescue Service (in person)
Dr Tim Little- Clinical Director North Shropshire Primary Care Network (in person)
Dr Jess Harvey- Clinical Director Southeast Shropshire Primary Care Network (in person)
Dr Deborah Shepherd - Clinical Director Southwest Shropshire Primary Care Network (in writing)
Sam Townsend- Divisional Clinical Manager, Adults and Community Services
Shropshire Community Health NHS Trust (in person)

Appendix 2

Rural Proofing for Health Toolkit (1).pdf

References

1. Time for a strategy for the rural economy (parliament.uk)
2. Health care in rural areas - House of Lords Library (parliament.uk)
3. Rural Proofing Report 2020 (publishing.service.gov.uk)
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6. Written questions and answers - Written questions, answers and statements - UK Parliament
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9. hwbb-strategy-2022-2027.pdf
10. Final local government finance settlement: England, 2022 to 2023 - GOV.UK (www.gov.uk)
11. shropshire fact sheet.pdf (rsnonline.org.uk)
12. Annual population survey (APS) QMI - Office for National Statistics
13. Understanding Society: Findings 2012 A complex and fascinating portrait of society | Understanding Society
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15. Date (shropshire.gov.uk)
16. Shropshire population change, Census 2021 – ONS
17. Ageing-in-rural-place.pdf
18. Appendix A ICT and Digital strategy final.pdf (shropshire.gov.uk)
19. Trust-Digital-Strategy-2022-25.pdf (sath.nhs.uk)
20. STW-Integrated-Care-Board-Appendices-FINAL.pdf (shropshiretelfordandwrekin.nhs.uk)
21. 211217 GM DIAN wider issues of digital + tech exclusion for older people.pdf
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23. NHS Long Term Workforce Plan (england.nhs.uk)
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25. https://www.ons.gov.uk/visualisations/censuspopulationchange/E06000051/
26. www.gov.uk/government/collections/rural-urban-definition
27. rural-proofing-guidance.pdf

<table>
<tr><td colspan="7">SHROPSHIRE HEALTH AND WELLBEING BOARD
Report</td></tr>
<tr><td>Meeting Date</td><td colspan="6">19 September 2024</td></tr>
<tr><td>Title of report</td><td colspan="6">Children and Young People JSNA update</td></tr>
<tr><td>This report is for
(You will have been advised which applies)</td><td>Discussion and agreement of recommendations</td><td></td><td>Approval of recommendations (With discussion by exception)</td><td>x</td><td>Information only (No recommendations)</td><td></td></tr>
<tr><td>Reporting Officer & email</td><td colspan="6">Rachel.robinson@shropshire.gov.uk and
Jessica.edwards@shropshire.gov.uk</td></tr>
<tr><td rowspan="4">Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply</td><td>Children & Young People</td><td>x</td><td colspan="3">Joined up working</td><td>x</td></tr>
<tr><td>Mental Health</td><td>x</td><td colspan="3">Improving Population Health</td><td>x</td></tr>
<tr><td>Healthy Weight & Physical Activity</td><td>x</td><td colspan="3">Working with and building strong and vibrant communities</td><td>x</td></tr>
<tr><td>Workforce</td><td></td><td colspan="3">Reduce inequalities (see below)</td><td>x</td></tr>
<tr><td>What inequalities does this report address?</td><td colspan="6"></td></tr>
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Report content - Please expand content under these headings or attach your report ensuring the three headings are included.

1. Executive Summary

This report presents to the Health and Wellbeing Board the final drafts of two out of five chapters of the Children and Young People JSNA:

- Population and Context for children and young people
- Early Years (0-4 years)

These chapters were presented to the Health and Wellbeing Board in April 2024 for feedback and comment. Following this, the chapters have been thoroughly reviewed by the Early Help & Prevention Partnership Board and Shropshire Integrated Place Partnership Board and were well received. Recommendations were jointly developed and are presented to the Board. We are seeking approval of the two JSNA chapters and endorsement of the recommendations.

2. Recommendations

Recommendations are based on the Areas of Need highlighted in the 0-4 year olds chapter (Appendix 2, pages 119 onwards):

1. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.
2. To continue to monitor **child and infant mortality**, adjusting action plans as required to ensure appropriate mitigations are in place.
3. To improve data recording to show the accurate position of **emergency admissions of 0-4s,** distinct from 0-4s who required same day emergency care. To monitor the level of emergency admissions of 0-4s and take appropriate action.
4. To increase uptake of pregnancy and childhood **immunisations** to provide protection and reduce the risks associated with these illnesses.
5. To continue to increase **breastfeeding rates** at 6-8 weeks to achieve at least the national average.

6. To continue to increase and monitor the number of families **accessing the mandated contacts** offered by the health visiting service.
7. To ensure the **cost of living** support and support for health and wellbeing is well promoted through all services, including promoting the take up of **healthy start vouchers**
8. To reduce the number of 0-4 year olds whose **parents use drugs and alcohol** who become looked after and to increase the number of parents receiving **appropriate support at the earliest opportunity.**
9. To reduce the number of 0-4s **living in households where domestic abuse** occurs by supporting the workforce to **identify perpetrators** and support them to **behaviour change programmes**
10. For all health and social care agencies to ensure they appropriately assess the **mental health** needs of the child, mother and family and signpost to relevant services and intervention.
11. To develop **Women's Health Hubs** across Shropshire aligning with development of **Community & Family Hubs** to improve outcomes for women & children aged 0-4.
12. To publish the **Best Start for Life offer** to enable families to access information about services and support to increase visibility and accessibility of services and improve child outcomes.
13. To continue to increase **awareness of early help and prevention offers** to support families and prevent escalation.
14. To continue to monitor the level of children who are **overweight or obese at reception** and to deliver on the Early Years actions of the Healthier Weight Strategy
15. To engage with **stakeholders to inform delivery of recommendations**.

3. Report

The Children and Young People JSNA will provide a detailed understanding of the needs of children, young people and families in Shropshire to inform the direction and development of local services, with a view to reducing health inequalities through identification, prevention and early intervention. Due to the vast scope of this report, Shropshire's Children and Young people JSNA is structured as a 'JSNA pack', comprising of individual chapters for each stage of the life course:
1. Population and context for children and young people
2. Maternity (pregnancy & birth)
3. Early Years (0-4 years)
4. School aged children (5-11 and 11-16 years)
5. Young people (16-19 years)

Population and context for children and young people chapter and Early Years (0-4 years) now in final draft:

Population and context for children and young people chapter – Appendix 1
This chapter presents data and intelligence about Shropshire's overall population, children population and the factors that can affect health or impact on health inequalities, such as deprivation, poverty, drugs and alcohol and rural inequalities.

Early Years (0-4 years) chapter – Appendix 2
This chapter presents an overview of the health and wellbeing of babies, infants and children aged 0-4 across Shropshire. Other chapters are referenced throughout to refer to for certain insights and further information. The period between conception and the age of 5 is recognized as having a significant influence on a person's life. The environment a baby experiences whilst in the womb and the first 2 years of life are particularly critical for cognitive, emotional and physical development, likewise, the health and mental health of parents at this time is also critical to family health and wellbeing.

Given the broad range of needs and services for children under 5 years, this report is not an in-depth review of any one specific service, but instead aims to:

- describe the population profile of children under 5 and their families in Shropshire- please also see the Population and Context chapter
- identify risk factors that impact on maternal, infant and child health outcomes - please also see the Population and Context chapter
- provide an overview of the wider determinants of health and their impact on the under 5s and their families- please also see the Population and Context chapter
- identify relevant national guidance and local policy in relation to early years
- provide an overview of the health and wellbeing of under 5s
- provide an overview of current service provision and assessment of outcomes including gaps in relation to domains impacting on early childhood outcomes; physical, psychosocial and emotional, cognitive and language development
- identify vulnerable children, and/or at-risk groups
- identify gaps, barriers, and unmet needs in current service provision

The timeline for completion of the Children and Young People's JSNA chapters is shown below:

- September 2024 – Presentation of Population and Context and Early Years (0-4s) chapters to the Health and Wellbeing Board for approval
- Late September 2024- Publication of the Population and Context and Early Years (0-4s) chapters
- October 2024- Presentation of remaining chapters: Maternal health, School aged children and Young people to ShIPP
- November 2024- Presentation of the remaining chapters: Maternal health, School aged children and Young people to the Health and Wellbeing Board
- Early December- publication of remaining three chapters of the CYP JSNA
- January 2025- commencement of webinars to showcase and promote the JSNA

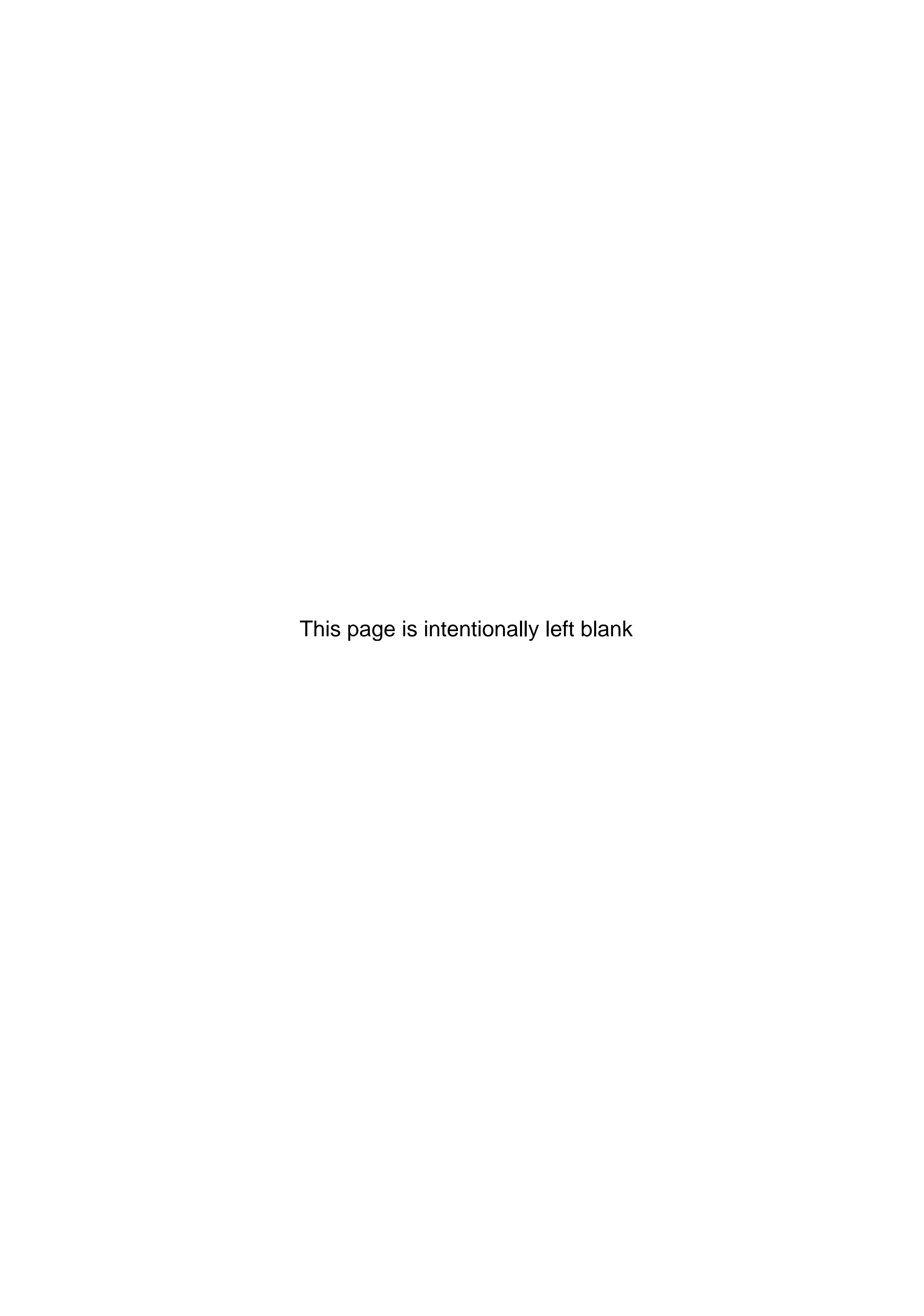
Delivery of the JSNA recommendations will be undertaken and monitored. Further updates on delivery and impact will be brought to the Board.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	None	
Financial implications (Any financial implications of note)	None	
Climate Change Appraisal as applicable	None	
Where else has the paper been presented?	System Partnership Boards	ShIPP, Early Help Partnership Board
	Voluntary Sector	ShIPP, Children's Practice Oversight Group
	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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead**
Cllr Cecilia Motley

Appendices
Appendix A. Population and Context Chapter – Children and Young People
Appendix B. Population & Context JSNA Summary – presentation
Appendix C. Early Years (0-4 year olds) Chapter
Appendix D. Early Years JSNA summary – presentation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Children and Young People Needs Assessment

Chapter 1: Population and context

2024

Authors:
Raqeebah Agberemi, Senior Public Health Intelligence Analyst
Jessica Edwards, Public Health Intelligence Manager

Introduction

The Children and Young People JSNA will provide a detailed understanding of the needs of children, young people and families in Shropshire to inform the direction and development of local services, with a view to reducing health inequalities through identification, prevention and early intervention.

Due to the vast scope of this product, Shropshire's Children and Young people JSNA will be structured as a 'JSNA pack', comprising of individual chapters for each stage of the life course:

Core JSNA chapters

1. Population and context for children and young people
2. Maternity (pregnancy & birth)
3. Early Years (0-4 years)
4. School aged children (5-11 and 11-16 years)
5. Young people (16-19 years)

This chapter presents data and intelligence about Shropshire's overall population, children population and the factors that can affect health or impact on health inequalities, such as deprivation, poverty, drugs and alcohol and rurality.

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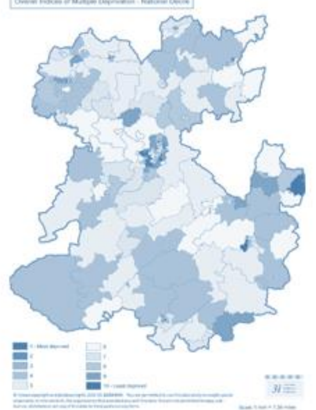
Shropshire Population

2021/22

Shropshire

Population change (%) of local authority areas in England between 2011 and 2021



Overall deprivation is low. Ludlow East and Harlescott fall within the 10% most deprived areas in England.

Population by Age

	Shropshire	England
0 - 14	48,000 (14.8%)	9,838,700 (17.4%)
15 - 64	193,700 (59.9%)	36,249,800 (64.2%)
65 and over	82,000 (25.3%)	10,401,200 (18.4%)
85 and over	10,800 (3.3%)	1,370,400 (2.4%)

Shropshire's total population

323,600

a 5.7% rise from 306,100 people in 2011 **(England 6.6% rise)**

Population Density

per hectare

per hectare

181 schools of which 15 are independent and 19 are special

44,581 pupils aged 0-19

16.9% of pupils eligible for **free school meals**

Smallest state primary school – 25 pupils

Smallest state secondary school – 512 pupils

93.2% from white background, 95.7% with English as first language

25.3% aged 65+ compared to 18.4% in England

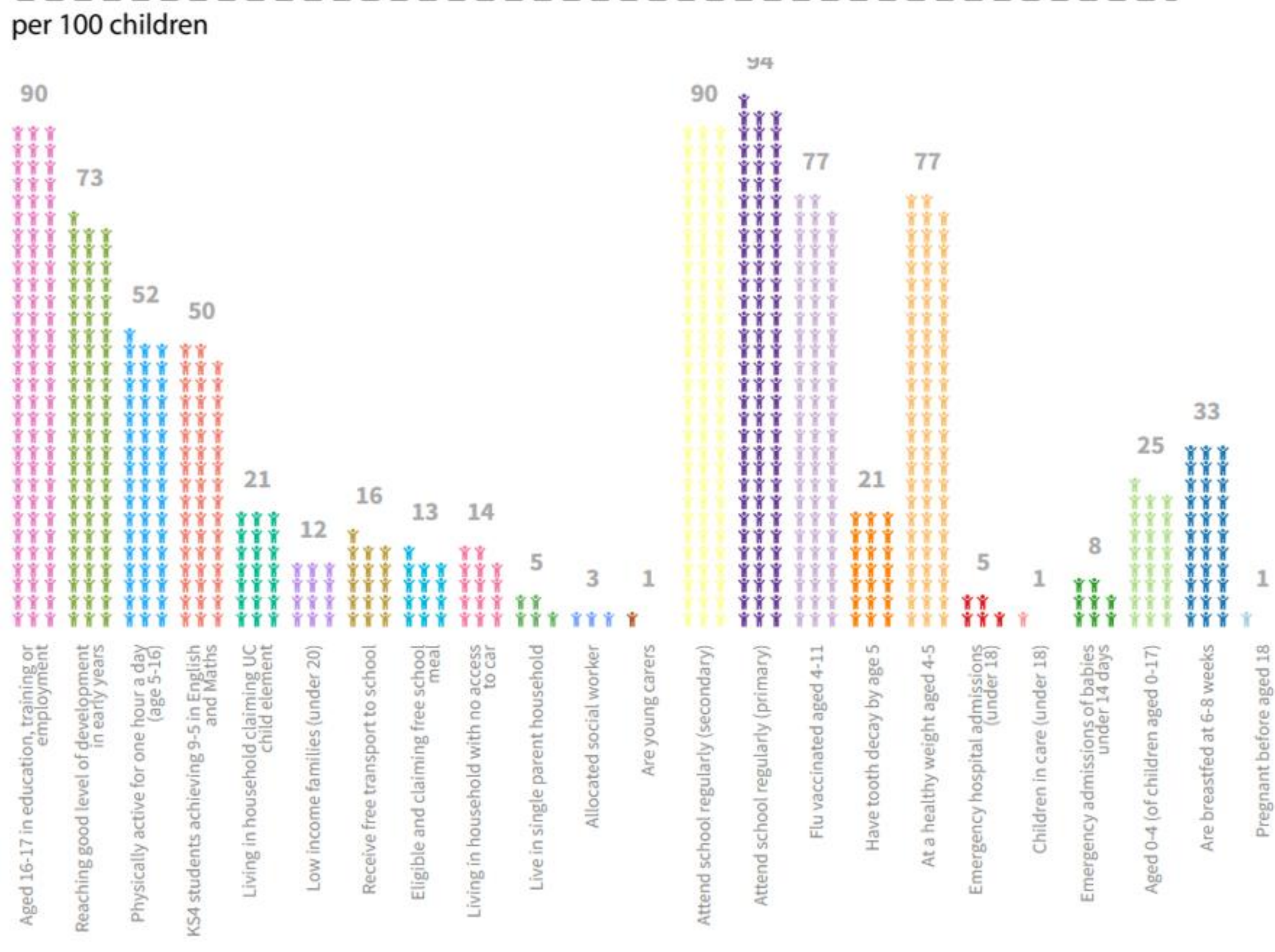
64,834 aged 0-19 or 20.1% England 23.0%

Employment rate of 76.2%, West Midlands 73.6%

504 looked after children in Shropshire

Evidence of rural **food insecurity and 16.5% fuel poverty** across the county

Our Children in Shropshire



Shropshire’s population

Shropshire is a diverse, large, predominantly rural, inland County, situated in the West Midlands. It is the second largest inland rural county in England and is approximately ten times the size of all the Inner London Boroughs put together. It covers 1,235 square miles and there are no areas in Shropshire that are considered major or minor conurbations average. It is one of the most sparsely populated counties; with just one person per hectare.

Overall, Shropshire is a rural county with around 66% of the population living in areas classified as rural. Around 34% of the population resides in areas classed as being urban. Much of the South-West of Shropshire is classified as being sparsely populated.

Shrewsbury is home to around a third of the population and is a key employment, shopping and cultural centre for Shropshire, as well as being a popular destination for tourists and visitors. The county's economy is based mainly on agriculture, tourism, food industries, healthcare and other public services. The profile of Shropshire County, its history, geography and population distribution make delivering services effectively and efficiently more difficult.

Summary

- On Census Day, 21 March 2021, the size of the usual resident population in Shropshire was 323,606 people: this is an increase of 6% (17,477) since 2011, when it was 306,129 people.
- Shropshire's population increased, at 6%, compares to a 6% increase for the West Midlands and a 7% increase for England.
- As of 2021, Shropshire is ranked 32 out of the 33 local authority areas in the West Midlands for population density, with around 1.01 persons per hectare of land. The population density for the West Midlands is 4.58 persons per hectare and for England it is 4.34 persons per hectare
- Of the 323,606 people in Shropshire, 163,923 were women (50.7% of the population) and 159,683 men (49.3%). The female population of Shropshire has increased by 6% and the male population has increased by 5% since 2011.
- In Shropshire, 14.8 % (47,918) of the population are children aged under 15, 59.8% (193,602) are adults aged 15 to 64 and 25.4% (82,090) are aged 65 and over; 3.3% (10,825) of the resident population are 85 and over.
- This compares to 18.1% aged 0 to 14, 63.1% aged 15 to 64 and 18.8% aged 65 and over for the West Midlands region as a whole, and 17.4% aged 0 to 14, 64.2% aged 15 to 64 and 18.4% aged 65 and over for England.
- Since 2011, Shropshire has seen a 3% decrease in children aged under 15, no change in adults aged 15 to 64 and a 30% increase in those aged 65 and over.

Population structure

The highest proportion of residents fall into the 55-59 age group in Shropshire (25,538 people or 7.6%). In the West Midlands the largest group are those aged 50 54 (6.7%) and in the England it is those aged 30 - 34 (6.8%).

In 2021, 20.0% (64,838) of Shropshire’s population were aged under 19.

Chart showing the proportion of residents by five-year age bands in Shropshire (%), 2021 compared to the West Midlands and England. Source: LG Inform.

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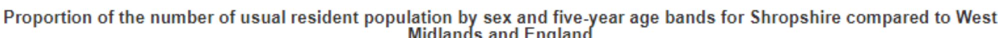

Chart showing the number of residents by five-year age bands and sex in Shropshire, 2021.
Source: LG Inform

Table showing the number and proportion of residents by gender and age groups in Shropshire (%), 2021. Source: Census 2021, ONS.

Age band	Shropshire			
	2021			
	Female	Male	Total	%
0 - 4	7,020	7,403	**14,423**	4.5%
5-9	7,883	8,366	**16,249**	5.0%
10-14	8,406	8,841	**17,247**	5.3%
15 - 19	8,063	8,856	**16,919**	5.2%
20 - 24	7,007	8,119	**15,126**	4.7%
25 - 29	8,120	8,752	**16,872**	5.2%
30 - 34	8,976	8,977	**17,953**	5.5%
35 - 39	8,677	8,588	**17,265**	5.3%
40 - 44	8,450	8,234	**16,684**	5.2%
45 - 49	10,226	9,752	**19,978**	6.2%
50 - 54	12,516	11,794	**24,310**	7.5%
55 - 59	12,958	12,580	**25,538**	7.9%
60 - 64	11,678	11,286	**22,964**	7.1%
65 - 69	10,631	10,186	**20,817**	6.4%
70 - 74	11,361	10,587	**21,948**	6.8%
75 - 79	8,973	8,039	**17,012**	5.3%
80 - 84	6,327	5,161	**11,488**	3.5%
85 - 89	3,917	2,886	**6,803**	2.1%
90 and over	2,738	1,285	**4,023**	1.2%
Total	**163,927**	**159,692**	**323,619**	**100%**

Ethnicity

In 2021 in Shropshire, 96.7% of the population reported themselves as White and the remaining 3.3% reported themselves belonging to ethnic groups other than white (10,733 people), a rise from 2.0% from the 2011 Census and lower compared to England as a whole (19.0%).

The most common ethnic group across all age groups was White. The younger populations in Shropshire are more ethnically diverse than the older population, with 5.6% of residents aged 24 and under belonging to ethnic groups other than White. Mixed and multiple ethnic groups make up 2.8% of this and Asian, Asian British and Asian Welsh make up 1.8%.

Table showing the proportion of residents by ethnic groups and age groups in Shropshire (%), 2021. Source: Census 2021, ONS.

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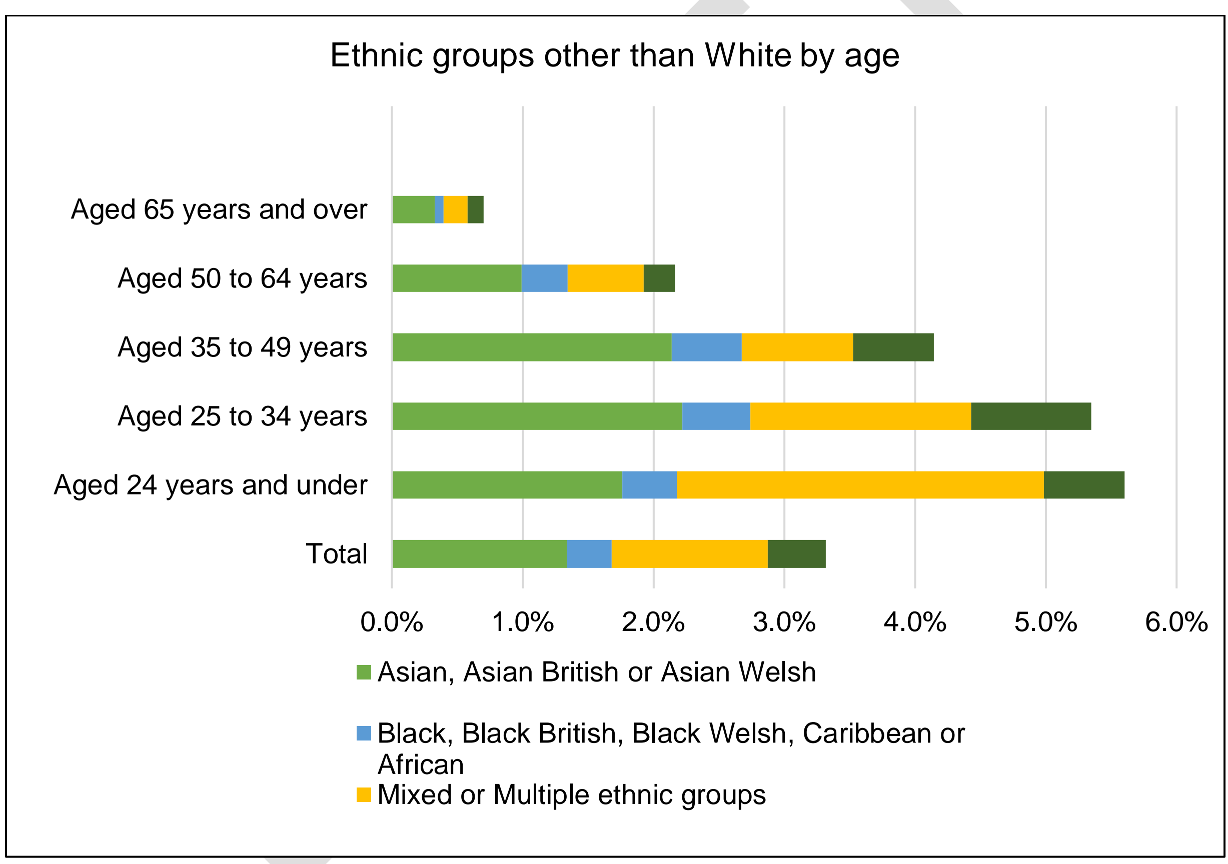
Age	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	Other ethnic group	White
Total	1.3%	0.3%	1.2%	0.4%	96.7%
Aged 24 years and under	1.8%	0.4%	2.8%	0.6%	94.4%
Aged 25 to 34 years	2.2%	0.5%	1.7%	0.9%	94.7%
Aged 35 to 49 years	2.1%	0.5%	0.8%	0.6%	95.9%
Aged 50 to 64 years	1.0%	0.3%	0.6%	0.2%	97.8%
Aged 65 years and over	0.3%	0.1%	0.2%	0.1%	99.3%

Chart showing the proportion of residents by ethnic groups other than White and age groups in Shropshire (%), 2021. Source: Census 2021, ONS.

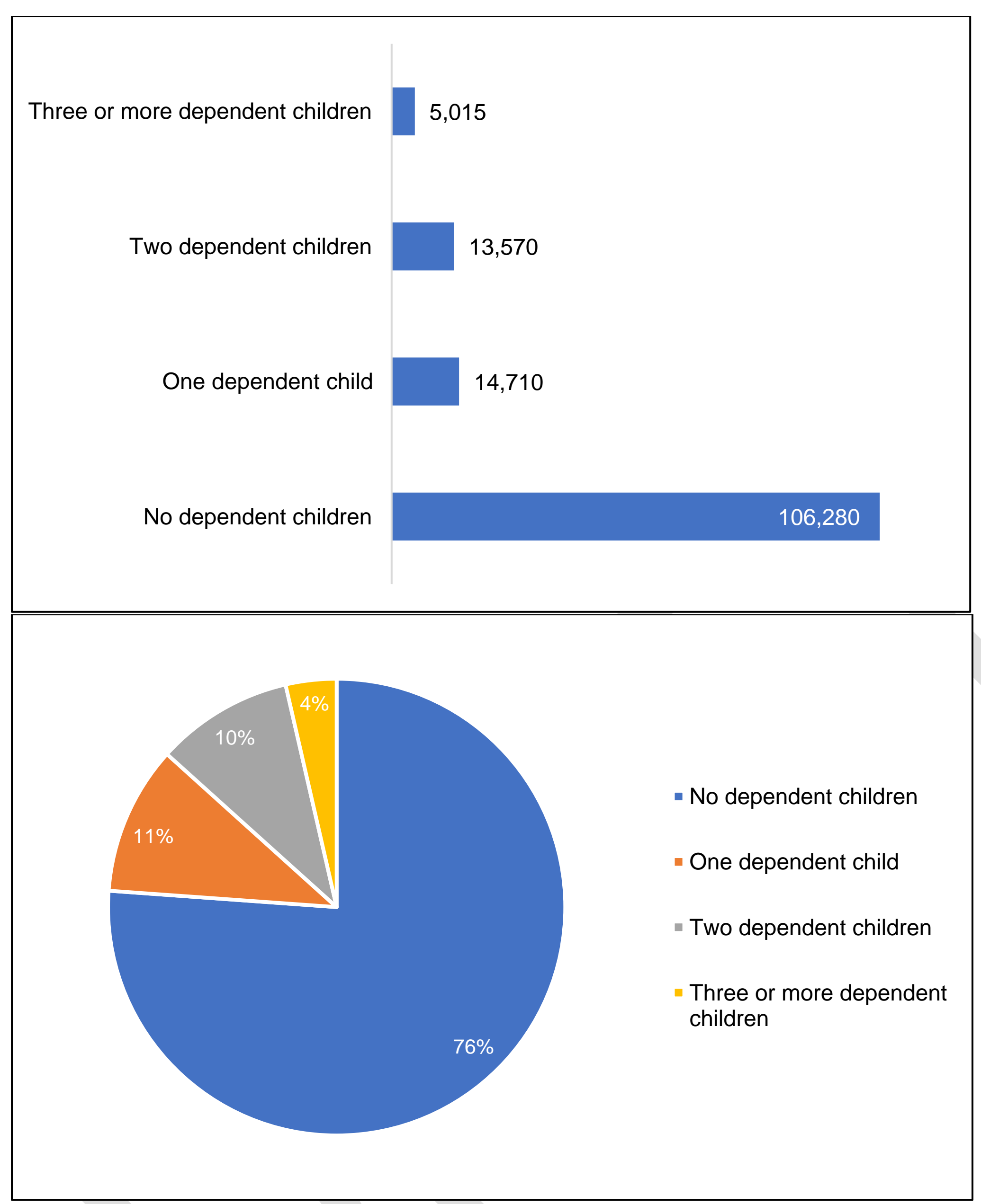


To see the ethnic profile of school aged children in Shropshire, click here.

Household composition

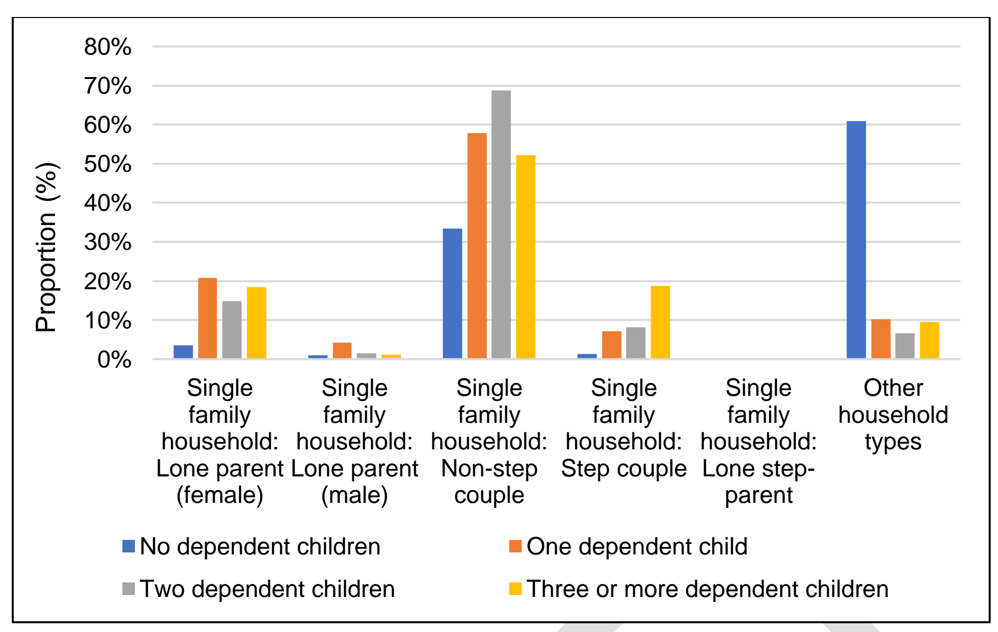
The 2021 Census indicates that there 18,585 households with 2 or more children living in the property, equating to 14% of all households on Shropshire. Majority of households in Shropshire, 76%, had no dependents.

Chart showing the number of children living in the household. Source ONS Census 2021



Based on Census 2021, a high proportion (61%) of single family households (non-step couple) in Shropshire had more than one dependent children. Other household types (households containing only those aged 66-and-over have been categorised as "other household types) had the highest proportion of no dependent children as shown in the chart below.

Chart showing the proportion of dependent children by household type in Shropshire. Source: 2021 Census, ONS.



Population change

Between the last two censuses (held in 2011 and 2021), the population of Shropshire increased by 5.7%, from around 306,129 in 2011 to around 323,606 in 2021.

The population here increased at a similar rate to the overall population of the West Midlands (6.2%), but by a smaller percentage than the overall population of England (up 6.6% since the 2011 Census).

When split by 5-year age bands, the largest increase in population between 2011 and 2021 was observed among the 70 to 74 and the 75 to 79 age bands at 45%. An increase in the 90+ population was also observed between 2011 and 2021 at 42%. The largest decrease in population was observed among those aged 40 to 44.

Among children and young people aged under 19 overall there has been a fall of 18%, with the largest reduction among those aged 15-19 years old.

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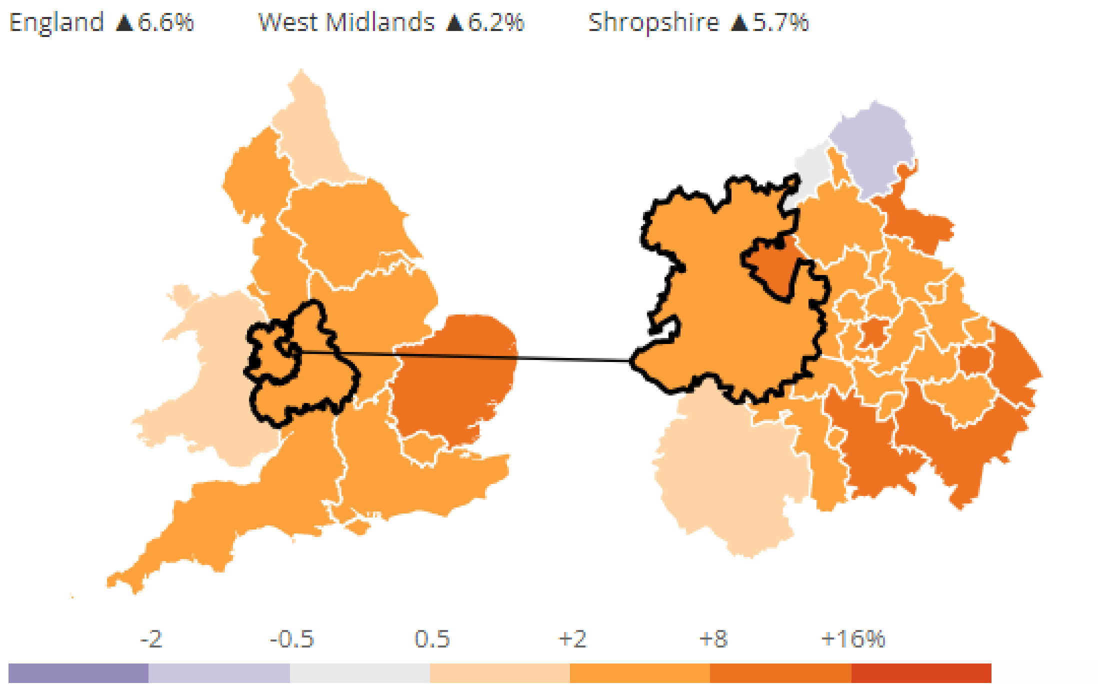
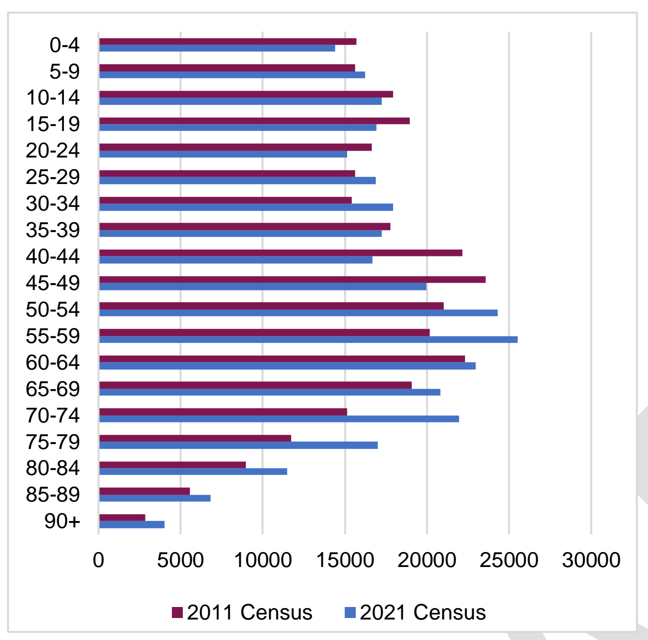
Population growth was lower in Shropshire than across the West Midlands

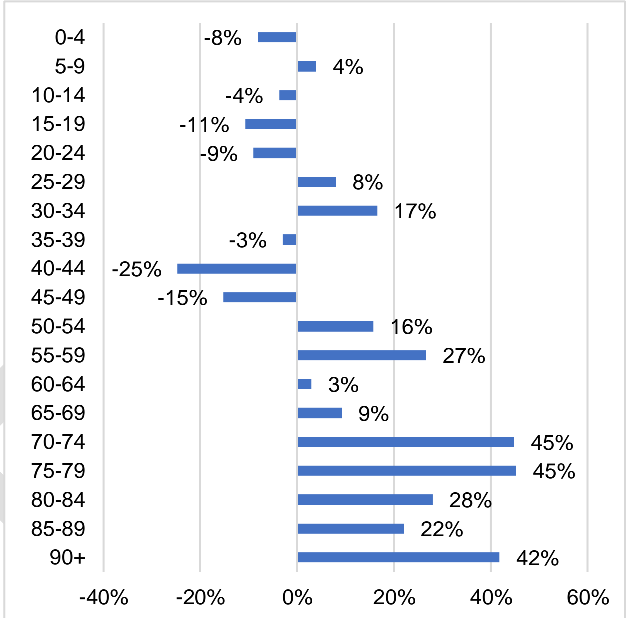
Percentage population change, Shropshire and surrounding areas, 2011 Census to Census 2021



Source: Office for National Statistics – 2011 Census and Census 2021

Chart showing the number of residents by 5-year age bands and percentage change in Shropshire (%), 2021. Source: Census 2021, ONS; LG Inform.





Fewer couples with dependent children

Shropshire saw the West Midlands' second-largest percentage-point fall in the share of households including a couple with dependent children (from 19.5% in 2011 to 16.9% in 2021).

Across the West Midlands, the percentage of households including a couple with dependent children fell from 19.7% to 19.0%, while the percentage in Powys (the local authority area that shares the largest boundary with Shropshire) fell from 17.6% to 15.6%.

Chart showing the percentage of households by household composition in Shropshire. Source: 2011 and 2021 Census, ONS.

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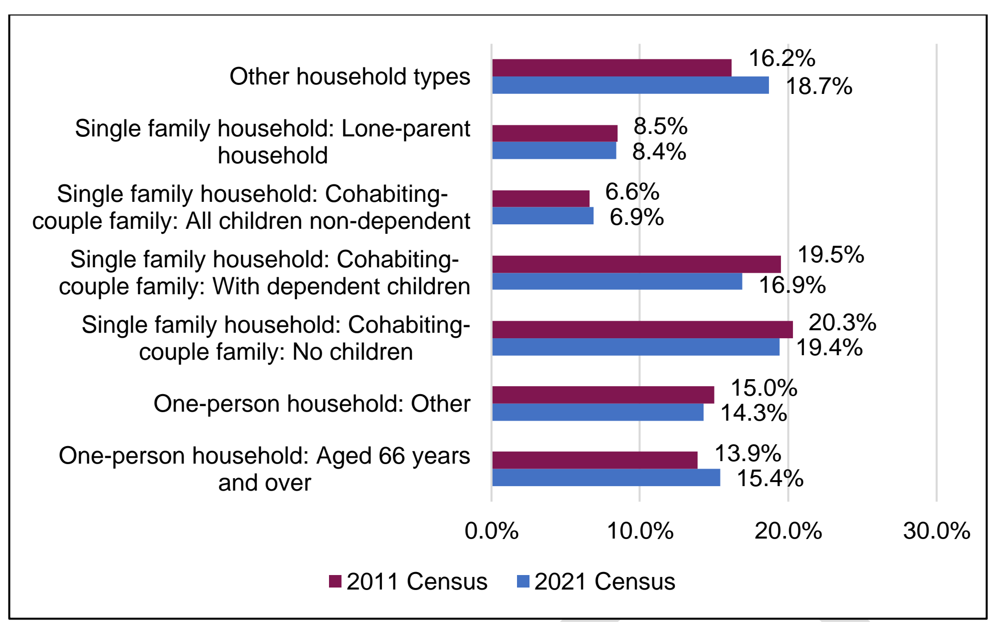

For more information around household composition in Shropshire, see here.

An older Shropshire

Between the last two censuses, the average (median) age of Shropshire increased by four years, from 44 to 48 years of age.

This area had a higher average (median) age than the West Midlands as a whole in 2021 (40 years) and a higher average (median) age than England (40 years).

The median age is the age of the person in the middle of the group, meaning that one half of the group is younger than that person and the other half is older.

Between 2011 and 2021, the number of people aged 50-64 years rose by around 9,300 (an increase of 14.7%), while the number of residents between 35-49 years fell by around 9,600 (15.1% decrease).

Chart showing the proportion of residents by five-year age bands in Shropshire, 2011 and 2021 Census. Source: LG Inform.

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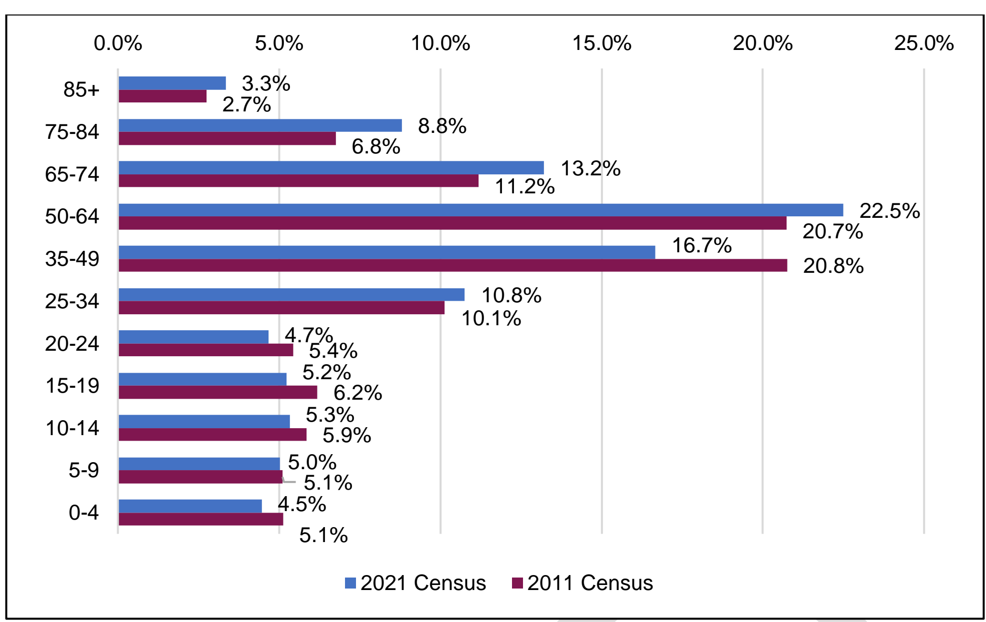

Compared to 2011, there has been an increase of 29.5% in people aged 65 years and over, an increase of 0.1% in people aged 15 to 64 years, and a decrease of 2.5% in children aged under 15 years.

Largest rises over the last 10 years have been among those aged 70-74 and 75-79, both with an increase of 45.0%. The largest fall was among those aged 40-44, with a 24.0% reduction.

Shropshire 2050

Shropshire's population is forecast to grow by 20.2% between 2018 and 2050, which is the equivalent of an additional 65,000 people. The rapidly ageing population means that growth will be concentrated in the 65+ age bracket, which is projected to increase by 62.8% or by 48,800 people by 2050. By 2050, the proportion of the population that is 65 or over is expected to increase to 32.9% compared with 24.3% in 2018.

In contrast, the 0-19 population is projected to record much more modest growth of 6.7% between 2018 and 2050, equating with approximately 4,500 additional children and young people. The proportion of the population falling in the 0-19 age bracket looks set to decline from 20.7% in 2018 to 18.4% in 2050.

Chart showing growth in total population and for the 0-19 and 65+ age brackets to 2050. Source: SNPP 2018 based projected on to 2050 by Shropshire Council.

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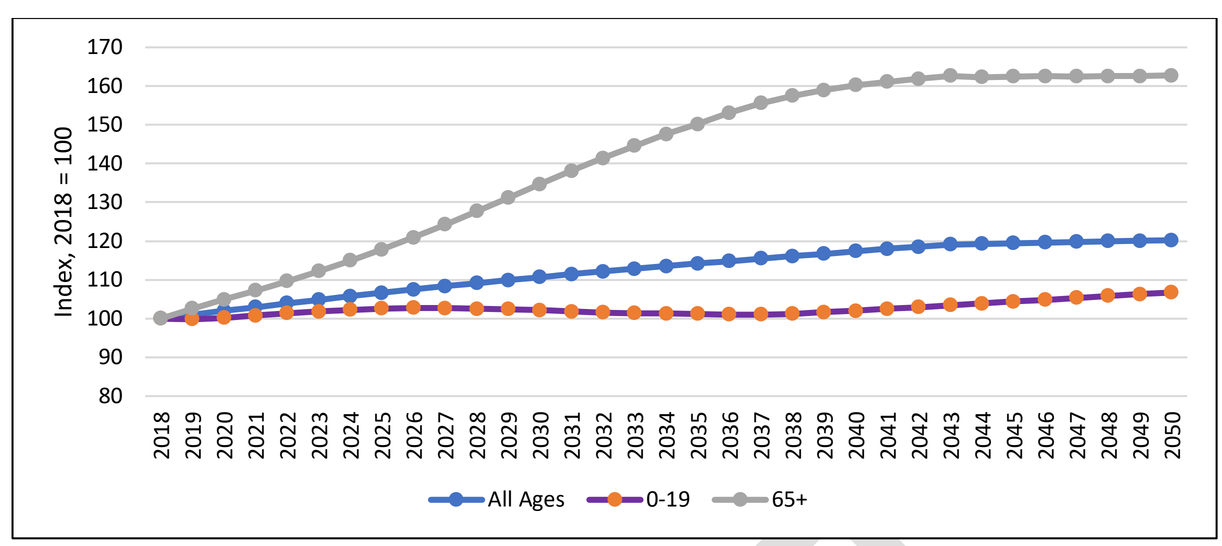
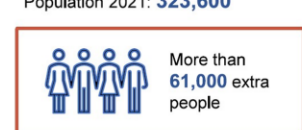


Shropshire Council

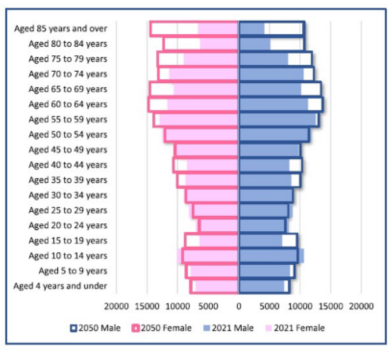
Population projections 2050

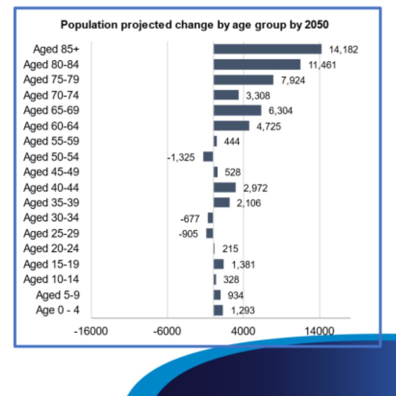
Population 2021: **323,600**

Population 2050: **385,000**



- The population in Shropshire will grow by 61,000 people by 2050, a **rise of 19% compared to 2021.**
- Largest rises will be among those **aged 65+.**
- **0-19 year old group will grow by 3,933 people, rise of 6%** compared to 2021. Largest rise in CYPs among 15-19 year olds (+1,381 people).





Shropshire's child population

Overall, comparing local indicators with England averages, the health and wellbeing of children in Shropshire is better than England. The infant mortality rate is similar to England with an average of 12 infants dying before age 1 each year. Recently, there have been 4 child deaths (1 to 17 year olds) each year on average.

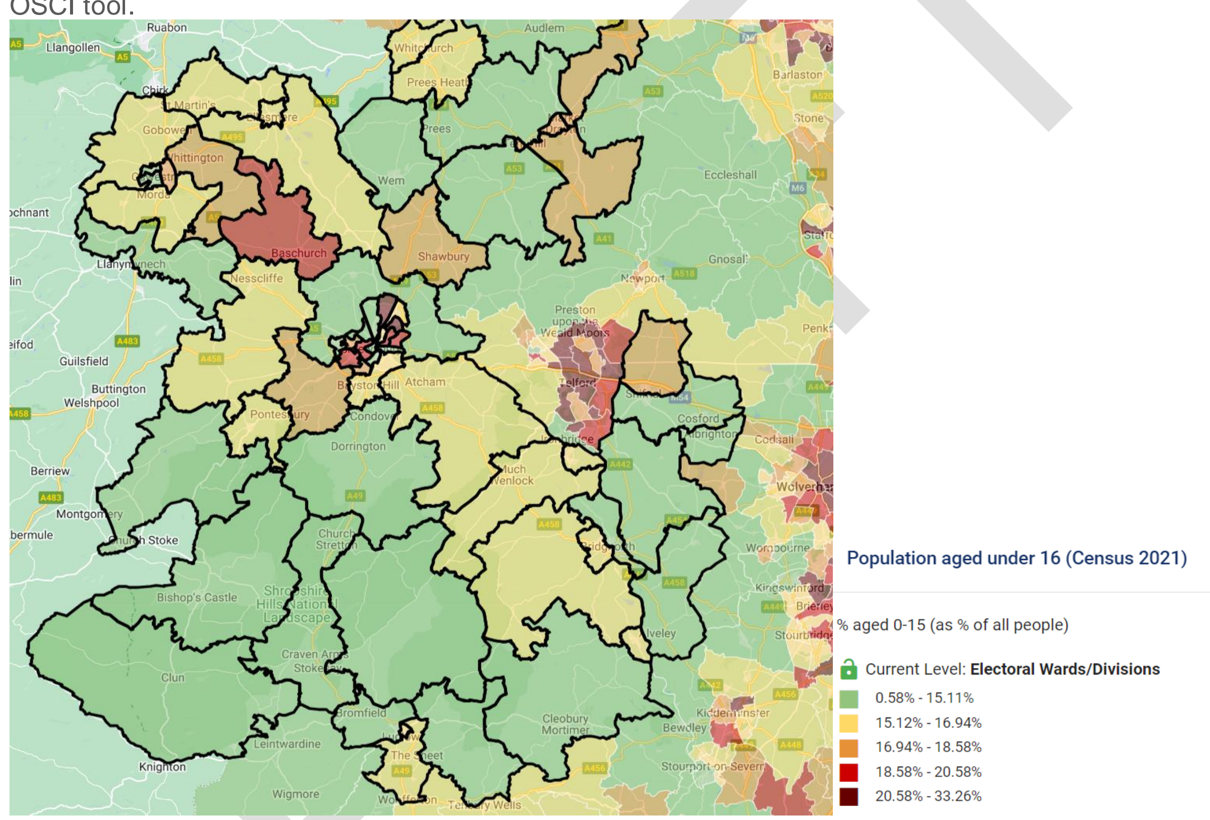
Table showing child population indicators in Shropshire, West Midlands and England

	Period	Local	Region	England
Live births	2021	2,639	63,846	595,948
Children aged 0 to 4 years	2021	14,400 (4.4%)	333,300 (5.6%)	3,058,200 (5.4%)
Children aged 0 to 19 years	2021	65,000 (20.0%)	1,433,200 (24.1%)	13,040,500 (23.1%)
Children aged 0 to 19 years –		67,600 (18.9%)	1,493,000 (23.5%)	13,357,000 (22.5%)

projected population				
School children from minority ethnic groups	2022	3,550 (9.2%)	360,835 (39.9%)	2,835,124 (35.0%)
School pupils with social, emotional and mental health needs	2022	914 (2.3%)	25,831 (2.8%)	250,272 (3.0%)
Children living in poverty	Financial year ending 2021	16.8%	24.6%	18.5%
Life expectancy at birth	2020-22	Females – 83.9 Males – 79.8	Females – 82.2 Males – 78.1	Females – 82.8 Males – 78.9

Where do children and young people aged 15 and under live in Shropshire?

Map showing where population aged under 15 live in Shropshire by ward. Source: Shropshire's OSCI tool.



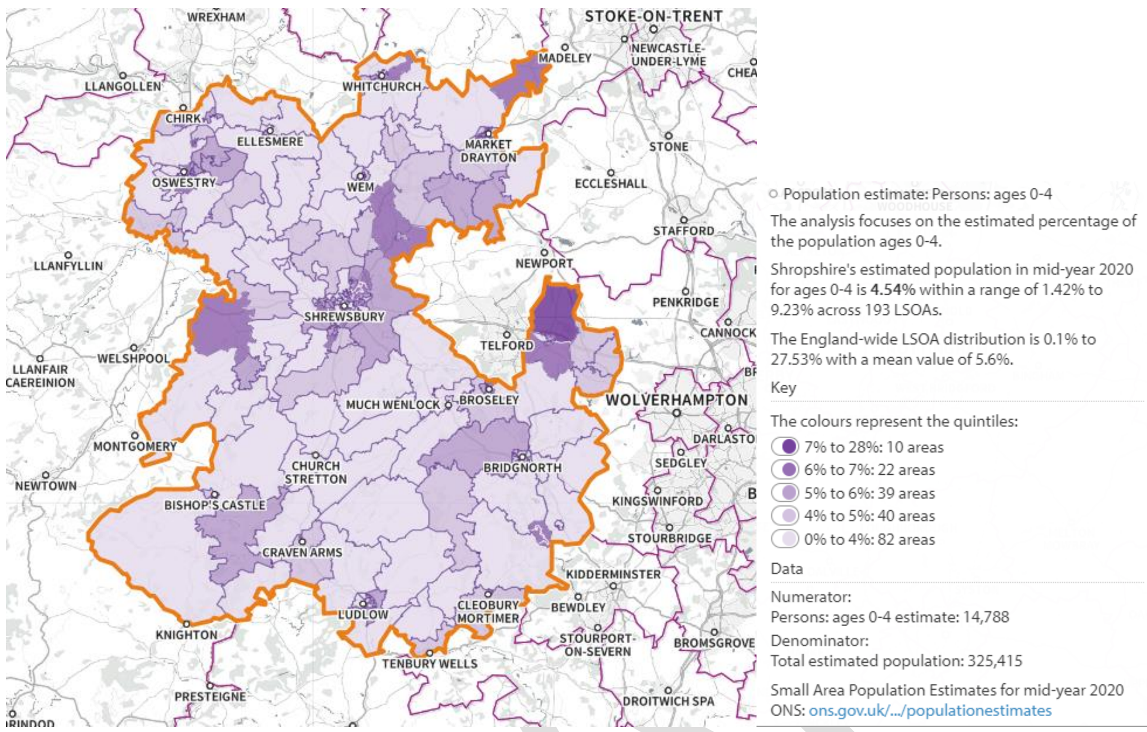
Where do children and young people aged 0-19 live in Shropshire?

Areas with the largest number of children aged 0-19 are: Bayston Hill, Column and Sutton, Oswestry East, Market Drayton West and Wem, with more than 1,800 children and young people living in each these wards.

Ward Name	0-4s	5-9s	10-14s	15-19s	Total 0-19s	All Ages
Abbey	159	166	155	145	625	4,231
Albrighton	255	197	237	212	901	4,455
Alveley and Claverley	138	228	192	152	710	4,136
Bagley	229	224	212	203	868	4,697
Battlefield	315	311	286	204	1,116	4,968
Bayston Hill, Column and Sutton	558	665	609	546	2,378	12,460
Belle Vue	151	233	256	225	865	4,610
Bishop's Castle	142	170	184	191	687	3,818
Bowbrook	258	286	220	154	918	4,834
Bridgnorth East and Astley Abbotts	255	250	330	281	1,116	6,899
Bridgnorth West and Tasley	329	412	373	332	1,446	7,253
Broseley	261	262	288	196	1,007	4,995
Brown Clee	143	160	226	206	735	4,070
Burnell	177	203	307	661	1,348	5,056
Castlefields and Ditherington	269	270	242	185	966	4,610
Cheswardine	246	284	280	223	1,033	4,522
Chirbury and Worthen	97	118	154	147	516	3,021
Church Stretton and Craven Arms	349	374	447	387	1,557	9,272
Clee	153	216	275	187	831	4,592
Cleobury Mortimer	309	315	383	362	1,369	7,653
Clun	137	162	209	278	786	4,017
Copthorne	227	228	324	272	1,051	4,364
Corvedale	105	159	202	116	582	3,692
Ellesmere Urban	190	260	275	198	923	4,304
Gobowen, Selattyn and Weston Rhyn	362	341	418	471	1,592	7,016
Harlescott	347	344	293	282	1,266	4,964
Highley	235	207	189	140	771	3,798
Hodnet	179	184	207	322	892	4,781
Llanymynech	158	213	215	174	760	4,363
Longden	184	244	244	191	863	4,198
Loton	185	191	269	305	950	4,227
Ludlow East	193	217	217	170	797	4,026
Ludlow North	114	114	119	108	455	3,813
Ludlow South	175	188	207	241	811	4,166
Market Drayton East	325	308	270	223	1,126	5,636
Market Drayton West	445	549	544	444	1,982	8,920
Meole	248	273	312	255	1,088	4,556
Monkmoor	274	273	307	234	1,088	4,529
Much Wenlock	136	174	264	193	767	4,078
Oswestry East	554	582	517	477	2,130	9,605
Oswestry South	126	186	223	275	810	4,507
Oswestry West	175	237	233	150	795	4,078
Porthill	175	249	347	639	1,410	4,949
Prees	173	222	236	212	843	4,595
Quarry and Coton Hill	186	199	178	170	733	4,937
Radbrook	281	293	317	223	1,114	4,947
Rea Valley	187	261	294	217	959	4,615
Ruyton and Baschurch	168	230	349	279	1,026	4,438
Severn Valley	222	249	283	196	950	4,666
Shawbury	272	312	316	235	1,135	5,200
Shifnal North	338	312	295	283	1,228	5,821
Shifnal South and Cosford	361	362	357	357	1,437	6,650
St Martin's	197	221	264	199	881	4,491
St Oswald	216	261	255	257	989	4,729
Sundorne	271	320	319	265	1,175	4,226
Tern	182	245	284	222	933	4,853
The Meres	163	184	299	528	1,174	5,164
Underdale	267	328	295	277	1,167	4,505
Wem	342	400	574	490	1,806	8,835
Whitchurch North	372	410	444	357	1,583	7,707
Whitchurch South	191	211	258	192	852	4,468
Whittington	221	256	264	222	963	4,259
Worfield	136	154	171	170	631	3,570
Total (Shropshire)	**14,788**	**16,657**	**18,113**	**16,708**	**66,266**	**325,415**

Population aged 0 - 4 years old

Map showing population aged 0-4 years old (%) by Ward, Shropshire (ONS mid 2020). Source: OHID SHAPE tool.



The highest number of 0-4 year olds live in Bayston Hill, Column and Sutton ward, Oswestry East and Market Drayton West.

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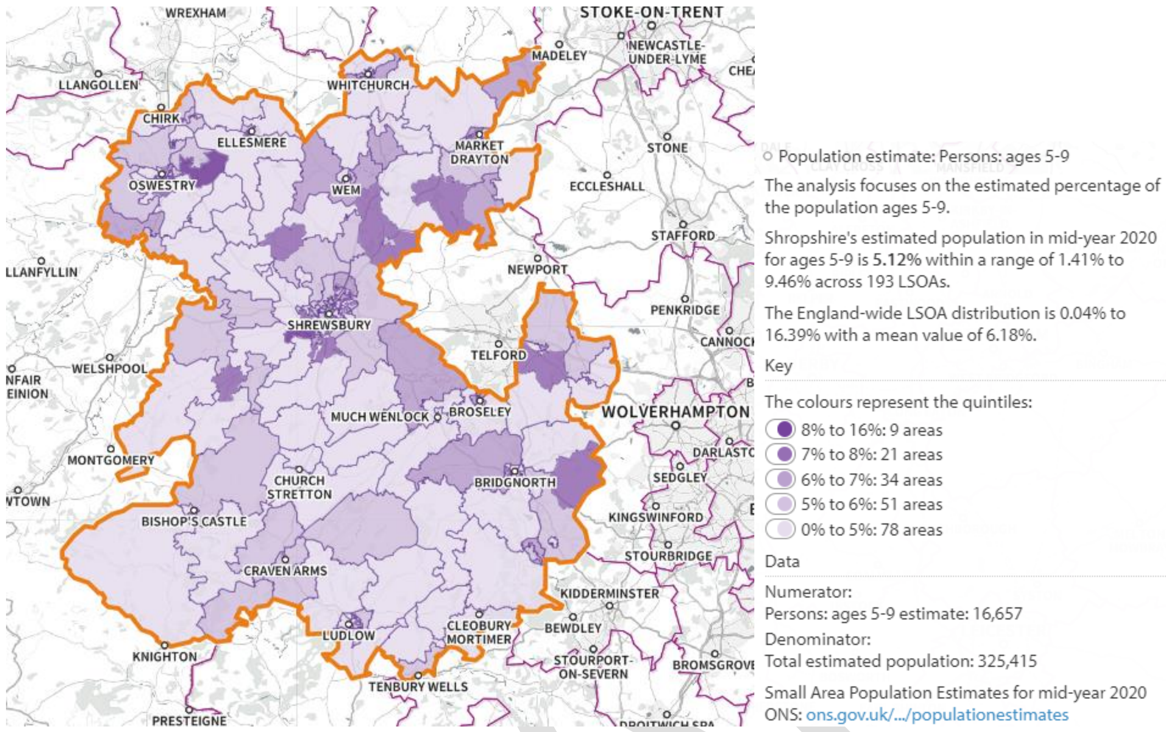
Ward Name	0-4s
Bayston Hill, Column and Sutton	558
Oswestry East	554
Market Drayton West	445
Whitchurch North	372
Gobowen, Selattyn and Weston Rhyn	362
Shifnal South and Cosford	361
Church Stretton and Craven Arms	349
Harlescott	347
Wem	342
Shifnal North	338
Bridgnorth West and Tasley	329
Market Drayton East	325
Battlefield	315
Cleobury Mortimer	309
Radbrook	281
Monkmoor	274
Shawbury	272
Sundorne	271
Castlefields and Ditherington	269
Underdale	267
Broseley	261
Bowbrook	258
Albrighton	255
Bridgnorth East and Astley Abbotts	255
Meole	248
Cheswardine	246
Highley	235
Bagley	229
Copthorne	227
Severn Valley	222
Whittington	221
St Oswald	216
St Martin's	197
Ludlow East	193
Whitchurch South	191
Ellesmere Urban	190
Rea Valley	187
Quarry and Coton Hill	186
Loton	185
Longden	184
Tern	182
Hodnet	179
Burnell	177
Ludlow South	175
Porthill	175
Oswestry West	175
Prees	173
Ruyton and Baschurch	168
The Meres	163
Abbey	159
Llanymynech	158
Clee	153
Belle Vue	151
Brown Clee	143
Bishop's Castle	142
Alveley and Claverley	138
Clun	137
Much Wenlock	136
Worfield	136
Oswestry South	126
Ludlow North	114
Corvedale	105
Chirbury and Worthen	97

Population aged 5 - 9 years old

Map showing population aged 5-9 years old (%) by Ward, Shropshire (ONS mid 2020) Source: OHID SHAPE tool.



The highest number of 5-9 year olds live in Bayston Hill, Column and Sutton ward, Oswestry East and Market Drayton West.

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Ward Name	5-9s
Bayston Hill, Column and Sutton	665
Oswestry East	582
Market Drayton West	549
Bridgnorth West and Tasley	412
Whitchurch North	410
Wem	400
Church Stretton and Craven Arms	374
Shifnal South and Cosford	362
Harlescott	344
Gobowen, Selattyn and Weston Rhyn	341
Underdale	328
Sundorne	320
Cleobury Mortimer	315
Shawbury	312
Shifnal North	312
Battlefield	311
Market Drayton East	308
Radbrook	293
Bowbrook	286
Cheswardine	284
Meole	273
Monkmoor	273
Castlefields and Ditherington	270
Broseley	262
Rea Valley	261
St Oswald	261
Ellesmere Urban	260
Whittington	256
Bridgnorth East and Astley Abbotts	250
Porthill	249
Severn Valley	249
Tern	245
Longden	244
Oswestry West	237
Belle Vue	233
Ruyton and Baschurch	230
Alveley and Claverley	228
Copthorne	228
Bagley	224
Prees	222
St Martin's	221
Ludlow East	217
Clee	216
Llanymynech	213
Whitchurch South	211
Highley	207
Burnell	203
Quarry and Coton Hill	199
Albrighton	197
Loton	191
Ludlow South	188
Oswestry South	186
Hodnet	184
The Meres	184
Much Wenlock	174
Bishop's Castle	170
Abbey	166
Clun	162
Brown Clee	160
Corvedale	159
Worfield	154
Chirbury and Worthen	118
Ludlow North	114
Total (Shropshire)	**16,657**

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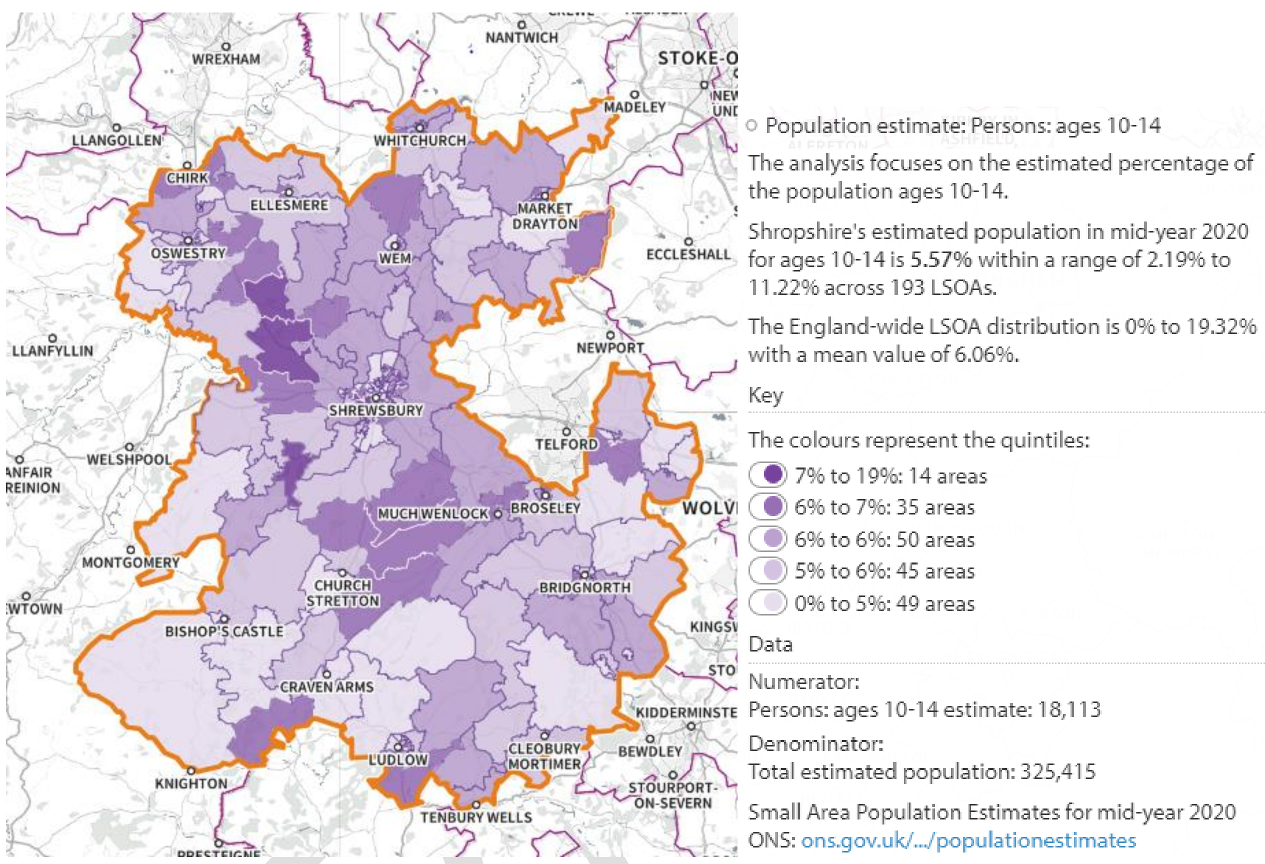
Population aged 10 - 14 years old

Map showing population aged 10-14 years old (%) by Ward, Shropshire (ONS mid 2020) Source: OHID SHAPE tool.



The highest number of 10-14 year olds live in Bayston Hill, Column and Sutton ward, Wem and Market Drayton West.

Ward Name	10-14s
Bayston Hill, Column and Sutton	609
Wem	574
Market Drayton West	544
Oswestry East	517
Church Stretton and Craven Arms	447
Whitchurch North	444
Gobowen, Selattyn and Weston Rhyn	418
Cleobury Mortimer	383
Bridgnorth West and Tasley	373
Shifnal South and Cosford	357
Ruyton and Baschurch	349
Porthill	347
Bridgnorth East and Astley Abbotts	330
Copthorne	324
Sundorne	319
Radbrook	317
Shawbury	316
Meole	312
Monkmoor	307
Burnell	307
The Meres	299
Underdale	295
Shifnal North	295
Rea Valley	294
Harlescott	293
Broseley	288
Battlefield	286
Tern	284
Severn Valley	283
Cheswardine	280
Ellesmere Urban	275
Clee	275
Market Drayton East	270
Loton	269
Whittington	264
St Martin's	264
Much Wenlock	264
Whitchurch South	258
Belle Vue	256
St Oswald	255
Longden	244
Castlefields and Ditherington	242
Albrighton	237
Prees	236
Oswestry West	233
Brown Clee	226
Oswestry South	223
Bowbrook	220
Ludlow East	217
Llanymynech	215
Bagley	212
Clun	209
Ludlow South	207
Hodnet	207
Corvedale	202
Alveley and Claverley	192
Highley	189
Bishop's Castle	184
Quarry and Coton Hill	178
Worfield	171
Abbey	155
Chirbury and Worthen	154
Ludlow North	119
Total (Shropshire)	**18,113**

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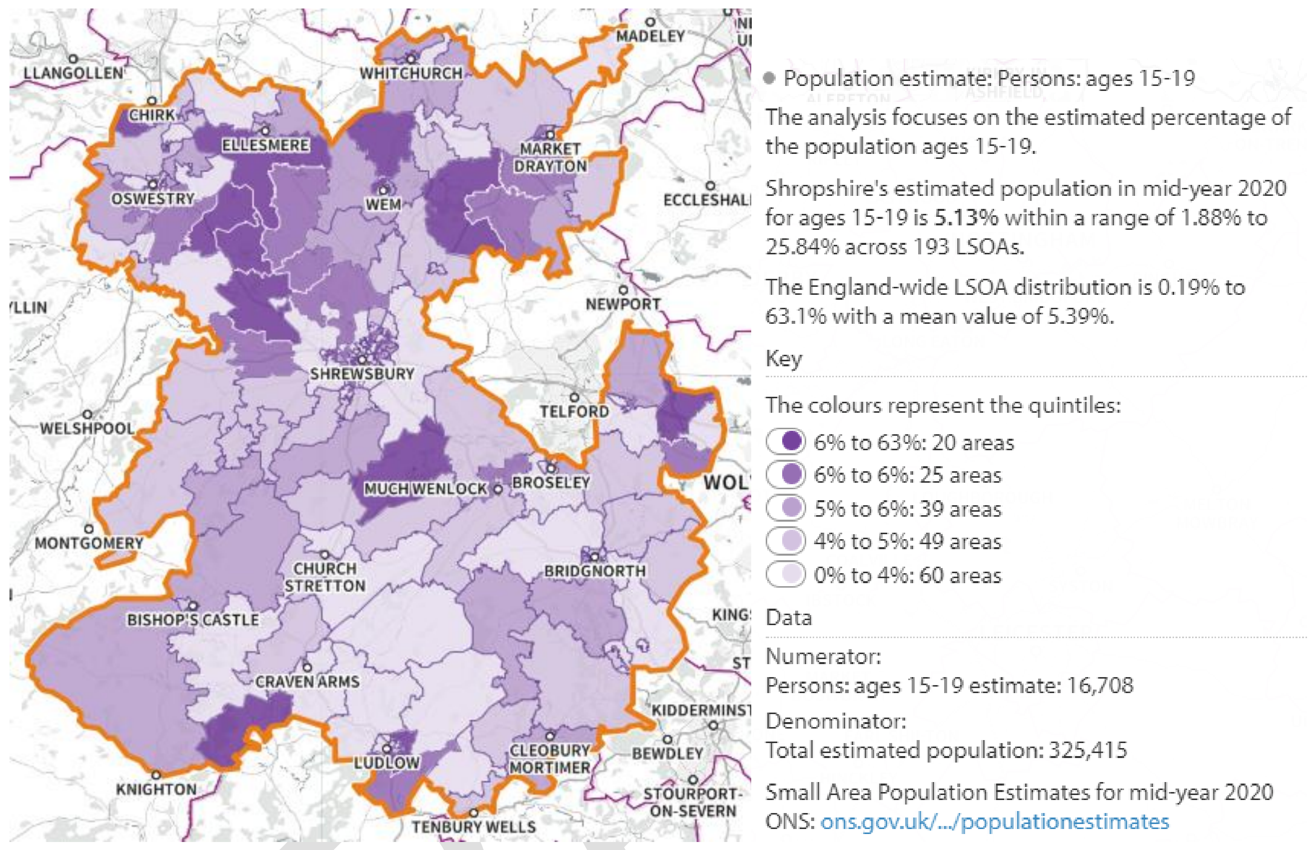
Population aged 15 - 19 years old

Map showing population aged 15-19 years old (%) by Ward, Shropshire (ONS mid 2020) Source: OHID SHAPE tool.



The highest number of 15-19 year olds live in Burnell, Porthill, Bayston Hill, Column and Sutton ward.

Ward Name	15-19s
Burnell	661
Porthill	639
Bayston Hill, Column and Sutton	546
The Meres	528
Wem	490
Oswestry East	477
Gobowen, Selattyn and Weston Rhyn	471
Market Drayton West	444
Church Stretton and Craven Arms	387
Cleobury Mortimer	362
Whitchurch North	357
Shifnal South and Cosford	357
Bridgnorth West and Tasley	332
Hodnet	322
Loton	305
Shifnal North	283
Harlescott	282
Bridgnorth East and Astley Abbotts	281
Ruyton and Baschurch	279
Clun	278
Underdale	277
Oswestry South	275
Copthorne	272
Sundorne	265
St Oswald	257
Meole	255
Ludlow South	241
Shawbury	235
Monkmoor	234
Belle Vue	225
Radbrook	223
Cheswardine	223
Market Drayton East	223
Tern	222
Whittington	222
Rea Valley	217
Albrighton	212
Prees	212
Brown Clee	206
Battlefield	204
Bagley	203
St Martin's	199
Ellesmere Urban	198
Broseley	196
Severn Valley	196
Much Wenlock	193
Whitchurch South	192
Longden	191
Bishop's Castle	191
Clee	187
Castlefields and Ditherington	185
Llanymynech	174
Ludlow East	170
Quarry and Coton Hill	170
Worfield	170
Bowbrook	154
Alveley and Claverley	152
Oswestry West	150
Chirbury and Worthen	147
Abbey	145
Highley	140
Corvedale	116
Ludlow North	108
Total (Shropshire)	**16,708**

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Shropshire's school population

The School Census is a statutory requirement for all schools and provides information on the school, students and their characteristics. Data is collected and reported for each of the three terms (autumn, spring, summer) and can be used to inform local needs and requirements.

School Population

On the Autumn 2023 Shropshire school census, there are just under 40,000 children who attend Shropshire local authority schools. 94% of children who attend Shropshire schools live in Shropshire, however, there are children who live in Telford and Wrekin, Cheshire East, Cheshire West and Central, Herefordshire, Malvern Hills, Newcastle under Lyme, Powys, South Staffordshire, Stafford, Wolverhampton, Wrexham and Wyre Forest.

Table showing the number of pupils attending Shropshire schools living in Shropshire and surrounding local authorities.

Local Authority Name	Number of pupils	% of pupils
Shropshire	37,074	94.0%
Telford and Wrekin	1015	2.6%
Powys	504	1.3%
Wrexham	228	0.6%
South Staffordshire	127	0.3%
Malvern Hills	117	0.3%
Wolverhampton	99	0.3%
Wyre Forest	67	0.2%
Newcastle-under-Lyme	65	0.2%
Herefordshire, County of	53	0.1%
Cheshire East	32	0.1%
Cheshire West and Chester	8	0.0%
Stafford	7	0.0%
Not known	39	0.1%
Grand Total	**39,435**	**100.0%**

There are 1,624 children who are aged 0-4 who attend Shropshire schools. 75% of these are children in the N2 school year (aged 3 at 31st August, but turning 4 during the year).

Table showing the total number of pupils attending Shropshire by school year

School Year	Pupils who live in Shropshire	Total Pupils at Shropshire schools
E1 or E2 (0, or 1 at 31st August, turning 1 or 2 during year)	27	29
N1 (2 at 31st August, turning 3 during the year)	355	371
N2 (3 at 31st August, turning 4 during the year)	1,180	1,224
Total aged 0-4 at 31st August	**1,562**	**1,624**
Reception	2,701	2,777

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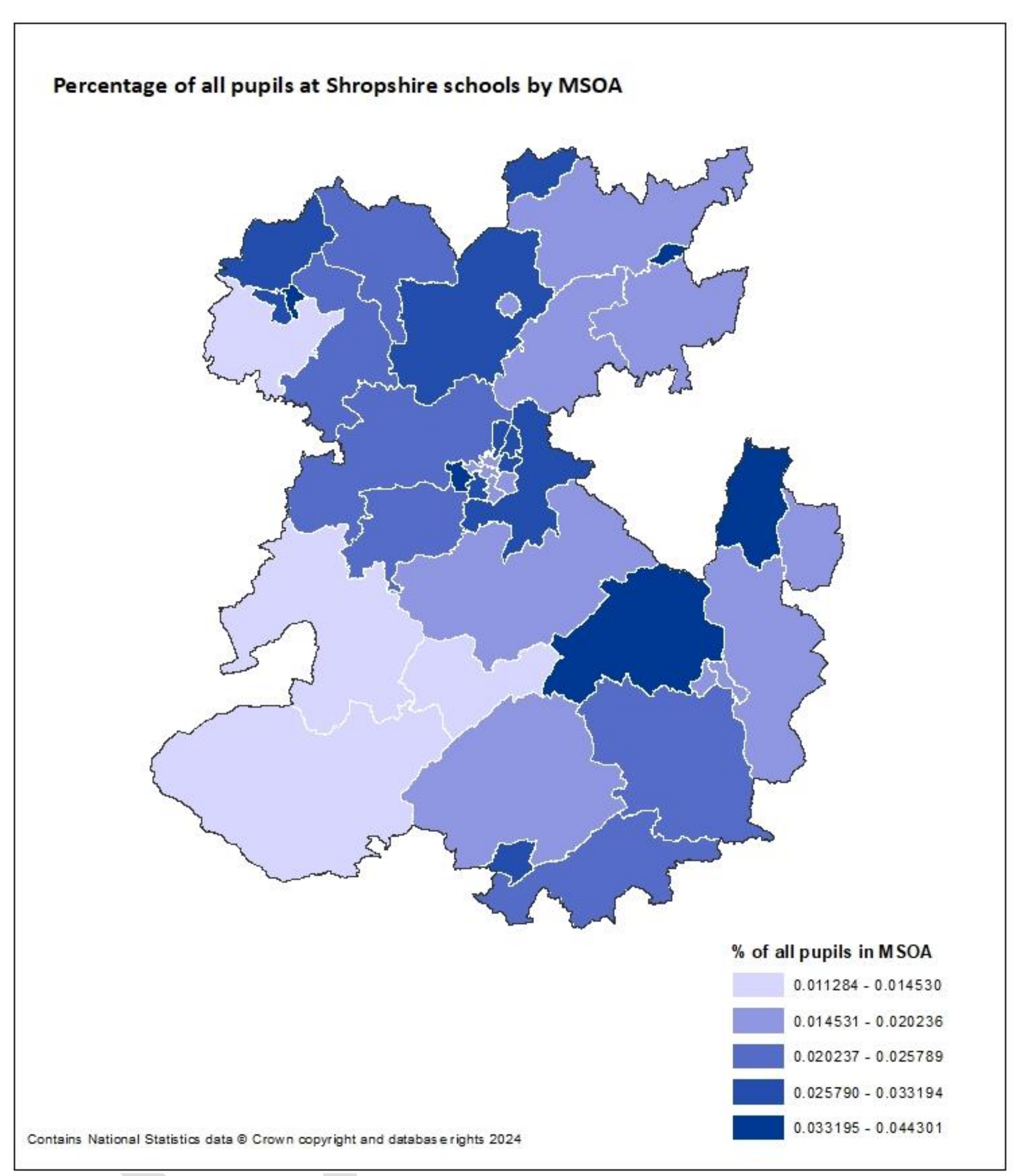
Year 1	2,775	2,878
Year 2	2,976	3,072
Year 3	2,976	3,089
Year 4	2,936	3,057
Year 5	2,886	3,015
Year 6	2,990	3,111
Total between Reception and Year 6	**20,240**	**20,999**
Year 7	3,027	3,278
Year 8	2,901	3,187
Year 9	2,880	3,148
Year 10	2,857	3,144
Year 11	2,869	3,165
Total between Year 7 and Year 11	**14,534**	**15,922**
Year 12	346	413
Year 13	374	459
Year 14	18	18
Total between Year 12 and Year 14	**738**	**890**
Any age	**37,074**	**39,435**

Map showing the proportion of all pupils at Shropshire schools by MSOA



Languages spoken

English (93%) was the most common language recorded on the census for children attending Shropshire schools. There were 66 different language codes used, although 5 of these were not specified (2,018 pupils) i.e., information not obtained / refused / other than English / believed to be other than English / believed to be English. In total 663 pupils (1.7%) had a language that was known and was not English.

Table showing the languages spoken by children attending Shropshire schools.

Language Code List	Pupils	% of pupils
English*	36754	93.2%
Other than English*	1129	2.9%
Information not obtained*	501	1.3%
Believed to be Other than English*	200	0.5%
Believed to be English*	158	0.4%
Polish	125	0.3%
Bulgarian	94	0.2%
Malayalam	59	0.1%
Romanian	50	0.1%
Ukrainian	46	0.1%
Refused*	30	0.1%
Chinese	24	0.1%
Arabic	21	0.1%
Other language than listed	244	0.6%
When known, any language other than English total	663	1.7%

The map below shows that there seems to be a higher percentage of pupils whose language is known but is not English in the North of the County, with one MSOA having 85 (12.8%) and another having 73 (11%), of the 663 pupils – 15 lived outside of Shropshire.

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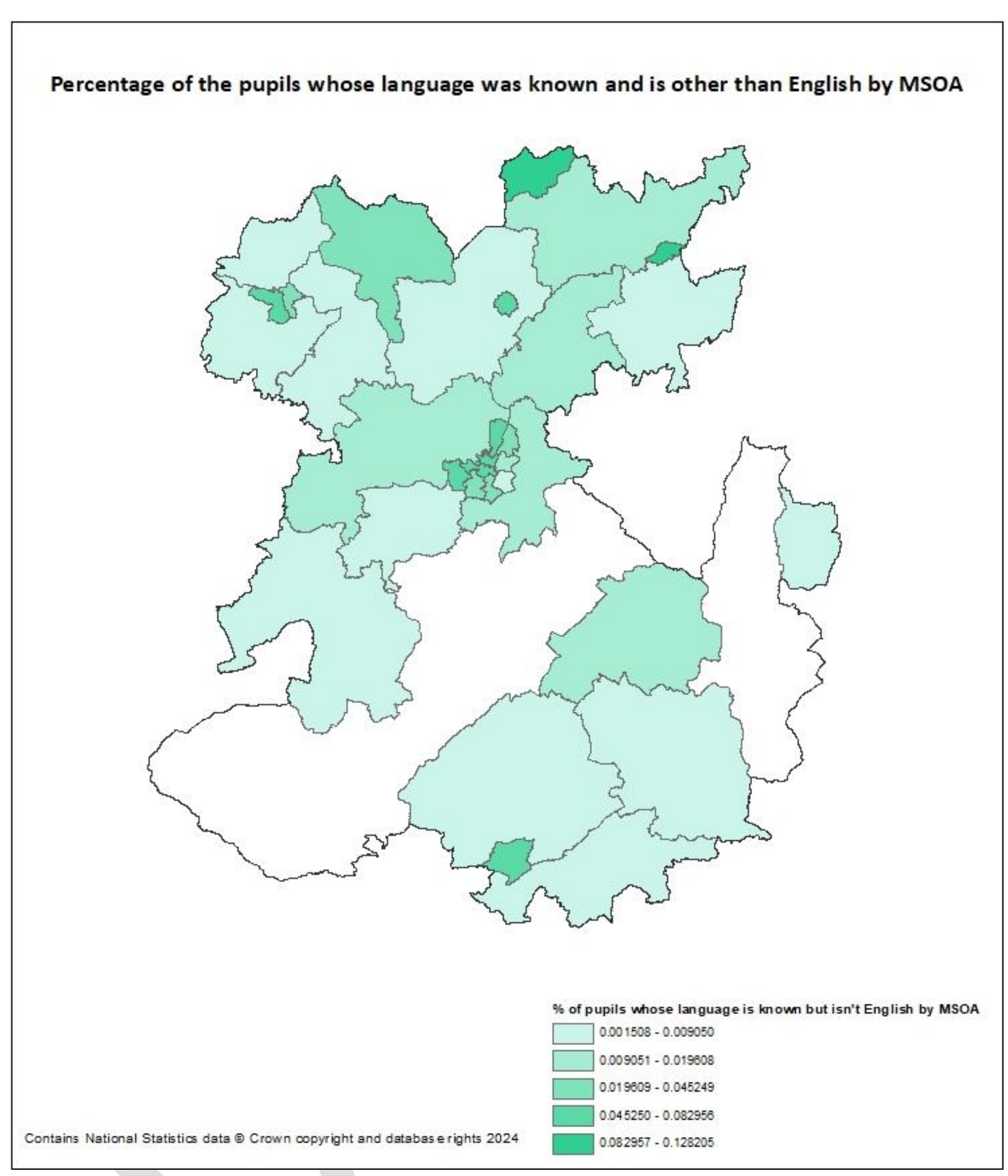
Map showing the proportion of pupils whose language is known and is other than English by MSOA.



Children with Special Educational Needs

Just over 83% of pupil's at Shropshire schools have no special educational needs (SEN), however, 5,103 pupils require SEN support, and 1,493 pupils have an education, health and care plan.

SEN Provision	**Number of pupils**	% of Pupils
No Special Educational Need	32,839	83.3%
SEN Support	5,103	12.9%
Education, Health and Care Plan	1,493	3.8%
Grand Total	**39,435**	100.0%

SEN Provision by Year Group	Education, Health and Care Plan	SEN Support	No Special Educational Need	**Grand Total**
E1 or E2	0.0%	0.0%	100.0%	100.0%
N1	0.0%	3.2%	96.8%	100.0%
N2	0.7%	3.3%	96.0%	100.0%
R	3.1%	6.6%	90.3%	100.0%
1	3.3%	9.5%	87.3%	100.0%
2	3.5%	11.2%	85.3%	100.0%
3	3.1%	14.8%	82.0%	100.0%
4	4.3%	16.1%	79.7%	100.0%
5	3.8%	18.1%	78.1%	100.0%
6	4.2%	17.6%	78.3%	100.0%
7	4.3%	15.8%	79.9%	100.0%
8	4.3%	14.6%	81.1%	100.0%
9	3.6%	14.8%	81.6%	100.0%
10	4.6%	12.6%	82.9%	100.0%
11	3.8%	10.4%	85.8%	100.0%
12	5.3%	6.3%	88.4%	100.0%
13	6.1%	2.4%	91.5%	100.0%
14	100.0%	0.0%	0.0%	100.0%
All Pupils	**1493**	**5103**	**32839**	**39435**

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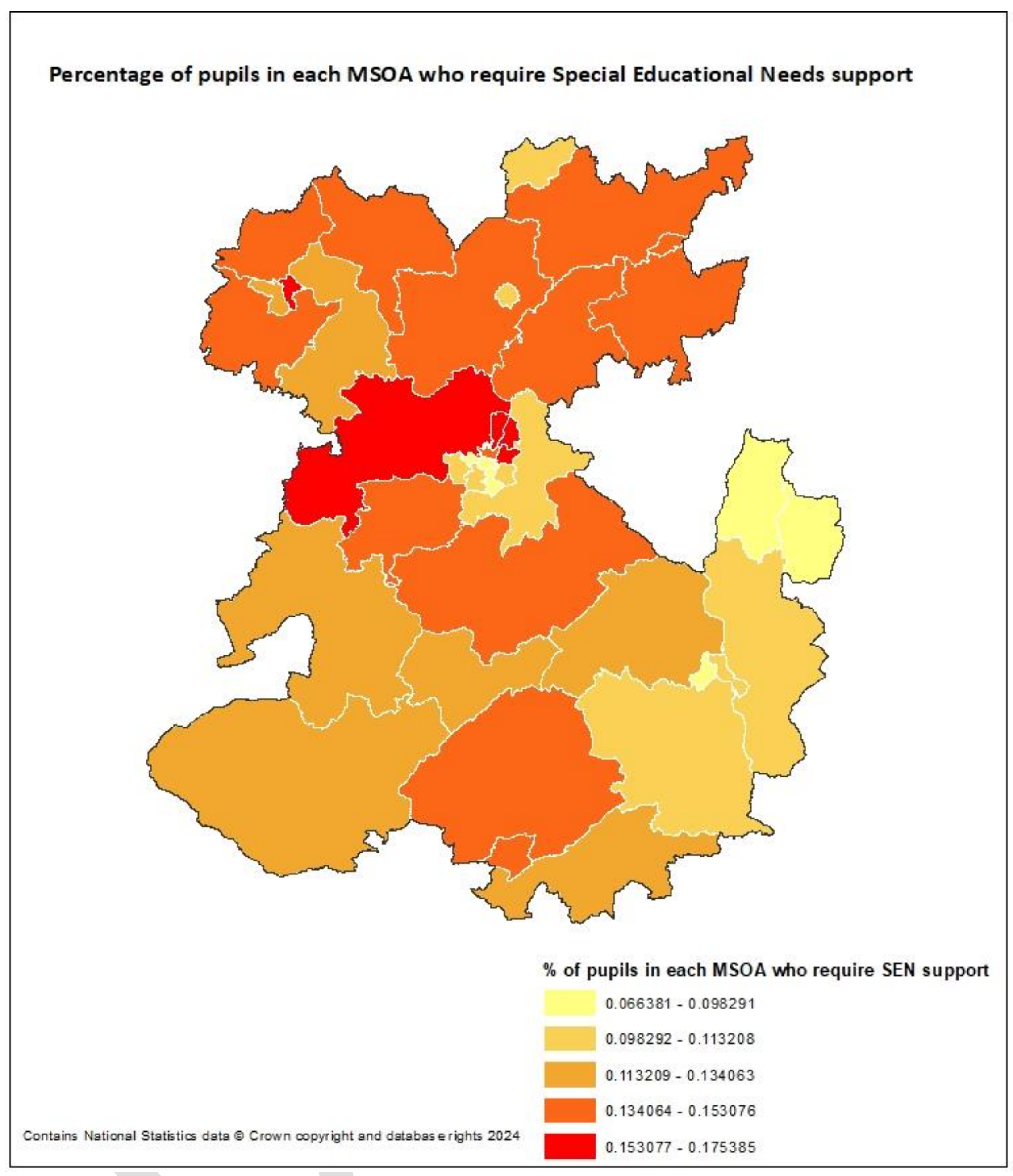
Percentage of pupils in each MSOA who require Special Educational Needs support
% of pupils in each MSOA who require SEN support
0.066381 - 0.098291
0.098292 - 0.113208
0.113209 - 0.134063
0.134064 - 0.153076
0.153077 - 0.175385
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Child Safety and Well-being Shropshire

Whitchurch
Ellesmere
Market Drayton
Shrewsbury
Oswestry
Wem
Shrewsbury
Shifnal
Albrighton
Church Stretton
Bridgnorth
Bishops Castle
Craven Arms
Ludlow

1 = Most deprived
2
3
4
5
6
7
8
9
10 = Least deprived

5% of Shropshire's population (15,082) **live in the 20% most deprived areas** in England (Decile 1 and 2), 2019

513
Babies, infants and children aged 0-4 **live in the top 5 most deprived areas** of Shropshire (2019)

0.120
Income Deprivation Affecting Children Index **(IDACI) score 2019**
(England, 0.178)

14.4%
of children under 16 living in absolute **low income families** 2021/22
(England, 15.3%)

18.0%
households in Shropshire in **fuel poverty** 2021

9
per 1,000 0-17 year old **children are in households with toxic trio***, 2021/21
(England, 9 per 1,000)

161
Children aged 0 -4 looked after as of 31 March 2023 in Shropshire (24% of all CLA vs 18% nationally)

8,765
A&E attendances (0-4s) during 2022/23, rate of 617.3 per 1,000
(England, 797.3)

2,595
Emergency admissions 0-4s, 180.8 per 1,000 2021/22
(England, 161.5)

125
admissions caused by **unintentional and deliberate injuries** children 0-4s, 2021/22, 87.1 per 10,000
(England, 103.6)

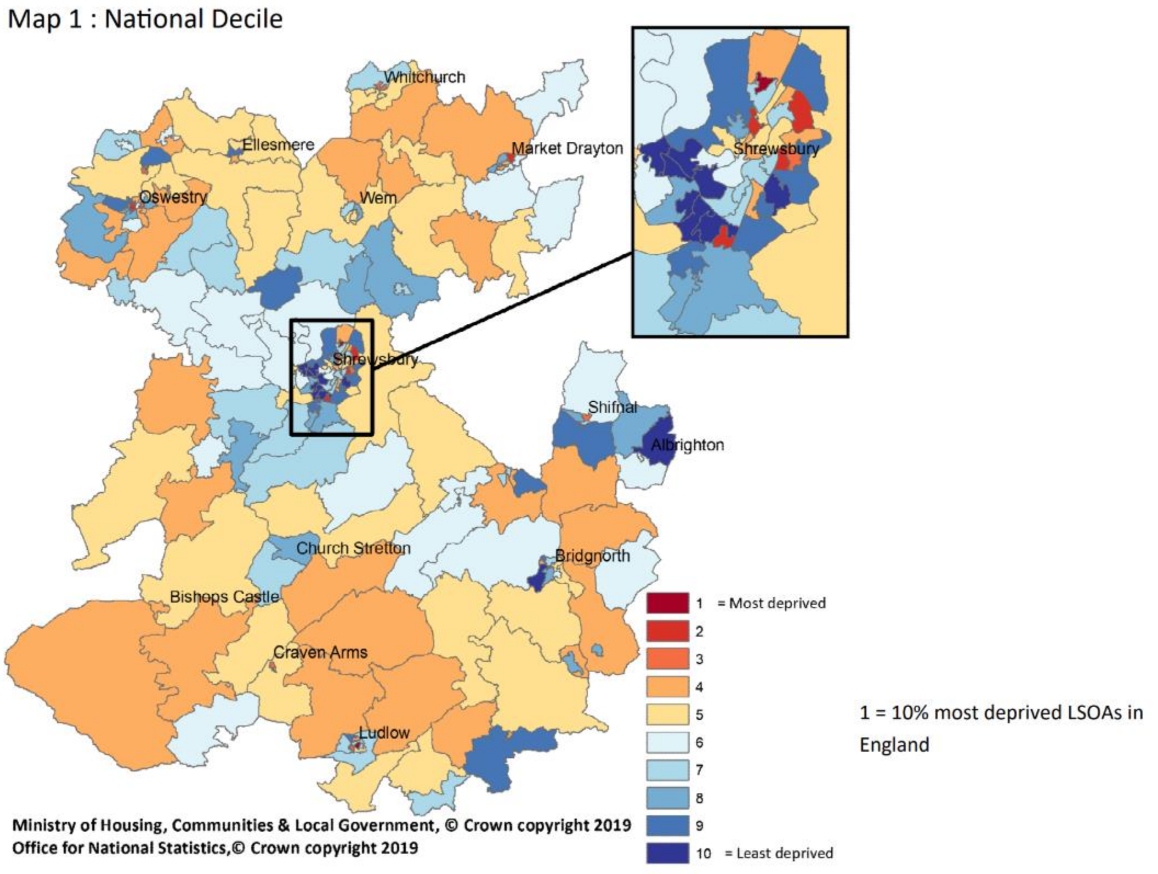
Red = worse, orange = similar, green =better than national rate

*co-occurring parental substance misuse, mental ill health and domesti

Deprivation

The Indices of Deprivation (IMD, 2019) combine a range of economic, social and housing indicators to provide a measure of relative deprivation, i.e., they measure the position of areas against each other within different domains. A rank of 1 indicates highest deprivation.

Shropshire has become slightly more deprived since 2015 with an increase in the average score from 16.7 in 2015 to 17.2 in 2019, an increase of 0.5. Shropshire is the 174th most deprived local authority in England out of a total of 317 lower tier authorities (rank of average score). This measure shows Shropshire has become relatively more deprived compared to other areas since 2015.



1 = 10% most deprived LSOAs in England

See here for more deprivation (IMD 2019) facts and figures for Shropshire.

In 2019, two LSOAs out of 193 LSOAs in Shropshire were in the 10% most deprived nationally, equating to 1% of all of Shropshire's LSOAs. These two LSOAs are located in Harlescott, North Shrewsbury and Ludlow East.

Child poverty

Childhood poverty is a strong predictor of poor health outcomes in adulthood and premature mortality. There are multiple indicators which measure child poverty. These measures each have unique methodologies and report different proportions of children experiencing poverty. However, they all show that children in Shropshire are less likely to experience poverty compared to the national average for these measures.

Children in absolute low income families (under 16s)

Absolute or relative low income is defined as a family in low income Before Housing Costs (BHC) in the reference year or in the reference year in comparison with incomes in 2010/11, respectively. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics.

In Shropshire in 2021-22, 14.4% of children and young people aged under 16 were estimated to be living in absolute low income families, equating to 7,397 children.

This ranks Shropshire 5th lowest in the West Midlands region and below the regional and national average.

Percentage of children aged 0-15 in absolute low income families in Shropshire, and its regional neighbours, 2021-22. Source: Child and Maternal Health Profile, Fingertips, OHID

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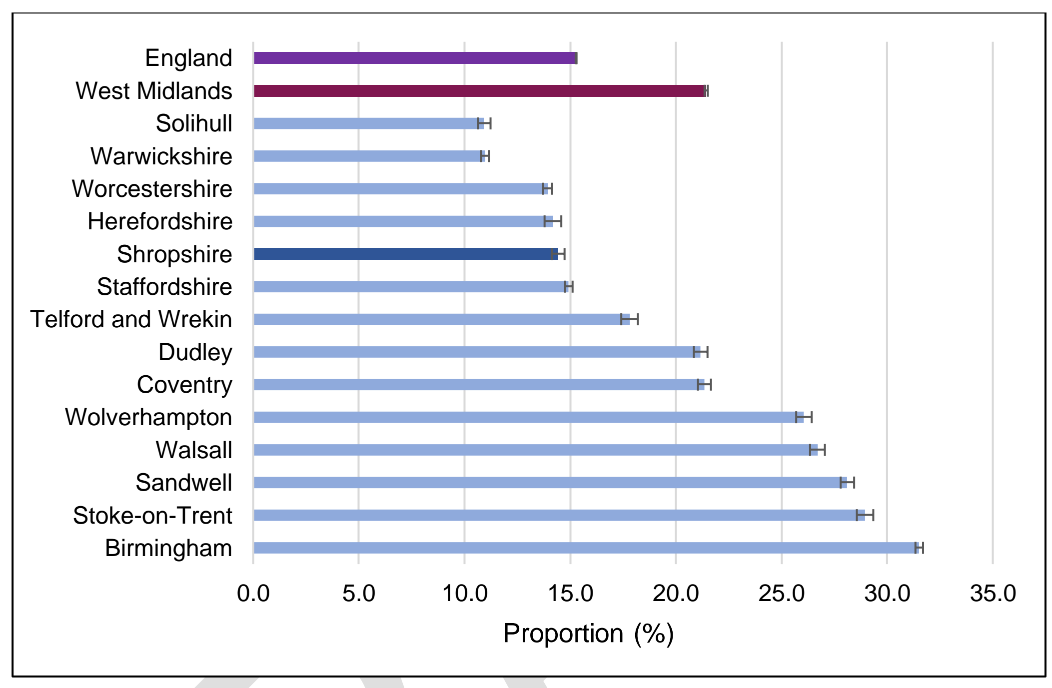

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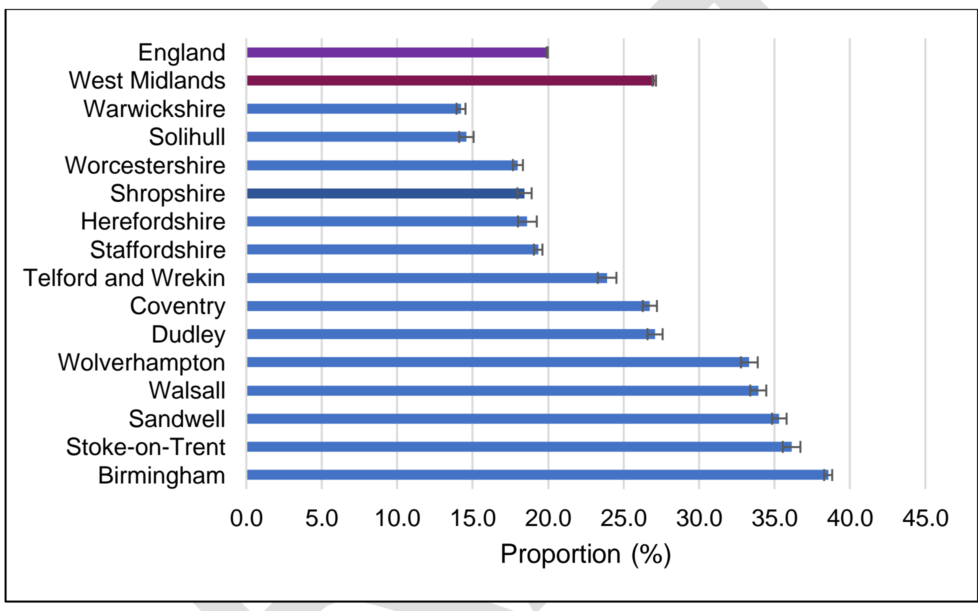
Children in relative low income families (under 16s)

In Shropshire in 2021-22, 18.4% of children and young people aged under 16 were estimated to be living in relative low income families, equating to 9,449 children.

This ranks Shropshire 4th lowest in the West Midlands region and below the regional and national average.

Percentage of children aged 0-15 in relative low income families in Shropshire, and its regional neighbours, 2021-22. Source: Child and Maternal Health Profile, Fingertips, OHID



Below shows a map of the West Midlands region with Shropshire outlined, showing the relative levels of children living in poverty in the financial year ending 2021, divided into national quartiles. Source: OHID Child Health Profile 2023

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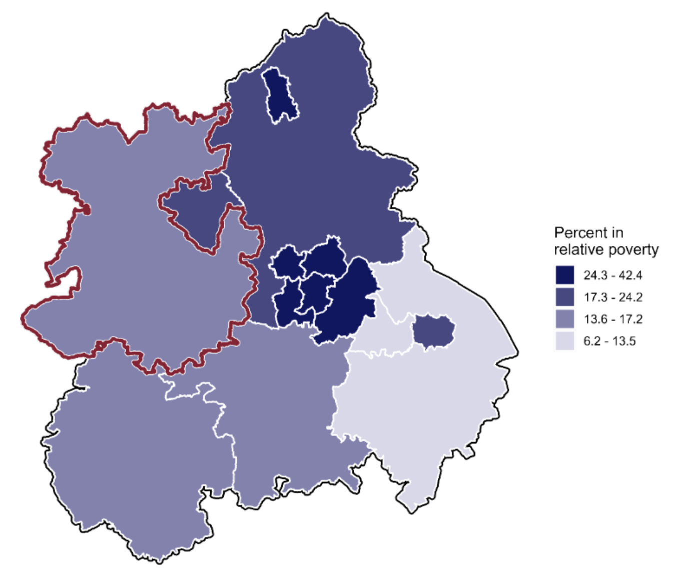
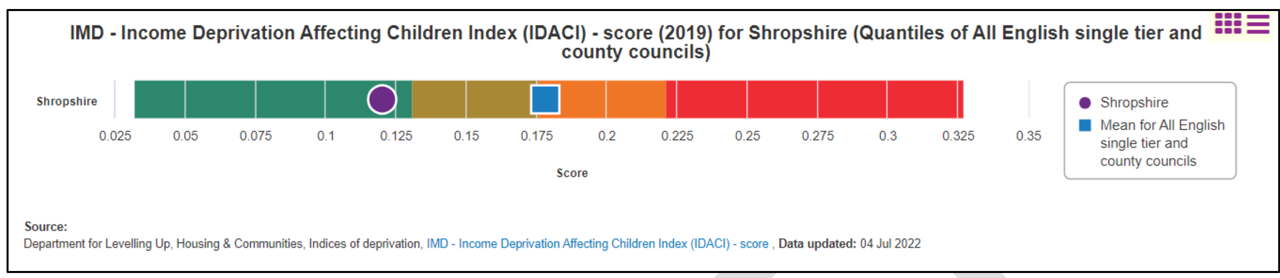


Deprivation Affecting Children Index (IDACI)

The Marmot Review (2010) suggests that childhood poverty leads to premature mortality and poor health outcomes in adult life[1]. The Income Deprivation Affecting Children Index (IDACI) measure is part of IMD 2019 which looks at the percentage of children aged under-16 years old living in income deprived households. This is based on families receiving one of the following means tested benefits - Income Support, Income Based Job Seekers Allowance, Income based Employment and Support Allowance, Pension Credit (Guarantee), Working Tax Credit or Child Tax Credit.

Shropshire has an Income Deprivation Affecting Children Index (IDACI) score of 0.120 (2019). This measures the proportion of all children aged 0 to 15 living in income deprived families. The national score is 0.172, higher than Shropshire's score.

[1] LG inform: Health and Wellbeing in Shropshire: A Focus on Children



Map showing IDACI score for child poverty by ward in Shropshire, compared to the England average, 2019. Source: OHID Local Health

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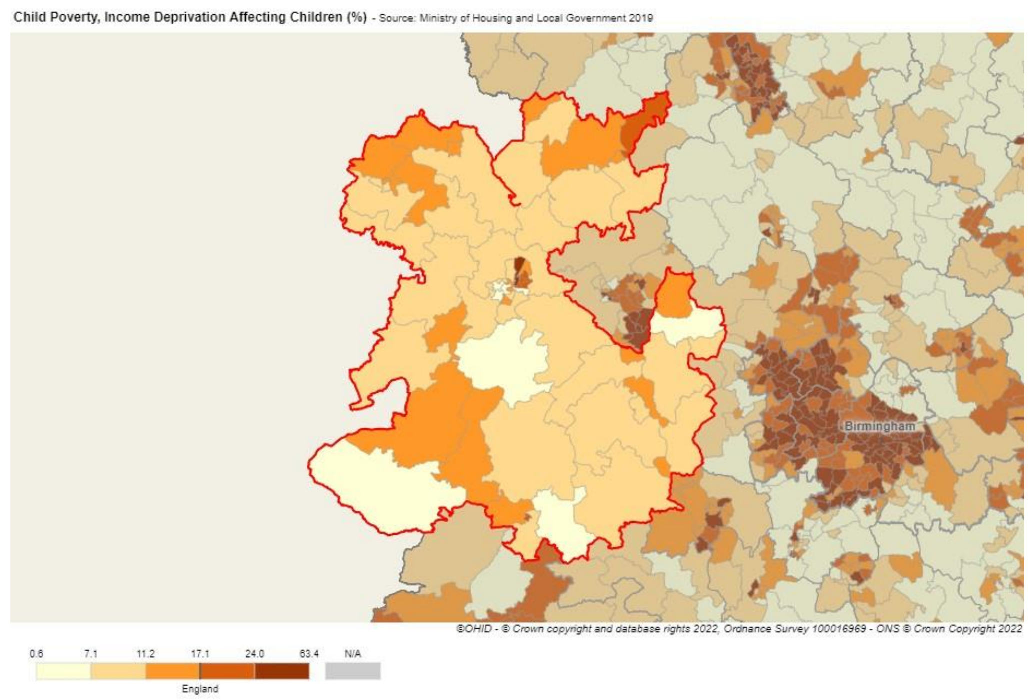

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Eligibility and claiming free school meals

In Shropshire, 18.0% of pupils attending nursery and primary schools and 17.2% of pupils attending secondary school are eligible for and claiming free school meals, rates lower than the national average. In England, 23.9% of pupils attending nursery and primary schools and 22.7% of pupils attending secondary school for England.

Free School Meals

In total, 19% of pupils (7,300) at Shropshire schools are eligible for free school meals – eligibility seems to increase as children get older, with just over 10% of the children aged 0-4 (168) being eligible for a free school meal.

	Free School Meal eligibility	Total pupils	% of pupils eligible for Free School Meal
E1 or E2 (0, or 1 at 31st August, turning 1 or 2 during year)	1	29	3%
N1 (2 at 31st August, turning 3 during the year)	30	371	8%
N2 (3 at 31st August, turning 4 during the year)	137	1224	11%
Total aged 0-4 at 31st August	168	1624	10%
Reception	315	2777	11%
Year 1	446	2878	15%
Year 2	486	3072	16%
Year 3	645	3089	21%
Year 4	616	3057	20%
Year 5	653	3015	22%
Year 6	738	3111	24%
Total between Reception and Year 6	3899	20999	19%
Year 7	687	3278	21%
Year 8	672	3187	21%
Year 9	614	3148	20%
Year 10	584	3144	19%
Year 11	574	3165	18%
Total between Year 7 and Year 11	3131	15922	20%
Year 12	54	413	13%
Year 13	40	459	9%
Year 14	8	18	44%
Total between Year 12 and Year 14	102	890	11%
Any age	**7300**	**39435**	**19%**

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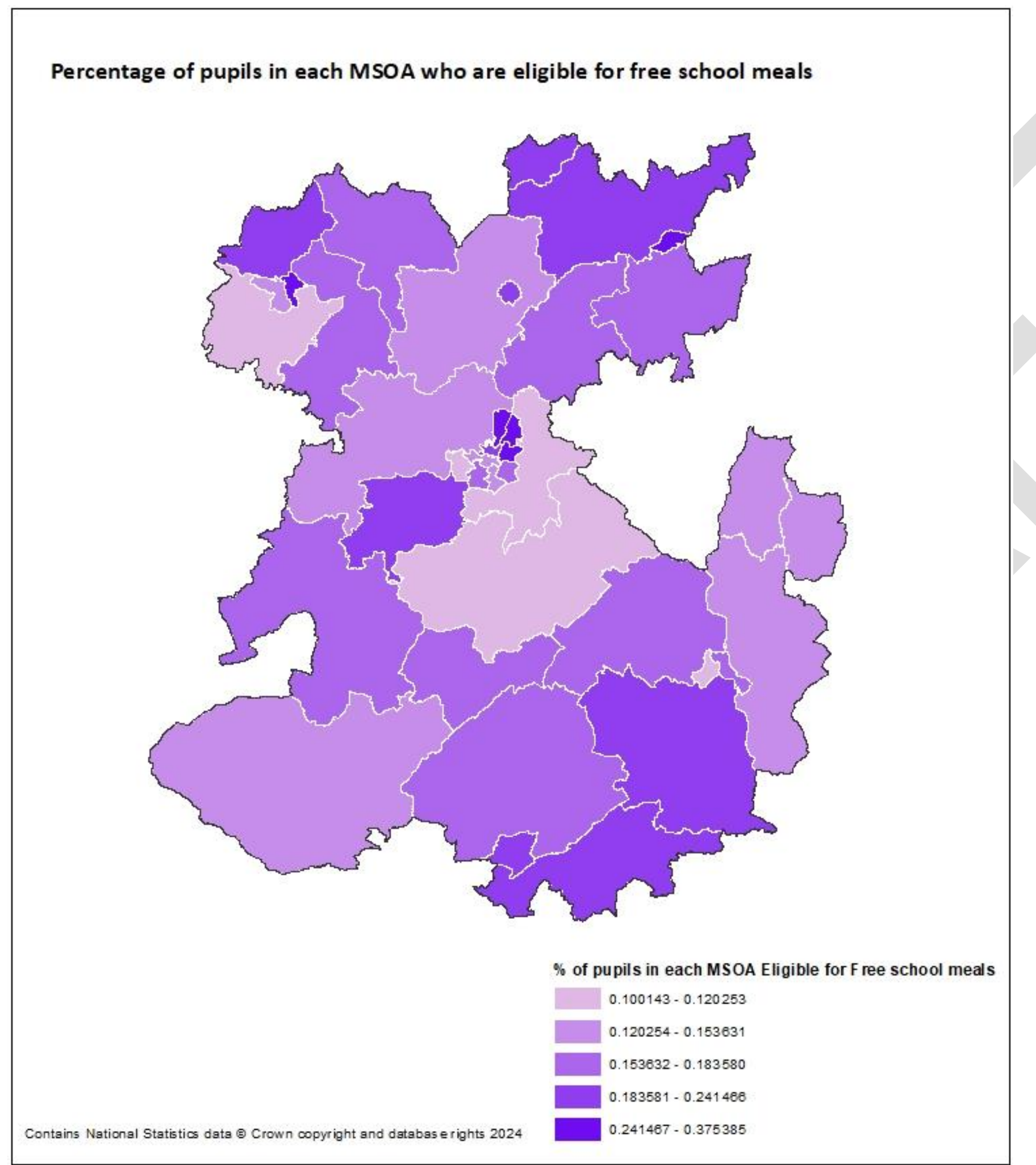
Percentage of pupils in each MSOA who are eligible for free school meals
% of pupils in each MSOA Eligible for Free school meals
0.100143 - 0.120253
0.120254 - 0.153631
0.153632 - 0.183580
0.183581 - 0.241466
0.241467 - 0.375385
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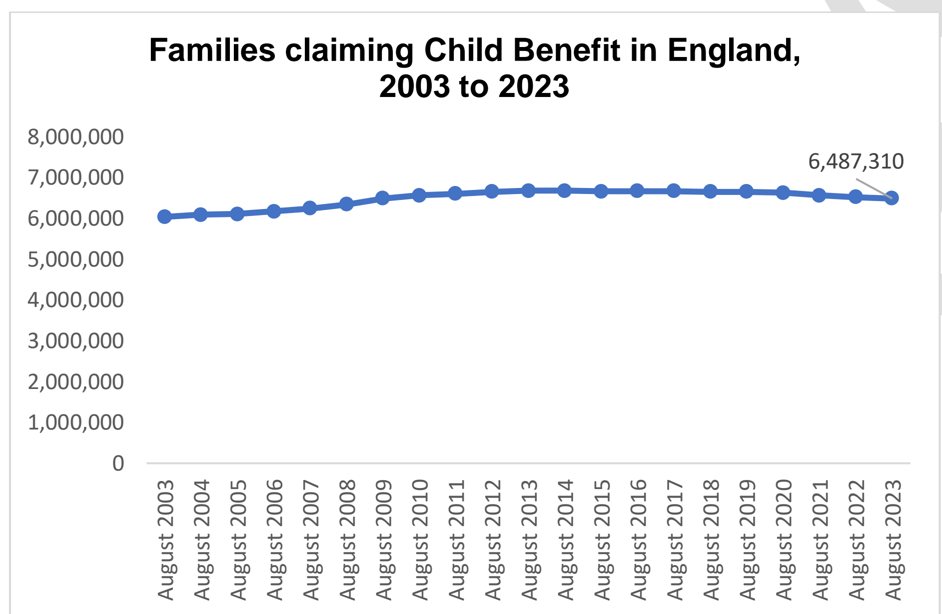
Child Benefits

Families claiming Child Benefit

On 31 August 2023, across the United Kingdom there were:

- 7.65 million families claiming Child Benefit, with 6.91 million families in receipt of Child Benefit payments. This is a decrease of 47,000 claiming families and 106,000 families in payment when compared to August 2022
- 741,000 families who chose to opt-out of receiving payments
- 13.04 million children in families claiming Child Benefit, and 11.92 million children in payment recipient families. This is a fall of approximately 159,000 children in claiming families, and 236,000 children for whom payment is received since August 2022
- 1.12 million children in families who had opted out of payments

For the same period, across England, there were 6.48 million families claiming Child Benefit, a decrease of 38,000 families compared to August 2022. Regionally, numbers are highest among families living in the South East and London regions. In August 2023, 714,000 families were claiming child benefits in the West Midlands.



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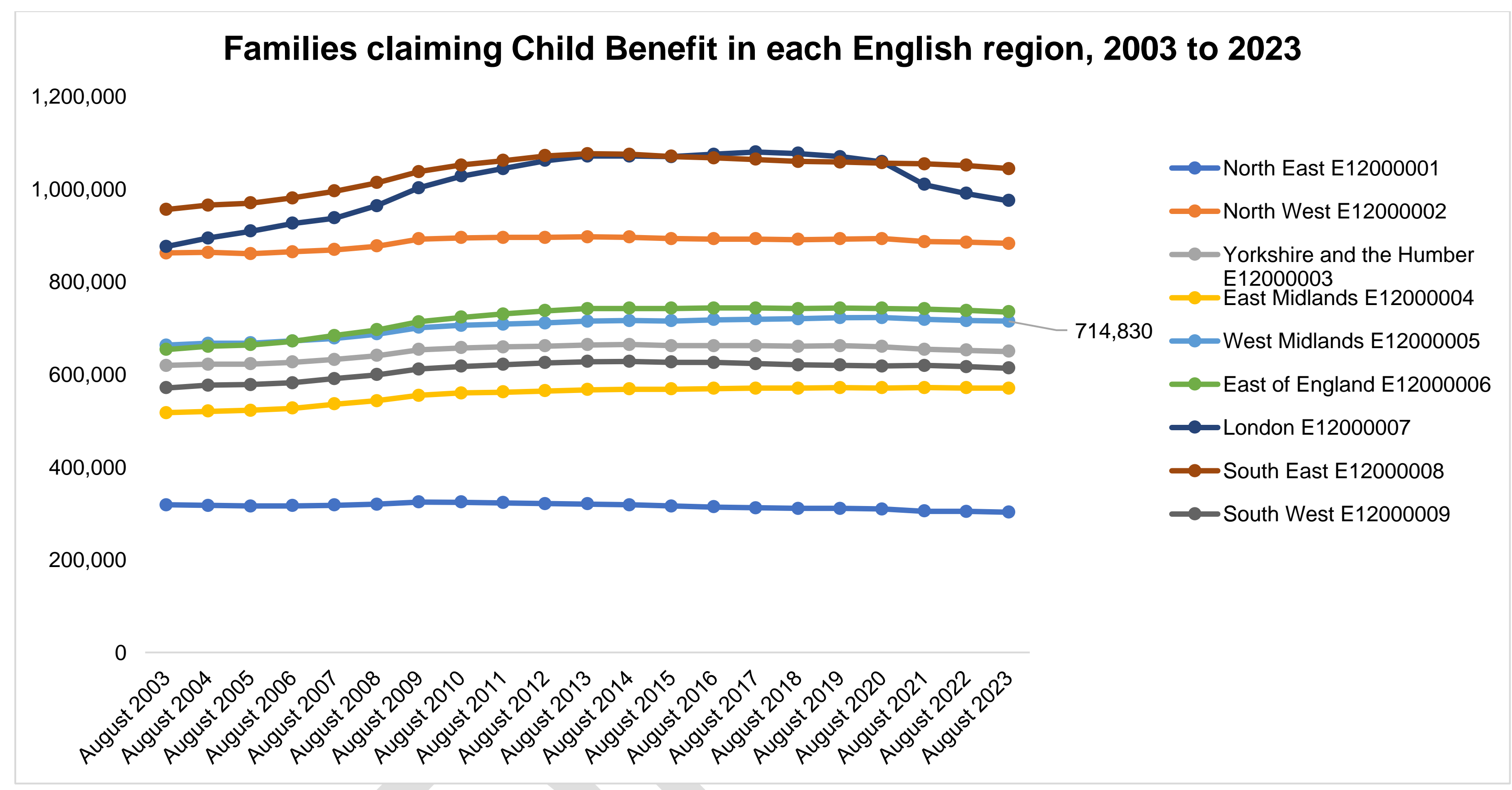

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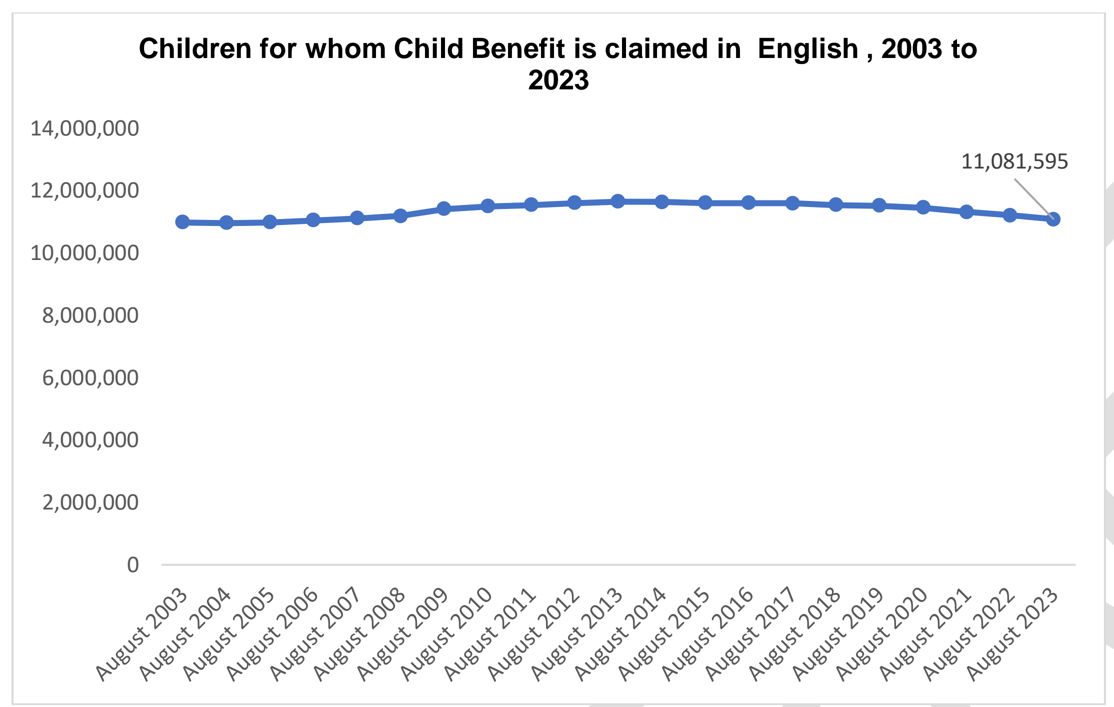
Children for whom child benefit was claimed:

Nationally, in August 2023, there were 11,081,595 children for whom child benefit was claimed. A slight fall compared to the previous year:



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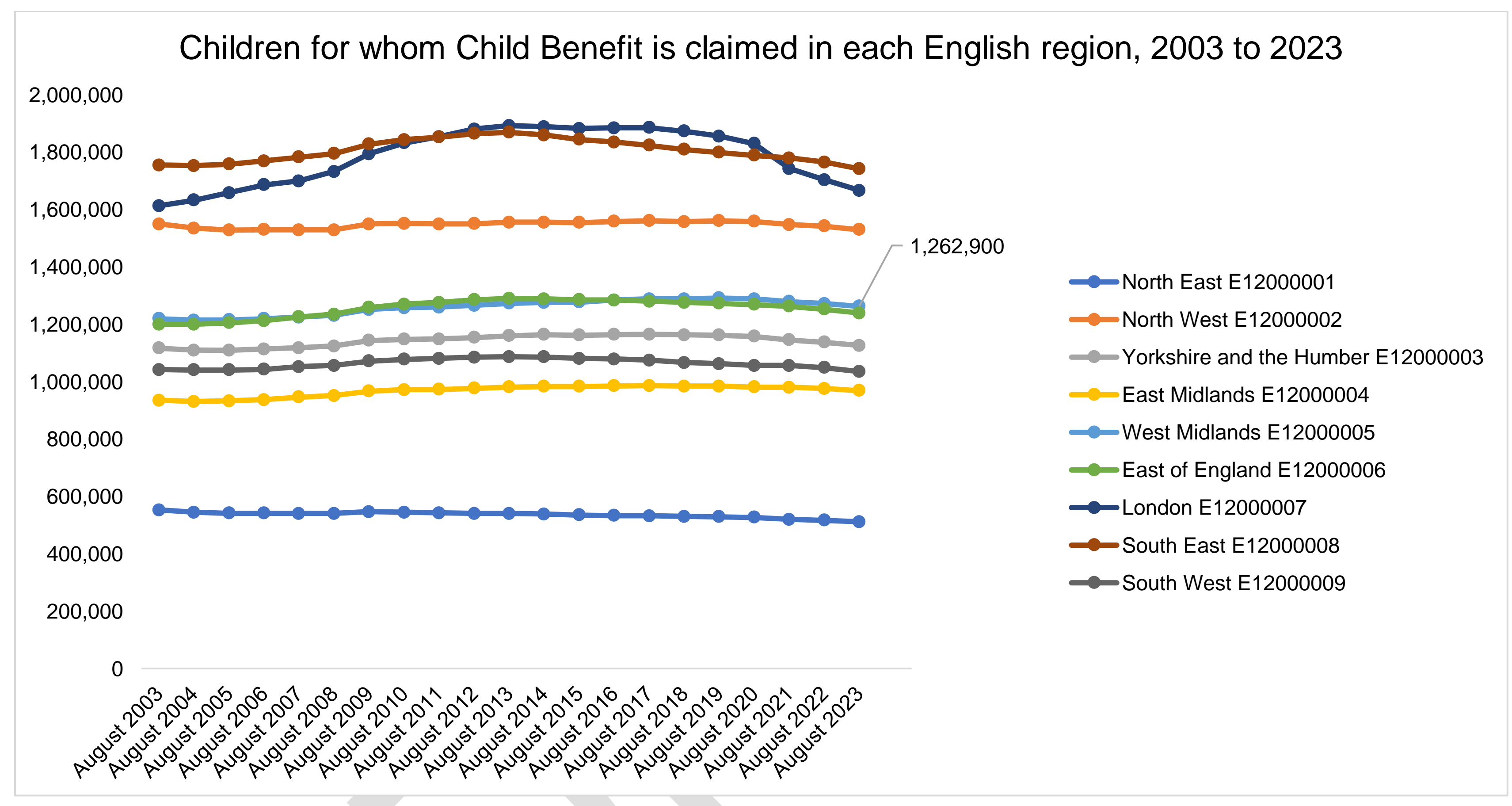
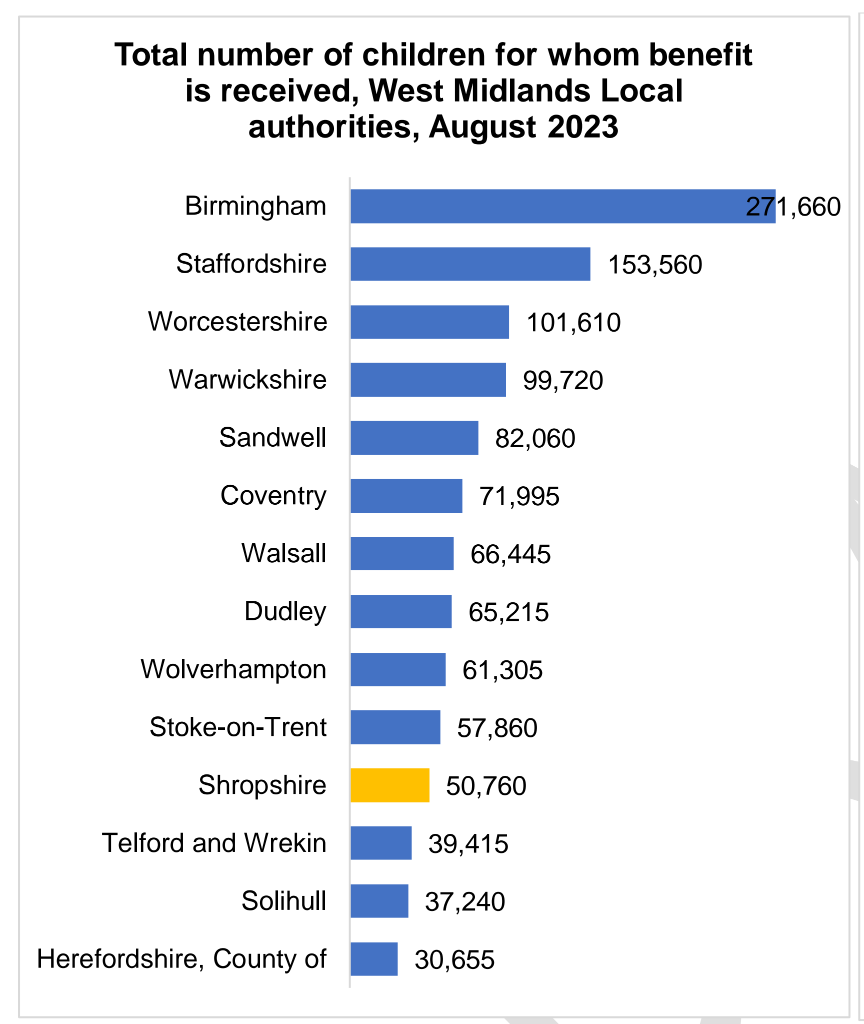
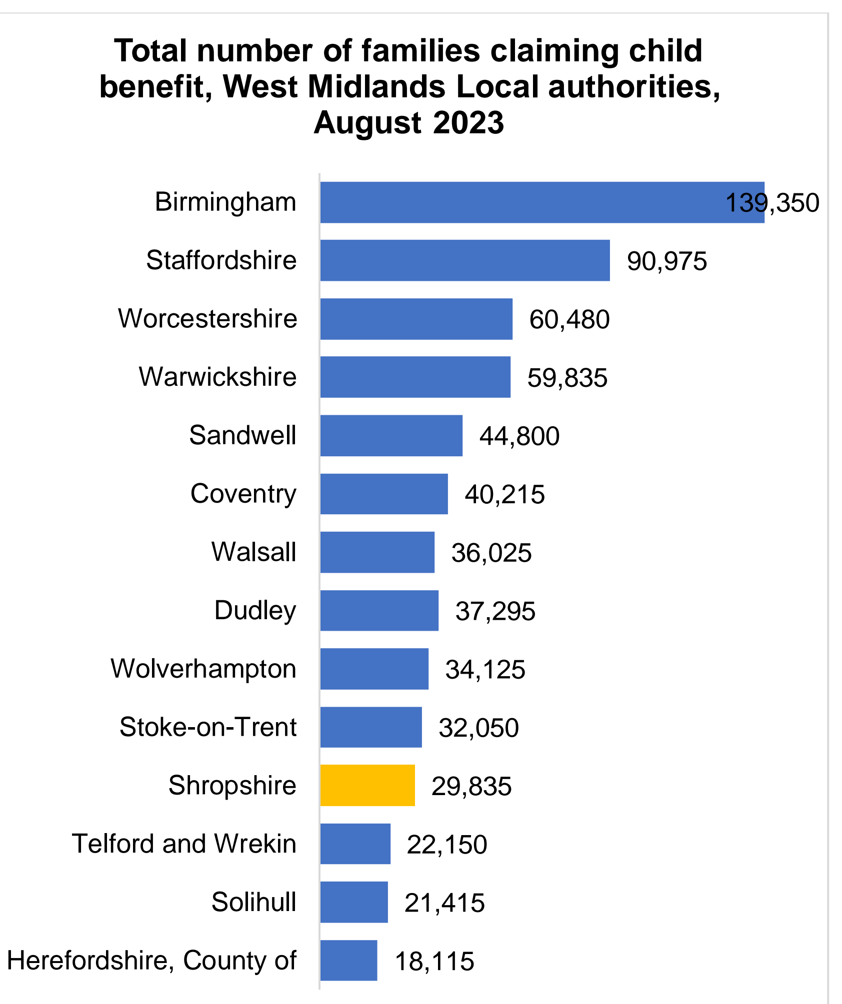
Regionally and local picture

Regionally, the highest number of children for whom child benefit is claimed is in the South East and London. In the West Midlands, there was 1.2 million children for whom child benefit was claimed in August 2023, a fall of ~9,000 children compared to August 2022.



In August 2023, in the West Midlands region, Birmingham has the highest number of children for whom benefit is received and also the highest number of families claiming child benefit. In Shropshire, benefit is received for 50,760 children. 29,835 families claim this child benefit.





Compared to the previous year, all local authorities in the West Midlands have seen a minor decrease in the number of children for whom child benefit is claimed. In Shropshire, this was a reduction of 1,010 children, equating to a 2% decrease, The third largest fall in the regio:

Total number of children for whom benefit is received, West Midlands Local authorities, August 2022-23

Area Name	Aug-22	Aug-23	Year on year change	% change
Herefordshire, County of	31,160	30,655	-505	-1.6%
Shropshire	**51,770**	**50,760**	**-1,010**	**-2.0%**
Stoke-on-Trent	58,325	57,860	-465	-0.8%
Telford and Wrekin	39,590	39,415	-175	-0.4%
Staffordshire	155,220	153,560	-1,660	-1.1%
Warwickshire	100,790	99,720	-1,070	-1.1%
Birmingham	276,195	271,660	-4,535	-1.6%
Coventry	73,000	71,995	-1,005	-1.4%
Dudley	65,645	65,215	-430	-0.7%
Sandwell	82,960	82,060	-900	-1.1%
Solihull	38,270	37,240	-1,030	-2.7%
Walsall	67,260	66,445	-815	-1.2%
Wolverhampton	61,745	61,305	-440	-0.7%
Worcestershire	103,960	101,610	-2,350	-2.3%

Across all local authorities in the West Midlands region, the highest number of children for who benefit is received is among those aged 5-10, making up a third of all children whom child benefit is received. In Shropshire, this is also true with 16,780 children aged 5-10 receiving child benefits, equating to 33% of all children for whom child benefit received.

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Total number of children for whom benefit is received by age group, West Midlands Local authorities, August 2023

Area Name	Children: Under 5	Children: 5 to 10	Children: 11 to 15	Children: 16 and over	Total number of children
Herefordshire, County of	6,635	10,190	9,220	4,610	30,655
Shropshire	11,260	16,780	15,190	7,530	50,760
Stoke-on-Trent	13,515	19,320	17,120	7,910	57,860
Telford and Wrekin	8,860	13,055	11,750	5,745	39,415
Staffordshire	35,530	50,880	44,850	22,300	153,560
Warwickshire	22,720	33,185	29,530	14,285	99,720
Birmingham	58,830	90,140	80,550	42,140	271,660
Coventry	15,970	23,990	21,645	10,390	71,995
Dudley	15,170	21,740	18,815	9,490	65,215
Sandwell	18,060	27,170	24,410	12,420	82,060
Solihull	7,800	12,390	11,295	5,755	37,240
Walsall	15,150	22,185	19,385	9,730	66,445
Wolverhampton	13,555	20,465	18,195	9,090	61,305
Worcestershire	22,640	33,605	30,120	15,250	101,610

Area Name	Children: Under 5	Children: 5 to 10	Children: 11 to 15	Children: 16 and over	Total number of children

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Herefordshire, County of	22%	33%	30%	15%	30,655
Shropshire	22%	33%	30%	15%	50,760
Stoke-on-Trent	23%	33%	30%	14%	57,860
Telford and Wrekin	22%	33%	30%	15%	39,415
Staffordshire	23%	33%	29%	15%	153,560
Warwickshire	23%	33%	30%	14%	99,720
Birmingham	22%	33%	30%	16%	271,660
Coventry	22%	33%	30%	14%	71,995
Dudley	23%	33%	29%	15%	65,215
Sandwell	22%	33%	30%	15%	82,060
Solihull	21%	33%	30%	15%	37,240
Walsall	23%	33%	29%	15%	66,445
Wolverhampton	22%	33%	30%	15%	61,305
Worcestershire	22%	33%	30%	15%	101,610

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Rurality and inequalities

Given the rural nature of Shropshire, the ease with which people can access services such as work, healthcare, education and shopping is an important and challenging issue.

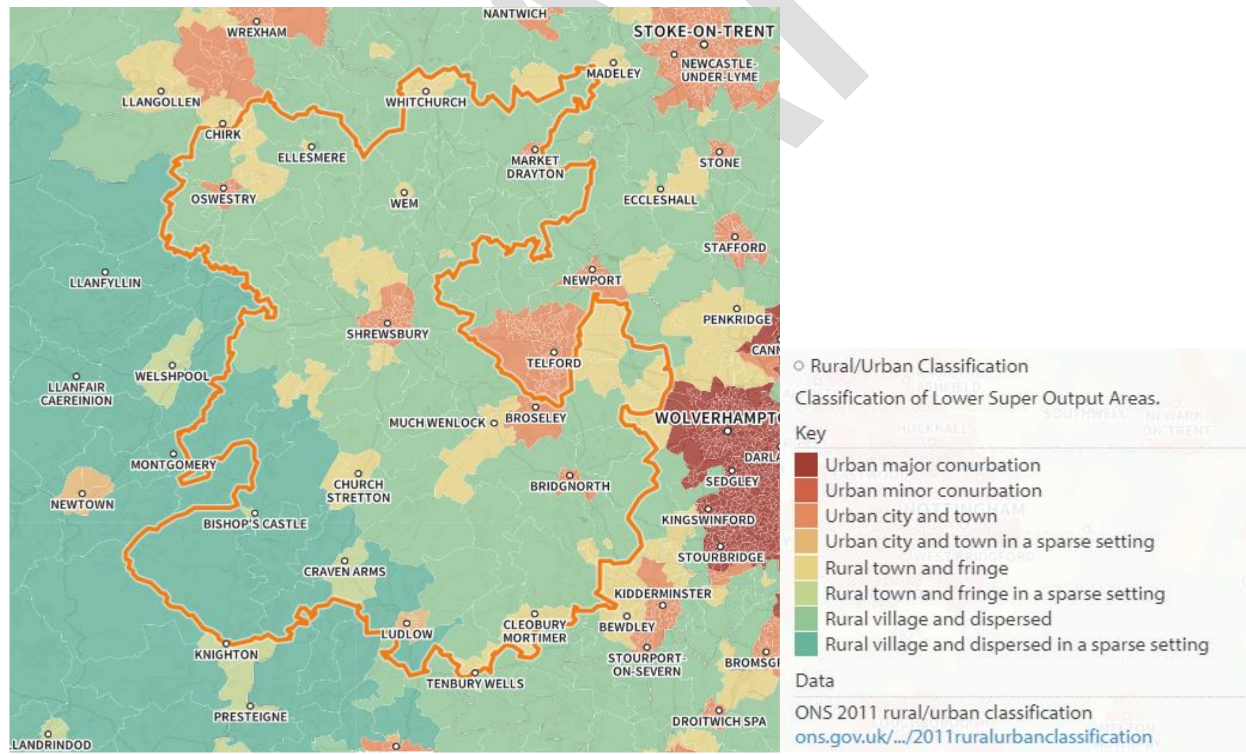
Rural and Urban classification

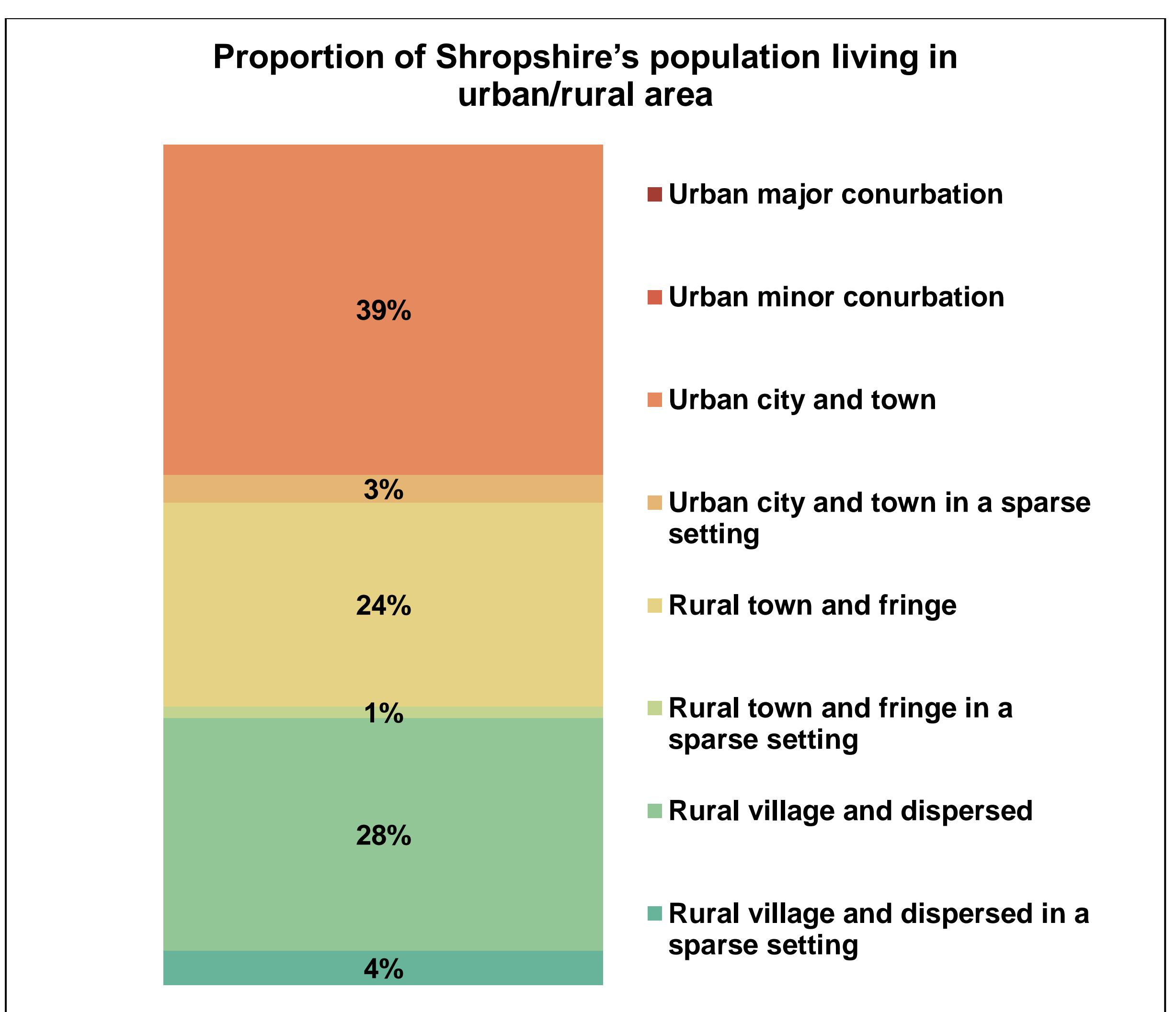
57% of Shropshire's total population live in a “rural” setting (green and yellow in the map below).

58% of LSOAs in Shropshire are classified as “rural”, equating to 186,658 people (57% of Shropshire's total population). 33% are classified as “rural village and dispersed” or “rural village and dispersed in sparse setting”

- 186,658 people classified as living in a “rural” setting (green/yellow), 57% of Shropshire's total population.
- 103,310 people classified as living in “rural village and dispersed” or “rural village and dispersed in sparse setting” category. 32% of Shropshire’s total population.
- 127,800 people classified as living in “rural town and fringe”, 24% of Shropshire’s population.
- 0 people living in urban major or minor conurbation

Map showing rural and urban classification in Shropshire (ONS). Source: OHID SHAPE tool





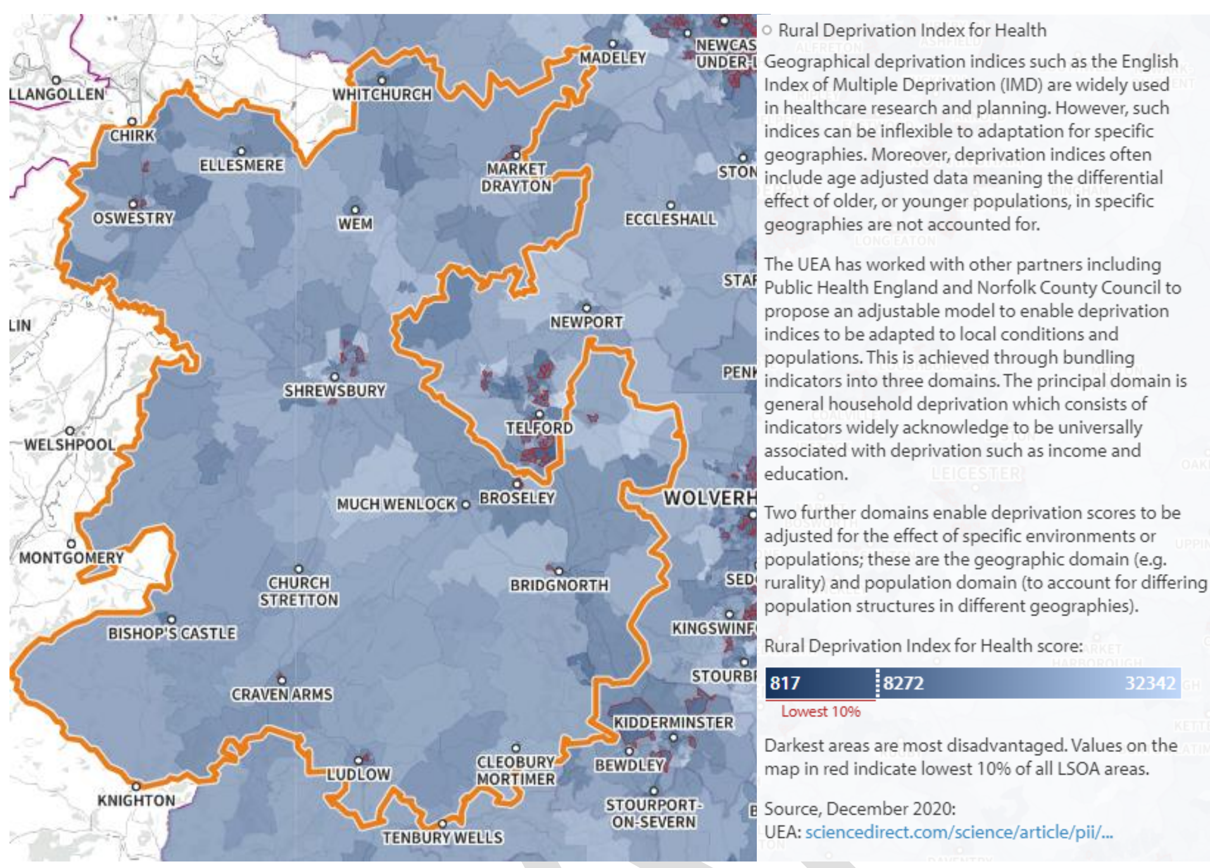
Rural deprivation index (RDI) for health

Geographical deprivation indices such as the English Index of Multiple Deprivation (IMD) have been widely used in healthcare research and planning since the mid-1980s. However, such indices normally provide a measure of disadvantage for the whole population and can be inflexible to adaptation for specific geographies or purposes. This can be an issue, as the measurement of deprivation is subjective and situationally relative, and the type of deprivation experienced within rural areas may differ from that experienced by urban residents.

An adjustable model to enable deprivation indices to be adapted to local conditions and populations has been developed by Norfolk County Council. The model has the potential to provide a starting point for those who wish to create a summary deprivation measure, considering rurality or other local geographic factors, particularly as part of a range of approaches that can be used to allocate or apply for resources.

In Shropshire, 46 of the 193 LSOAs in Shropshire are in quintile 1 (i.e., most deprived), with 43,927 residents living across these 46 LSOAs. This means 1 in 4 (24%) of Shropshire's LSOAs are within the most deprived quintile nationally.

Map showing Rural Deprivation Index (RDI) in Shropshire. Source: Shape Atlas

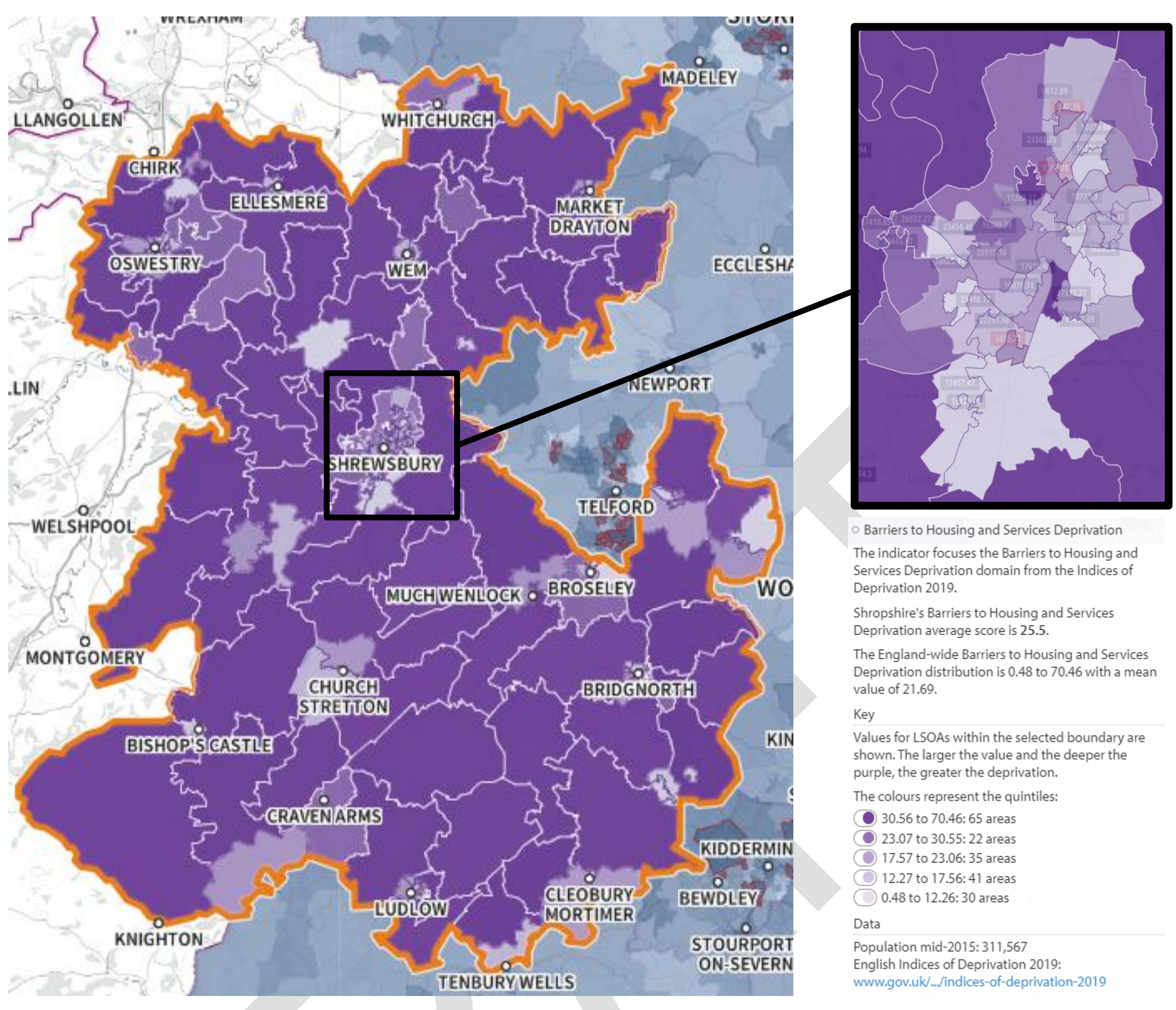


Barriers to housing and services: IMD 2019

This IMD 2019 domain measures the physical and financial accessibility of housing and key local services. Shropshire has an average score of 25.4 and is ranked 68th most deprived local authority in England out of a total of 317 lower tier authorities.

47 Shropshire LSOA's are within the 10% most deprived nationally, 35 LSOAs in Shropshire are ranked within the 5% most deprived for the Barriers to Housing and Services Domain nationally.

Map showing Rural Deprivation Index (RDI) in Shropshire. Source: Shape Atlas



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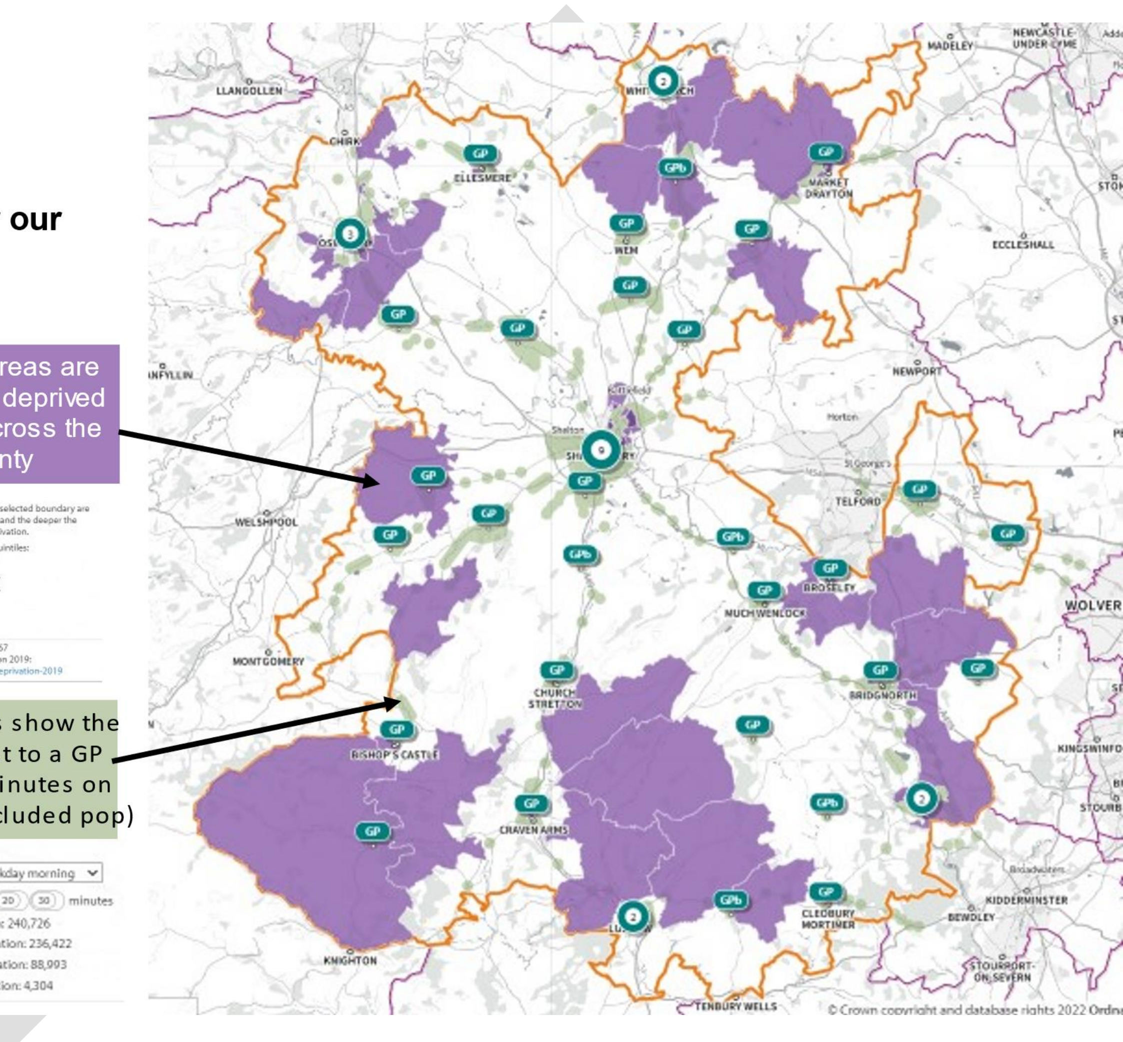
Access to GPs

E.g. access to GP practices among for our most deprived communities

63% (236,422) residents in Shropshire can access a GP practice within 15 mins using public transport

37% (88,993) of residents in Shropshire **cannot** access a GP practice within 15 mins using public transport



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Drugs and alcohol

This section has been taken from the Drug and Alcohol Needs Assessment.

For more detail and data, please follow the link.

Parents/carers and families in substance misuse services

The next section presents profile and outcomes data for parents with problem alcohol and drug use in Shropshire. The data comes from the Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020. Supporting children and families affected by parental alcohol and drug use pack, NTDMS[2]. Except for numbers in treatment, the numbers presented here are for new presentations to treatment only. This includes clients who started treatment between 1 April 2019 and 31 March 2020.

To prevent potential patient identification, all local figures for Shropshire in this report have been rounded to 1 or the nearest 5. Proportions have been calculated from the rounded figures. This is true of all local data except for the overall numbers in treatment.

This report includes benchmark comparisons to local data. These are the areas identified as the nearest neighbours for Shropshire using the Chartered Institute of Public Finance & Accountancy (CIPFA) 2018 Model: Cheshire East, Cheshire West and Chester, Central Bedfordshire, Northumberland, Warrington, Stockport, East Riding of Yorkshire, Herefordshire, Solihull, Isle of Wight, Bath and North East Somerset, South Gloucestershire, North Somerset, Wiltshire, Cornwall & Isles of Scilly. Please see the appendix for a table of these benchmark areas including upper tier local authority codes.

Green coloured text = better than the national average
Orange text = similar to the national average
Red test = worse than the national average

- Prevalence and unmet need gap: 54% opiate dependent parents and 68% for alcohol dependent parents (both lower than national rates)
- In 2019 to 2020, 34% (706) of children in needs assessments identified alcohol misuse by a parent or other adult living with the child as an issue. Drug misuse was a factor in 35% (723) of assessments.
- 546 new presentations to treatment (FY 2019/20) aged between 18 and 99. Of those:
  - 133 (24%) were parents or adults living with children
  - 151 (28%) were parents not living with children
  - 261 (48%) were not a parent and had no contact with children
- Majority of new presentations by parents to service were for alcohol misuse (62%).
  - 19% presented with non-opiate & alcohol problems
  - 12% for non-opiate
  - 8% for opiate misuse
- For parents presenting with alcohol misuse, the rate was higher than the benchmark areas.
- 63% of parents or adults living with children presented with a mental health treatment need, higher than the benchmark of 54%.
- The rate of need for mental health treatment and unmet need was similar to the benchmark for parents not living with children.
  - Of those, 1 in 5 (19%) did not receive mental health treatment, similar to the benchmark figure.
- In Shropshire during 2019-20, there were 1,384 adults in treatment. Of these:

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[2] Parents with problem alcohol and drug use: Data for England and Shropshire, 2019 to 2020 Supporting children and families affected by parental alcohol and drug use

    - 380 (27%) were parents or adults living with children
    - 358 (26%) were parents not living with children
    - 646 (47%) were not parents
- 43% of all adults in treatment during 2019-20 were parents or carers (either living with or not living with children), equating 738 people
- Rates of referral into drug and alcohol treatment were low from children and family social services across all parental groups
- Among parents living with children in treatment, it was non opiate users who spent the longest average number of days in treatment (167 days), compared with 110 days on average in benchmark areas.
- Majority (71%) of parents living with children and not living with children who presented to treatment in 2019-20 were not receiving children or families' support, lower than the benchmark figure of 78%.
- 14% of parents living with children and 10% of parents not living with children had a child protection plan in place, both higher than the benchmark values.
- Support received during treatment:
    - 4% of newly presenting parents living with children received family or parenting recovery support, lower than the benchmark of 7%
    - 7% of parents not living with children received family or parenting recovery support, higher than the benchmark figure of 5%
    - 3% of newly presenting parents living with children received housing or employment recovery support, similar to the benchmark.
    - 3% of newly presenting parents not living with children received housing or employment recovery support compared to the benchmark figure of 8%
- Completion rates were lower across all parental groups in Shropshire compared to benchmark areas:
    - 22% of parents living with children successfully completing compared to the benchmark of 29%
    - 17% of parents not living with children completed compared to 21% in benchmark areas on average.

Domestic abuse

Domestic abuse affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status.

Some 30,475 women in Shropshire will experience domestic abuse during their lifetime. This equates to one in four women being likely to experience domestic violence, from a population figure of 121,900 for women over 16[3].

The Domestic Act 2021 recognises all children as victims of Domestic abuse if they see hear or experience the effects of the abuse, are aged under 18 years old and related to either the victim or the perpetrator.

Children are affected in many ways by Domestic abuse, even after a short time. These effects include[4]:

- feeling frightened, anxious or depressed
- becoming withdrawn, low self-esteem, difficulty forming healthy relationships
- bed-wetting
- Hypervigilance around changes in mood and atmosphere

[3] Shropshire Council
[4] SSCP

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- poor concentration
- inconsistent regulation of emotions includes becoming distressed, upset or angry
- problems with school, risk of exclusion
- using alcohol, drugs or self-harming

National prevalence

The Crime Survey for England and Wales (CSEW) year ending March 2023 estimated that 4.4% of people aged 16 years and over (2.1 million) experienced domestic abuse in the last year[5].

There was no significant change in the prevalence of domestic abuse experienced in the last year by people aged 16 to 59 years compared with the previous year, but a significant decrease compared with the year ending March 2020, a year largely unaffected by the coronavirus (COVID-19) pandemic.

An estimated 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse in the last year; a prevalence rate of approximately 5.7% of women and 3.2% of men. This is a prevalence rate of approximately 6 in 100 women and 3 in 100 men (Figure below).

The percentage of people aged 75 years and over who experienced domestic abuse in the last year was lower than all other age groups.

A higher proportion of people aged 16 years and over in the Mixed and White ethnic groups experienced domestic abuse in the last year compared with those in the Asian or Asian British group.

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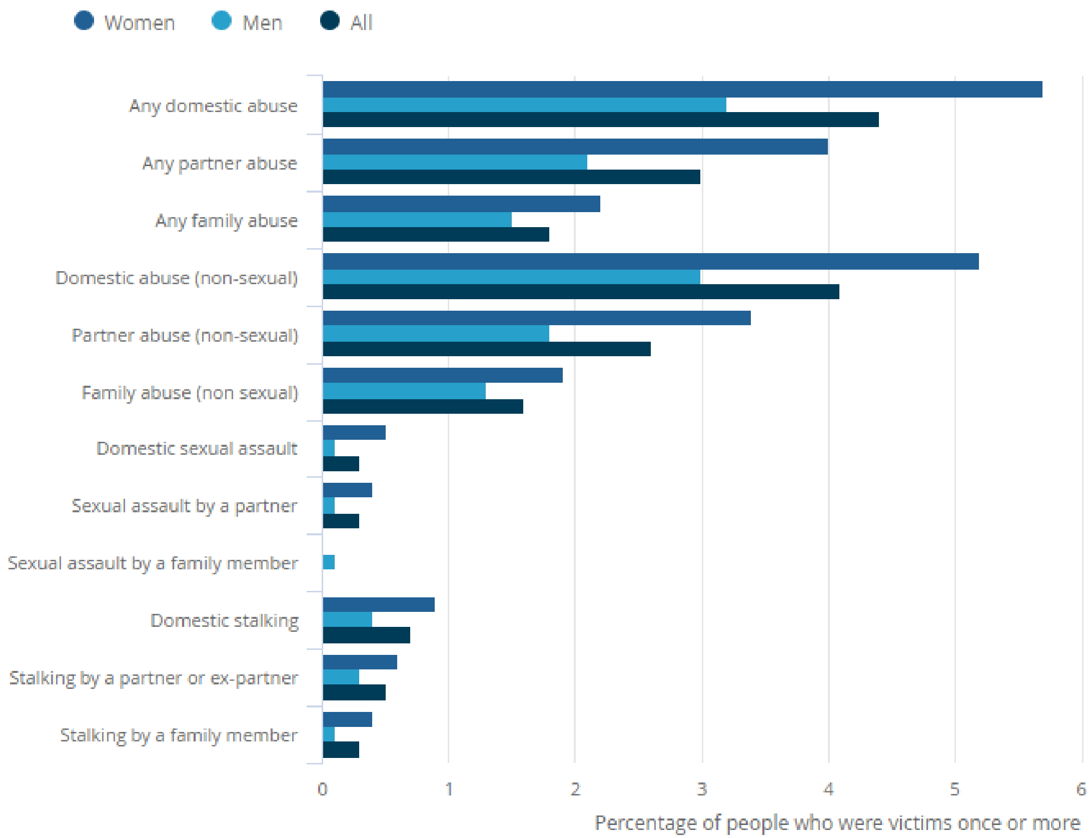
[5] ONS

Figure 1: A higher proportion of women than men were victims of domestic abuse in the last year

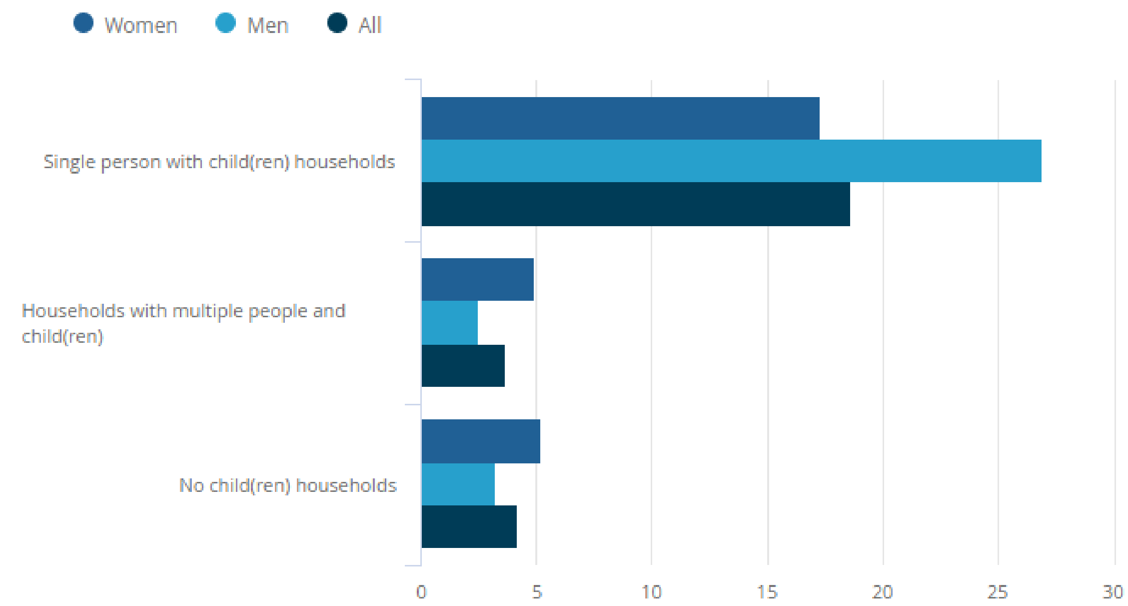
Prevalence of domestic abuse in the last year for people aged 16 years and over, by sex and type of abuse, England and Wales, year ending March 2023



It has been estimated that for the year ending March 2023 across England and Wales, that the proportion of domestic abuse experienced in the last year was higher in households composed of a single person with one or more children (18.6%), compared with households with no children (4.2%), and households with multiple people and one or more children (3.7%) (Figure 9).

Figure 9: A larger percentage of people living in a single-parent household experienced domestic abuse in the last year

Prevalence of domestic abuse in the last year for people aged 16 years and over by household structure, and sex, England and Wales, year ending March 2023



Source: Crime Survey for England and Wales (CSEW) from the Office for National Statistics

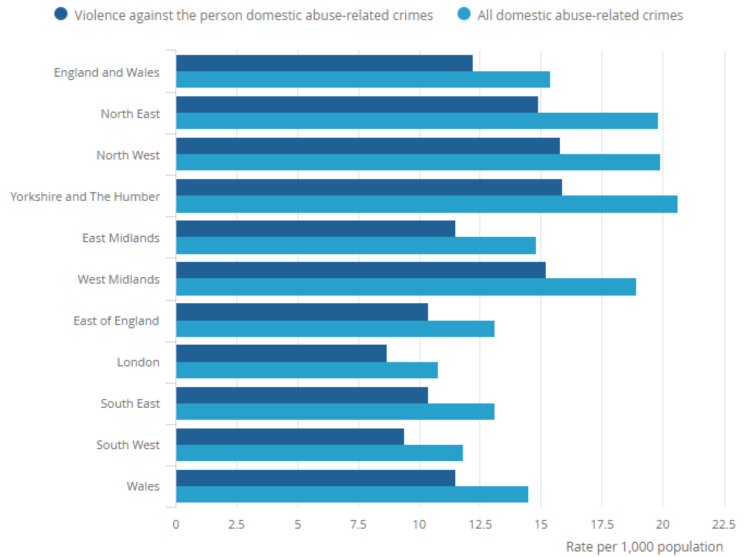
West Midlands, West Mercia Police Force and Shrophire prevalence

Regional

In the year ending March 2023, the highest rate of domestic abuse-related crimes recorded by the police was in Yorkshire and The Humber (20.6 per 1,000 population). The lowest rate was in London (10.8 per 1,000 population). Although this could reflect differences in the rates of domestic abuse across regions, it could also reflect regional differences in the reporting of domestic abuse to the police and how the police subsequently record these offences. The rate for the West Midlands was 18.9 per 1,000 for all domestic abuse crimes and 15.2 per 1,000 for violence against the person domestic abuse crimes, higher than the national rates for England and Wales of 15.4 and 12.2 respectively.

Figure 11: Yorkshire and The Humber had the highest recorded rates of domestic abuse-related crimes

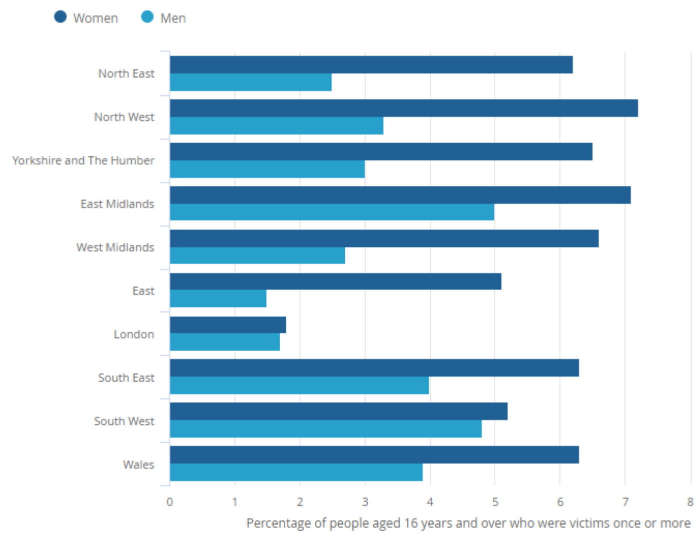
Rate of domestic abuse-related crimes recorded by the police, English regions and Wales, year ending March 2023



Regionally, there were significantly higher rates of domestic abuse experienced by women compared with men, particularly in the North West, Yorkshire and the Humber, West Midlands, East of England and South East. This gap was largest for the West Midlands, where 6.6% of women were victims of domestic abuse in the last year, compared with 2.7% of men (Figure below)[6].

Figure 10: A lower proportion of women in London experienced any domestic abuse in the last year compared with all other regions

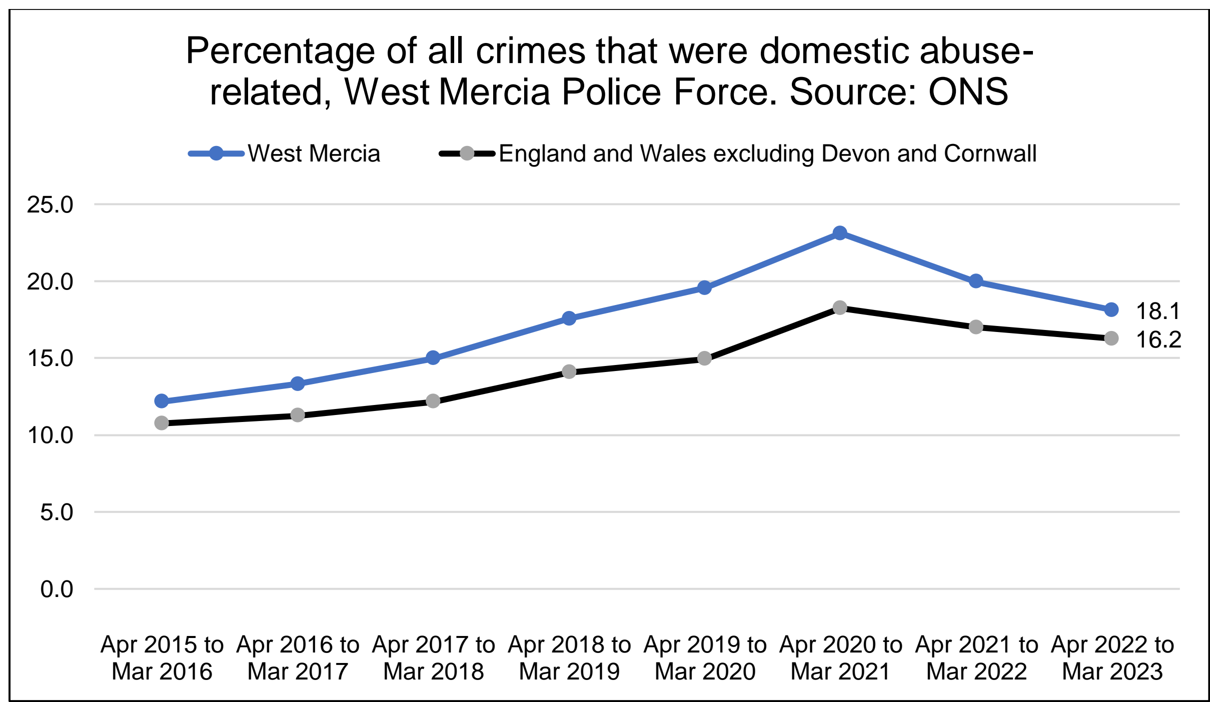
Prevalence of domestic abuse in the last year for people aged 16 years and over, English regions and Wales, by sex, year ending March 2023



6 ONS

Sub-regional (West Mercia area)

Across the West Mercia Police (WMP) Force, 18.1% of all crimes were domestic abuse related, higher than the England and Wales rate of 12.1%. This equates to 64,571 domestic abuse related crimes across the West Mercia area. The rate for WMP has been higher than the national rate since March 2016 and saw a steep rise until March 2021, almost doubling between 2016 and 2021. More recently, the rate has dropped in WMP and nationally[7]. This is partly due to the change in methodology the Police now use to record DA crimes. See here for more information: Briefings - Domestic Abuse Commissioner



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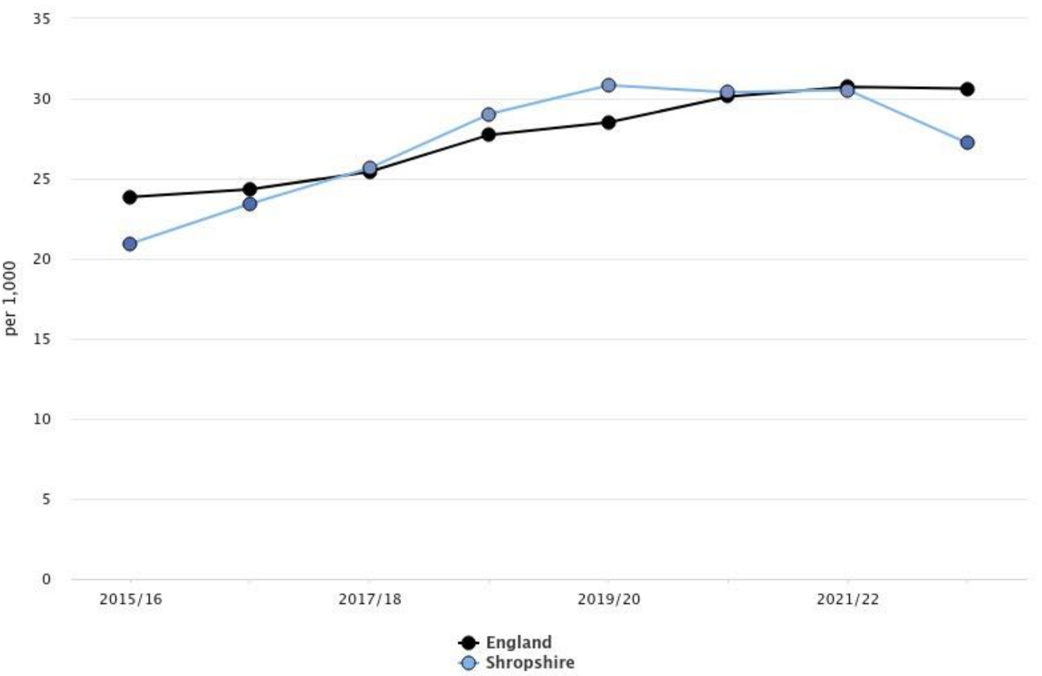
Shropshire

In Shropshire, the rate of domestic abuse related incidents and crimes increased between 2015/16 and 2019/20, however we are now seeing a fall in rate to lower than the national rate at 27.2 per 1,000 population for 2022/23 [8].

[7] ONS
[8] OHID fingertips



In 2022, Shropshire's Domestic Abuse Needs Assessment was published, including a section on children and young people. For more information, the main report here.

Services available for children and young people provided by SDAS and Victim Support are provided in section 10 of the report, and the response of Shropshire Council Children's Services is outlined in section 12, along with a more detailed data breakdown

Due to the limited specialist service provision, there is limited data on children and young people's needs relating to domestic abuse. It should also be noted that most of the data available refers to children and young people who have had concerns raised about them, not, as with adult victims, reporting issues for themselves.
The refresh of Shropshire's Domestic Abuse Needs Assessment is in development, due to be published in 2024.

2022 Domestic Abuse Needs Assessment findings:

In 2021/22:

- Rise in SDAS accommodation based services
- 278 open early help episodes were for under 18s with domestic abuse identified as an issue in their most recent assessment, a rise compared to the previous year.
- 6,041 Children's Services domestic abuse contacts were made, a small decrease compared to the previous year.
- Rise in Victim Support, doubling since the previous year

The numbers of children involved with Children's Social Care, or who have experienced a police incident or other concern that has led to a notification to Children's Services, compared with the low numbers able to be supported by SDAS (due to funding-related limited capacity), highlights the significant gap in specialist support for children and young people and the volume of service provision that may be required.

Disclosures, reporting or referrals for child victims/survivors (including unborn)	2020/21	2021/22	Change
SDAS Accommodation-based services *Number of children accommodated with a parent*	49	65	↑
SDAS Community-based CYP service *NB: provision of two part time workers limits capacity*	27	53	↑
SDAS Community-based service (outreach and IDVA) *Number of adult victims/survivors with involvement in Children's Social Care, including those with Care Orders*	264	245	↓
Shropshire Council Children's Early Help Services *Under 19s with open early help episode at the end of each year (31/03) with domestic abuse identified as issue in most recent assessment*	226	278	↑
Shropshire Council Children's Social Care Services *Children's Services domestic abuse contacts*	7,288	6,041	↓
Shropshire Council Children's Social Care Services *Open Child Protection and Child in Need cases where domestic abuse was identified on the referral/assessment (snapshot)*		1,020	
Shropshire Council Children's Social Care Services *Open Looked After Children cases where domestic abuse was identified on the referral/assessment (snapshot)*		485	
Victim Support (young people aged 16 & 17)	13	27	↑
West Mercia Police Youth Justice Service (06/2020 to 06/2022)		9	

Source: Domestic Abuse Needs Assessment (2022) for Shropshire, including a section on children and young people, see here.

Data was provided by Shropshire Council's Operation Encompass lead. Operation Encompass is a nationally recognised scheme that provides notifications to schools of domestic abuse incidents reported to police in which children are in the household (explained in more detail below, see also 12.29). The needs assessment gathered data on the notifications made to schools in the previous eleven months (covering the school year, September 2021 to July 2022). There was an average of 144 notifications made each month across all forms of provision. (NB: notifications are not made when the lead is away.)

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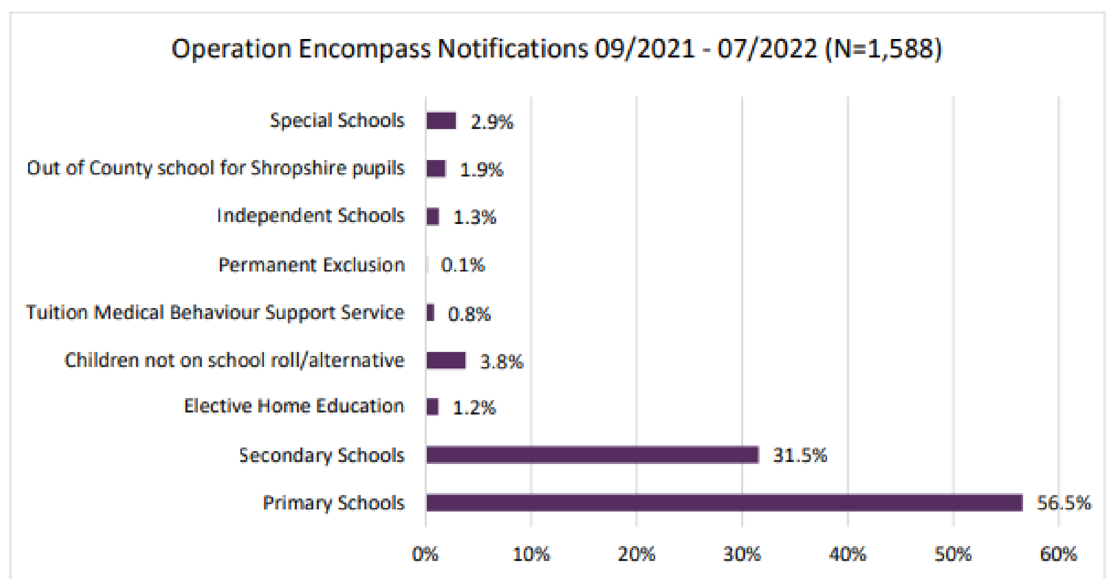

Source: Domestic Abuse Needs Assessment (2022) for Shropshire, including a section on children and young people, see here.

Children's social care domestic abuse contacts in Shropshire

In Shropshire in 2023-24, there were 6,619 Children's social care contacts involving domestic abuse, a 3% rise compared to the previous year and a 10% rise compared to 2021/22.

Note: a contact may not necessarily be referred into Children's social care

Chart showing Children's Social Care Contacts aged 0-4 with a domestic abuse flag over time. Source: Shropshire Council Social Care Team

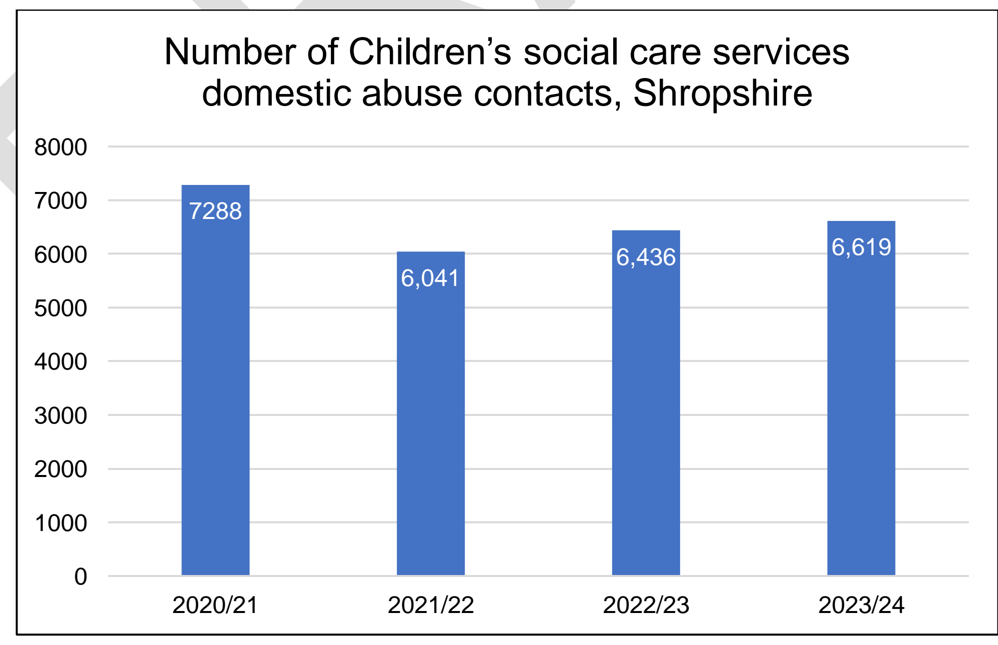

Table and chart showing Children's Social Care Contacts aged 0-4 with a domestic abuse flag for 2022-23 and 2023-24. Source: Shropshire Council Social Care Team

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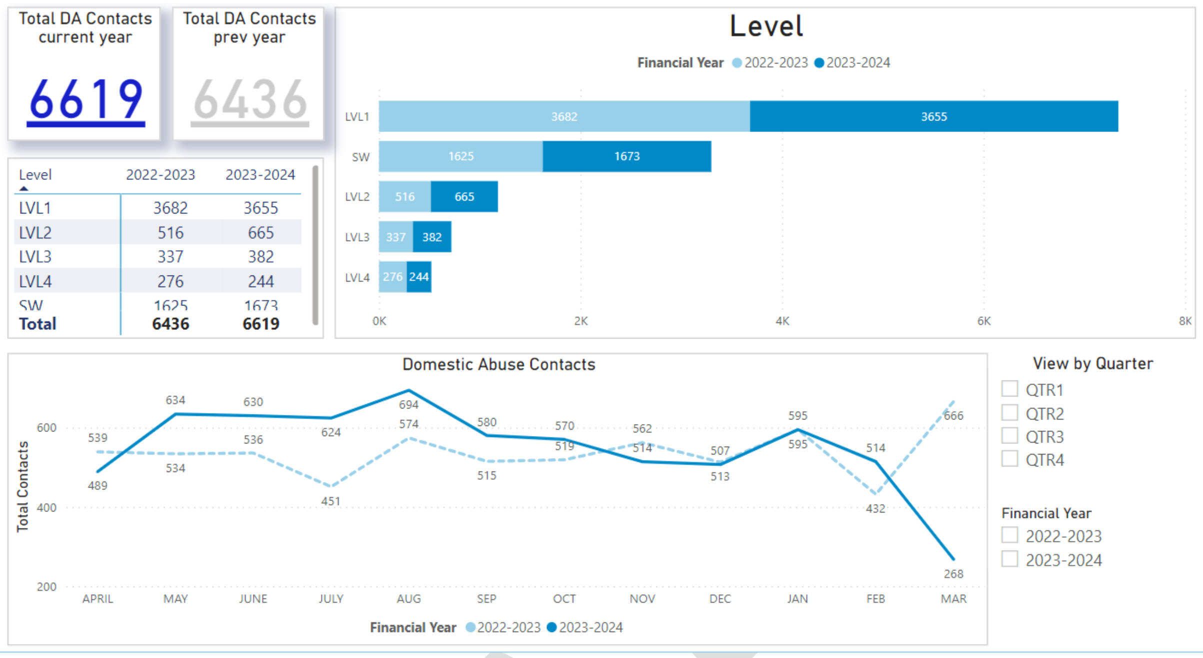
LVL= Levels 1,2,3
SW = where a child was allocated social worker and S47/strategy meeting or social work assessment took place.



In 2023/24, Level 1 contacts made up 55% of all contacts however a rise was seen among level 2 and level 3 contacts and SW contacts. These figures refer to Children's social care contacts and referrals, however domestic abuse can be identified beyond referral and at any time during the social care process therefore figures are likely to be higher.

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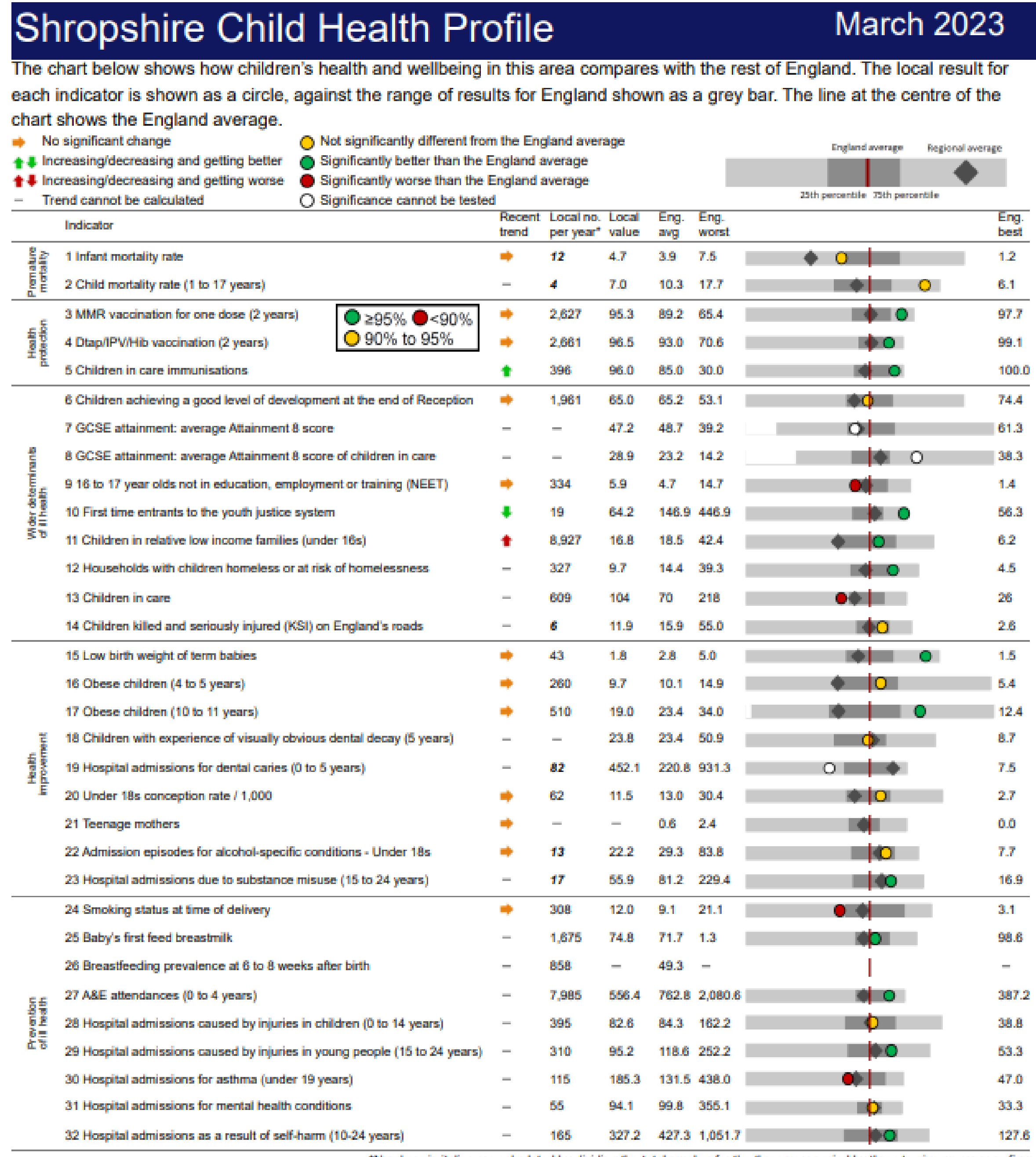
Child Health Profile (all ages)

This profile provides a high-level overview of the health and wellbeing of children and young people in Shropshire. As this profile and metrics span all children aged 0-19, this is included in the Population and Context chapter. Metrics for specific age groups are included in age-specific chapters of the JSNA in more detail.



Shropshire Child Health Profile

March 2023

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

- No significant change
- Increasing/decreasing and getting better
- Increasing/decreasing and getting worse
- – Trend cannot be calculated
- Not significantly different from the England average
- Significantly better than the England average
- Significantly worse than the England average
- Significance cannot be tested

England average · Regional average · 25th percentile · 75th percentile

≥95% · <90% · 90% to 95%

	Indicator	Recent trend	Local no. per year*	Local value	Eng. avg	Eng. worst	Eng. best
Premature mortality	1 Infant mortality rate		*12*	4.7	3.9	7.5	1.2
	2 Child mortality rate (1 to 17 years)	–	*4*	7.0	10.3	17.7	6.1
Health protection	3 MMR vaccination for one dose (2 years)		2,627	95.3	89.2	65.4	97.7
	4 Dtap/IPV/Hib vaccination (2 years)		2,661	96.5	93.0	70.6	99.1
	5 Children in care immunisations		396	96.0	85.0	30.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of Reception		1,961	65.0	65.2	53.1	74.4
	7 GCSE attainment: average Attainment 8 score	–	–	47.2	48.7	39.2	61.3
	8 GCSE attainment: average Attainment 8 score of children in care	–	–	28.9	23.2	14.2	38.3
	9 16 to 17 year olds not in education, employment or training (NEET)		334	5.9	4.7	14.7	1.4
	10 First time entrants to the youth justice system		19	64.2	146.9	446.9	56.3
	11 Children in relative low income families (under 16s)		8,927	16.8	18.5	42.4	6.2
	12 Households with children homeless or at risk of homelessness	–	327	9.7	14.4	39.3	4.5
	13 Children in care	–	609	104	70	218	26
	14 Children killed and seriously injured (KSI) on England's roads	–	*6*	11.9	15.9	55.0	2.6
Health improvement	15 Low birth weight of term babies		43	1.8	2.8	5.0	1.5
	16 Obese children (4 to 5 years)		260	9.7	10.1	14.9	5.4
	17 Obese children (10 to 11 years)		510	19.0	23.4	34.0	12.4
	18 Children with experience of visually obvious dental decay (5 years)	–	–	23.8	23.4	50.9	8.7
	19 Hospital admissions for dental caries (0 to 5 years)	–	*82*	452.1	220.8	931.3	7.5
	20 Under 18s conception rate / 1,000		62	11.5	13.0	30.4	2.7
	21 Teenage mothers		–	–	0.6	2.4	0.0
	22 Admission episodes for alcohol-specific conditions - Under 18s		*13*	22.2	29.3	83.8	7.7
	23 Hospital admissions due to substance misuse (15 to 24 years)	–	*17*	55.9	81.2	229.4	16.9
Prevention of ill health	24 Smoking status at time of delivery		308	12.0	9.1	21.1	3.1
	25 Baby's first feed breastmilk	–	1,675	74.8	71.7	1.3	98.6
	26 Breastfeeding prevalence at 6 to 8 weeks after birth	–	858	–	49.3	–	–
	27 A&E attendances (0 to 4 years)	–	7,985	556.4	762.8	2,080.6	387.2
	28 Hospital admissions caused by injuries in children (0 to 14 years)	–	395	82.6	84.3	162.2	38.8
	29 Hospital admissions caused by injuries in young people (15 to 24 years)	–	310	95.2	118.6	252.2	53.3
	30 Hospital admissions for asthma (under 19 years)	–	115	185.3	131.5	438.0	47.0
	31 Hospital admissions for mental health conditions	–	55	94.1	99.8	355.1	33.3
	32 Hospital admissions as a result of self-harm (10-24 years)	–	165	327.2	427.3	1,051.7	127.6

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

Source: OHID Child Health Profile 2023

To view the full Child Health Profile, which provides a snapshot of child health in Shropshire see here. It is designed to help local government and health services improve the health and wellbeing of children and tackle health inequalities.

Metrics worse than the England average (reds):

- **16-17 year olds not in education, employment or training** - in 2023, 7.9% of 16 to 17 year olds in Shropshire were not in education, employment or training. This is higher than the national average of 5.2% and ranks Shropshire 2nd worst in the region and 13th highest out of all local authorities in England.

- **Children looked after** - In 2022/23, there were 656 children in care in Shropshire, equating of a rate of 111 in 10,000 children aged under 18 in Shropshire who are looked after. This includes all children being looked after by a local authority; those subject to a care order under section 31 of the Children Act 1989; and those looked after on a voluntary basis through an agreement with their parents under section 20 of that Act. This is higher than the overall rate in England of 71 in 10,000 children aged under 18. Shropshire's rate is increasing and getting worse compared to the national rate, rising from 68 per 10,000 in 2019/20 to 111 per 10,000 in 2022/23. Compared to its similar neighbours, Shropshire is an outlier for a rate above England and the rising trend.

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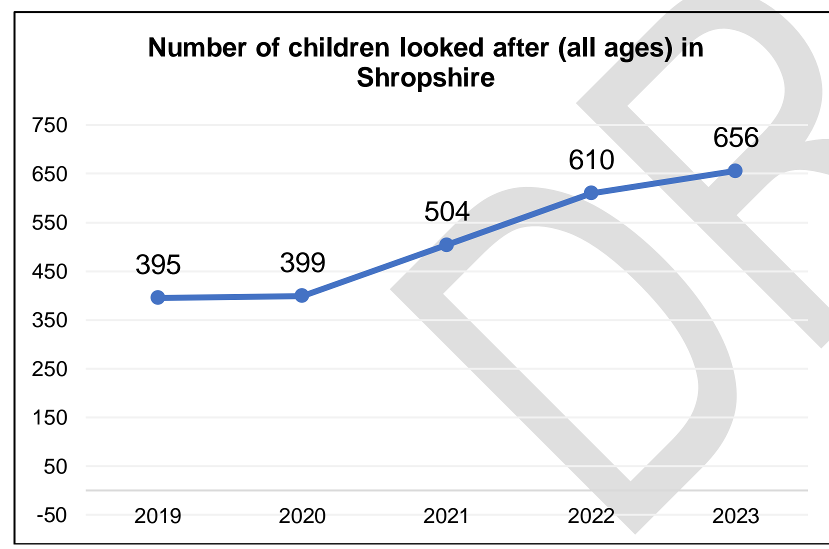
Charts showing the number and rate of children looked after in Shropshire and England. Source: OHID Fingertips



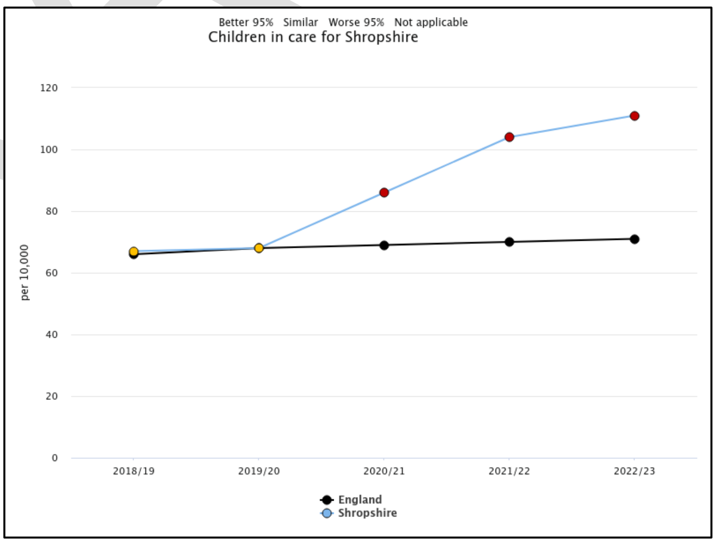
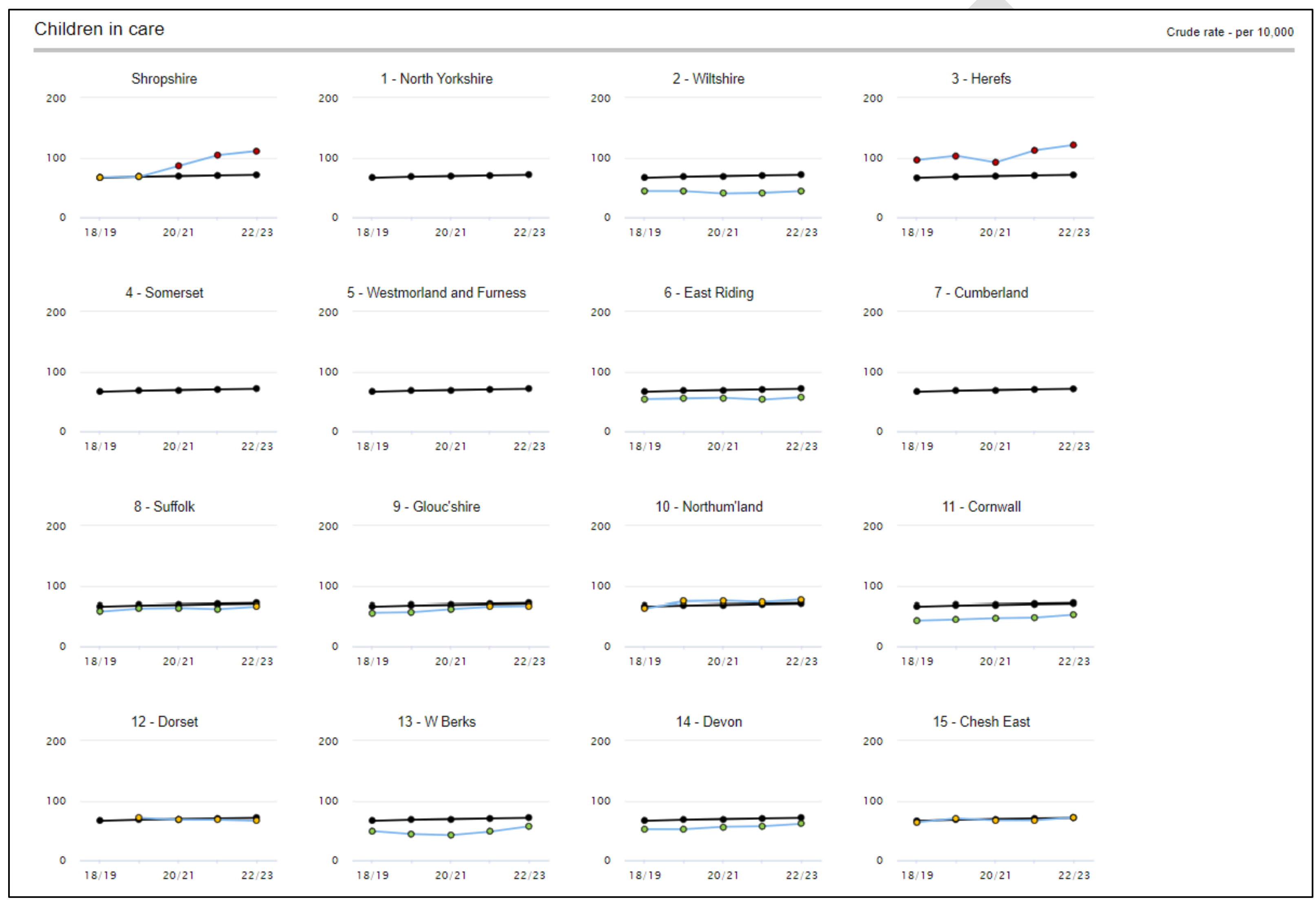


Chart showing the rate of children looked after in Shropshire and its nearest statistical neighbours. Source: OHID Fingertips



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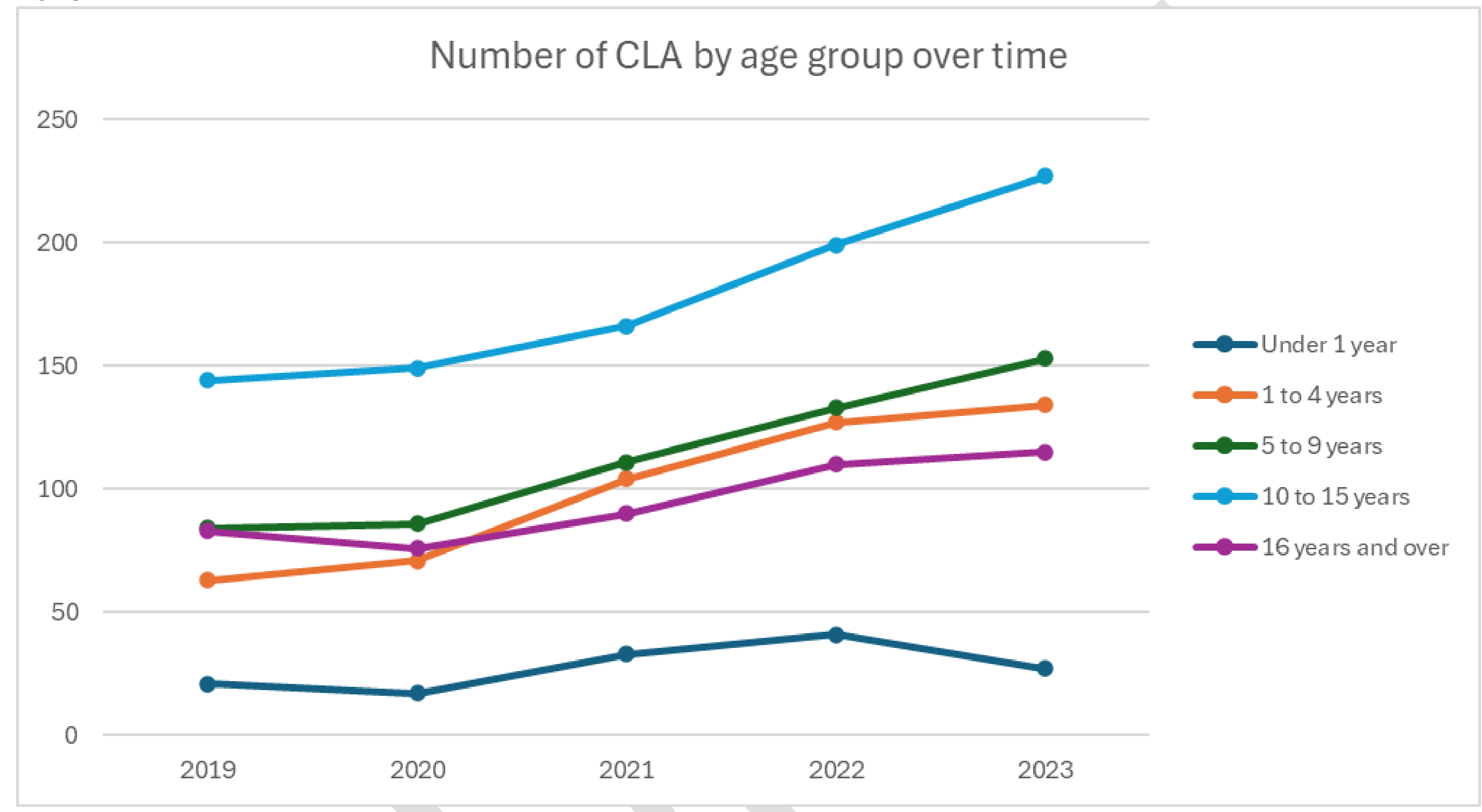
The rise in children looked after in Shropshire is being driven by 10-15 year olds and 5-9 year olds, particularly between 2021 and 2023:



As of 31 March 2023, more than one third of children looked after were aged 10-15 years old and a further quarter were aged 5-9 years old. Shropshire has a higher proportion of children looked after in the 1-4 year old age group and 5- 9 year old age group:

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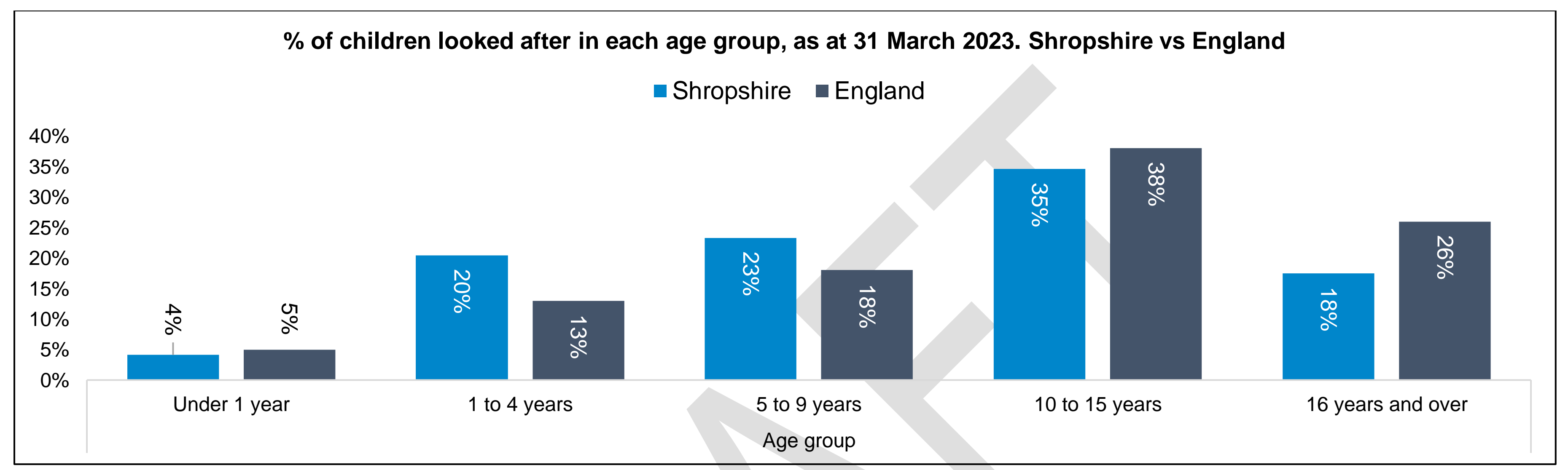

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- **Smoking at time of delivery** - During 2022/23 in Shropshire, 11.4% of mothers were known to be smokers at the time of delivery, equating to 283 women. This is significantly higher than the regional rate of 9.1% and national rate of 8.8%, ranking Shropshire third highest in the region. There has been no significant change compared to the previous time period. More detail can be found in the Maternity chapter of this JSNA.

- **Hospital admissions caused by asthma** - In Shropshire in 2022/23, there were 110 hospital admissions caused by asthma in under 19 year olds, equating to a rate of 176.5 per 100,000, higher than the regional and national rates of 157.4 and 122.2 respectively. Overall, there was a fall in admissions between 2015/16 and 2020/23 however then the rate doubled between 2020/21 to 2021/22 and has stayed at this higher level in the year 2022/23.

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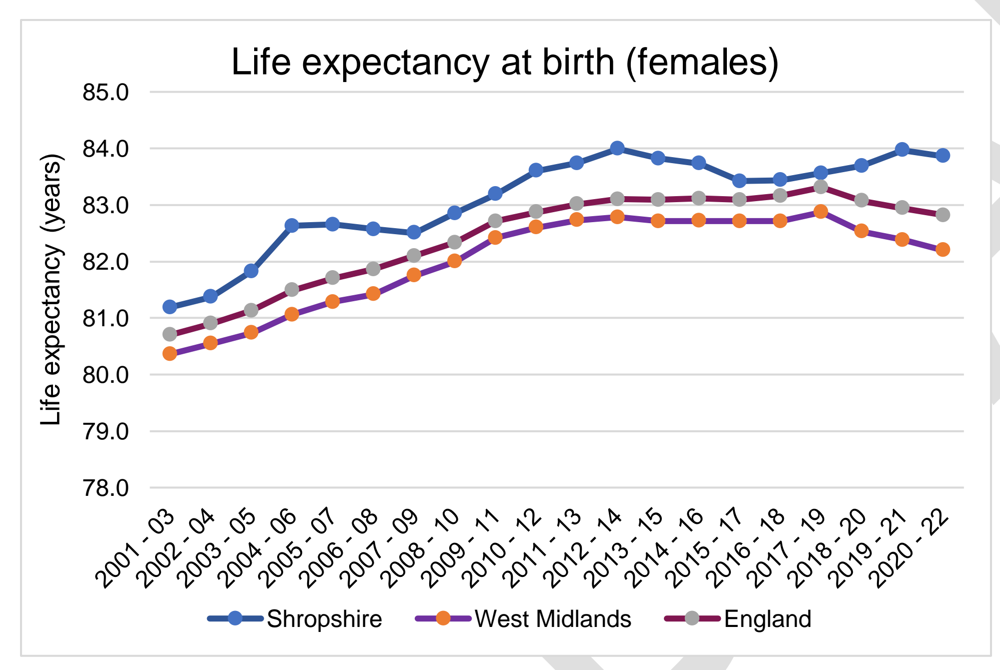
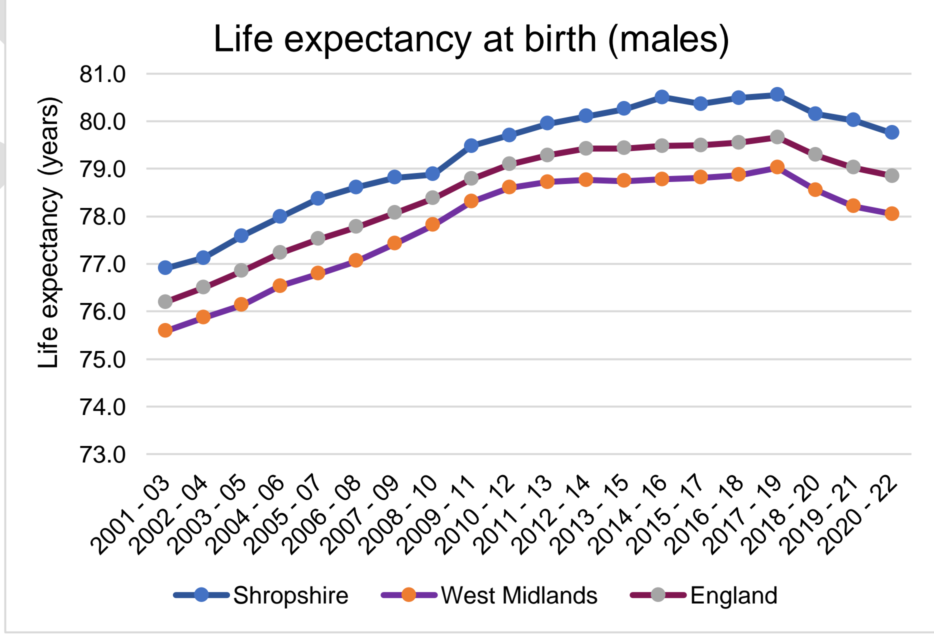
General Health of the population

Life expectancy at birth

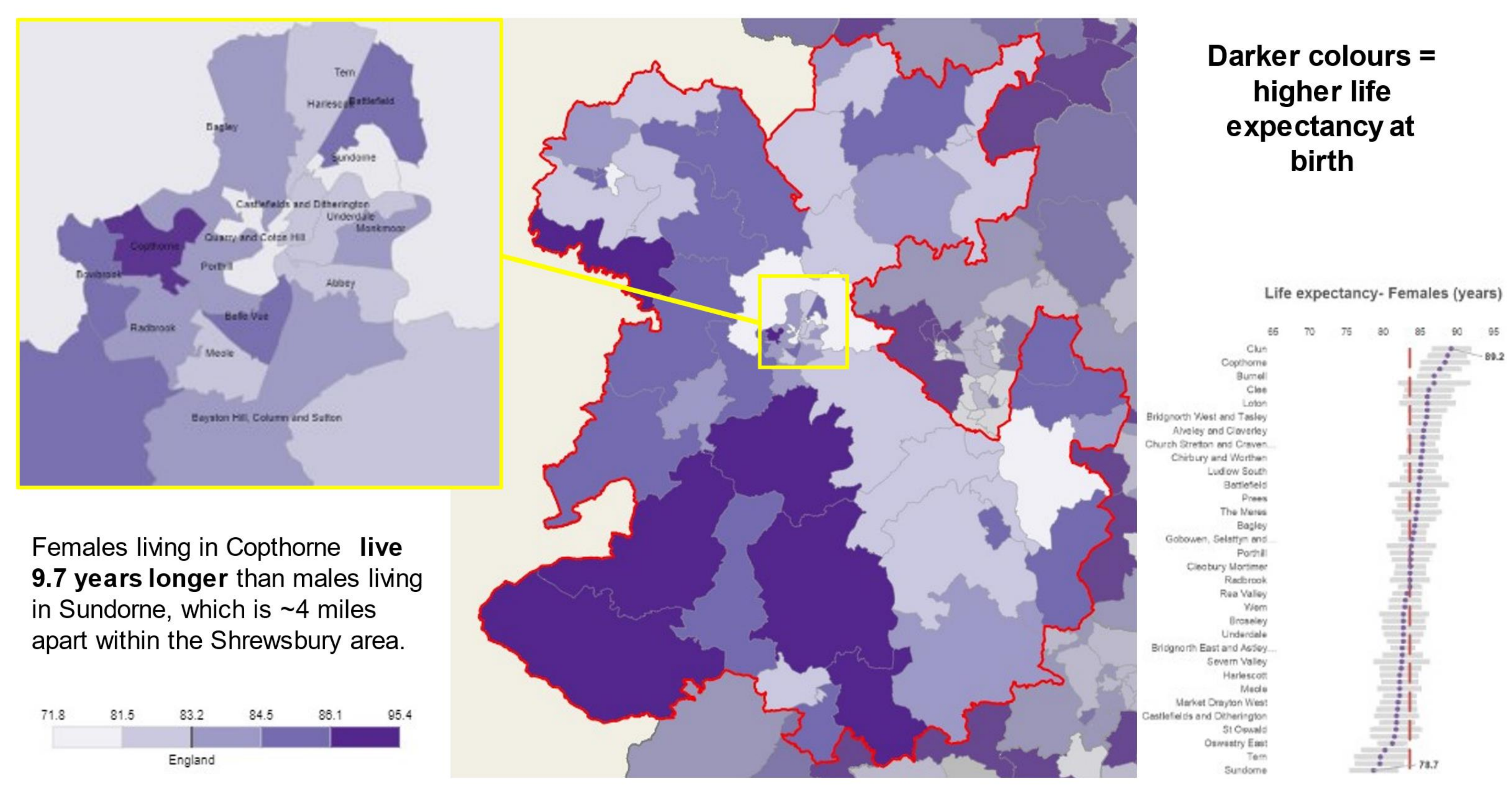
Life expectancy at birth in Shropshire is higher among females compared to males. Both are rising over time and are above the regional and national average.

Life expectancy at birth in females and males in Shropshire, including West Midlands and England comparisons, 2001-03 to 2020-22. Source: Public Health Profiles, Fingertips, OHID





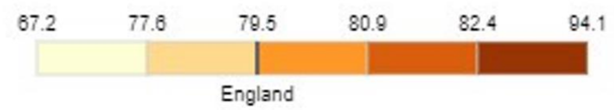
Life expectancy at birth (Females) - 2016 to 2020 - Shropshire

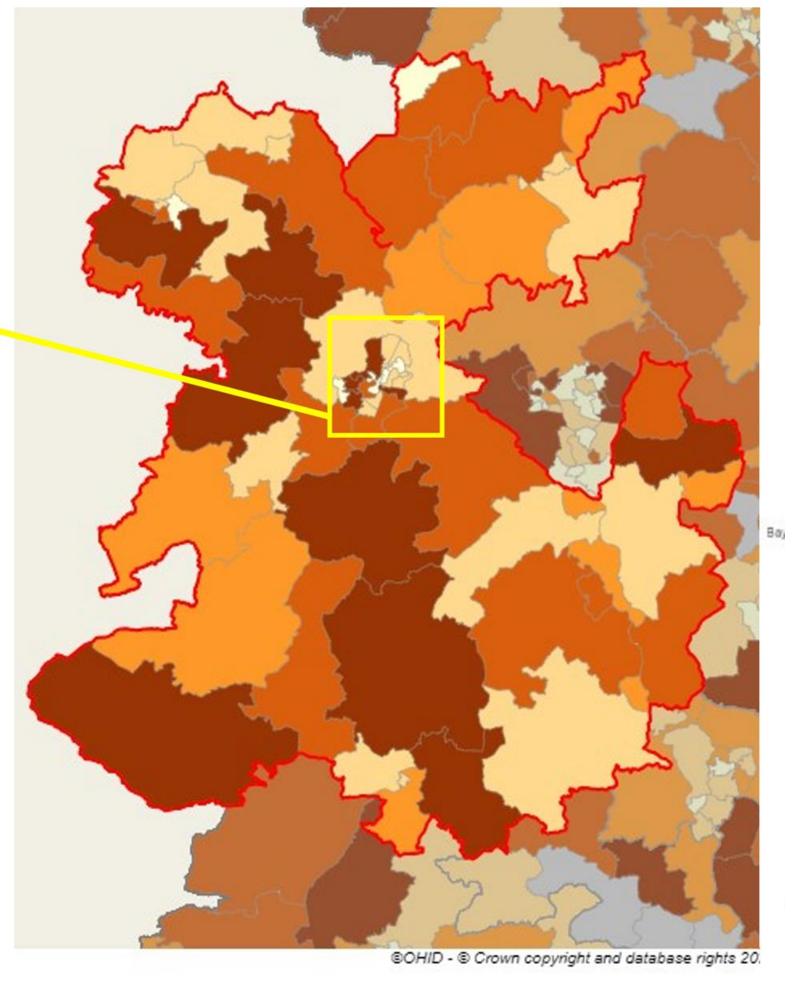


Females living in Copthorne **live 9.7 years longer** than males living in Sundorne, which is ~4 miles apart within the Shrewsbury area.

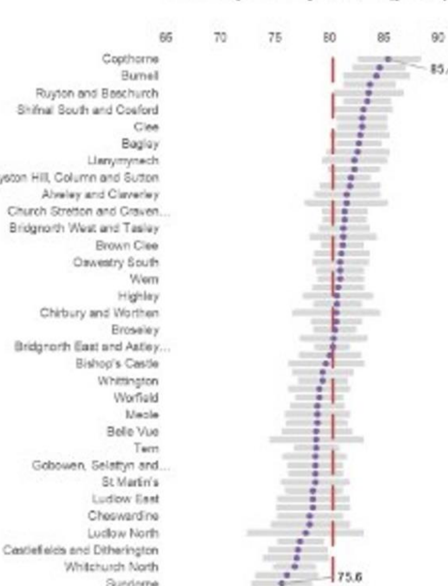
Life expectancy at birth (Males)- 2016 to 2020- Shropshire

Males living in Copthorne **live 9.8 years longer** than males living in Sundorne, which is ~4 miles apart within the Shrewsbury area.





Darker colours = higher life expectancy at birth



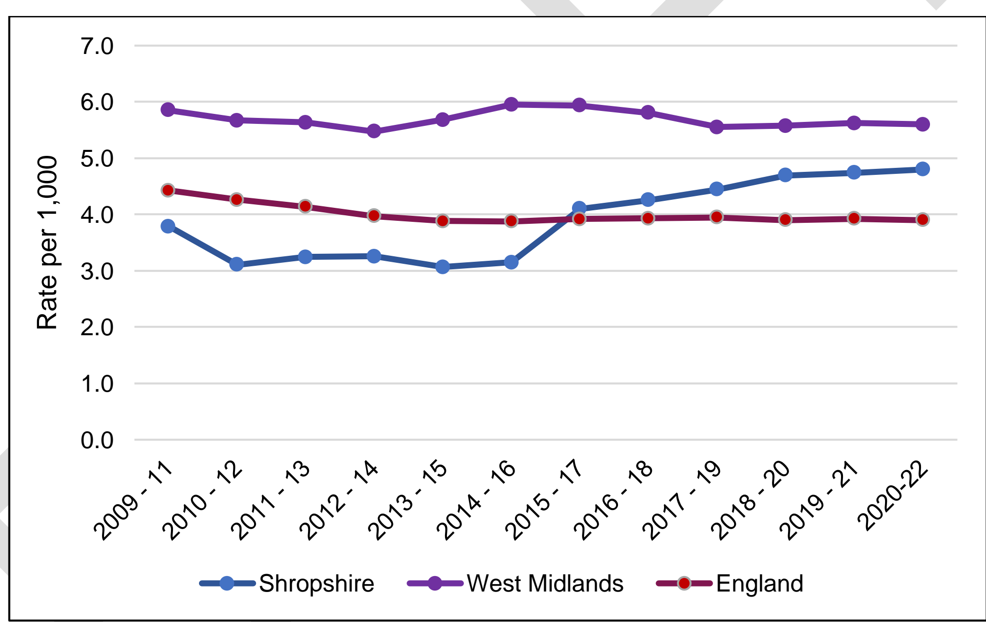
Infant Mortality

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life in particular, are considered to reflect the health and care of both mother and new-born [9].

In the period 2020-22, there were 37 deaths under one year of age in Shropshire. This equates to an infant mortality rate of 4.8 per 1,000 live births. This is the sixth lowest regionally, similar to the regional rate of 5.6 per 1,000 and the national rate of 3.9 per 1,000 live births. Shropshire's rate was the highest compared to its statistical neighbours.

Shropshire's rate increased between 2014-16 and 2018-20 but recently has started to level off. Overall, the national rate has been declining over time however now remains steady compared to the previous period.

Infant mortality rate in Shropshire, including West Midlands and England comparisons, 2009-11 to 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID



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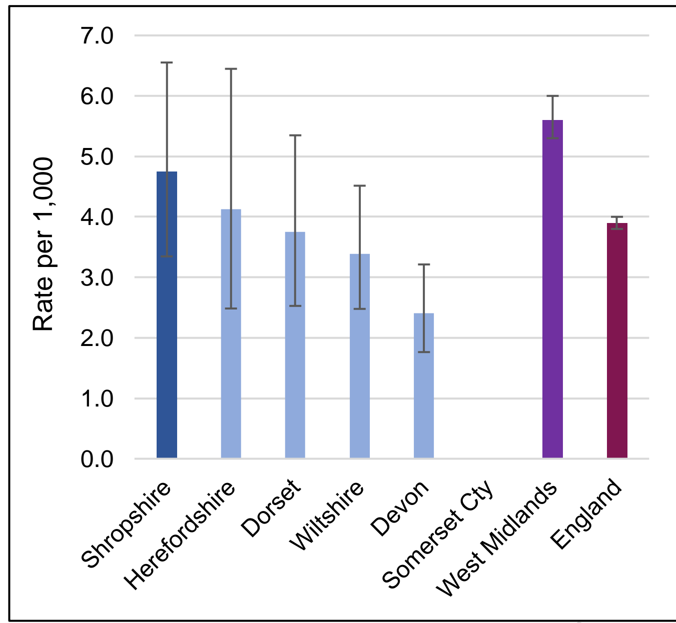
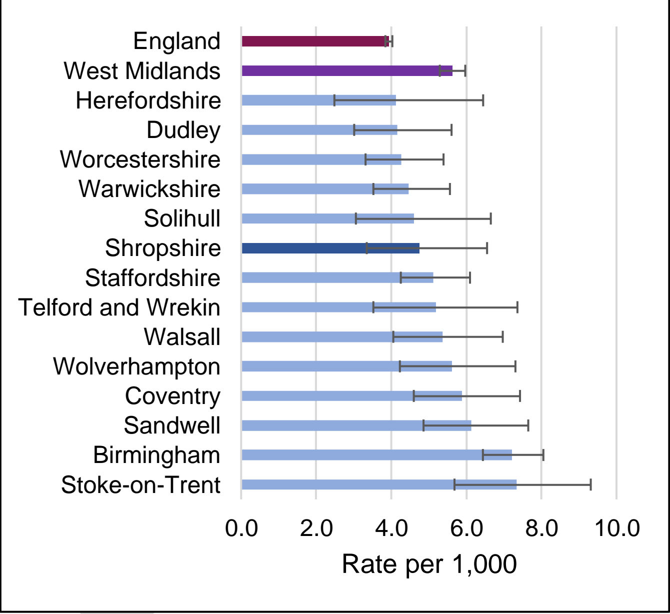
Infant mortality rate in Shropshire, including statistical neighbours, West Midlands and England comparisons, 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID





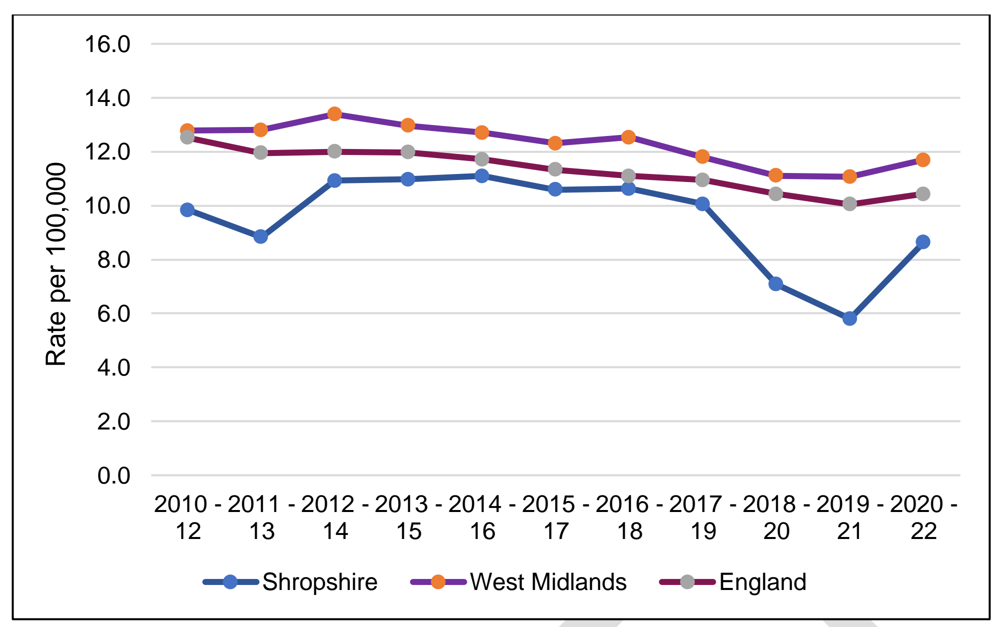
Child mortality rate

Death in childhood represents not only a tragedy for that child's family but also a loss to wider society in terms of lost years of productive life. After the age of one year, the commonest cause of death in young people is injuries. Many of these injury related deaths are potentially avoidable. The need to provide adequate support to those children and families with life-limiting or life-threatening conditions is also recognised.

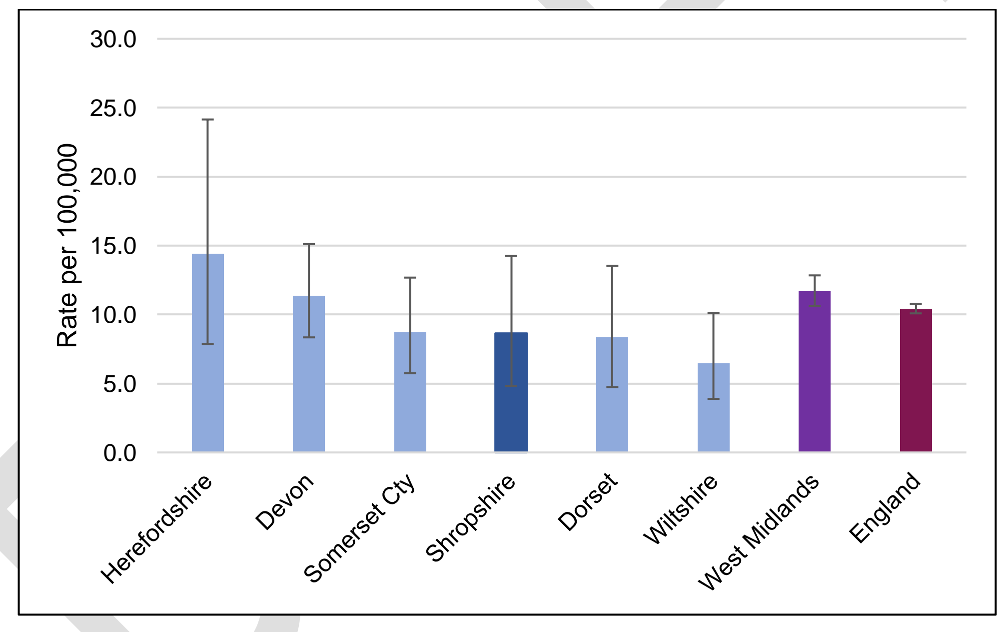
Between 2020-22 in Shropshire, there were 15 deaths among children aged 1-17 year old equating to a rate of 8.6 deaths per 100,000 1-17 year olds, an increase from 10 deaths during the previous period (5.8 deaths per 100,000). Shropshire's child mortality rate was the second lowest in the region and was similar to the regional and national rate of 11.7 deaths per 100,000 and 10.4 deaths per 100,000 respectively[10]. Shropshire's rate was the third lowest amongst its statistical neighbours.

Child mortality rate per 100,000 (1-17 years) in Shropshire, including West Midlands and England comparisons, 2010-12 to 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID

[10] OHID Fingertips: Child Health Profiles



Child mortality rate in Shropshire, including statistical neighbours, West Midlands and England comparisons, 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID



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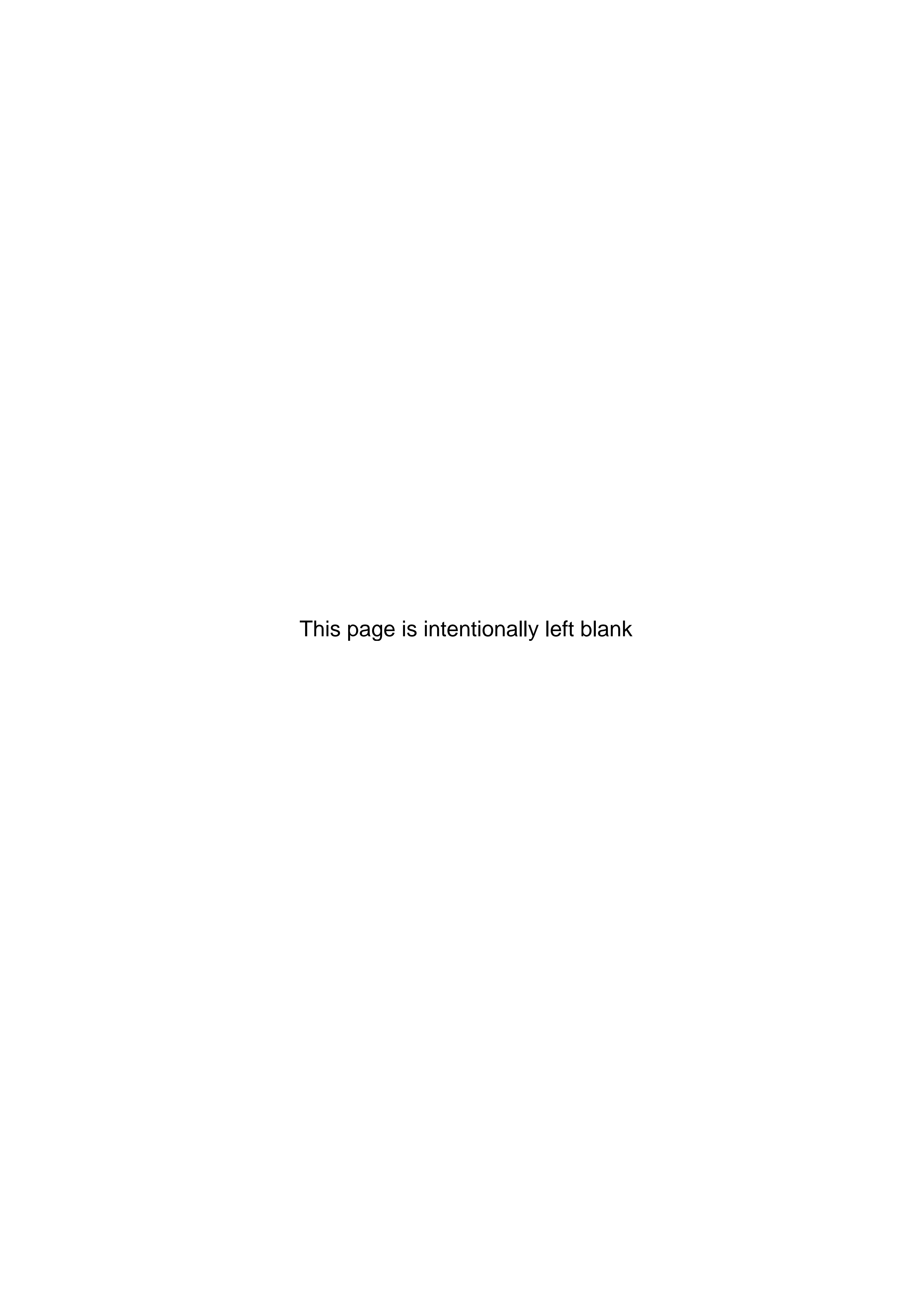
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Children and Young People JSNA

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Population and Context (0-19s) Chapter Summary

August 2024

What is a JSNA?

"a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve the health and wellbeing outcomes and reduce inequalities"

Joint	jointly produced by health, local authorities and community and voluntary organisations to provide a picture of people's needs and to help them work together to find answers to those needs.
Strategic	they identify the 'big picture' of the health and wellbeing needs and differences across Shropshire.
Needs	they set out to find what people require to help their health and wellbeing and identify where these requirements are not being met. Considers wider determinants of health; the communities in which we live and the health and care we receive
Assessment	facts and figures, together with people's knowledge, experience and opinions are used to find out what people's current and future needs are. The JSNAs use a wide range of data collected from different sources including the Census, GPs, hospital admissions, social services, housing, police, leisure, education voluntary and community organisations.

Shropshire Council

JSNA design

Due to the vast scope of this product, Shropshire's Children and Young people JSNA is structured as a 'JSNA pack', comprising of individual chapters for each stage of the life course:

Core JSNA chapters

1. Population and context
2. Maternity (pregnancy & birth)
3. Early Years (0-4 years)
4. School aged children (5-11 and 12-16 years)
5. Young people (17-19 years)

Additionally, the development of 'Spotlight JSNA's' will be developed following the publication of the core 5 chapters to explore key areas of need further. The topics of the Spotlight JSNAs are being determined through engagement with stakeholders using a stakeholder survey and other forums.

Multiagency engagement and stakeholder activities were used to scope assets, opportunities and identify relevant data in 2023/2024.

Contents

- Population structure, change and future trends
- Ethnicity
- Household composition
- Shropshire's child population
- Shropshire's school population
- Wider determinants of health
  - Deprivation
  - Rurality
  - Child poverty
  - Families on benefits
  - Parents/carers in substance misuse services
  - Domestic abuse
- Indicators of the general health of the entire population: Life expectancy, Infant and Child Mortality
- Child Health Profile (0-19s – OHID)- **Metrics which span all ages are included in this chapter.** Metrics specific to an age group can be found in the age-specific chapter.

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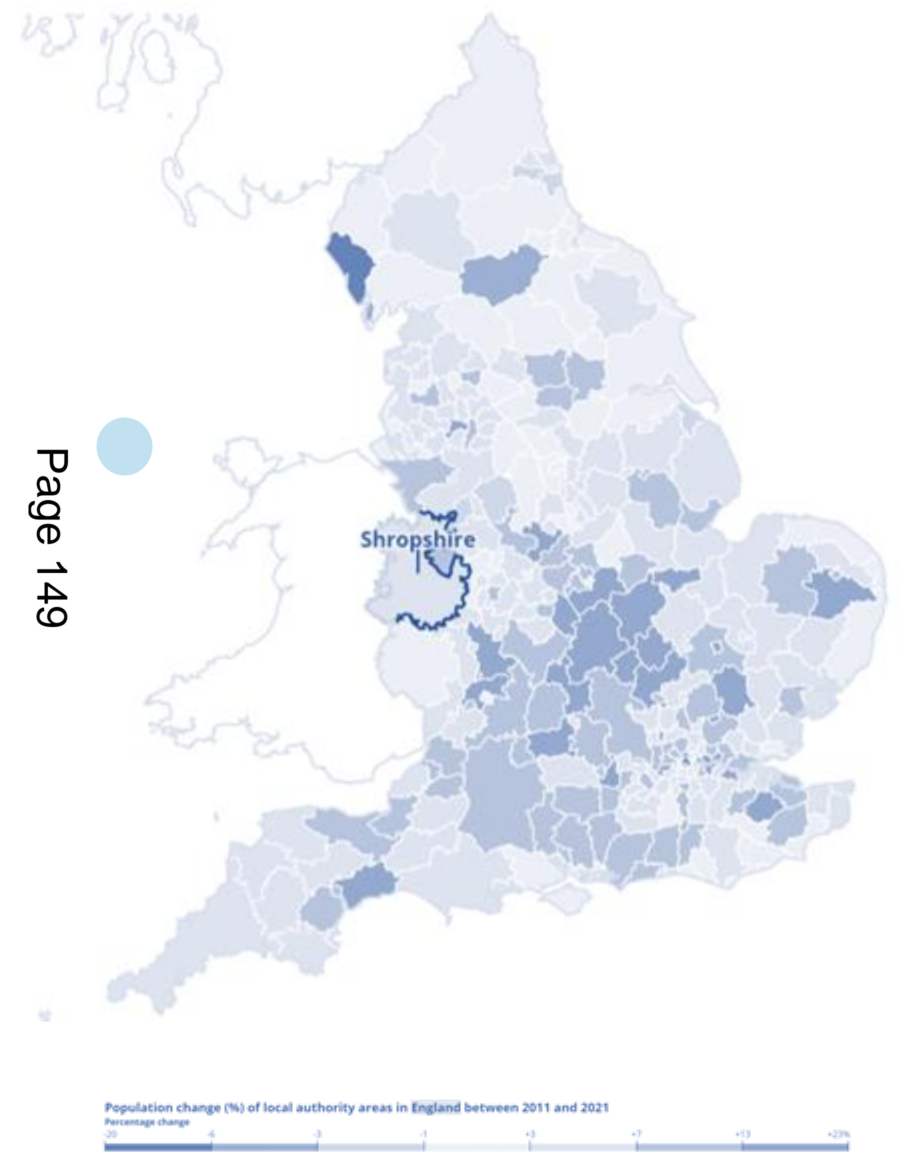
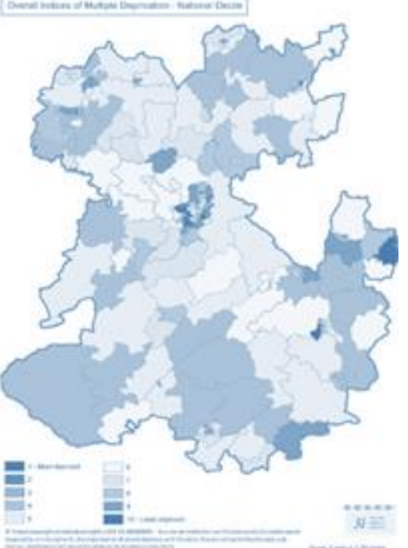
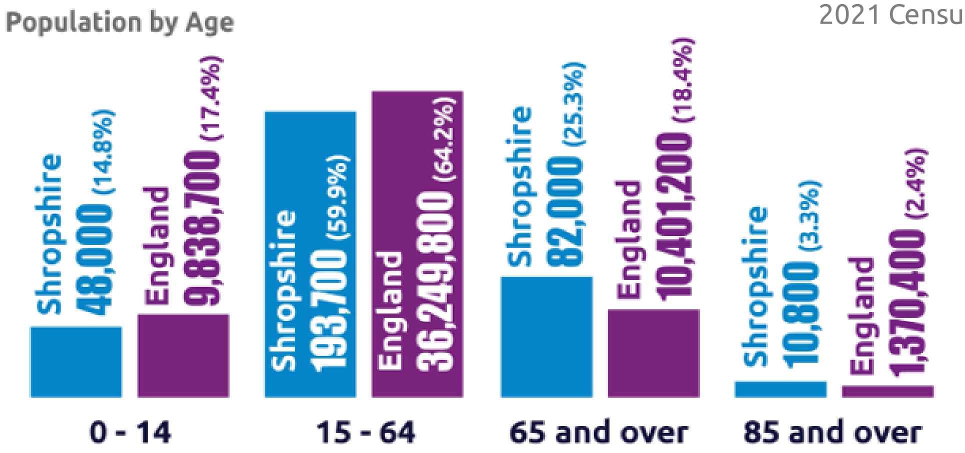
Shropshire's Population





Overall deprivation is low. Ludlow East and Harlescott fall within the 10% most deprived areas in England.

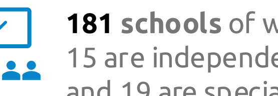


306,100 people in 2011 **(England 6.6% rise)**
2021 Census

181 schools of which 15 are independent and 19 are special

44,581 pupils aged 0-19

18.1% of pupils eligible for **free school meals** (2022/23)



Smallest state primary school – 25 pupils

Smallest state secondary school – 512 pupils

93.2% from white background, 95.7% with English as first language (2021)

25.3% aged 65+ compared to 18.4% in England

64,838 aged 0-19 or 20.0%, England 23.1% (2021)

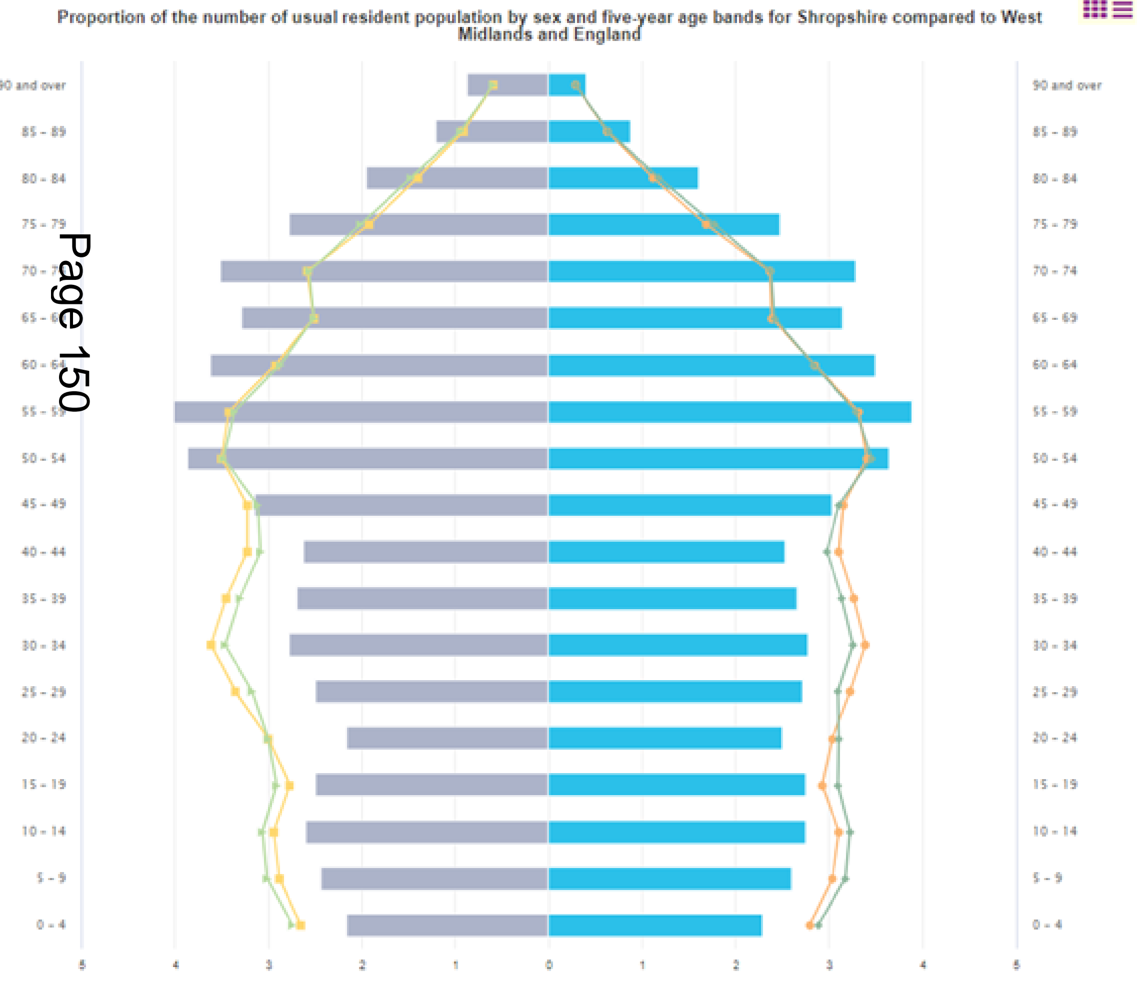
Employment rate of 77.3%, West Midlands 73.6% (2022/23)

609 looked after children in Shropshire (2022/2023)

Evidence of rural **food insecurity and 18.0% fuel poverty** across the county (2021)

Population Structure 2021

Population pyramid showing the number and proportion of residents by gender and age in Shropshire, West Midlands and England, 2021. Source: [Census 2021](), ONS.



- Largest proportion of residents aged 55-59 in Shropshire (25,538 people, 7.6%). In the West Midlands, the largest group were those aged 50 54 (6.7%) and in the England, those aged 30 - 34 (6.8%).

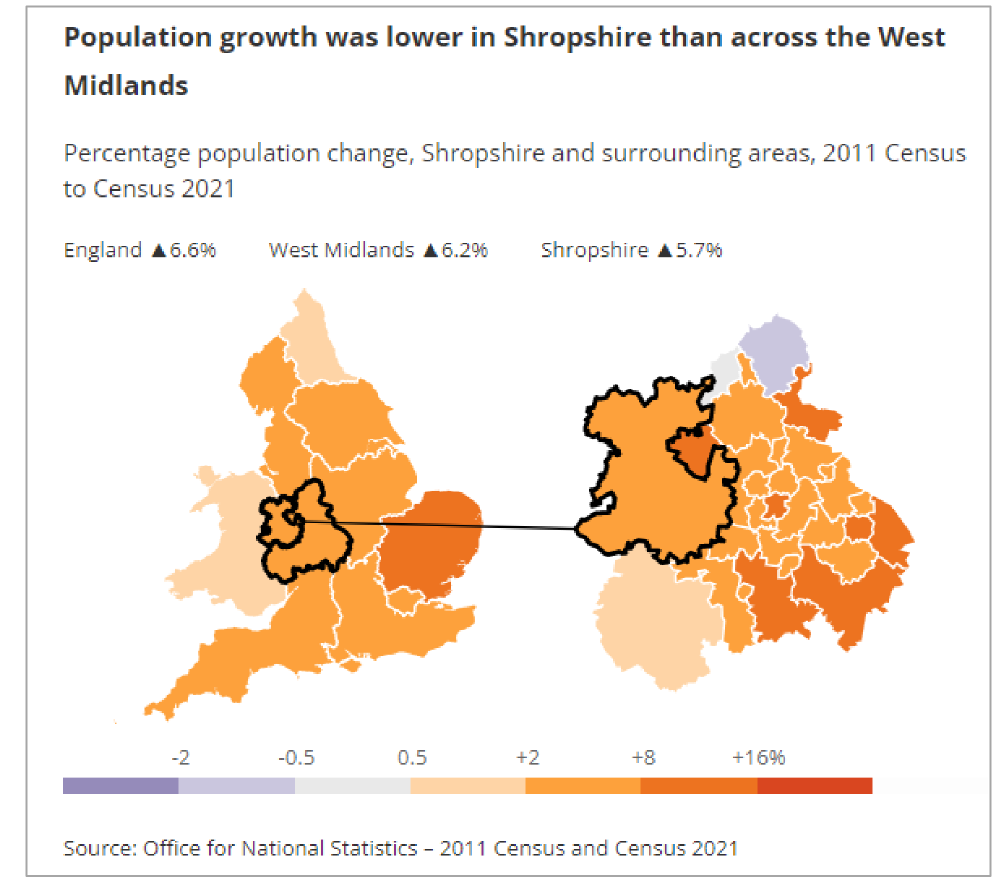
- In 2021, **20.1% (64,838) of Shropshire's population were aged 0-19 years old, similar to the England proportion of 23.1%.**

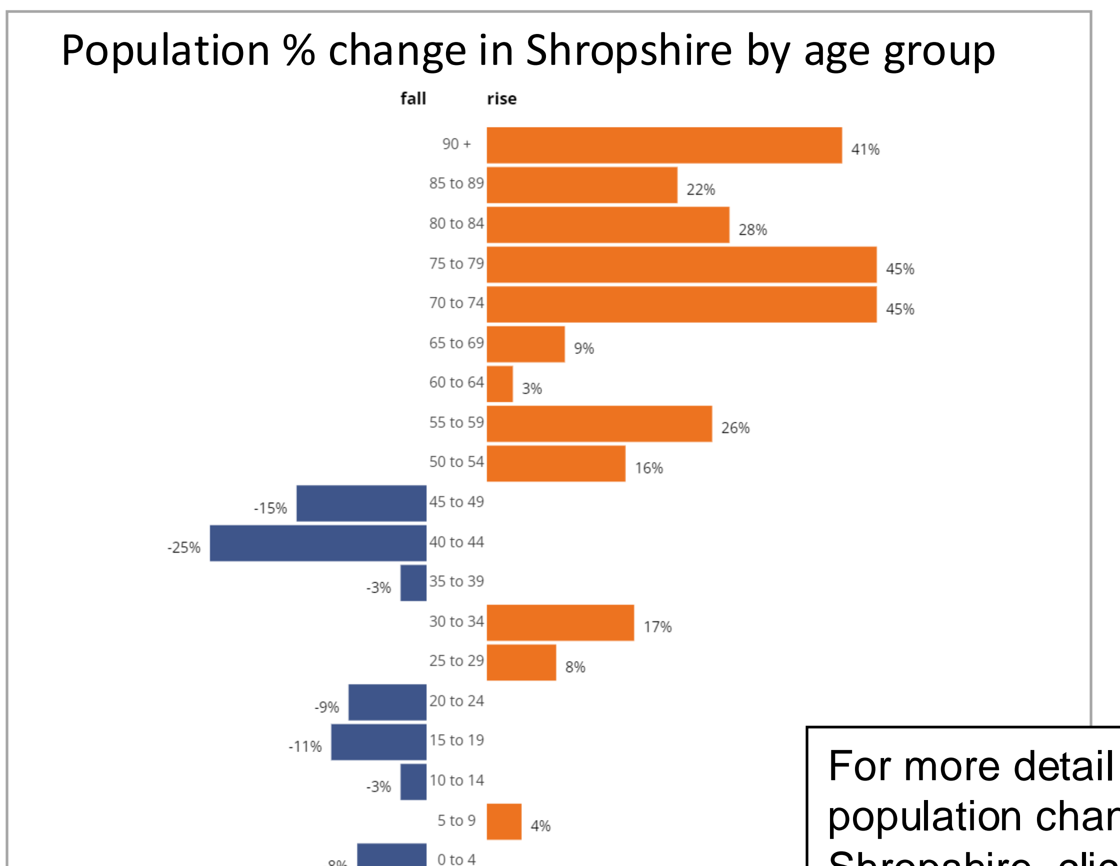
- Shropshire - Female residents broken down by age band (5 year bands) (%)
- Total for England - Female residents broken down by age band (5 year bands) (%)
- Total for Shropshire region - Female residents broken down by age band (5 year bands) (%)
- Shropshire - Male residents broken down by age band (5 year bands) (%)
- Total for England - Male residents broken down by age band (5 year bands) (%)
- Total for Shropshire region - Male residents broken down by age band (5 year bands) (%)

For more detail on Shropshire's population, click [here]().

Population change (2011 vs 2021)

- Population **increased by 5.7% overall (**306,000 in 2011 to 323,000 in 2021), **lower** than the overall increase for the West Midlands Region (6.2%) and England (6.6%).
- **Largest increase among the 70 to 74 and the 75 to 79** age bands at 45%.
- 0-19 **children and young people population fell by 18%,** with the largest reduction seen among 15-19 year olds.



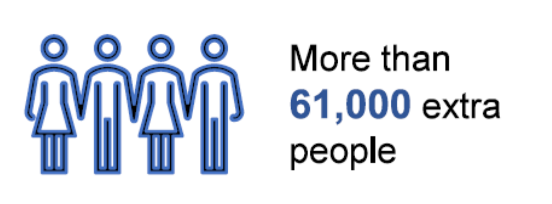


For more detail on population changes in Shropshire, click here.

Population projections 2050

- The population in Shropshire will grow by 61,000 people by 2050, a **rise of 19% compared to 2021.**
- Largest rises will be among those **aged 65+.**
- **0-19 year old group will grow by 3,933 people, rise of 6%** compared to 2021. Largest rise in CYPs among 15-19 year olds (+1,381 people).

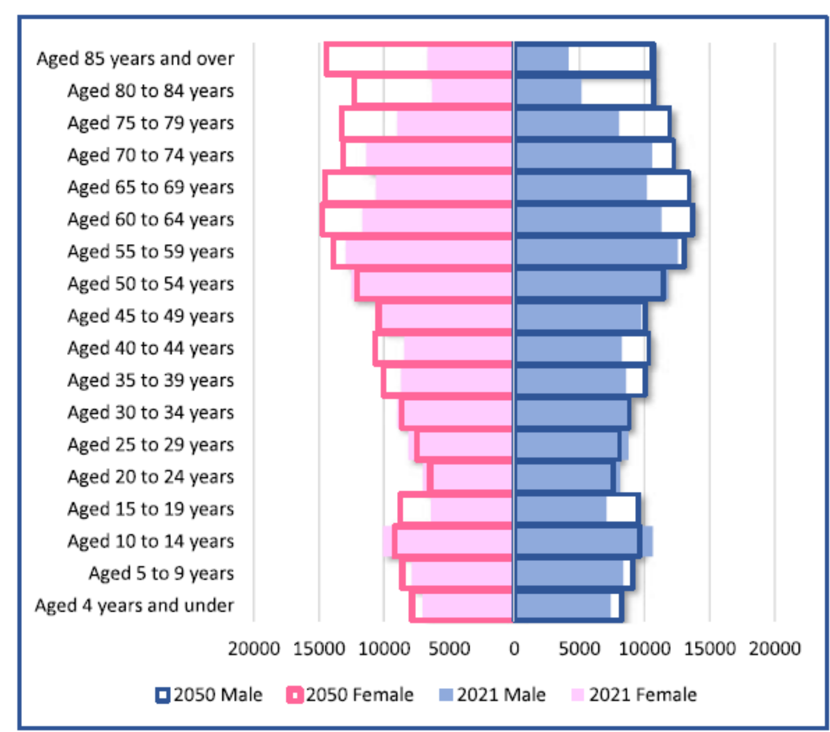
Population 2021: **323,600**

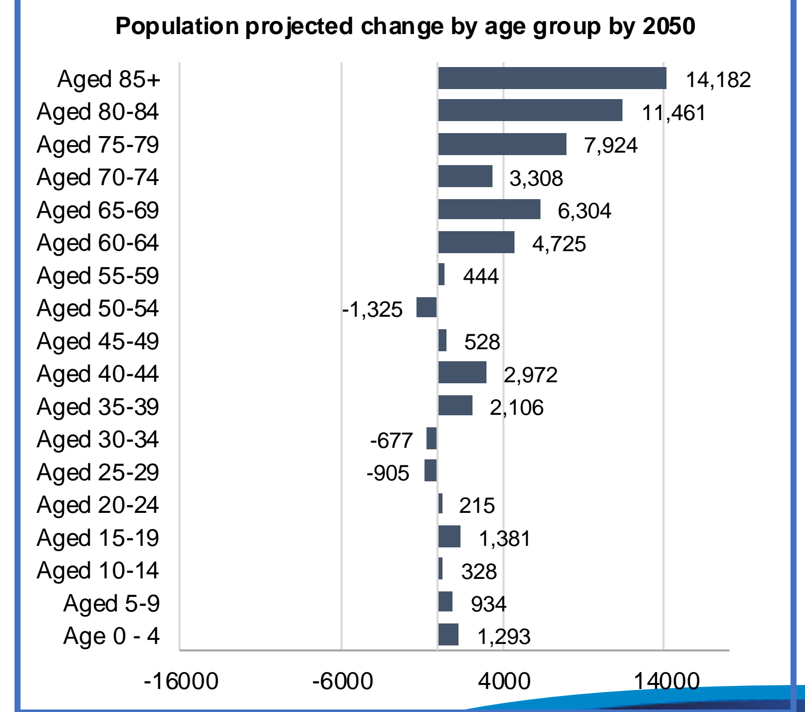


Population 2050: **385,000**

19% growth 2021-2050

26% growth 1991-2021





Household Composition

Fewer couples with dependent children

Shropshire saw the West Midlands' second-largest percentage-point fall in the share of households including a couple with dependent children (from 19.5% in 2011 to 16.9% in 2021).

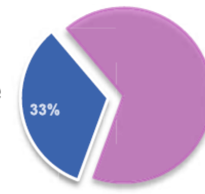
Number of Households 2021: **139,600**

Almost **40,000** extra Households

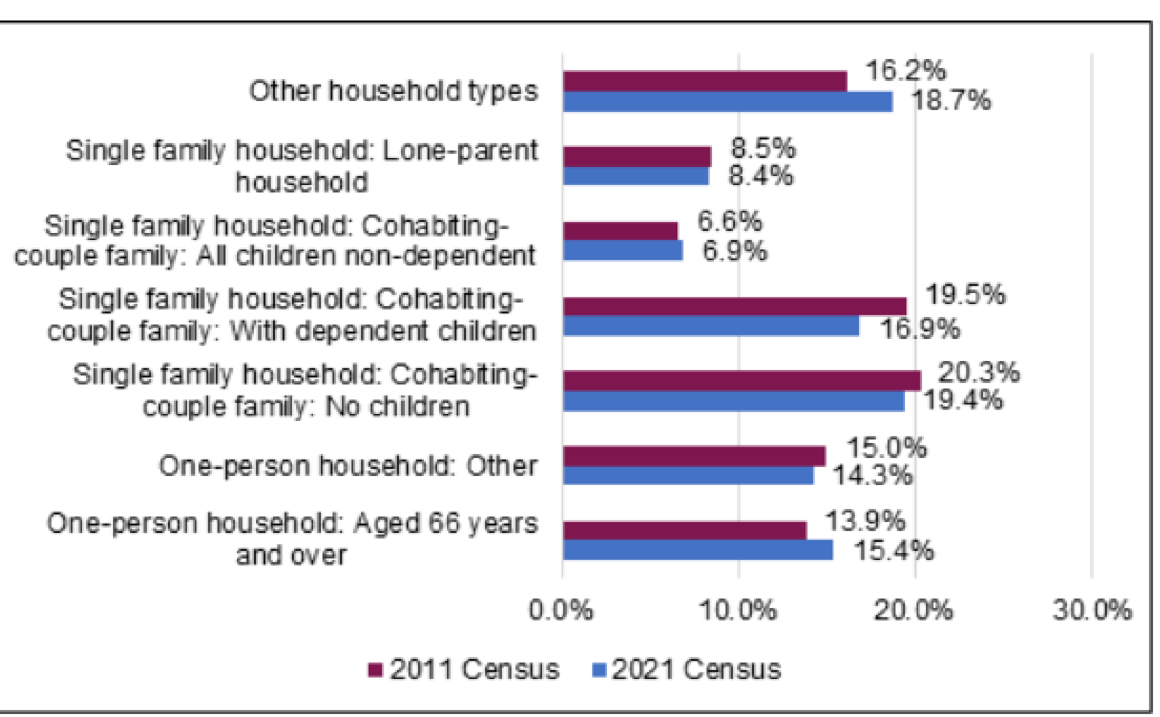
Number of Households 2050: **179,300**

28% growth 2021-2050
34% growth 1991-2021

A third of households will be single person

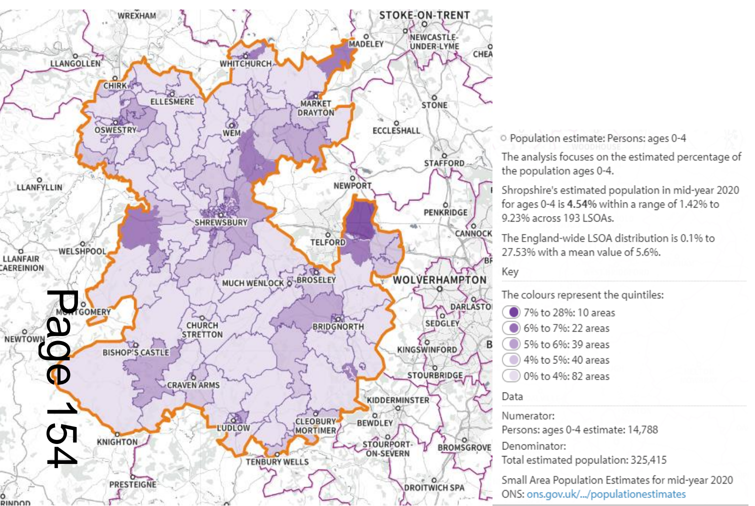


18,000 more single person households
+44% growth 2021-2050

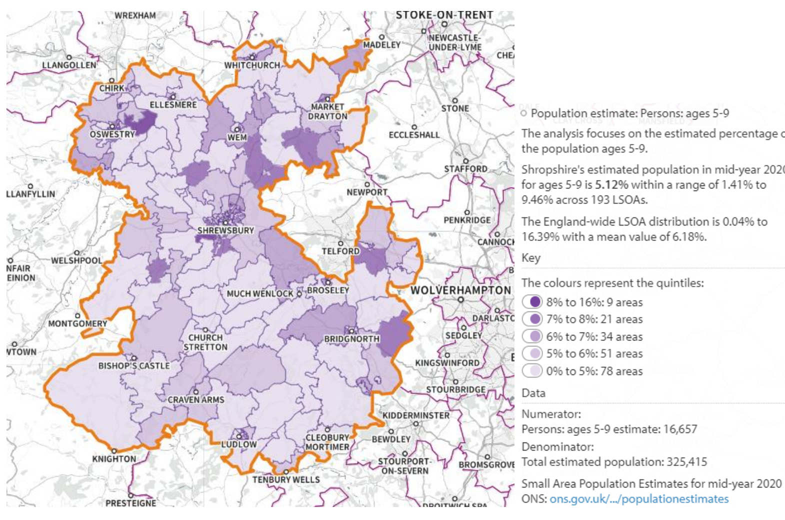


Where do our CYPs live?

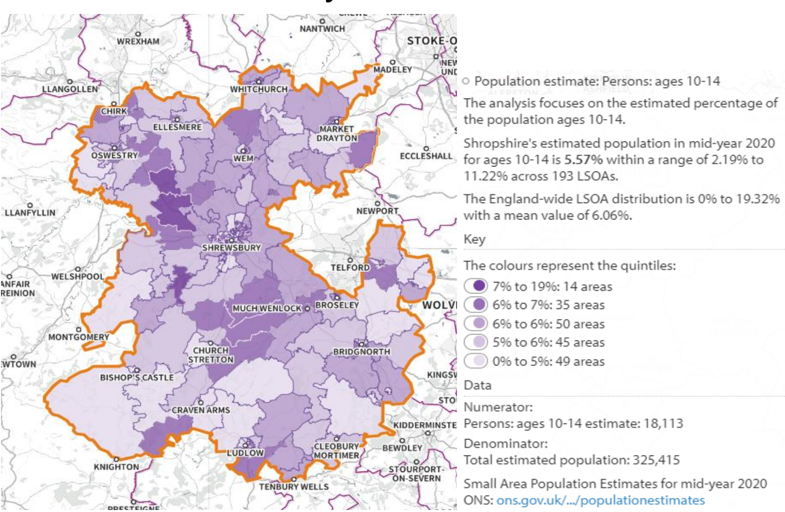
0-4 year olds



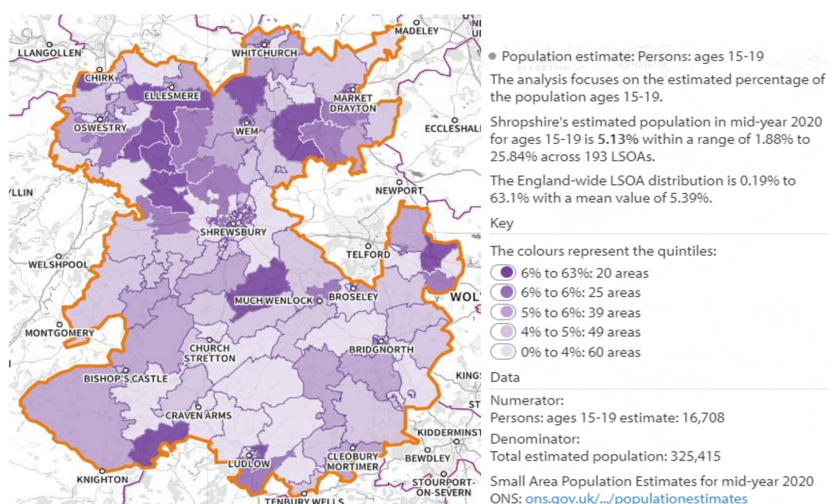
5-9 year olds



10-14 year olds

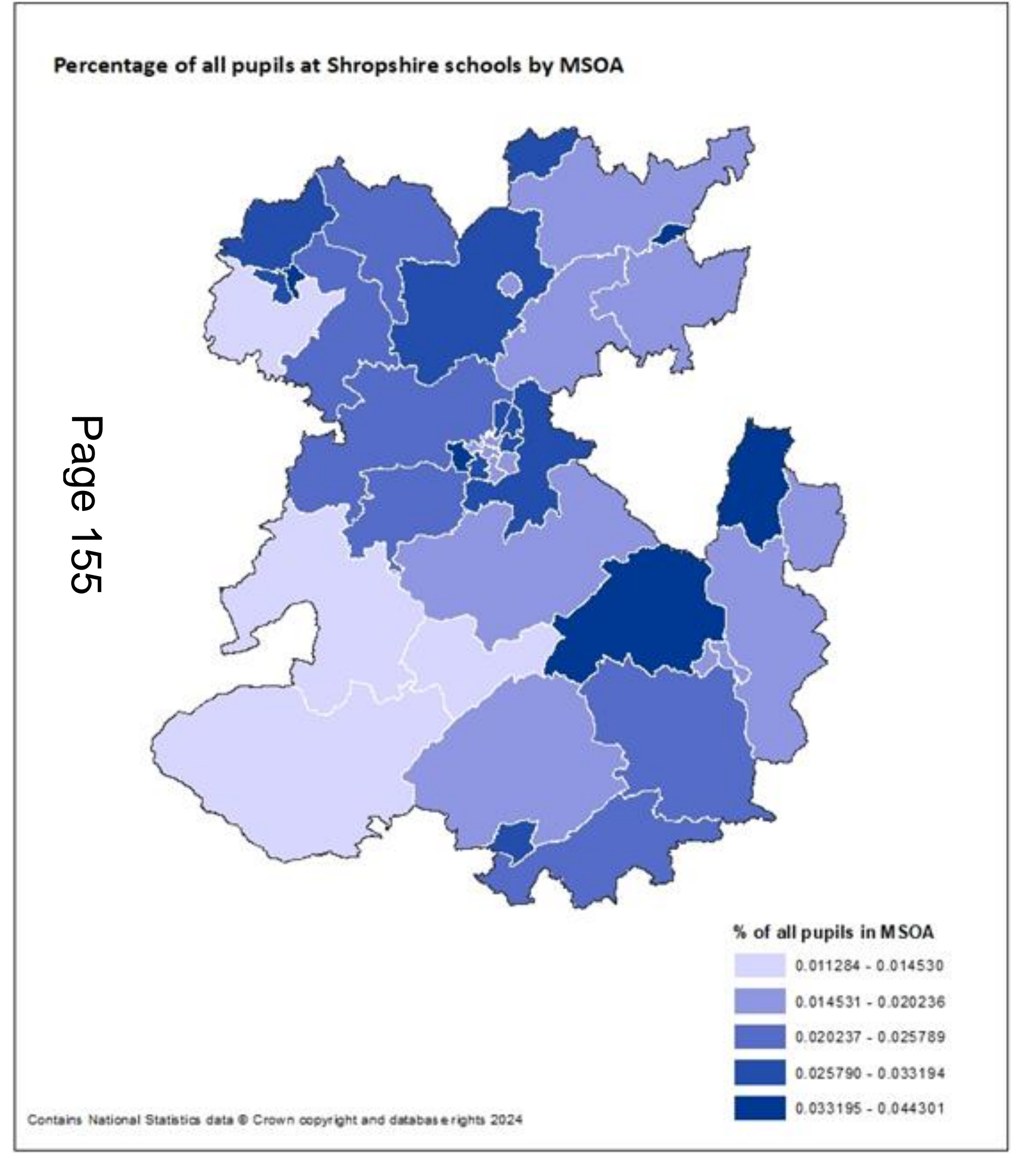


15-19 year olds



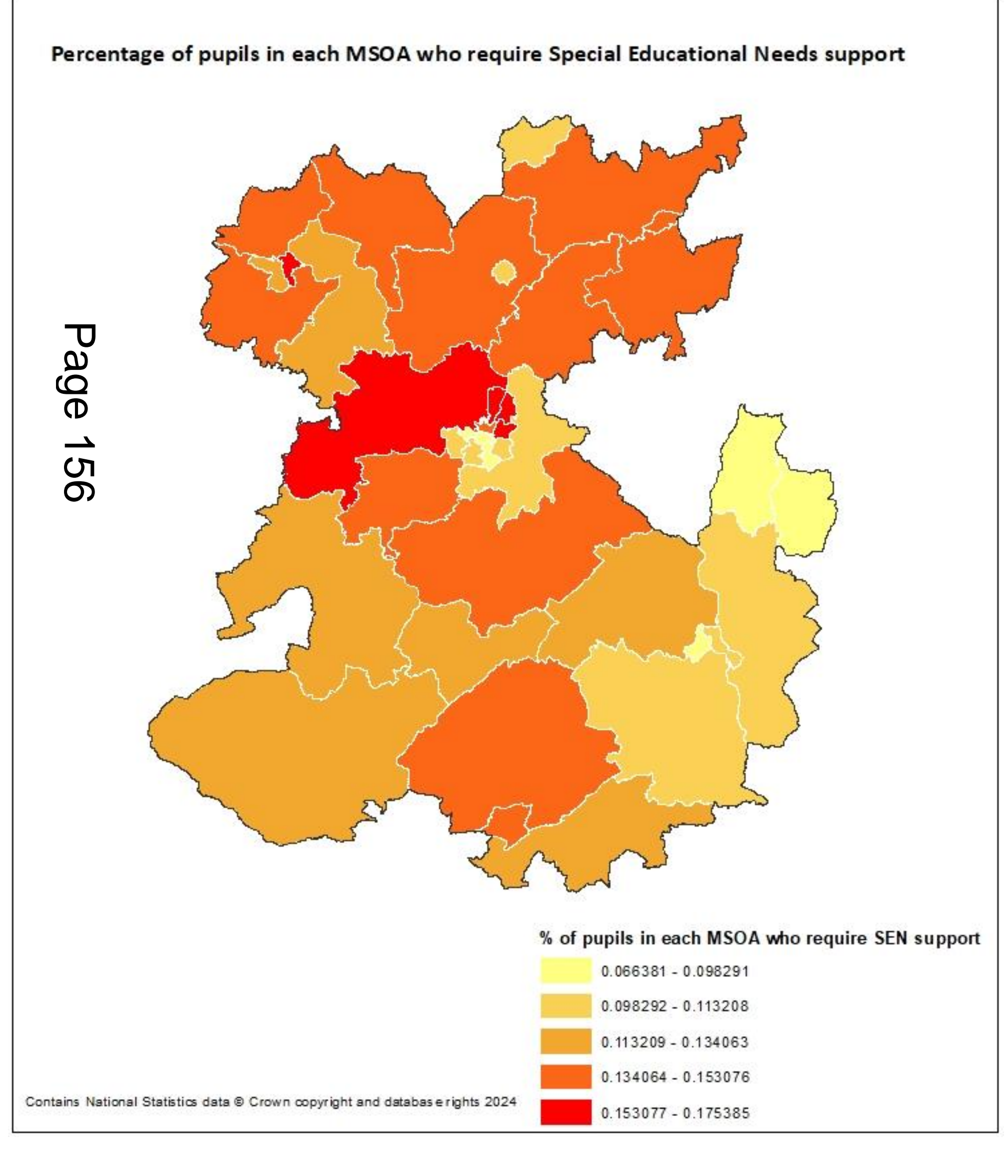
- Areas with the largest number of children aged 0-19 are: Bayston Hill, Column and Sutton, Oswestry East, Market Drayton West and Wem, with more than 1,800 children and young people living in each of these wards.
- When broken down further, there are variations in the areas CYPs in Shropshire live.
  - The highest number of 0-4 year olds live in Bayston Hill, Column and Sutton ward, Oswestry East and Market Drayton West

Shropshire's school population



- Based on the Shropshire school census, there are just under 40,000 children who attend Shropshire local authority schools.
- 94% of children who attend Shropshire schools live in Shropshire, however, there are children who live in other areas.
- There are 1,624 children who are aged 0-4 who attend Shropshire schools. 75% of these are children in the N2 school year (aged 3 on 31st August but turning 4 during the year).

School population - SEND support



- 5,103 pupils (12.9%) of the school population require SEN support
- 1,493 pupils (3.8%) have an education, health and care plan.

Wider determinants of health and risk factors

Child Safety and Well-being Shropshire

More detail can be found in the full report.

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Ellesmere
Whitchurch
Market Drayton
Oswestry
Wem
Shrewsbury
Shifnal
Albrighton
Church Stretton
Bridgnorth
Bishops Castle
Craven Arms
Ludlow
1 = Most deprived
2
3
4
5
6
7
8
9
10 = Least deprived

5% of Shropshire's population (15,082) live in the 20% most deprived areas in England (Decile 1 and 2), 2019

513 Babies, infants and children aged 0-4 live in the top 5 most deprived areas Shropshire (2019)

0.120 Income Deprivation Affecting Children Index (IDACI) score 2019 (England, 0.178)

14.4% of children under 16 living in absolute low income families 2021/22 (England, 15.3%)

18.0% households in Shropshire in fuel poverty 2021

9 per 1,000 0-17 year old children are in households with toxic trio*, 2021/21 (England, 9 per 1,000)

161 Children aged 0-4 looked after as of 31 March 2023 in Shropshire (24% of all CLA vs 18% nationally)

8,765 A&E attendances (0-4s) during 2022/23, rate of 617.3 per 1,000 (England, 797.3)

2,595 Emergency admissions 0-4s, 180.8 per 1,000 2021/22 (England, 161.5)

125 admissions caused by unintentional and deliberate injuries children 0-4s, 2021/22, 87.1 per 10,000 (England, 103.6)

Red = worse, orange = similar, green = better than national rate

*co-occurring parental substance misuse, mental ill health and domesti

Areas of need

This provides a high level overview of the Health and Wellbeing of children and young people aged 0-19 in Shropshire.

Metrics which span all ages are included in this chapter. Metrics specific to an age group are included in their relevant chapter.

Shropshire Child Health Profile — March 2023

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

- → No significant change
- ↑↓ Increasing/decreasing and getting better
- ↑↓ Increasing/decreasing and getting worse
- – Trend cannot be calculated
- Not significantly different from the England average
- Significantly better than the England average
- Significantly worse than the England average
- Significance cannot be tested

England average / Regional average / 25th percentile / 75th percentile

Vaccination key: ≥95% / <90% / 90% to 95%

Domain	Indicator	Recent trend	Local no. per year*	Local value	Eng. avg	Eng. worst	Eng. best
Premature mortality	1 Infant mortality rate	→	*12*	4.7	3.9	7.5	1.2
	2 Child mortality rate (1 to 17 years)	–	*4*	7.0	10.3	17.7	6.1
Health protection	3 MMR vaccination for one dose (2 years)	→	2,627	95.3	89.2	65.4	97.7
	4 Dtap/IPV/Hib vaccination (2 years)	→	2,661	96.5	93.0	70.6	99.1
	5 Children in care immunisations	↑	396	96.0	85.0	30.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of Reception	→	1,961	65.0	65.2	53.1	74.4
	7 GCSE attainment: average Attainment 8 score	–	–	47.2	48.7	39.2	61.3
	8 GCSE attainment: average Attainment 8 score of children in care	–	–	28.9	23.2	14.2	38.3
	9 16 to 17 year olds not in education, employment or training (NEET)	→	334	5.9	4.7	14.7	1.4
	10 First time entrants to the youth justice system	↓	19	64.2	146.9	446.9	56.3
	11 Children in relative low income families (under 16s)	↑	8,927	16.8	18.5	42.4	6.2
	12 Households with children homeless or at risk of homelessness	–	327	9.7	14.4	39.3	4.5
	13 Children in care	–	609	104	70	218	26
	14 Children killed and seriously injured (KSI) on England's roads	–	*6*	11.9	15.9	55.0	2.6
Health improvement	15 Low birth weight of term babies	→	43	1.8	2.8	5.0	1.5
	16 Obese children (4 to 5 years)	→	260	9.7	10.1	14.9	5.4
	17 Obese children (10 to 11 years)	→	510	19.0	23.4	34.0	12.4
	18 Children with experience of visually obvious dental decay (5 years)	–	–	23.8	23.4	50.9	8.7
	19 Hospital admissions for dental caries (0 to 5 years)	–	*82*	452.1	220.8	931.3	7.5
	20 Under 18s conception rate / 1,000	→	62	11.5	13.0	30.4	2.7
	21 Teenage mothers	→	–	–	0.6	2.4	0.0
	22 Admission episodes for alcohol-specific conditions - Under 18s	→	*13*	22.2	29.3	83.8	7.7
	23 Hospital admissions due to substance misuse (15 to 24 years)	–	*17*	55.9	81.2	229.4	16.9
Prevention of ill health	24 Smoking status at time of delivery	→	308	12.0	9.1	21.1	3.1
	25 Baby's first feed breastmilk	–	1,675	74.8	71.7	1.3	98.6
	26 Breastfeeding prevalence at 6 to 8 weeks after birth	–	858	–	49.3	–	–
	27 A&E attendances (0 to 4 years)	–	7,985	556.4	762.8	2,080.6	387.2
	28 Hospital admissions caused by injuries in children (0 to 14 years)	–	395	82.6	84.3	162.2	38.8
	29 Hospital admissions caused by injuries in young people (15 to 24 years)	–	310	95.2	118.6	252.2	53.3
	30 Hospital admissions for asthma (under 19 years)	–	115	185.3	131.5	438.0	47.0
	31 Hospital admissions for mental health conditions	–	55	94.1	99.8	355.1	33.3
	32 Hospital admissions as a result of self-harm (10-24 years)	–	165	327.2	427.3	1,051.7	127.6

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

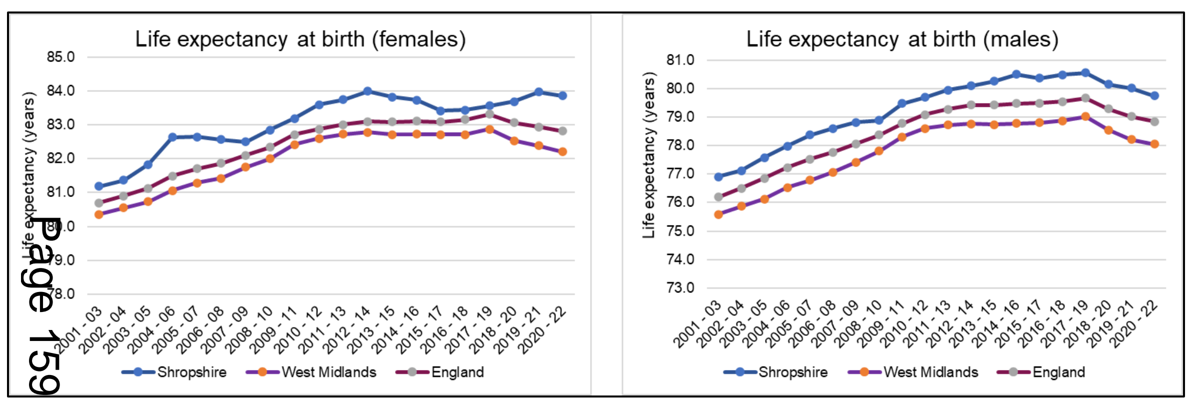
Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

More detail can be found in the full report.

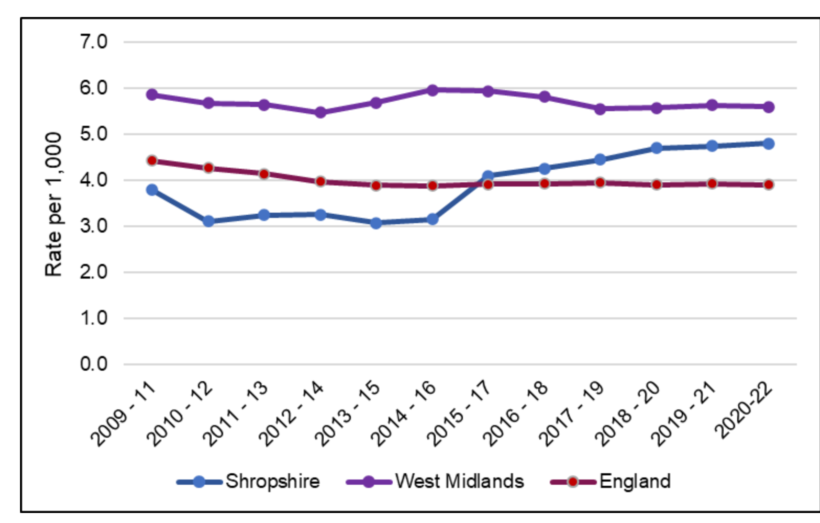
Indicators of general health of the population

Life expectancy at birth



Life expectancy at birth in Shropshire is higher among females compared to males. Both are rising over time and are above the regional and national average

Infant mortality



There were 37 deaths under one year of age in Shropshire, equating to an infant mortality rate of 4.8 per 1,000 live births. Sixth lowest regionally, similar to the regional rate of 5.6 per 1,000 and the national rate of 3.9 per 1,000 live births. Shropshire's rate was the highest compared to its statistical neighbours.

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Children and Young People Needs Assessment

Chapter 3: Early Years (aged 0-4)

2024

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Introduction

The JSNA will provide a detailed understanding of the needs of children, young people and families in Shropshire to inform the direction and development of local services, with a view to reducing health inequalities through identification, prevention and early intervention.

Due to the vast scope of this product, Shropshire's Children and Young people JSNA will be structured as a 'JSNA pack', comprising of individual chapters for each stage of the life course:

Core JSNA chapters

1. Population and context for Children and Young People
2. Maternity (pregnancy & birth)
3. Early Years (0-4 years)
4. School aged children (5-11 and 11-16 years)
5. Young people (16-19 years)

This chapter presents an overview of the health and wellbeing of babies, infants and children aged 0-4 across Shropshire. Other chapters are referenced throughout to refer to for certain insights and further information.

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The period between conception and the age of 5 is recognized as having a significant influence on a person's life. The environment a baby experiences whilst in the womb and the first 2 years of life are particularly critical for cognitive, emotional and physical development, likewise, the health and mental health of parents at this time is also critical to family health and wellbeing.

Objectives

Given the broad range of needs and services for children under 5 years, this report is not an in depth review of any one specific service, but instead aims to provide an overview.

The objectives of this chapter of the Children and Young People's needs assessment therefore are to include the following:

- To describe the population profile of children under 5 and their families in Shropshire- please also see the Population and Context chapter
- To identify risk factors that impact on maternal, infant and child health outcomes - please also see the Population and Context chapter
- To provide an overview of the wider determinants of health and their impact on the under 5s and their families- please also see the Population and Context chapter
- To identify relevant national guidance and local policy in relation to early years
- To provide an overview of the health and wellbeing of under 5s
- To provide an overview of current service provision and assessment of outcomes including gaps in relation to domains impacting on early childhood outcomes; physical, psychosocial and emotional, cognitive and language development
- To identify vulnerable children, and/or at risk groups
- To identify gaps, barriers, and unmet needs in current service provision
- To provide evidence-based recommendations to ensure that the needs of 0-5 year olds are met in Shropshire

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Executive summary

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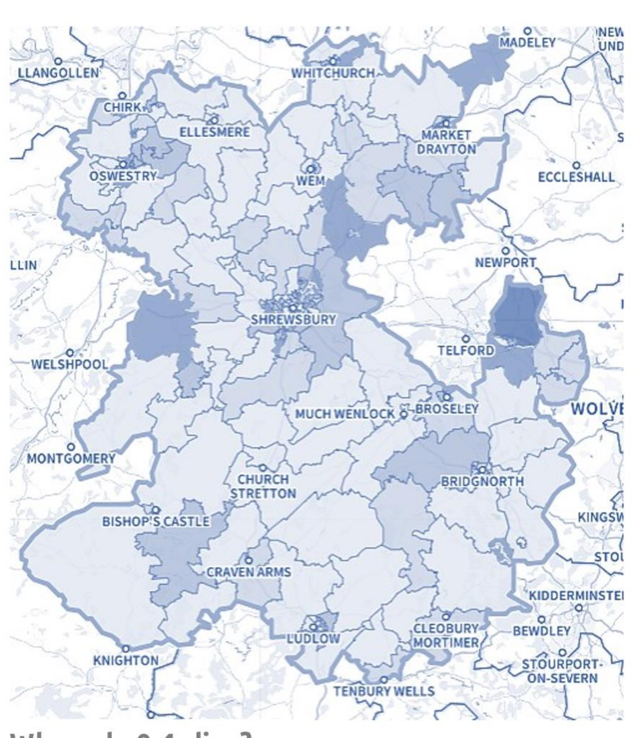
Early Years 0-4s Shropshire



Where do 0-4s live?

The colours represent the quintiles:
- 7% to 28%: 10 areas
- 6% to 7%: 22 areas
- 5% to 6%: 39 areas
- 4% to 5%: 40 areas
- 0% to 4%: 82 areas

14,423 aged 0-4 in 2021, **an 8% fall** from 2011 (England 7% fall)

4.5% aged 0-4 **of Shropshire's population** (England 5.4%)

2,567 live births in Shropshire (2022)

37 infant deaths during 2020-22, rate of 4.8 per 1,000 births

43 babies had **low birth weight** in 2021, 1.8% of all births

Overall deprivation is low in Shropshire. **513** or 3.6% of babies, infants and children aged 0-4 live in the top 5 most deprived areas (LSOAs) of Shropshire: Harlescott, Ludlow East, central Oswestry, Monkmoor and Meole Brace.

51% 49% Male Female

3.6% **0-4s from ethnic minority groups in** 2011, 567 children

290 **0-4s with SEN support** in 2022/23 (5.7% of all children <19 with SEN support in Shropshire)

2,033 new birth visits by 14 days, 80.8% vs England 79.9% (2022/23)

49.0% infants breastfed (provisional) at 6-8 weeks during Q4 2023/24 vs 52.0% England

105 hospital admissions for unintentional and deliberate injuries (0 to 4 years), 74 per 1k compared to 92 in England (2022/23)

2,690 per 1,000 emergency admissions (0-4 years) 189 per 1k compared to 158 in England (2022/23)

68% achieving good level of development at the end of reception in Shropshire, 67% England (2022/23)

22.1% reception aged children (4–5-year-olds) **overweight or obese**, England 21.3%

89.8% MMR vaccine coverage two doses in 2022/23, target =>95%

Doing well

1. **Low birth weight of term babies** is falling over time
2. The level of School readiness: **percentage of children achieving at least the expected level in communication and language skills at the end of Reception** is steady and above to the national average
3. **Hospital admissions caused by unintentional and deliberate injuries** in children (aged 0 to 4 years) is below the national average and falling over time
4. **Uptake of Healthy Start Voucher Scheme** is rising in Shropshire, with the gap closing between those eligible and those taking up the offer
5. Local data (not yet validated) indicates an **improvement in 4 out of 5 health visiting mandated contacts,** with a rising trend compared to the previous year.
6. Largest improvement seen in % of children receiving their visit at 2- 2 ½ years
7. Qualitative information tells us that stakeholders feel our **multi-agency working and digital offer** are particular strengths in Shropshire

Areas of need (below the national average)

1. **Smoking status at time of delivery** is above the national average but the rate is falling over time.
2. **Infant mortality** – whilst similar to the national average, the rate in Shropshire has been rising since 2014-16. The same trend is seen for **neonatal mortality** with a steeper rise in infant mortality compared to neonatal.
3. **Emergency admissions (0-4s)** and under 1s, admissions for asthma (0-9s)
4. **Population Vaccination coverage: MMR two doses** (5 years old) is below the national target of 95% but has remained steady over time
5. **Breastfeeding prevalence** – is below the national average but steadily improving over time
6. Uptake of **healthy start vouchers**
7. **Proportion of children receiving a 12 month review by 12 months** : below the national average and requires improvement at 47% compared to 83% nationally. However, this rate has been improving over time. The reason for this low rate is due to reviews taking place before 15 months, with a rate of 86%. This is due to mainly due to the timing that the invites are generated and parental choice. The service have made changes to the system to generate earlier appointments to ensure that these are more frequently prior to the child's first birthday.
8. Child development: % of children **achieving a good level of development at 2 to 2½ years** is below the national average but is improving
9. Child development: % of **children achieving the expected level** in communication skills, gross motor skills, fine motor skills, problem solving skills and personal social skills at 2 to 2½ years
10. **Stakeholders report transport/access and face to face provision is a barrier for health visiting**
11. Rise in **looked after children** over time in Shropshire, with 0-4 year olds making up 24% of all children looked after in the county. Shropshire had a higher proportion of looked after children in the 1-4 year old compared to nationally.

Data caveat: the data period covered in this report coincides with the COVID-19 pandemic and national lockdowns (March 2020 onwards), therefore data may not be a true representation of the service's performance due to the substantial impact on service delivery. For mandated service delivery, virtual contacts were counted as valid for all data for 2020 to 2021 during the period of the pandemic response.

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Policy and Guidance

Best Start for Life

The Best Start for life policy is a vision for brilliance in the 1,001 critical days from conception to age 2. Commissioned by the Prime Minister, and chaired by Rt Hon Andrea Leadsom MP, this vision was developed with input from families, professionals and academics.

The vision

The 1,001 critical days from conception to the age of two set the foundations for an individual's cognitive, emotional and physical development. Investing in this critical period presents a real opportunity to improve outcomes and tackle health disparities by ensuring that thousands of babies and families have improved access to quality support and services.

Developed as part of the early years healthy development review, this policy outlines 6 areas for action to improve the health outcomes of all babies in England.[1]:

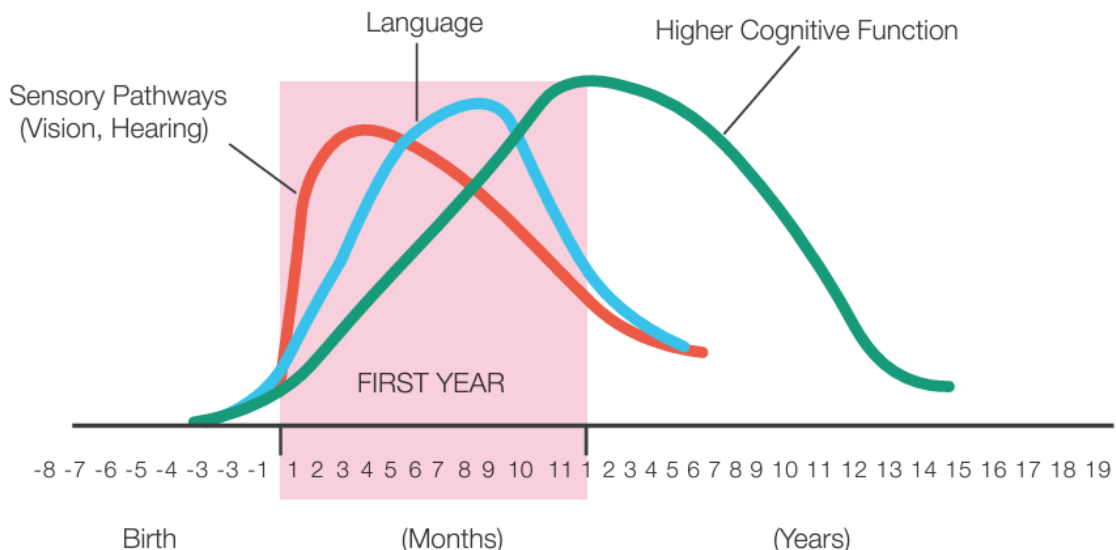
Action Areas

Ensuring families have access to the services they need
1. **Seamless support for families:** a coherent joined up Start for Life offer available to all families.
2. **A welcoming hub for families:** Family Hubs as a place for families to access Start for Life services.
3. **The information families need when they need it:** designing digital, virtual and telephone offers around the needs of the family.
Ensuring the Start for Life system is working together to give families the support they need
4. **An empowered Start for Life workforce:** developing a modern skilled workforce to meet the changing needs of families.
5. **Continually improving the Start for Life offer:** improving data, evaluation, outcomes and proportionate inspection.
6. **Leadership for change:** ensuring local and national accountability and building the economic case.

The policy highlighted the international, evidence-based agreement on the importance of the 1,001 critical days. During this time, our brains lay the foundations for the emotional health, physical wellbeing and social skills needed to live a healthy, happy life.

Figure 1: Human Brain Development from the Center on the Developing Child at Harvard University, available at https://developingchild.harvard.edu/

[1] https://www.gov.uk/government/publications/phe-strategy-2020-to-2025



Research shows that supporting babies' development can lead to lifelong benefits, including increased economic chances, longer life expectancy and reduction in crime.

Providing high quality services and support for babies is not only good for their lifelong potential, it can also reduce demand for public services by responding to risks early. Conversely, not dealing with issues at the earliest opportunity leaves individuals requiring more support later in life. This can be expensive. To give just one example, the Early Intervention Foundation estimated the cost of late intervention to be £17 billion a year in England and Wales.

To help minimise these costs and bring lifelong benefits to babies, Start for Life support must be focused on the right things and be well delivered. There are many services that all families rely on during the 1,001 critical days. These include midwifery, health visiting, infant-feeding support and perinatal mental health and parent-infant relationship support. Some families also require additional help across a range of areas such as smoking cessation, drugs and alcohol support, domestic violence reduction and debt and housing advice. Evidence points to several important areas that particularly impact a baby's health and development and where improvements in services are needed. This includes, but is not limited to, services that support breastfeeding, parent-infant relationships and perinatal mental health [2].

The services that families currently receive.

There are many different services available to support families throughout pregnancy, as their baby is born and in the months that follow. Currently, a small number of services are offered to every new parent or carer – these include midwifery and health visiting services, which sit alongside those services available to everyone, like General Practitioners (GPs) and NHS 111.

Many local partners offer a broader range of services to all their families, but a significant number only offer additional services on a 'targeted' basis in response to need. These additional services include breastfeeding support, mental health support, smoking cessation and intensive parenting support. Local authorities, working with partner organisations and agencies, have a statutory duty to safeguard and promote the welfare of all children,

[2] Best Start for Life: A Vision for the 1,001 critical days'
https://www.gov.uk/government/publications/phe-strategy-2020-to-2025

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including babies, in their area. All of these services are vital for ensuring every baby gets the best start.

The 6 Universal Start for Life services

Midwifery

Midwives provide personalised support to families throughout pregnancy and labour.

Health Visiting

Health visitors work with other Start for Life professionals after childbirth in supporting families. They are responsible for the 5 mandated child development reviews.

Parent-Infant Mental Health

These services ensure that parents, carers and babies are forming a secure bond and, where needed, provide mental health and relationship support.

Infant Feeding

Infant feeding services support parents with feeding their babies, breastfeeding support and advice on nutrition.

Special Educational Needs and Disability

Special educational needs and disability services support disabled or seriously ill babies and their families.

Safeguarding

Safeguarding services seek to protect babies from abuse and maltreatment.

Aims

The ambition of Best Start for Life is to help reduce inequalities and improve health outcomes for children and families across England to ensure all mothers experience good health before, during and after pregnancy and all children to have a happy healthy childhood[3].

- reduced rates of infant mortality and low birthweight
- improvements in rates of key protective factors linked to better child health outcomes, such as maternal mental health and breastfeeding
- higher rates of childhood immunisation
- more children ready to learn by the age of two and ready to start school by the age of five
- lower rates of tooth decay and hospital attendances due to preventable accidents and illnesses

[3] Public Health England's 5-year strategy

Health and Social Care Act 2012

The Health and Social Care Act 2012 sets out local authorities' statutory responsibility for commissioning public health services for children and young people aged 0 to 19 years.

Public health services commissioned by local authorities form part of the 'whole system' of support for children and young peoples' health and wellbeing. Local authorities are well placed to ensure integrated commissioning and delivery with a wide range of stakeholders who provide support for physical and mental health and wellbeing, including the NHS and the voluntary and community sector, schools and colleges[4].

The core public health offer

All families with babies are to be offered 5 mandated health visitor reviews before their child reaches 2 and a half years old. The early years reviews are offered to all families. However, this is not the extent of the health visiting service offer for families who may also require additional support from the health visiting team, for example feeding, child development, physical or mental health support.

The only mandated elements of provision for 5-19 services is the national child measurement programme at reception and year 6. However, there are opportunities to develop a framework of reviews based on evidence, intelligence, professional judgement and service user voice which provides opportunities to review health and wellbeing needs, support behaviour change and influence outcomes. This presents opportunities for bringing together a robust approach for improving outcomes for children and young people across both health and local authority led services for children and young people aged 0 to 19.

The core public health offer for all children includes:[5].

- child health surveillance (including infant physical examination) and development reviews
- child health protection and screening
- information, advice and support for children, young people and families or carers
- early intervention and targeted support for families with additional needs
- health promotion and prevention by the multi-disciplinary team
- defined support in early years and education settings for children with additional and
- complex health needs
- additional or targeted public health nursing support, for example, support for children in care, young carers, or children of military families

Healthy Child Programme

Good health, wellbeing and resilience are vital for all our children now and for the future of society. There is good evidence about what is important to achieve this through improving children and young people's public health. This is brought together in the national healthy child programme 0 to 19.

The 0 to 5 element of the healthy child programme is led by health visiting services and the 5 to 19 element is led by school nursing services. Together they provide place-based services and work in partnership with education and other providers where needed. The universal reach of the healthy child programme provides an invaluable opportunity from early in a

[4] Health and Social Care Act 2012
[5] Best Start in life and beyond: healthy child programme 0 to 19

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child's life to identify families that may need additional support and children who are at risk of poor outcomes.
The healthy child programme provides a framework to support collaborative work and more integrated delivery. It aims to:

- help parents, carers or guardians develop and sustain a strong bond with children
- support parents, carers or guardians in keeping children healthy and safe and reaching their full potential
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- promote oral health
- support resilience and positive maternal and family mental health
- support the development of healthy relationships and good sexual and reproductive health
- identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner
- make sure children are prepared for and supported in all childcare, early years and education settings and are especially supported to be 'ready to learn at 2 and ready for school by 5

Being ready for school is assessed as every child reaching a level of development which enables them to:

- communicate their needs and have good vocabulary
- become independent in eating, getting dressed and going to the toilet
- take turns, sit still and listen and play
- socialise with peers, form friendships and separate from parents
- have good physical health, including dental health
- be well nourished and within the healthy weight for height range
- have protection against vaccine-preventable infectious diseases, having received all childhood immunisations

It also involves:

- continued support through school age years to help every child to thrive and gain maximum benefit from education, driving high educational achievement
- identifying and helping children, young people and families with problems that might affect their chances later in life, including building resilience to cope with the pressures of life

The Healthy Child Programme aims to bring together health, education and other key partners to deliver an effective programme for prevention and support. Whilst recognising the contribution of other partners, there will be some elements which require clinical expertise and knowledge that can only be provided through services led and provided by the public health nursing workforce, for example, health visiting and school nursing teams [6].

Shropshire Council recognises that giving every child the Best Start in Life is imperative to reducing inequalities across the life course.

Healthy Child Programme: Pregnancy and first 5 years of life

Pregnancy and the first years of life are one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down, and is a time

[6] Best Start in life and beyond: healthy child programme 0 to 19

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when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. We have always known this, but new information about neurological development and the impact of stress in pregnancy, and further recognition of the importance of attachment, all make early intervention and prevention an imperative (Centre on the Developing Child, 2007). This is particularly true for children who are born into disadvantaged circumstances[7].

The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

The Healthy Child Programme is universal in reach. It sets out a range of public health support in local places to build healthy communities and to reduce inequalities. It also includes a schedule of interventions, which range from services for all through extra help to intensive support. The Healthy Child Programme is also personalised in response. All services and interventions need to be personalised to respond to families' needs across time. For most families most of this will be met by the universal offer.

The service model is based on 4 levels of service – community, universal, targeted and specialist, depending on individual and family need. The use of community-based assets is central to the universal offer, where health visitors and school nurses are well placed to identify and signpost to local community support. Contact points or universal health and wellbeing reviews can be utilised to identify needs and to develop a support offer or signpost to specialist services if required.

Effective implementation of the HCP should lead to:

- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- prevention of some serious and communicable diseases;
- increased rates of initiation and continuation of breastfeeding;
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;
- identification of factors that could influence health and wellbeing in families; and
- better short- and long-term outcomes for children who are at risk of social exclusion.

The full schedule of the HCP can be found here.

High impact areas

The high impact areas have been developed to improve outcomes for children, young people and families. They are based on evidence of where these services can have significant impact for all children, young people and families and especially those needing more support and impact of health inequalities[8].
Early years (health visiting and school nursing) high impact areas are:

[8] Best Start in life and beyond: healthy child programme 0 to 19

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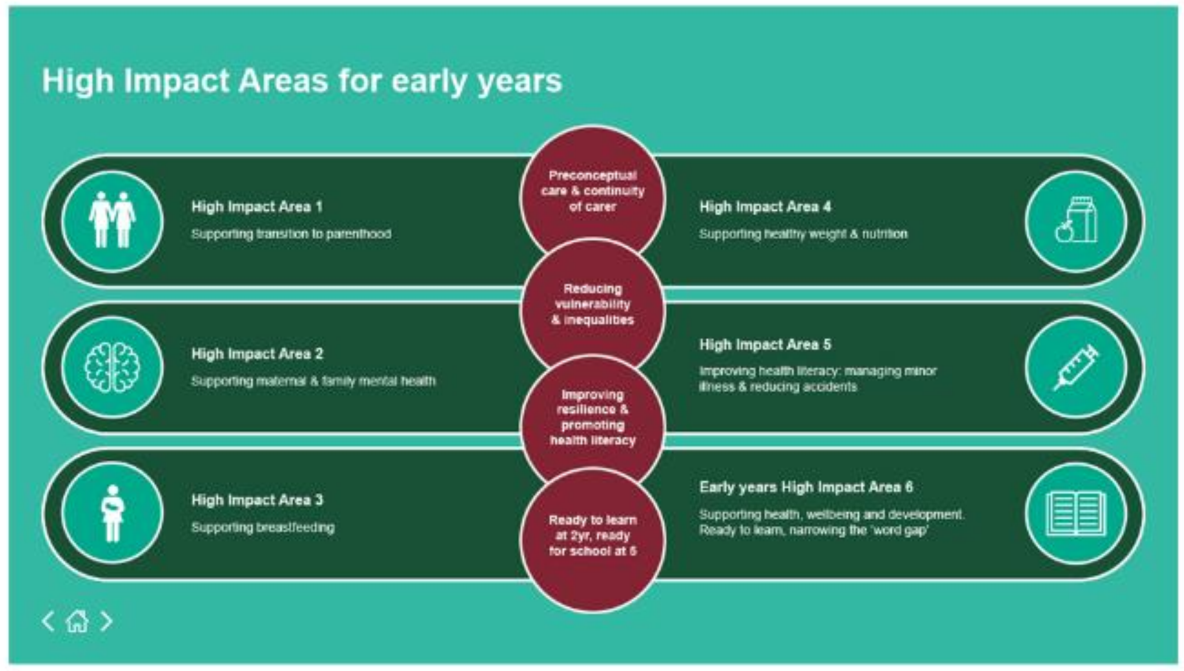
- supporting transition to parenthood and the early weeks
- supporting maternal and infant mental health
- supporting breastfeeding (initiation and duration)
- supporting healthy weight and healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing and development. Ready to learn, narrowing the ‘word gap



A bundle of indicators is available to measure performance and outcomes, for example through the Community Services Data Set (CSDS). Public Health Profiles are also available from the Child and Maternal Fingertips.

Health visitors

Health visitors, as public health nurses, use strength-based approaches, building non-dependent relationships to enable efficient and effective working with parents and families to support behaviour change, promote health protection and to keep children safe.

Health visitors also undertake a holistic assessment in partnership with the family, which builds on their strengths as well as identifying any difficulties. It includes the parents' capacity to meet their infant's needs, the impact and influence of wider family, community and environmental circumstances.

This period is an important opportunity for health promotion, prevention and early intervention approaches to be delivered. Working with parents and families, health visitors identify the most appropriate level of support and intervention for their individual needs.

Family Nurse Partnership

The Family Nurse Partnership (FNP) is an intensive, home visiting programme for vulnerable young women and their families that provides an evidence based and targeted service for vulnerable families. Commissioning and providing FNP will improve the life chances of first-time young parents and their children, helping to break the cycle of disadvantage by:

Local authorities commission the Family Nurse Partnership (FNP) programme, an evidence based, intensive parenting support intervention, as part of delivering the 0 to 5 public health offers for children as detailed in the Healthy Child Programme[9].

- supporting young mothers to build self-efficacy and engage with education, training and employment
- improving child health and development and early education outcomes particularly for boys, children of very young mothers and mothers who are not in education, training or employment
- delivering the Healthy Child Programme to first time young mothers
- helping young parents' access and engage with local services
- identifying safeguarding issues and working alongside statutory services to support interventions

FNP contributes to the Public Health Outcomes Framework (PHOF) for England which focuses on:

- increased healthy life expectancy
- reduced differences in life expectancy
- healthy life expectancy between communities

Specifically, FNP contributes to achieving the 6 early years high impact areas set out in the Healthy Child Programme (HCP) 0 to 19:

- supporting transition to parenthood and the early weeks
- supporting maternal and infant mental health
- supporting breastfeeding (initiation and duration)
- supporting healthy weight and healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing and development – ready to learn, narrowing the 'word gap'

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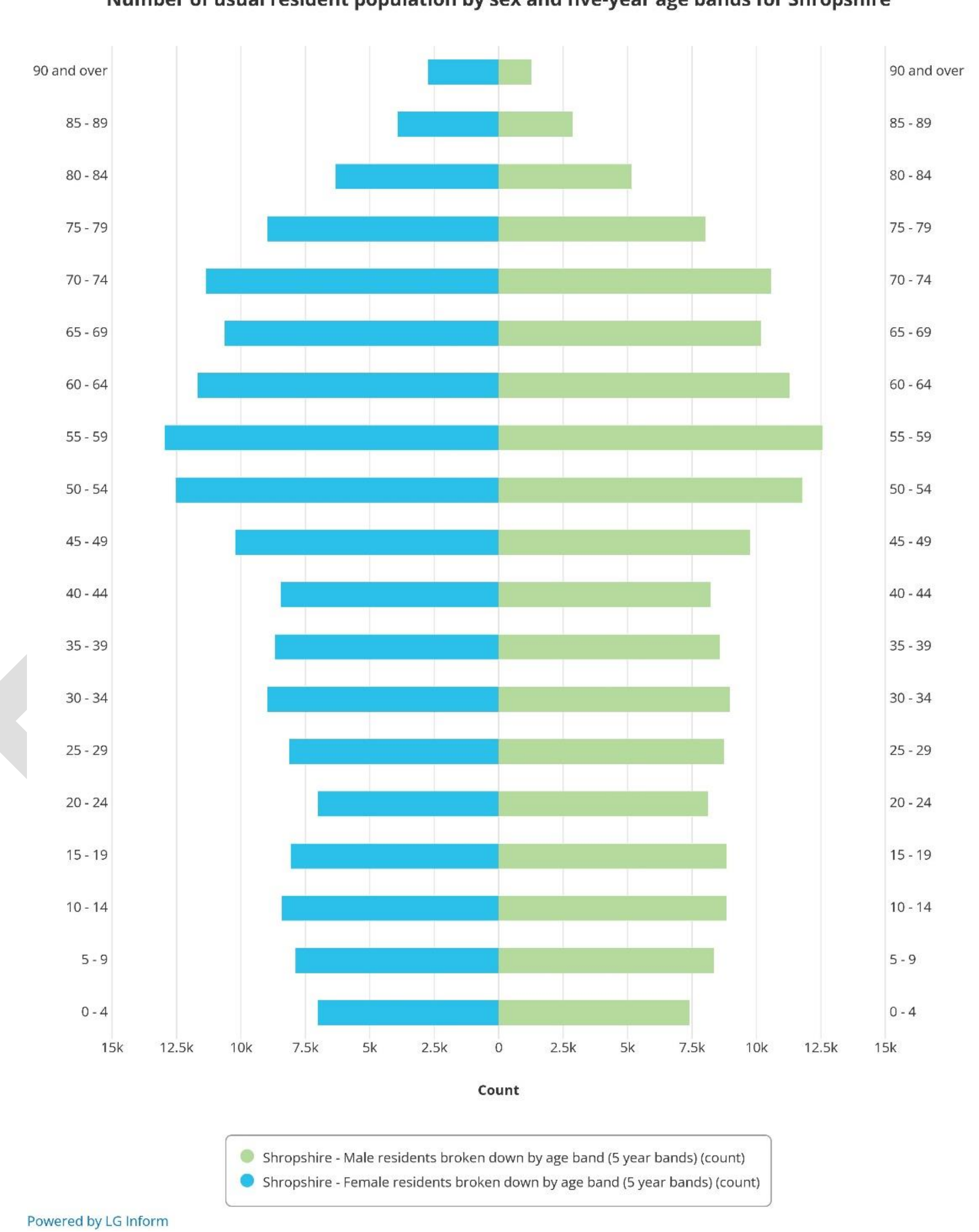
[9] Best start in life and beyond- Family Nursing Partnership

Population profile

In Shropshire, there are 14,422 infants, babies and children aged 0-4 year olds, 7,403 (51%) of which are male and 7,020 (49%) are female[10]. This equates to 4.5 % of Shropshire's total population[21].

Between 2011 and 2021, there was an 8% reduction in the number of infants, babies and children aged 0-4 in Shropshire[11].

Chart showing number of usual resident population by sex and five-year age bands in Shropshire. Source: LG Inform



10 Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)

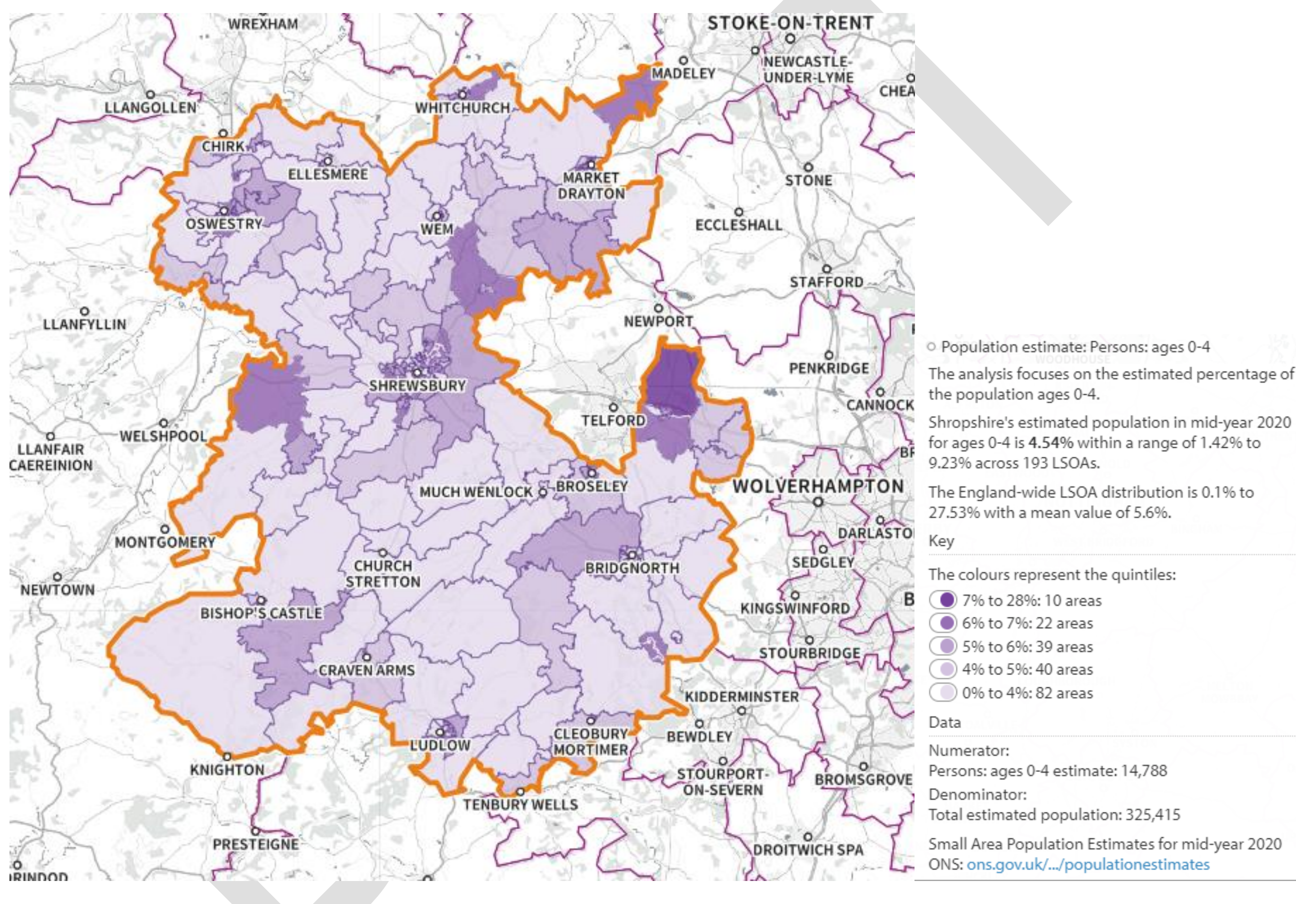
For more information on population change, see this report.

To view more population data and wider determinants of health for children and young people in Shropshire, please view the Population and Context Chapter of this JSNA pack.

Where do 0-4 year olds live?

The highest number of 0-4 year olds live in Bayston Hill, Column and Sutton ward, Oswestry East and Market Drayton West.

Map showing population aged 0-4 years old (%) by Ward, Shropshire (ONS mid 2020), Source: SHAPE tool



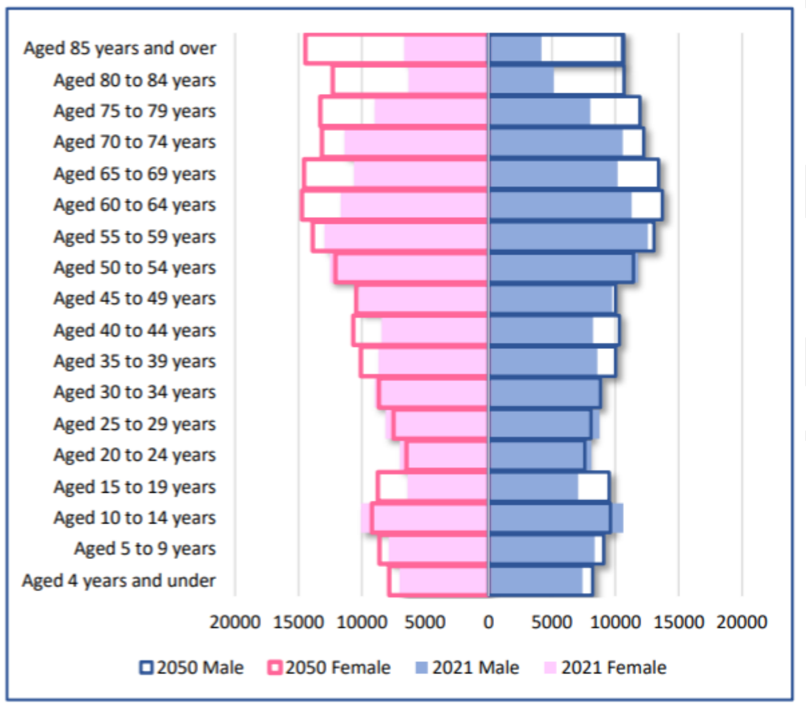
Future trends

Shropshire in 2050

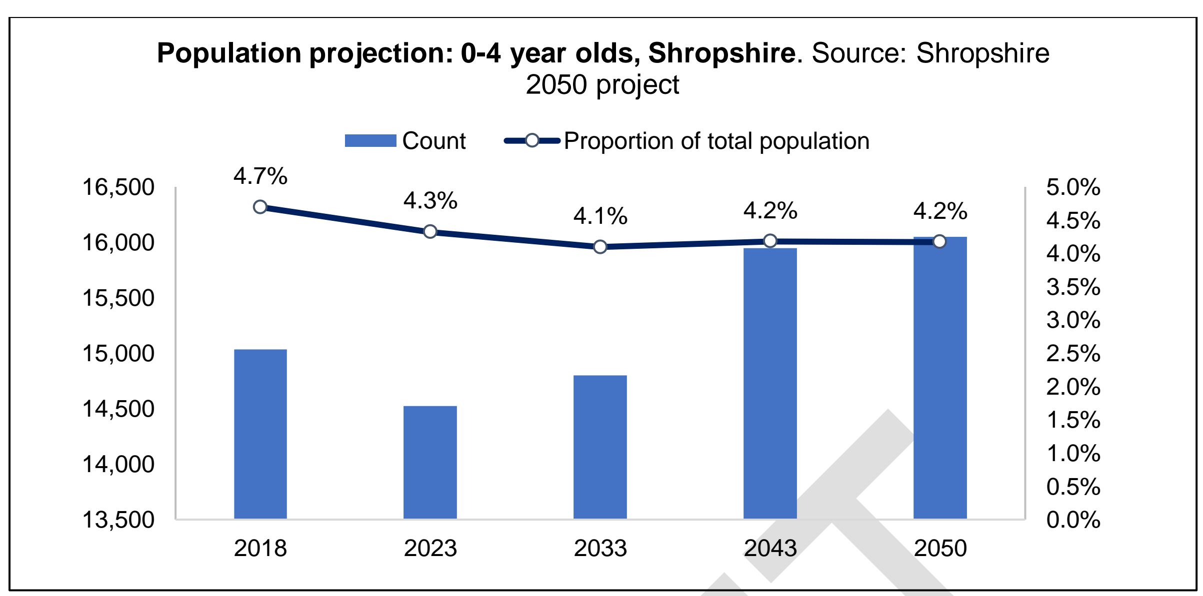
The below population pyramid shows what Shropshire's population is projected to look like in 2050. Notably, Shropshire is an ageing population and we expect to see a higher number of residents aged 65+.

There is a projected rise in 0-4s of 1.9% equating +1,293 babies by 2050. Whilst this is an increase in the number of children, the proportion of the population aged 0-4 will remain steady.

Chart showing population projections Shropshire between 2021 and 2050. Projections are SNPP to 2043, then rolled on to 2050 using PopGroup



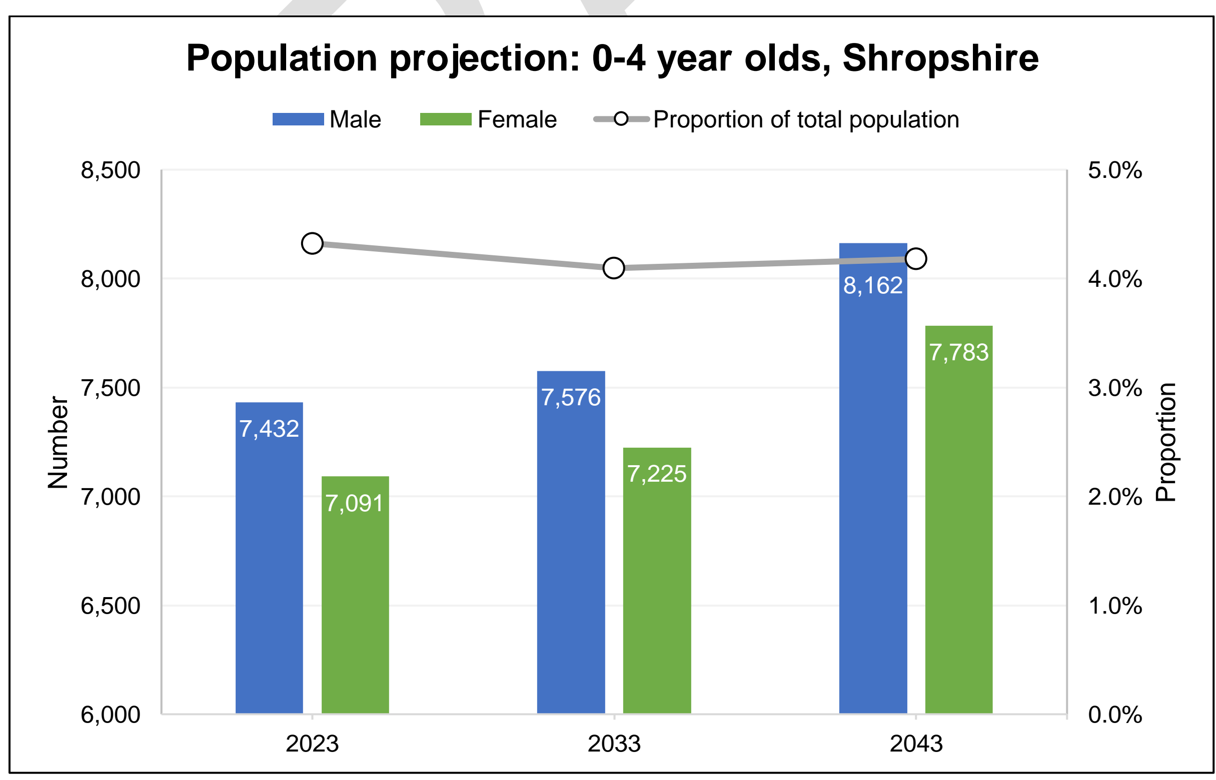
Charts showing population projections for 0–4-year-olds in Shropshire, 2018-2050. Projections are SNPP to 2043, then rolled on to 2050 using PopGroup.



The Office for National Statistics (ONS) population projections predict that the 0 to 4 years population in Shropshire would increase by 1.9% (281) between 2023 and 2033 and by 9.8% between 2023 and 2043 (1,423).

Nationally, the population in this age group is predicted to rise between 2023 and 2033 by 0.1%. Shropshire can therefore expect a greater demand for early years services in the future.

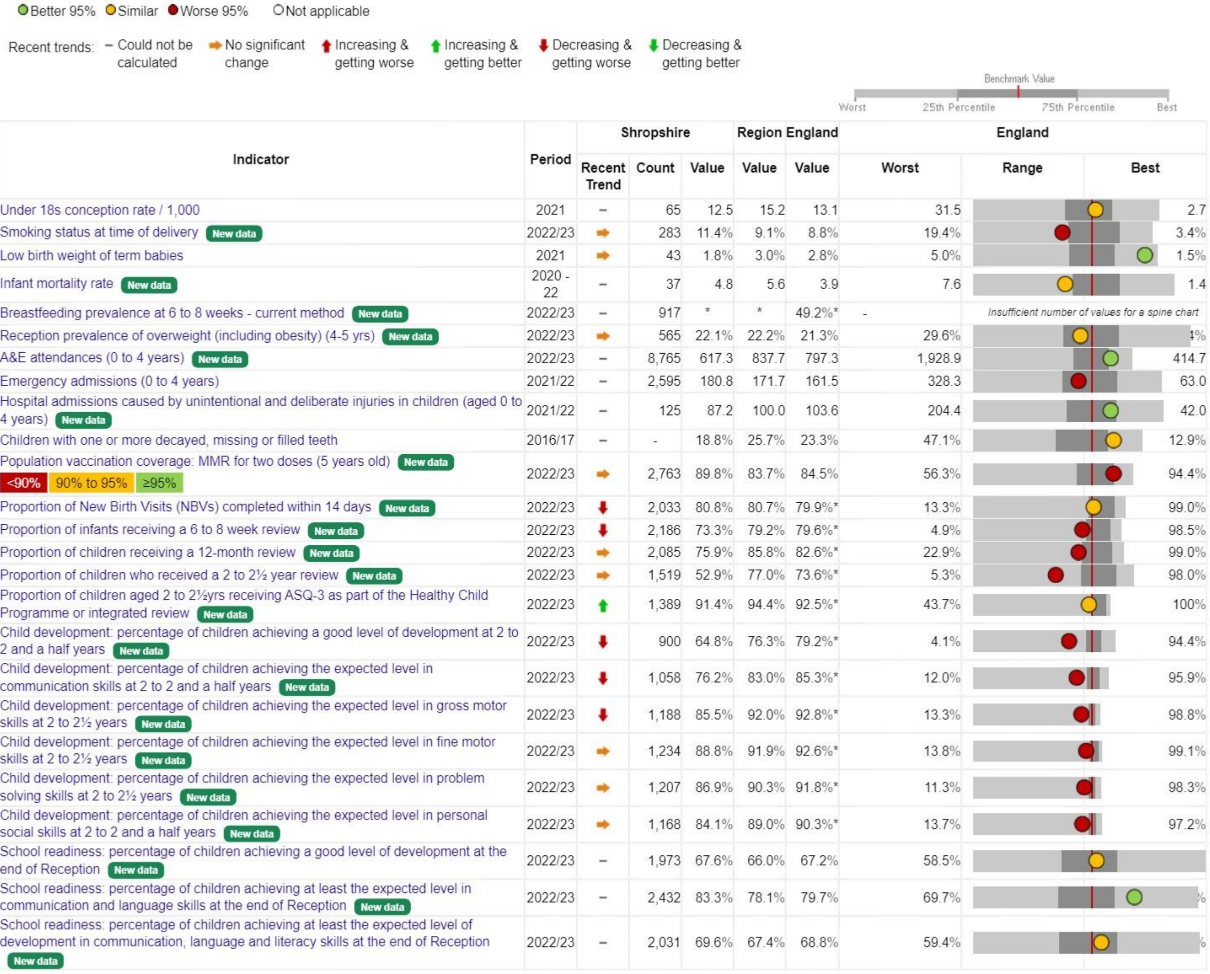
Chart showing ONS population projections for 0-4 year olds in Shropshire, 2023-2043.



Key statistics

High level summary

The data below presents a range of performance and outcome monitoring measures relating to babies and children aged 0-4 years old and are in line with assessing outcomes and the success of the Healthy Child Programme[11]:



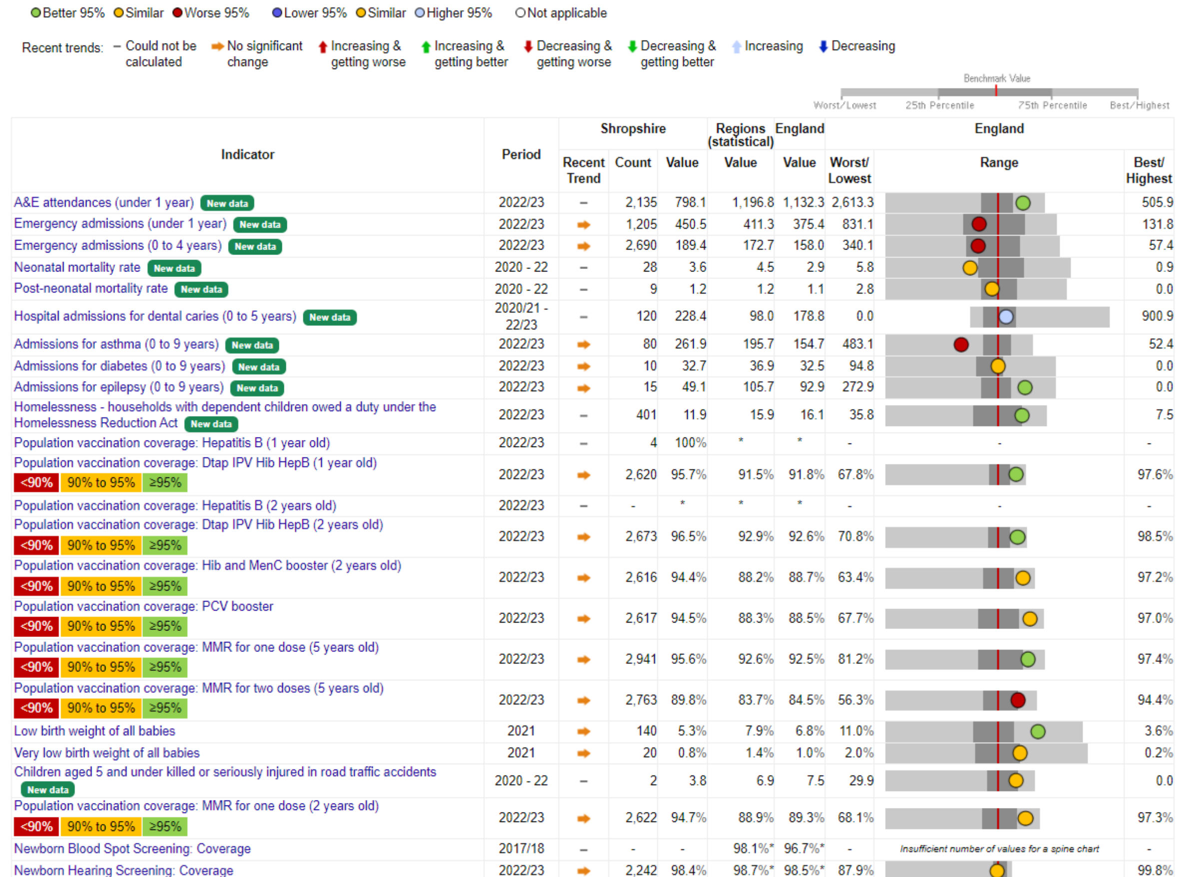
Better 95% | Similar | Worse 95% | Not applicable

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Shropshire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18s conception rate / 1,000	2021	–	65	12.5	15.2	13.1	31.5		2.7
Smoking status at time of delivery New data	2022/23	→	283	11.4%	9.1%	8.8%	19.4%		3.4%
Low birth weight of term babies	2021	→	43	1.8%	3.0%	2.8%	5.0%		1.5%
Infant mortality rate New data	2020 - 22	–	37	4.8	5.6	3.9	7.6		1.4
Breastfeeding prevalence at 6 to 8 weeks - current method New data	2022/23	–	917	*	*	49.2%*	-	Insufficient number of values for a spine chart	
Reception prevalence of overweight (including obesity) (4-5 yrs) New data	2022/23	→	565	22.1%	22.2%	21.3%	29.6%		4%
A&E attendances (0 to 4 years) New data	2022/23	–	8,765	617.3	837.7	797.3	1,928.9		414.7
Emergency admissions (0 to 4 years)	2021/22	–	2,595	180.8	171.7	161.5	328.3		63.0
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years) New data	2021/22	–	125	87.2	100.0	103.6	204.4		42.0
Children with one or more decayed, missing or filled teeth	2016/17	–	-	18.8%	25.7%	23.3%	47.1%		12.9%
Population vaccination coverage: MMR for two doses (5 years old) New data <90% 90% to 95% ≥95%	2022/23	→	2,763	89.8%	83.7%	84.5%	56.3%		94.4%
Proportion of New Birth Visits (NBVs) completed within 14 days New data	2022/23	↓	2,033	80.8%	80.7%	79.9%*	13.3%		99.0%
Proportion of infants receiving a 6 to 8 week review New data	2022/23	↓	2,186	73.3%	79.2%	79.6%*	4.9%		98.5%
Proportion of children receiving a 12-month review New data	2022/23	→	2,085	75.9%	85.8%	82.6%*	22.9%		99.0%
Proportion of children who received a 2 to 2½ year review New data	2022/23	→	1,519	52.9%	77.0%	73.6%*	5.3%		98.0%
Proportion of children aged 2 to 2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review New data	2022/23	↑	1,389	91.4%	94.4%	92.5%*	43.7%		100%
Child development: percentage of children achieving a good level of development at 2 to 2 and a half years New data	2022/23	↓	900	64.8%	76.3%	79.2%*	4.1%		94.4%
Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years New data	2022/23	↓	1,058	76.2%	83.0%	85.3%*	12.0%		95.9%
Child development: percentage of children achieving the expected level in gross motor skills at 2 to 2½ years New data	2022/23	↓	1,188	85.5%	92.0%	92.8%*	13.3%		98.8%
Child development: percentage of children achieving the expected level in fine motor skills at 2 to 2½ years New data	2022/23	→	1,234	88.8%	91.9%	92.6%*	13.8%		99.1%
Child development: percentage of children achieving the expected level in problem solving skills at 2 to 2½ years New data	2022/23	→	1,207	86.9%	90.3%	91.8%*	11.3%		98.3%
Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years New data	2022/23	→	1,168	84.1%	89.0%	90.3%*	13.7%		97.2%
School readiness: percentage of children achieving a good level of development at the end of Reception New data	2022/23	–	1,973	67.6%	66.0%	67.2%	58.5%		
School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception New data	2022/23	–	2,432	83.3%	78.1%	79.7%	69.7%		%
School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception New data	2022/23	–	2,031	69.6%	67.4%	68.8%	59.4%		%

[11] OHID Fingertips: Early Years



Better 95% · Similar · Worse 95% · Lower 95% · Similar · Higher 95% · Not applicable

Recent trends: – Could not be calculated · → No significant change · ↑ Increasing & getting worse · ↑ Increasing & getting better · ↓ Decreasing & getting worse · ↓ Decreasing & getting better · ↑ Increasing · ↓ Decreasing

Indicator	Period	Shropshire			Regions (statistical)	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
A&E attendances (under 1 year) New data	2022/23	–	2,135	798.1	1,196.8	1,132.3	2,613.3		505.9
Emergency admissions (under 1 year) New data	2022/23	→	1,205	450.5	411.3	375.4	831.1		131.8
Emergency admissions (0 to 4 years) New data	2022/23	→	2,690	189.4	172.7	158.0	340.1		57.4
Neonatal mortality rate New data	2020 - 22	–	28	3.6	4.5	2.9	5.8		0.9
Post-neonatal mortality rate New data	2020 - 22	–	9	1.2	1.2	1.1	2.8		0.0
Hospital admissions for dental caries (0 to 5 years) New data	2020/21 - 22/23	–	120	228.4	98.0	178.8	0.0		900.9
Admissions for asthma (0 to 9 years) New data	2022/23	→	80	261.9	195.7	154.7	483.1		52.4
Admissions for diabetes (0 to 9 years) New data	2022/23	→	10	32.7	36.9	32.5	94.8		0.0
Admissions for epilepsy (0 to 9 years) New data	2022/23	→	15	49.1	105.7	92.9	272.9		0.0
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act New data	2022/23	–	401	11.9	15.9	16.1	35.8		7.5
Population vaccination coverage: Hepatitis B (1 year old)	2022/23	–	4	100%	*	*	-	-	-
Population vaccination coverage: Dtap IPV Hib HepB (1 year old) <90% 90% to 95% ≥95%	2022/23	→	2,620	95.7%	91.5%	91.8%	67.8%		97.6%
Population vaccination coverage: Hepatitis B (2 years old)	2022/23	–	-	*	*	*	-	-	-
Population vaccination coverage: Dtap IPV Hib HepB (2 years old) <90% 90% to 95% ≥95%	2022/23	→	2,673	96.5%	92.9%	92.6%	70.8%		98.5%
Population vaccination coverage: Hib and MenC booster (2 years old) <90% 90% to 95% ≥95%	2022/23	→	2,616	94.4%	88.2%	88.7%	63.4%		97.2%
Population vaccination coverage: PCV booster <90% 90% to 95% ≥95%	2022/23	→	2,617	94.5%	88.3%	88.5%	67.7%		97.0%
Population vaccination coverage: MMR for one dose (5 years old) <90% 90% to 95% ≥95%	2022/23	→	2,941	95.6%	92.6%	92.5%	81.2%		97.4%
Population vaccination coverage: MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2022/23	→	2,763	89.8%	83.7%	84.5%	56.3%		94.4%
Low birth weight of all babies	2021	→	140	5.3%	7.9%	6.8%	11.0%		3.6%
Very low birth weight of all babies	2021	→	20	0.8%	1.4%	1.0%	2.0%		0.2%
Children aged 5 and under killed or seriously injured in road traffic accidents New data	2020 - 22	–	2	3.8	6.9	7.5	29.9		0.0
Population vaccination coverage: MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2022/23	→	2,622	94.7%	88.9%	89.3%	68.1%		97.3%
Newborn Blood Spot Screening: Coverage	2017/18	–	-	-	98.1%*	96.7%*	-	Insufficient number of values for a spine chart	-
Newborn Hearing Screening: Coverage	2022/23	→	2,242	98.4%	98.7%*	98.5%*	87.9%		99.8%

How these measures relate to the six high impact areas can be found here.

Under 18 conceptions (teenage pregnancy)

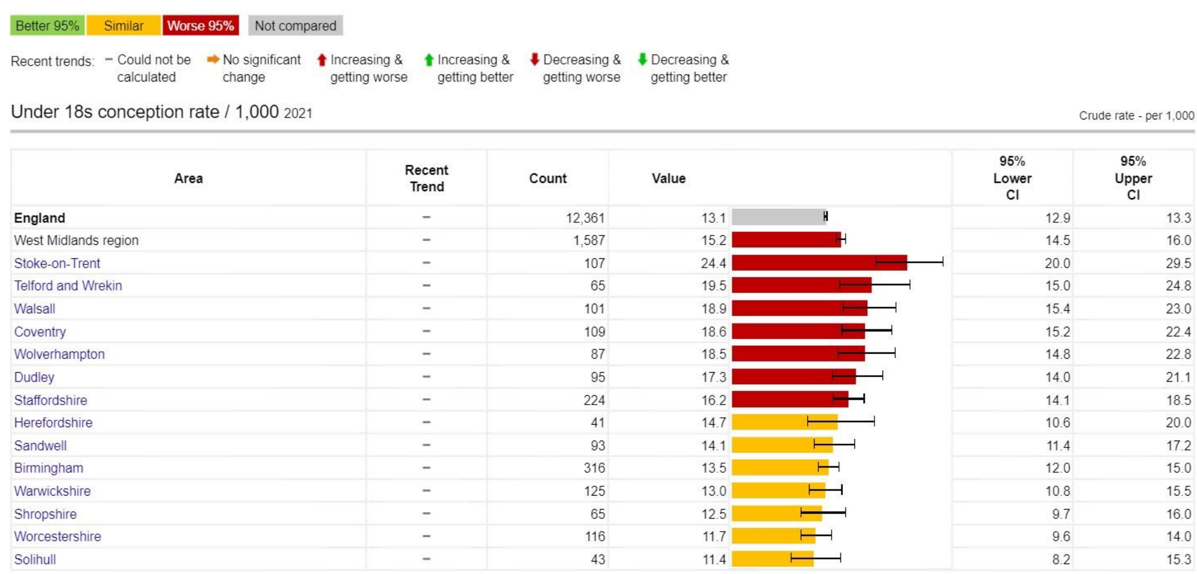
Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS[12]. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty[22].

[12] Public health profiles - OHID (phe.org.uk)

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children[22]. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers[22]. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems[22].

In 2021, there were 65 pregnancies among girls and women aged under 18, equating to rate of 12.5 per 1,000 population, similar to the national rate of 13.1 and below the regional rate. This ranks Shropshire third lowest in the West Midlands[13]. There is no trend data for this measure.

Under 18s conception rate per 1,000 in Shropshire including regional neighbours, with West Midlands and England comparisons, 2021. Source: Child and Maternal Health Profile, Fingertips, OHID



Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

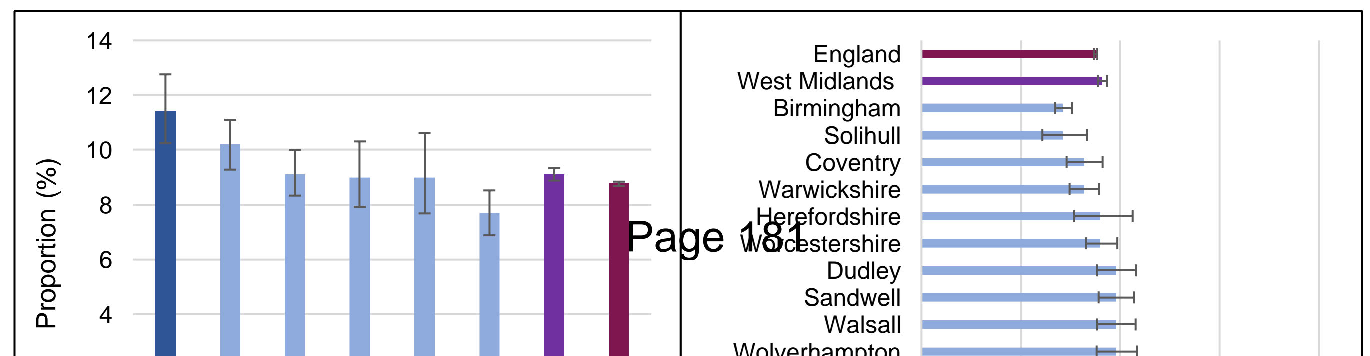
Under 18s conception rate / 1,000 2021 — Crude rate - per 1,000

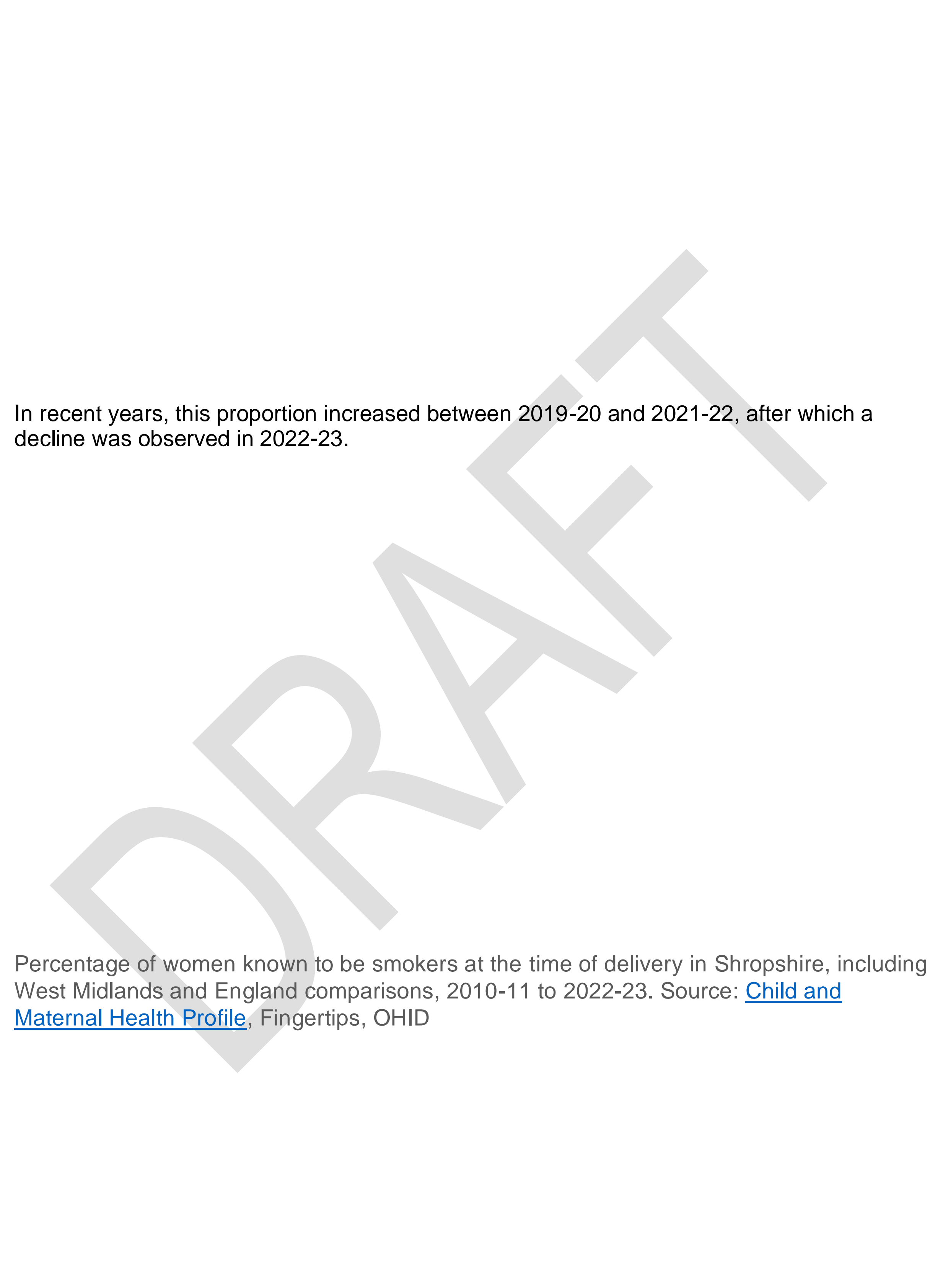
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	12,361	13.1	12.9	13.3
West Midlands region	–	1,587	15.2	14.5	16.0
Stoke-on-Trent	–	107	24.4	20.0	29.5
Telford and Wrekin	–	65	19.5	15.0	24.8
Walsall	–	101	18.9	15.4	23.0
Coventry	–	109	18.6	15.2	22.4
Wolverhampton	–	87	18.5	14.8	22.8
Dudley	–	95	17.3	14.0	21.1
Staffordshire	–	224	16.2	14.1	18.5
Herefordshire	–	41	14.7	10.6	20.0
Sandwell	–	93	14.1	11.4	17.2
Birmingham	–	316	13.5	12.0	15.0
Warwickshire	–	125	13.0	10.8	15.5
Shropshire	–	65	12.5	9.7	16.0
Worcestershire	–	116	11.7	9.6	14.0
Solihull	–	43	11.4	8.2	15.3

Smoking status at time of delivery

In the period 2022-23, 11.4% of women in Shropshire were known to be smokers at the time of delivery, a proportion significantly worse than the West Midlands average of 9.1% and England average of 8.8%. Shropshire currently ranks third highest in the West Midlands region and highest among its statistical neighbours[14].

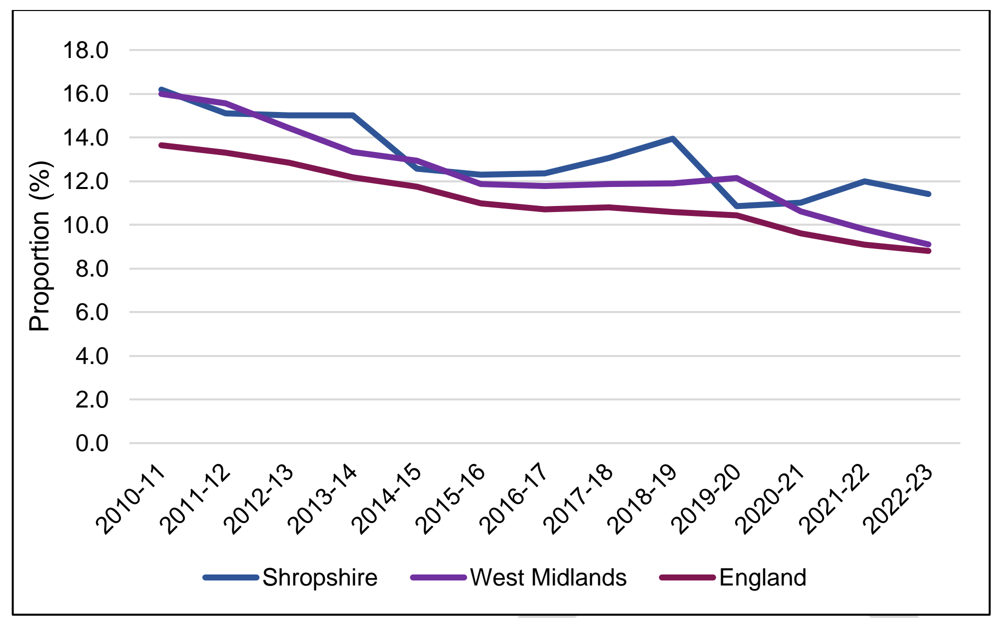
Percentage of women known to be smokers at the time of delivery in Shropshire including statistical and regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID





In recent years, this proportion increased between 2019-20 and 2021-22, after which a decline was observed in 2022-23.

Percentage of women known to be smokers at the time of delivery in Shropshire, including West Midlands and England comparisons, 2010-11 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Low birth weight

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life[15].

In 2021, 1.8% of infants (gestational age of at least 37 complete weeks) were born with a low birthweight, a proportion better than the West Midlands average of 3.0% and England average of 2.8%[16]. This proportion has been falling in Shropshire compared to the previous two years and currently ranks Shropshire second lowest in the West Midlands region and second lowest compared to its statistical neighbours.

Percentage of low of birth weight of infants in Shropshire, including statistical and regional neighbours, with West Midlands and England comparisons, 2021. Source: Child and Maternal Health Profile, Fingertips, OHID

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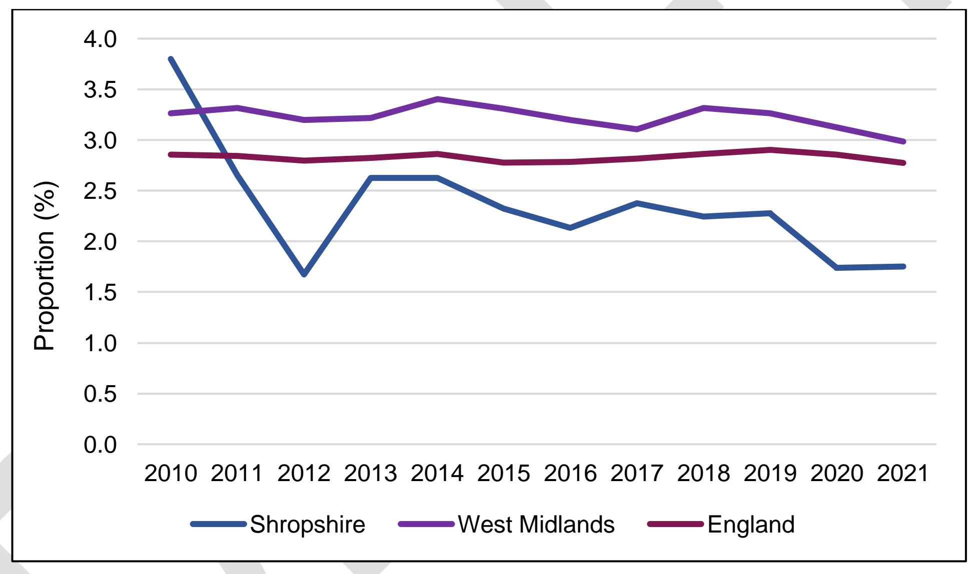
Percentage of low of birth weight of infants in Shropshire, including West Midlands and England comparisons, 2010 – 2021. Source: Child and Maternal Health Profile, Fingertips, OHID



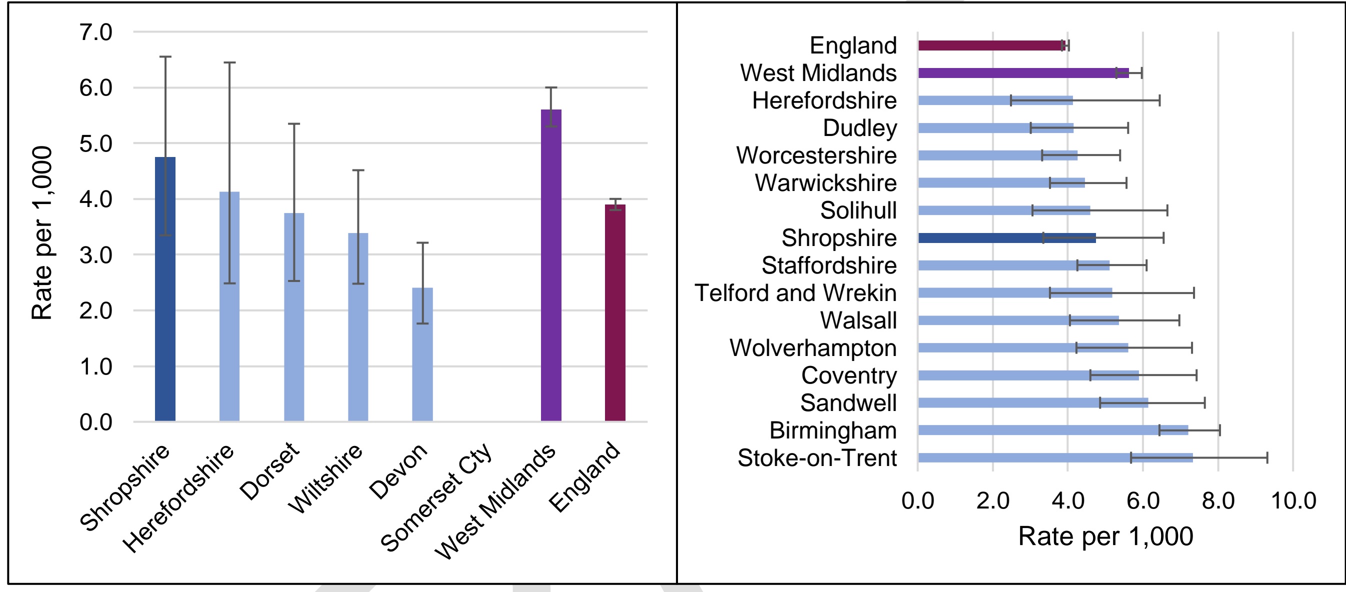
Infant mortality

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the

first 28 days of life in particular, are considered to reflect the health and care of both mother and new-born [17].

In the period 2020-22, there were 37 deaths under one year of age in Shropshire. This equates to an infant mortality rate of 4.8 per 1,000 live births[18]. This is the sixth lowest regionally, similar to the regional rate of 5.6 per 1,000 and the national rate of 3.9 per 1,000 live births. Shropshire's rate was the highest compared to its statistical neighbours.

Infant mortality rate in Shropshire including statistical and regional neighbours, with West Midlands and England comparisons, 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID



Shropshire's rate increased between 2014-16 and 2018-20 but recently has started to level off. Overall, the national rate has been declining over time however now remains steady compared to the previous period.

Infant mortality rate in Shropshire, including West Midlands and England comparisons, 2009-11 to 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID

[17] Child and Maternal Health - Data - OHID (phe.org.uk)
[18] Child and Maternal Health - Data - OHID (phe.org.uk)

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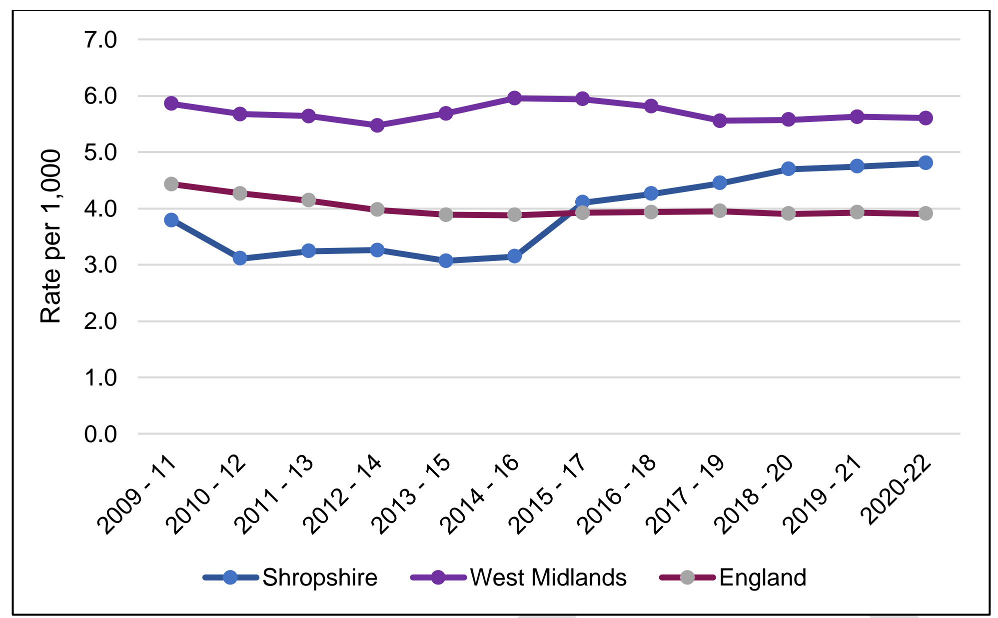

Neonatal mortality

In 2015, the Government announced an ambition to reduce the rate of stillbirths, neonatal and maternal deaths by 50% by 2030[19]. The Maternity Transformation Programme brings together a range of organisations and stakeholders to deliver on this ambition, among others[28]. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn[28]. The first 28 days of life – the neonatal period – represent the most vulnerable time for a child's survival[28].

In the period 2019-21, there were 29 neonatal deaths (deaths under 28 days) in Shropshire. This equates to a neonatal mortality rate of 3.7 per 1,000 live births[20]. This rate was the 5th lowest rate regionally, significantly lower to the regional rate of 4.3 per 1,000 and similar to the national rate of 2.8 per 1,000 live births. Shropshire's rate was the second highest compared to its statistical neighbours.

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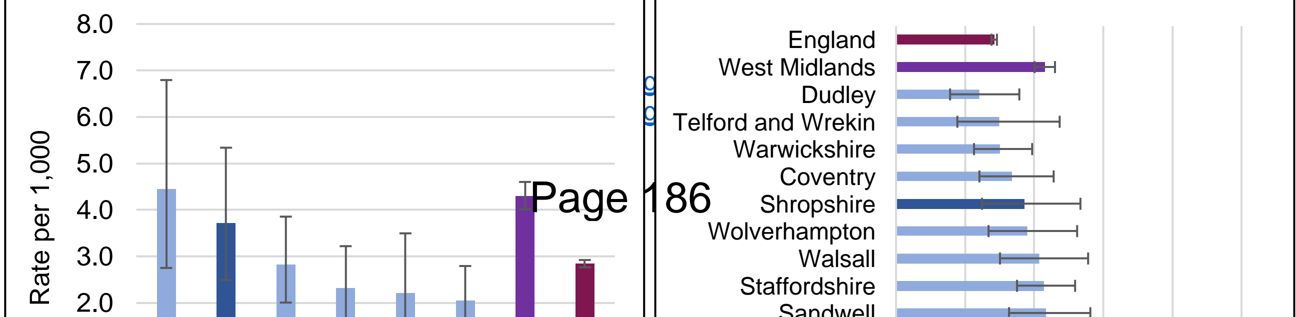
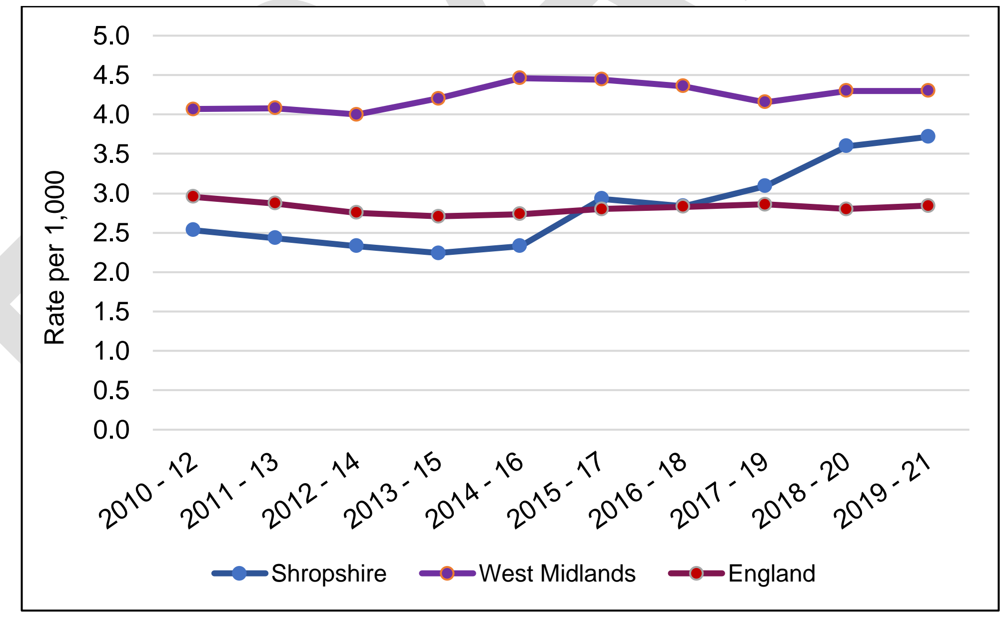
Neonatal mortality rate in Shropshire, including statistical and regional neighbours, with West Midlands and England comparisons, 2019-21. Source: Child and Maternal Health Profile, Fingertips, OHID



Neonatal mortality rate in the period 2019-21 was highest in males – 4.0 per 1,000 live births compared to females – 3.4 per 1,000 live births. As shown in the figure below, neonatal mortality in Shropshire has been increasing since 2014-16. This is opposite to the trend observed regionally and nationally where rates are levelling off.

Neonatal mortality rate in Shropshire, including West Midlands and England comparisons, 2010-12 to 2019-21. Source: Child and Maternal Health Profile, Fingertips, OHID



Stillbirth rate

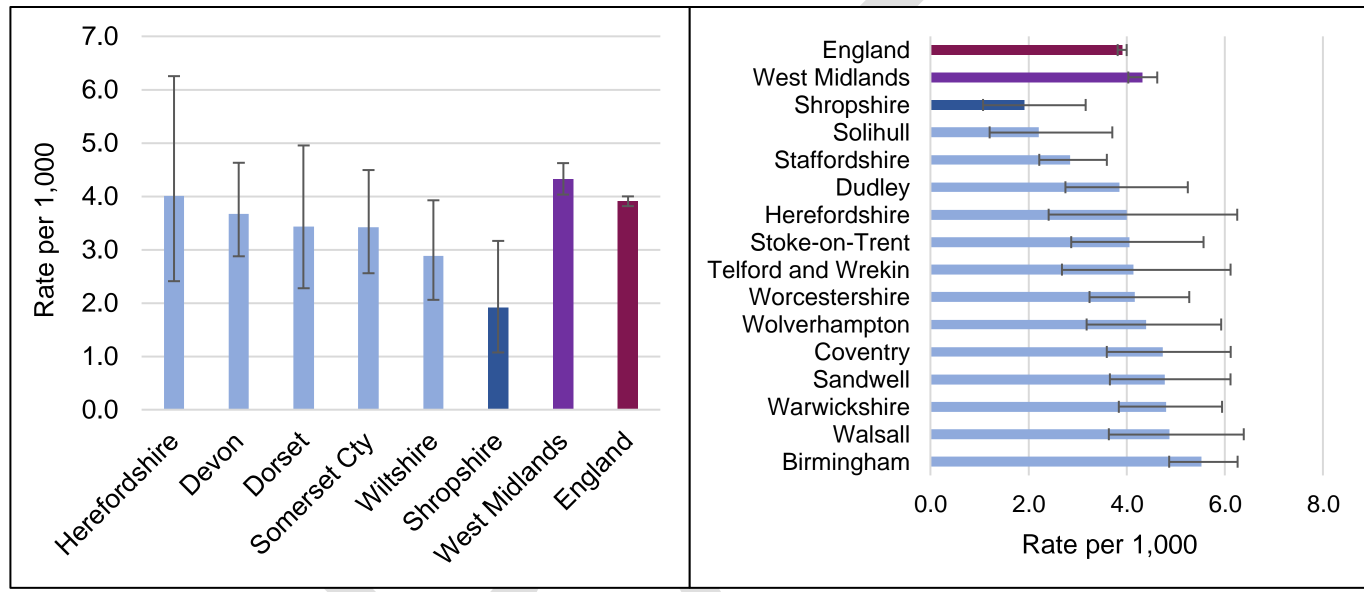
Stillbirth rates in the United Kingdom have shown little change over the last 20 years, and the rate remains among the highest in high income countries[21]. Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, and history of mental health problems, antepartum haemorrhage and fetal growth restriction (birth weight

[21] Child and Maternal Health - Data - OHID (phe.org.uk)

below the 10th customised weight percentile)[30]. In 2015 the government announced an ambition to halve the rate of stillbirths by 2030[30].

In the period 2019-21, there were 15 stillbirths (fetal deaths occurring after 24 weeks of gestation) in Shropshire[22]. This equates to a rate of 1.9 per 1,000 births. This rate was the lowest regionally, significantly lower than the regional rate of 4.3 per 1,000 and the national rate of 3.9 per 1,000[31]. Shropshire's rate was the lowest among its statistical neighbours as shown in the figure below.

Neonatal mortality rate in Shropshire including statistical and regional neighbours, with West Midlands and England comparisons, 2019-21. Source: Child and Maternal Health Profile, Fingertips, OHID



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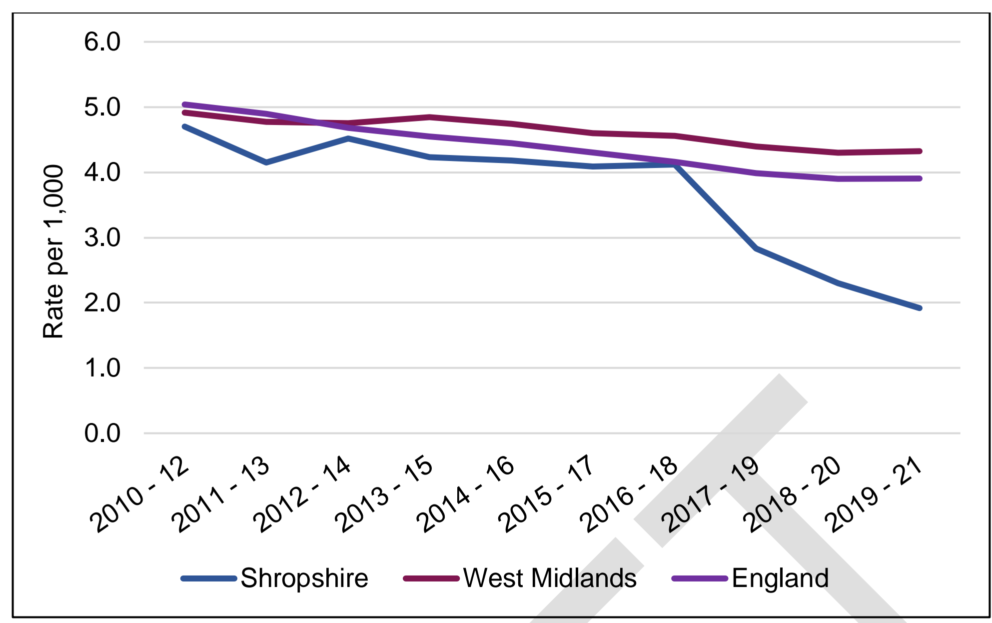
As shown in the figure below, Shropshire's stillbirth rate has decreased since 2010-12, with a 54% decrease seen between 2016-18 and 2019-21. Overall, the national and regional rate has been declining over time (since 2010-12).

Stillbirth rate in Shropshire, including West Midlands and England comparisons, 2010-12 to 2019-21. Source: Child and Maternal Health Profile, Fingertips, OHID

[22] Child and Maternal Health - Data - OHID (phe.org.uk)



Post-neonatal mortality

In the period 2019-21, there were 8 post-neonatal deaths (deaths occurring between 28 days and 1 year) in Shropshire[23]. This equates to a rate of 1.0 per 1,000 births. This rate was the 5th lowest regionally, similar to the regional rate of 1.3 per 1,000 and the national rate of 1.1 per 1,000. Shropshire's rate was the 2nd highest among its statistical neighbours as shown in the figure below.

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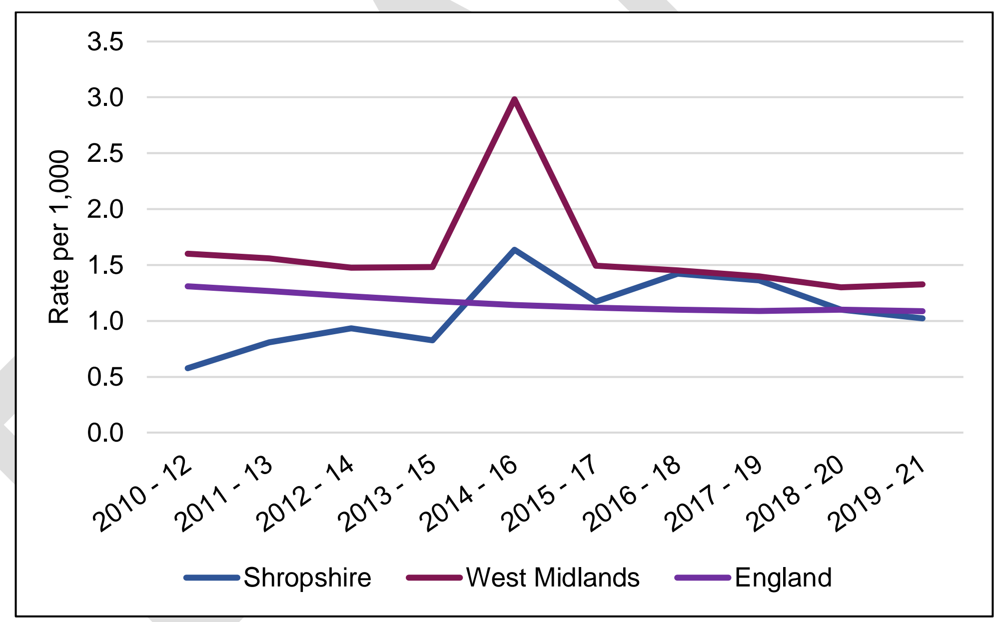
Post-neonatal mortality rate in Shropshire, including statistical and regional neighbours, with West Midlands and England comparisons, 2019-21. Source: Child and Maternal Health Profile, Fingertips, OHID

Shropshire's rate saw an increase between 2010-12 and 2014-16, after which a steady decrease in rate was observed. This trend is in line with what was observed regionally. Overall, the national rate has been stable and declining over time (since 2010-12).

Post-neonatal mortality rate in Shropshire, including West Midlands and England comparisons, 2010-12 to 2019-21. Source: Child and Maternal Health Profile, Fingertips, OHID



Breastfeeding

Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants (Quigley et al 2007.) Breast milk provides the ideal nutrition for infants in the first stages of life.

There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity. Mothers who do not breastfeed have an increased risk of

breast and ovarian cancers and may find it more difficult to return to their pre-pregnancy weight (World Cancer Research Fund; DH, cited in NICE Public health guidance PH11 [24]).

Current national and international guidance recommends exclusive breastfeeding for new-borns and for the first six months of infancy [25].

Increasing rates of breastfeeding initiation and continuation is also recommended within the DH Healthy Child Programme Breastfeeding initiation and uptake at 6-8 weeks are included in the NICE proposals for the Commissioning Outcomes Framework.

The longer-term strategic solution for data collection and reporting for this indicator is NHS Digital's Community Services Dataset (formerly the Children and Young Peoples (CYPHS) data set). It is mandatory for the providers of public funded services to submit the dataset to NHS Digital. Whilst the data set is operational and reporting has begun, providers are at different stages of maturity with their submissions or readiness to flow the data therefore it is expected to take some additional time for this data set to reach sufficient coverage for reporting purposes.

In addition to the statutory checks, breastfeeding and healthy start vouchers/vitamins are two other key service indicators for health and wellbeing

Breastfeeding prevalence at 6-8 weeks after birth

Shropshire's published breastfeeding data on OHID's Fingertips platform has data quality issues, which means comparisons to the regional and national average are not possible. Note: the denominator for this national measure is the number of infants due a 6-8 week review.

During 2022-23, in Shropshire, 917 infants were reported to be totally or partially breastfed at age 6-8 weeks [26]. A rise compared to the previous year's figure of 858 infants.

Breastfeeding prevalence at 6-8 weeks after birth in Shropshire, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

[24] https://www.nice.org.uk/guidance/ph11/chapter/2-public-health-need-and-practice

[25] http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/index.html http://www.nice.org.uk/nicemedia/live/11943/40097/40097.pdf

[26] **Definition:**
This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food. Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age. The numerator is the count of the number of infants recorded as being totally breastfed at 6-8 weeks and the number of infants recorded as being partially breastfed. The denominator is the total number of infants due a 6-8 weeks check.

Recent trend: Could not be calculated

Period		Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
	Shropshire						
2015/16	●	1,272	45.9%	44.0%	47.8%	*	43.2%*
2016/17		1,533	*	-	-	*	44.4%*
2017/18		1,360	*	-	-	*	43.1%*
2018/19		1,188	*	-	-	*	46.2%*
2019/20		1,030	*	-	-	*	48.0%*
2020/21		738	*	-	-	*	47.6%*
2021/22		858	*	-	-	*	49.2%*
2022/23		917	*	-	-	*	49.2%*

Source: OHID's (formerly PHE) interim reporting of health visiting metrics

To give an indication of the breastfeeding prevalence trends in Shropshire, the rate has been calculated using data from the provider, which has not yet been validated. Please treat with caution.

Provider data

The below data has not yet been validated but gives an indication of progress and direction of travel.

Prevalence of breastfeeding in Shropshire including number of infants partially/totally breastfed at 6-8 weeks and number of infants due a 6-8 week review, 2021-22 to 2022-23. Source: SHROPCOM Provider data

The annual breastfeeding prevalence for 2022/23 for Shropshire was 30.6%, below the national average of 49.2%. Whilst Shropshire's rate of babies breastfed at 6-8-weeks is below the national average, there has been a steady improvement quarter on quarter.

There is a rising trend in breastfeeding prevalence over time in Shropshire. At the end of Q4 2023/24, one third (49%) of infants due a 6-8 week check were partially or totally breastfed. This is the highest quarterly prevalence of breastfeeding since Q4 of 2021/22.

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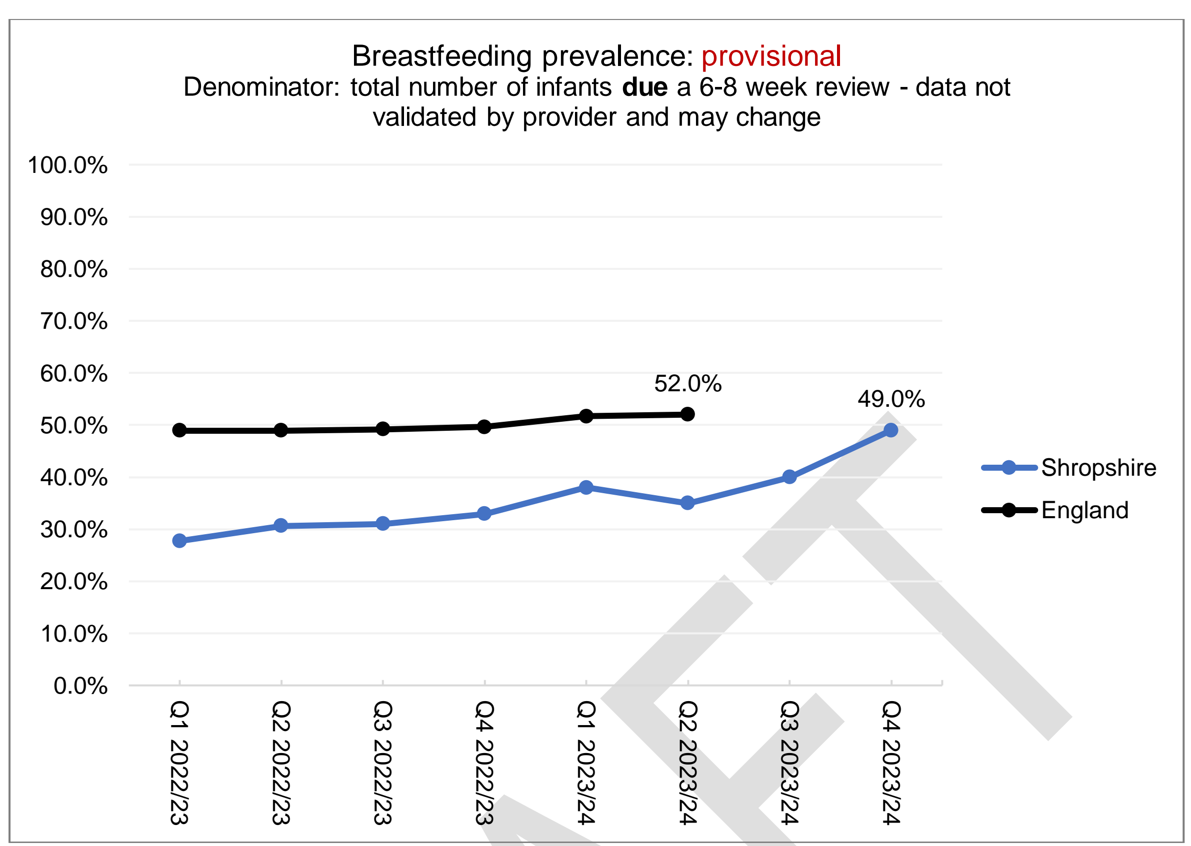

To view rates of breastfeeding where the denominator is the number of infants who received a 6-8 week review- see here.

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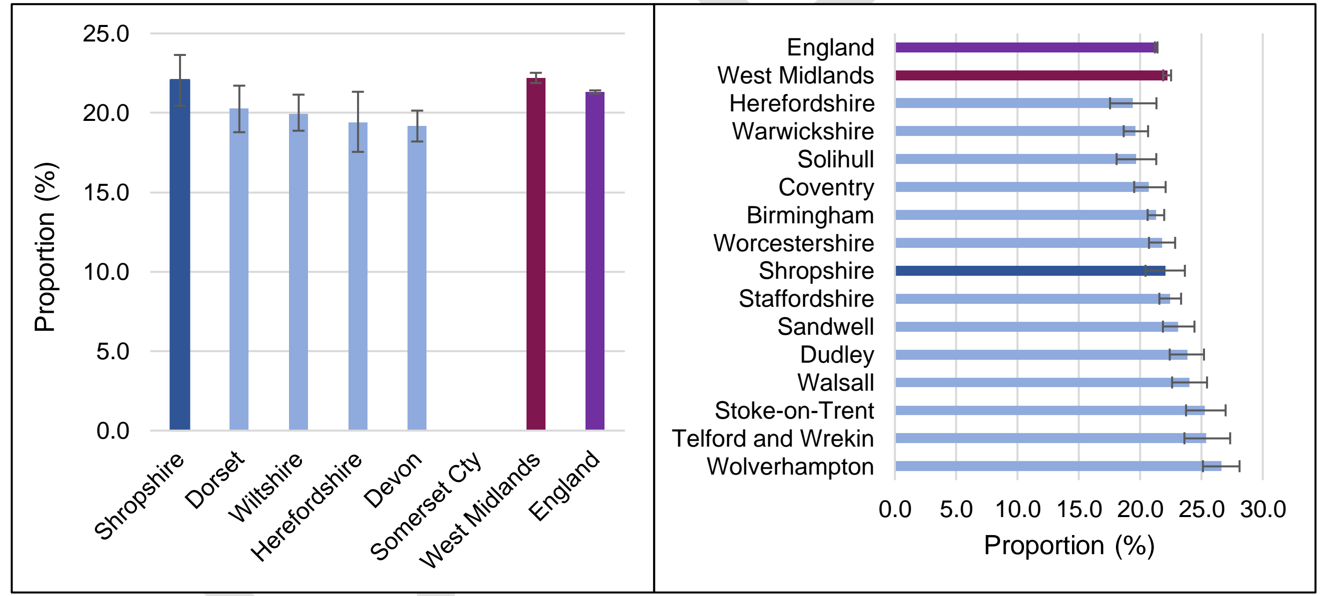
Overweight (including obesity) – Reception

Studies tracking child obesity into adulthood have found that the probability of children who are overweight or living with obesity becoming overweight or obese adults increases with age[27]. The health consequences of childhood obesity include increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying[29].

In the period 2022-23, 22.1% reception aged children (4–5-year-olds) were overweight or obese in Shropshire, a rate similar to the national average of 21.3% and to the regional average of 22.2%[28]. This proportion was the 7th lowest regionally and Shropshire's proportion was the highest among its statistical neighbours as shown in the figure below.

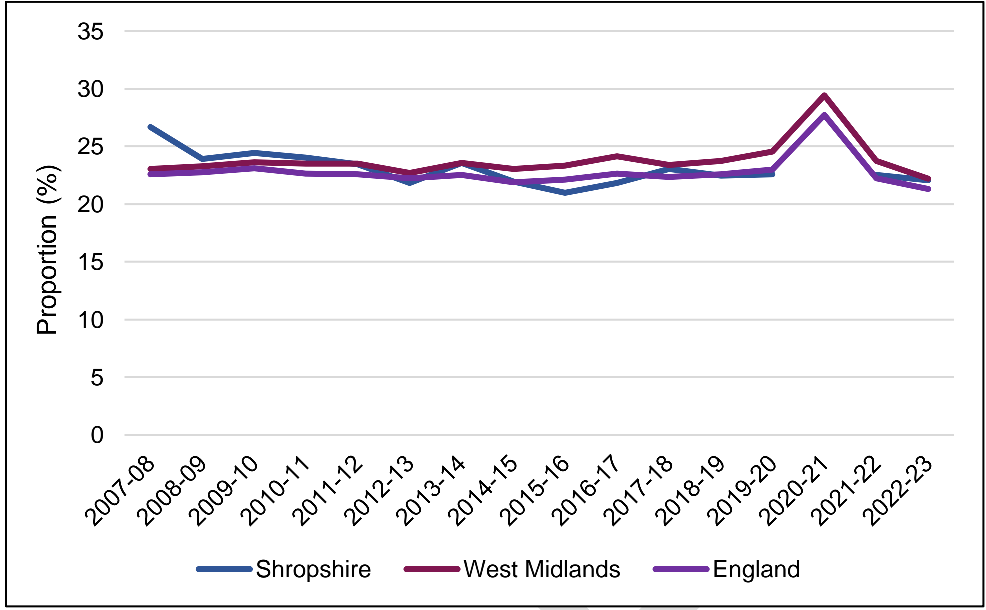
Proportion of children aged 4 to 5 years classified as overweight or living with obesity in Shropshire including statistical and regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



This proportion has decreased steadily over the last three years, however data from 2020-21 is missing. (2019/20 NCMP year was stopped due to the lockdown, and in 2020/21 areas were asked to only sample 10% of children, again due to COVID).

[27] Child and Maternal Health - Data - OHID (phe.org.uk)
[28] Child and Maternal Health - Data - OHID (phe.org.uk)

Proportion of children aged 4 to 5 years classified as overweight or living with obesity in Shropshire, including West Midlands and England comparisons, 2007-08 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Gobowen, Selattyn and Weston Rhyn 15.6%, Harlescott 14.0% and St Martin's 13.9% had the highest % of children in reception year (aged 4-5) classified as obese (2019 to 2022).

Map showing % of children in reception year (aged 4-5) classified as obese (2019 to 2022). Children are classified as obese where their BMI is greater than or equal to the 95th centile of the British 1990 growth reference. Data is collected by the National Child Measurement Programme, Health and Social Care Information Centre. Note the gaps in the mapped data are where data is not published due to small numbers of children in reception year in these areas.

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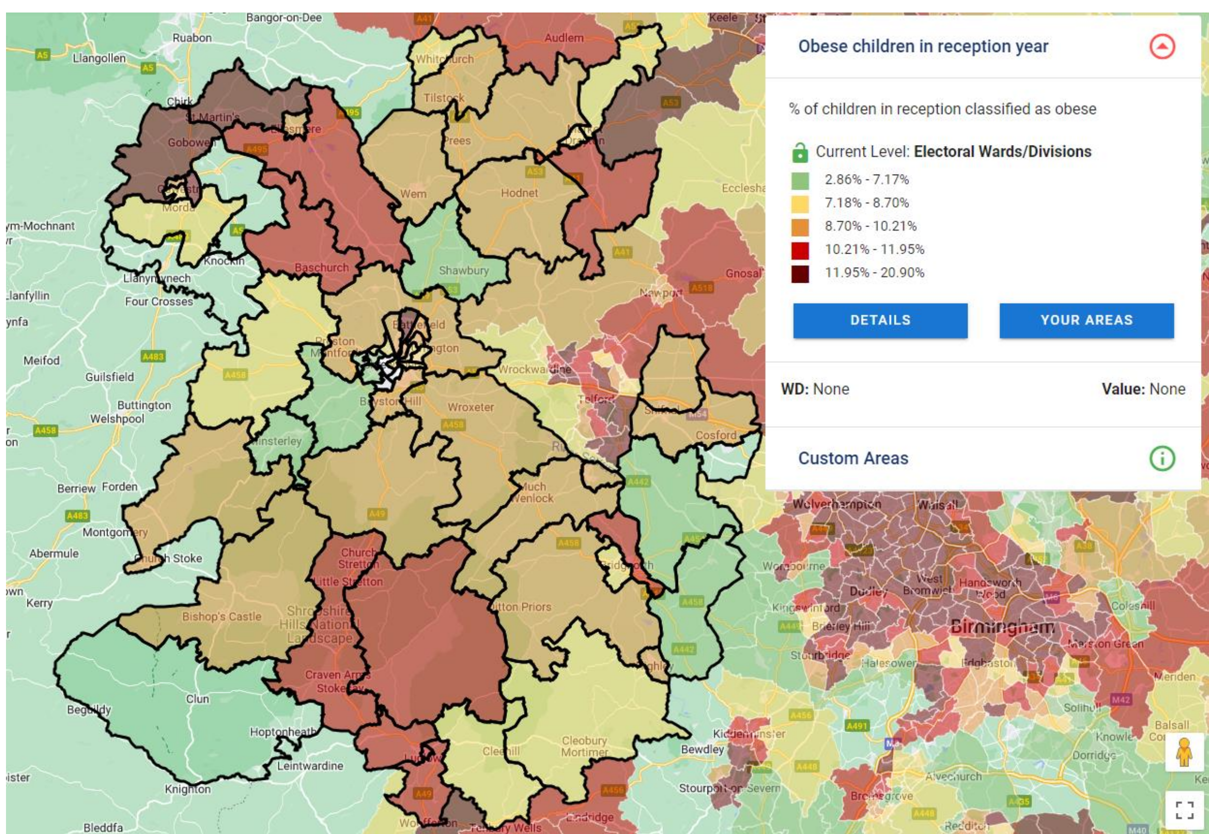


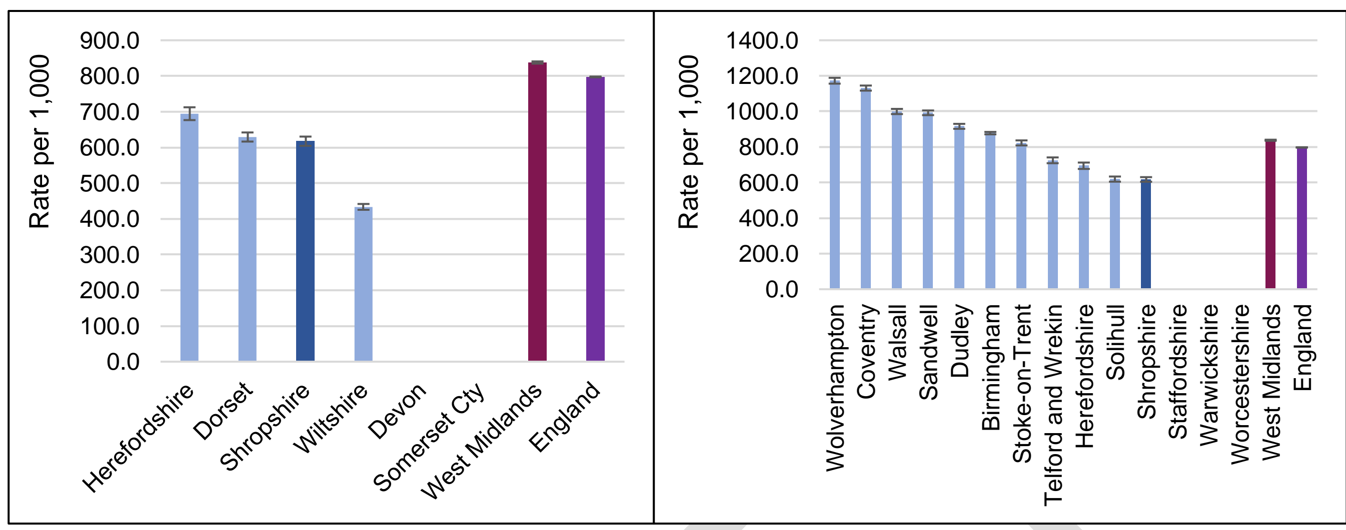
A&E Attendances (0-4s)

A&E attendances in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care[29].

In the period 2022-23, Shropshire's A&E attendance rate was 617.3 per 1,000 population. This equates to 8,765 attendances among children under five years old[30]. This was significantly better than the regional average of 837.7 per 1,000 and the national average of 797.3 per 1,000[32]. Shropshire had the fourth lowest A&E attendance in the region and among its statistical neighbours.

[29] Child and Maternal Health - Data - OHID (phe.org.uk)
[30] Child and Maternal Health - Data - OHID (phe.org.uk)

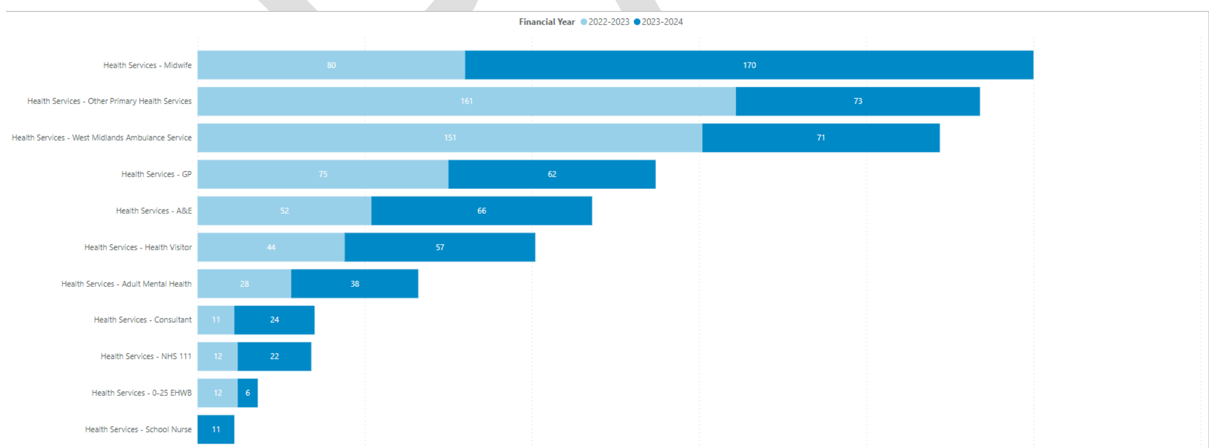
A&E attendance rate per 1,000 population aged 0-4 years in Shropshire and its statistical and regional neighbours, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Whilst Shropshire's rate of A&E attendances is lower than the national average, the number of 0-4 year old Children's Social Care contacts from A&E has risen among compared to the previous year, with 66 contacts in 2023-24 compared to 52 in 2022-23, a 27% rise year on year.

Other contact sources which have risen are Midwives (doubling compared to the previous year), health visitors (rise of 30%) and adult mental health services (rise of 36%).

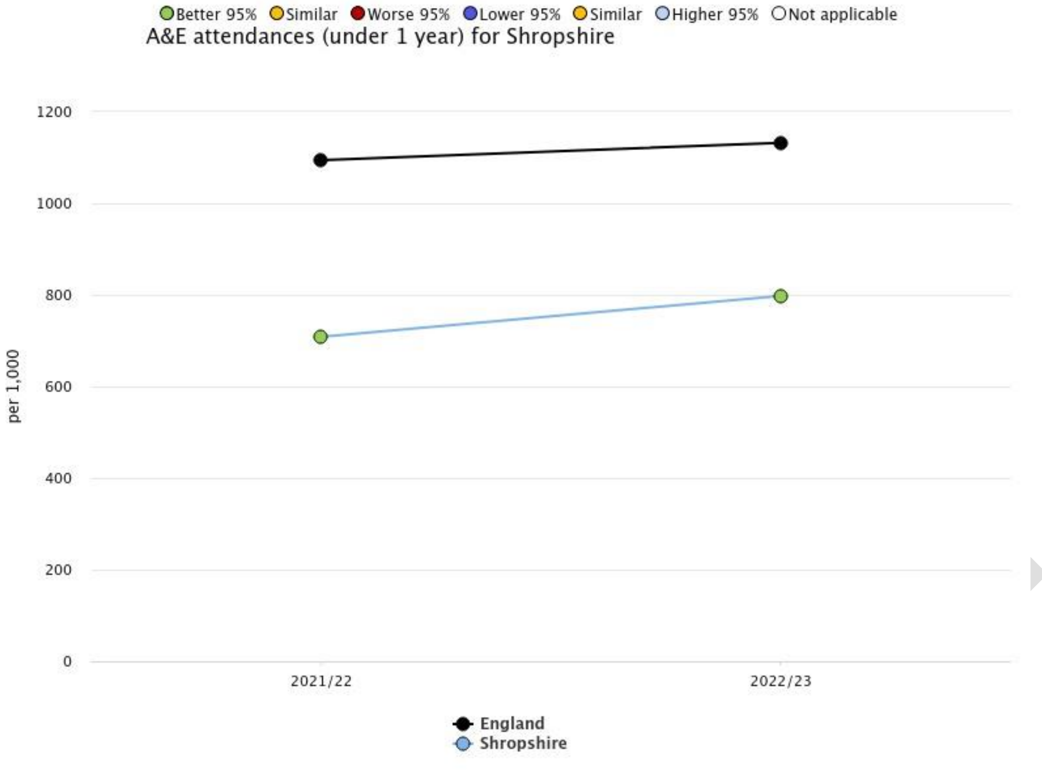
Chart showing the contact source for contacts with Children's social care aged 0-4, 2022-23 and 2023-24 across Shropshire. Source: Children's Services, Shropshire Council.



- ## A&E attendances (under 1 year)

During 2022/23, there were 2,135 A&E attendances among babies under 1 in Shropshire, equating to a rate of 798.1 per 1,000 babies aged under 1. Shropshire's rate has risen slightly compared to the previous year, however this is still below the national rate of 1,132.3. Shropshire has the second lowest rate of attendances in the West Midlands region and is mid table among it's statistical nearest neighbours.

Chart showing A&E attendances for babies under 1 years old in Shropshire. Source: Fingertips



Emergency admissions (aged 0 to 4 years)

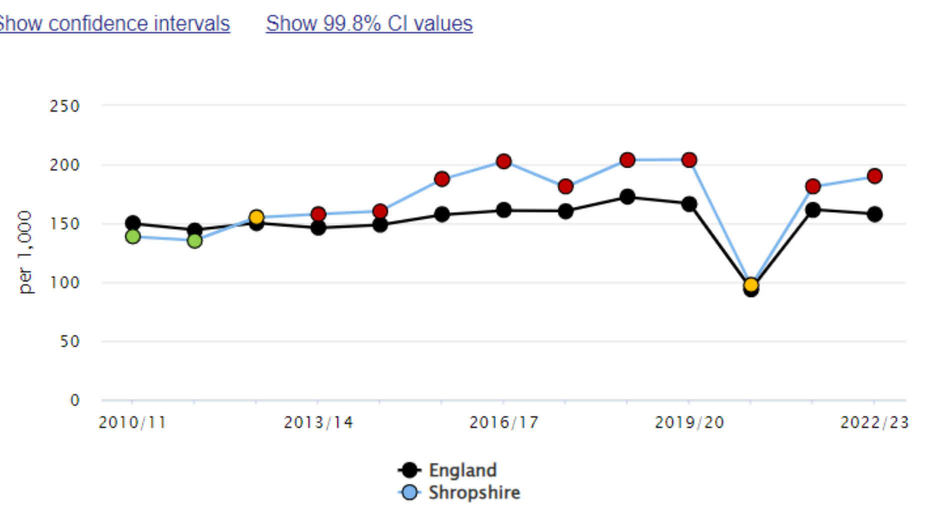
Approximately 35% of all admissions in the NHS in England are classified as emergency admissions, costing approximately £11 billion a year[31]. Admitting a patient to hospital as an emergency case is costly and frequently preventable, yet the number of emergency admissions to hospital has been rising for some time. From a public health point of view, emergency admissions data gives an indication of wider determinants of poor health, linked to areas such as housing and transport.

Over one quarter of emergency hospital admissions in children aged under 5 years in 2014-15 were for respiratory infections[33]. Factors such as smoking in the home and damp housing are known to increase the risk and severity of respiratory infections in young children.

Shropshire's rate has been above the national average since 2013-14. More recently, there has been a rise in emergency admissions, up from 181.0 per 1,000 in 2021-22 to 189.4 per 1,000 in 2022/23 [32]. This equates to 2,690 admissions, significantly worse than the national average of 158.0 per 1,000 and the regional average of 172.7 per 1,000[34]. Shropshire's rate was the 6th highest regionally and the 3rd lowest among its statistical neighbours in 2022-23.

Rate of emergency admissions (per 1,000) among 0 to 4 years old in Shropshire and England over time. Source: Child and Maternal Health Profile, Fingertips, OHID

[31] Child and Maternal Health - Data - OHID (phe.org.uk)
[32] Child and Maternal Health - Data - OHID (phe.org.uk)



Definition: Emergency admissions via A&E, GPs, Consultant outpatient clinic, Mental Health Services or Baby born at home as intended

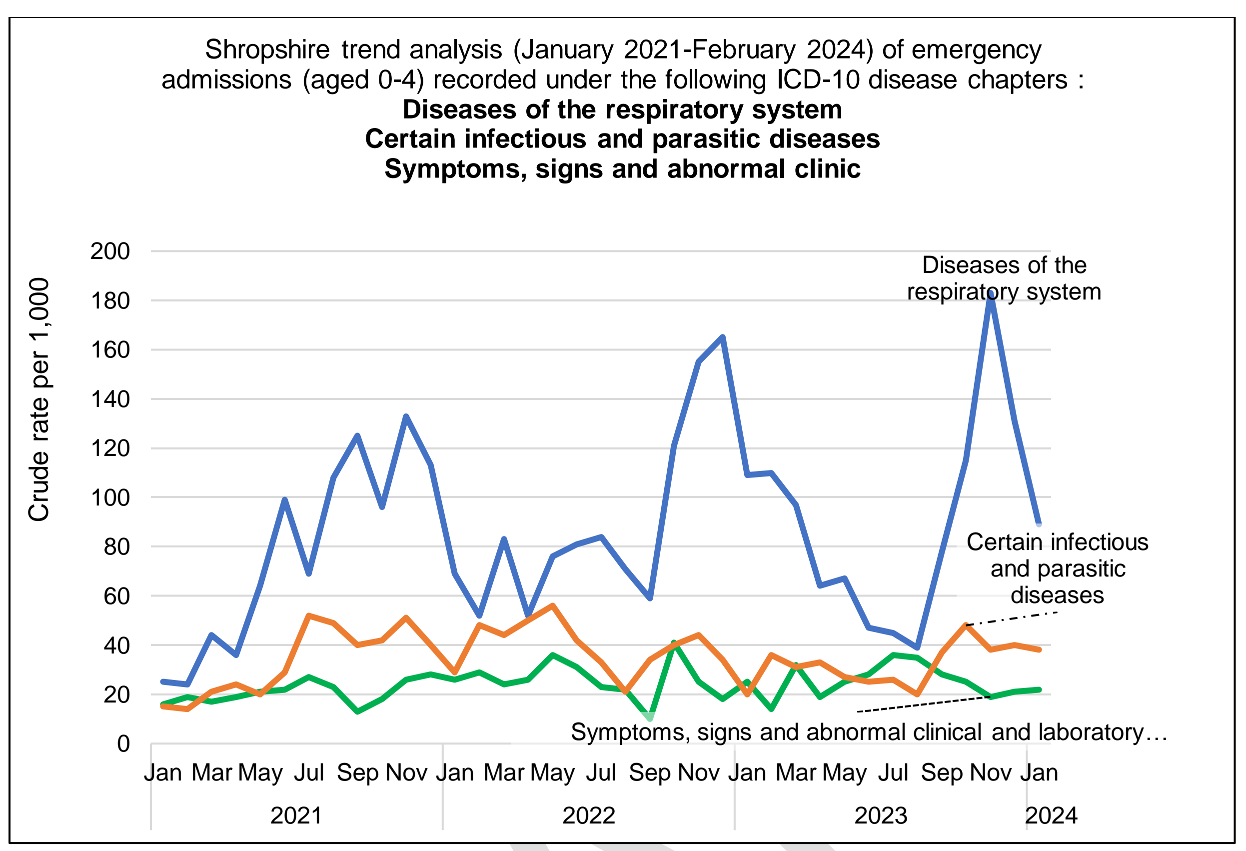
In 2022/23, more than two thirds of 0-4 emergency admissions were for three reasons:

- **Diseases of the respiratory system** (43%)
- **Certain infectious and parasitic diseases** (16%)
- **Symptoms, signs and abnormal clinical and laboratory findings,** not elsewhere classified (includes fevers, febrile illness, nausea and vomiting) (11%)
- Breaking these reasons down, showed acute **upper respiratory infection**, **viral infections** and **fevers** as key drivers

However, across Shropshire, Telford and Wrekin, half (53%) of 0-4 admissions recorded during the 2022/23 period had a zero length of stay.

This is due to the paediatric assessment unit referring babies and children into hospital for tests and monitoring followed by a same day discharge. Shropshire does not have a Same Day Emergency Care (SDEC) offer which, if in place, could reduce the rate of emergency admissions.

Seasonal pattern to the respiration admissions in persons aged 0-4, with activity peaking around December each year

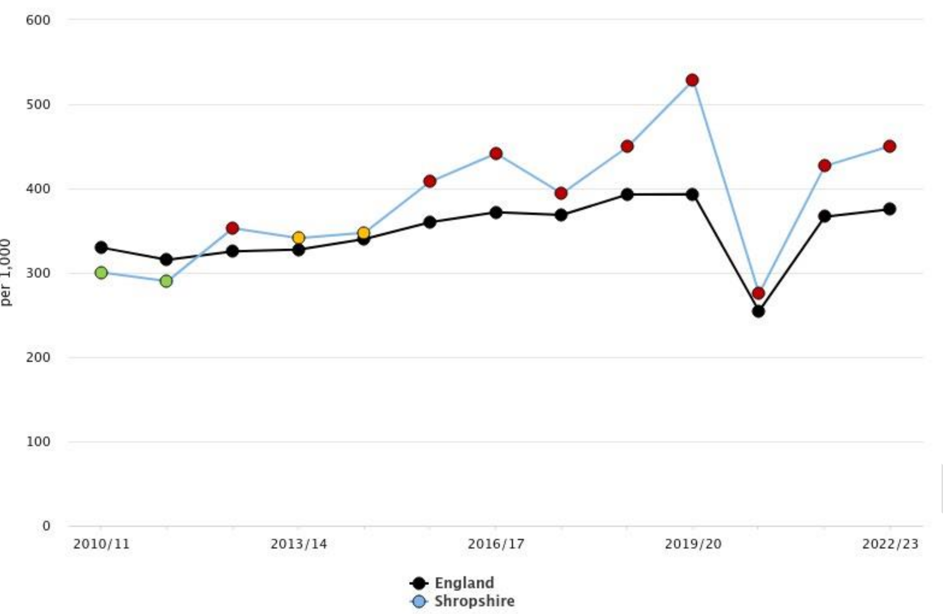


Emergency admissions (under 1)

Shropshire's rate has been above the national average since 2015-16. More recently, there has been a rise in emergency admissions among babies under 1, up from 426.6.0 per 1,000 in 2021-22 to 450.5 per 1,000 in 2022/23 [33]. This equates to 1,205 admissions, significantly worse than the national average of 375.4.0 per 1,000 and the regional average of 411.3 per 1,000[34]. Shropshire's rate was the 6th highest regionally and the 6th lowest among its 15 NHS England statistical neighbours in 2022-23.

Rate of emergency admissions (per 1,000) under 1 years old in Shropshire and England over time. Source: Child and Maternal Health Profile, Fingertips, OHID

[33] Child and Maternal Health - Data - OHID (phe.org.uk)



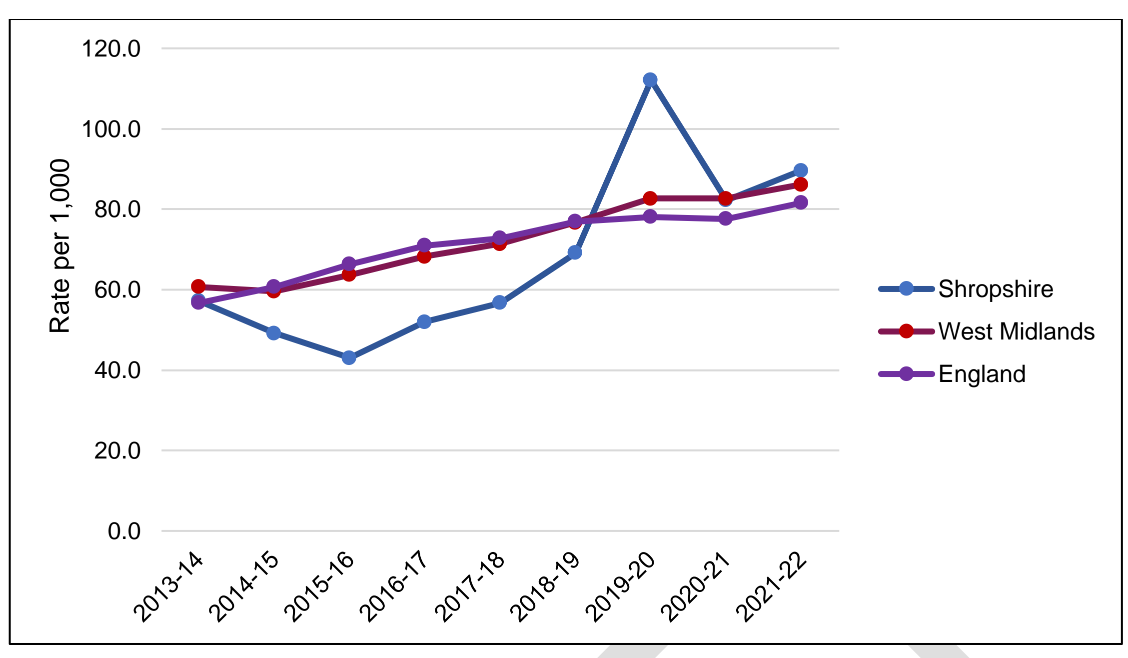
Admission of babies under 14 days

High levels of admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home[34]. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding[33].

In the period 2021-22, there were 195 emergency admissions of babies under 14 days in Shropshire[35]. This equates to a rate of 89.7 per 1,000 deliveries. This rate was the 7th highest regionally, similar to the regional rate of 86.2 per 1,000 and the national rate of 81.6 per 1,000[34].

Emergency admissions from babies aged 0-13 days (inclusive) expressed as a crude rate per 1,000 deliveries in Shropshire, including West Midlands and England comparisons, 2013-14 to 2021-22. Source: Child and Maternal Health Profile, Fingertips, OHID

[34] Child and Maternal Health - Data - OHID (phe.org.uk)
[35] Child and Maternal Health - Data - OHID (phe.org.uk)



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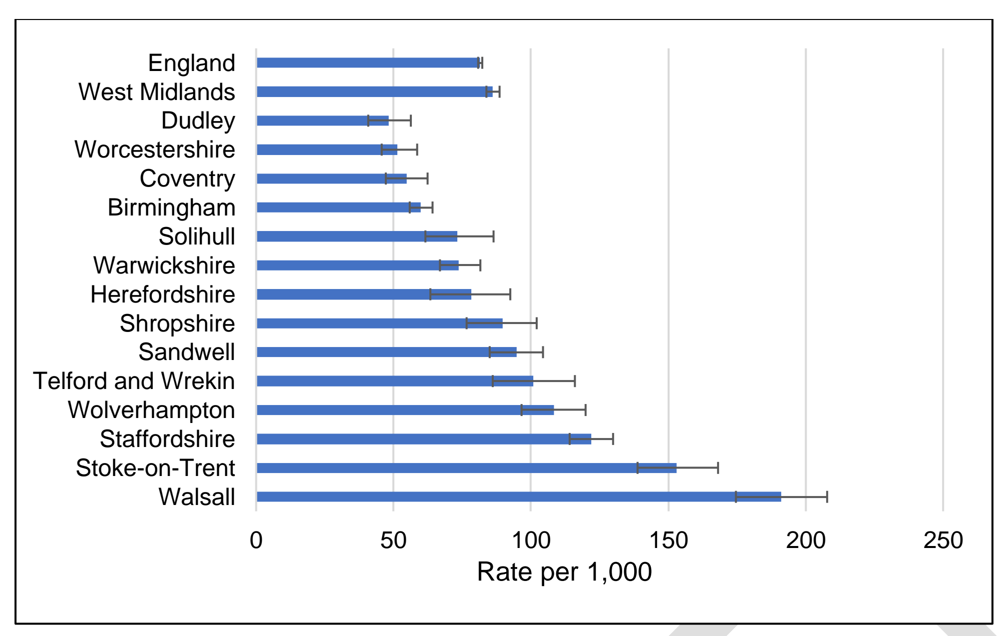
Emergency admissions from babies aged 0-13 days (inclusive) expressed as a crude rate per 1,000 deliveries in Shropshire including statistical and regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



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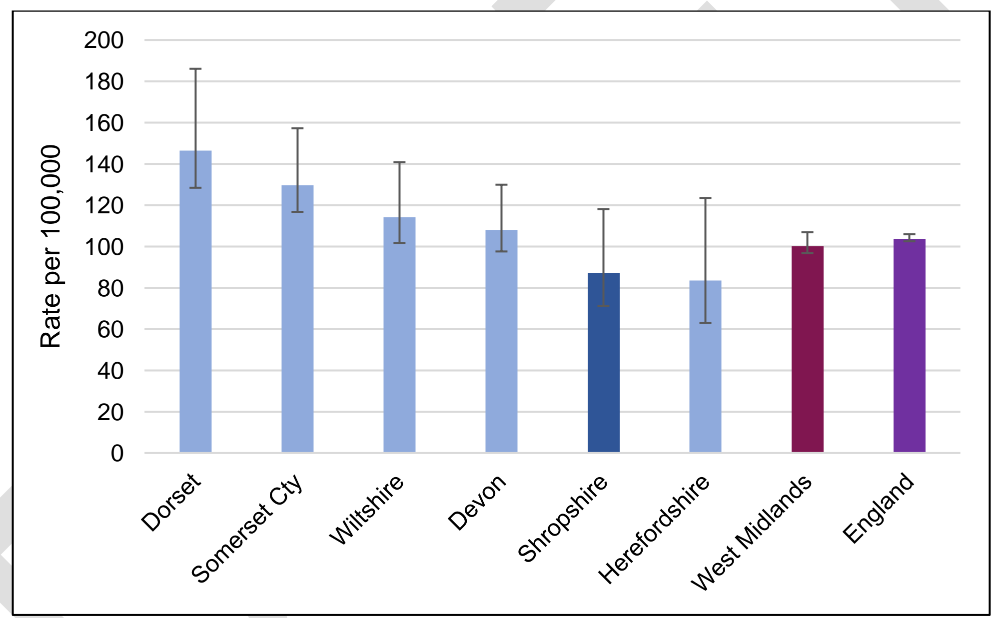
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years)

Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people[36]. They are also a source of long-term health issues, including mental health related to experience(s).

During 2021-22, Shropshire's rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years) was 87.1 per 10,000 population aged 0-4[37]. This equated to 125 admissions and was significantly below the regional average of 100.1 per 10,000 and national average of 103.6 per 10,000[36]. Shropshire's rate was among the lowest regionally and among its statistical neighbours.

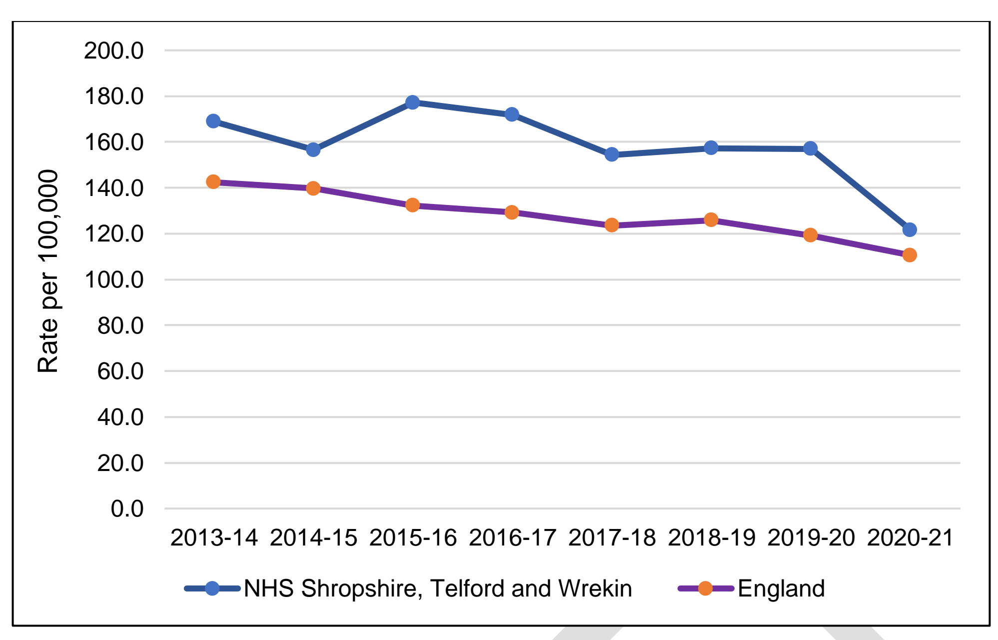
Rate of hospital admissions (per 100,000) among 0 to 4 years old due to unintentional and deliberate injuries in Shropshire and its statistical neighbours, including West Midlands and England comparisons, 2021-22. Source: Child and Maternal Health Profile, Fingertips, OHID



Rate in Shropshire, Telford and Wrekin has seen a steady decrease since 2013-14, from 168.9 per 100,000 in 2013-14 to 121.7 per 100,000 in 2020-21[38]. Overall, the national rate has been stable and declining over time (since 2013-14).

Rate of hospital admissions (per 100,000) among 0 to 4 years old due to unintentional and deliberate injuries in NHS Shropshire, Telford and Wrekin, including England comparison, 2013-14 to 2020-21. Source: Public Health Profile, Fingertips, OHID

[36] Child and Maternal Health - Data - OHID (phe.org.uk)
[37] Child and Maternal Health - Data - OHID (phe.org.uk)
[38] Public health profiles - OHID (phe.org.uk)



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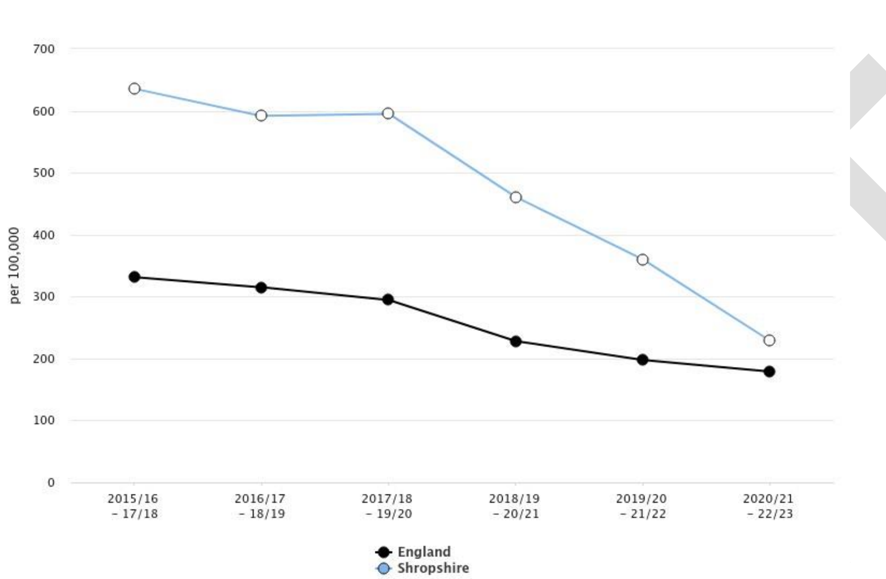
Hospital admissions for dental caries (0-5 years)

In Shropshire between 2020/21-22/23, there were 120 hospital admissions for dental caries among those aged 5 and below, equating to a rate of 228.4 per 100,000 which is above the national average of 178.8. However, this rate has been decreasing over time at a faster pace than seen nationally.



Percentage of 5 year olds with experience of visually obvious dental decay

Oral health is an integral part of overall health; when children are not healthy this affects their ability to learn, thrive and develop. This indicator therefore links to a key policy: Getting the Best Start in Life. Poor oral health is a priority under Best Start in Life, it was also a topic of a Health Select Committee inquiry, and the most common cause of hospital admission for 5 to 9 year olds. This indicator allows benchmarking of oral health of young children across England, and is an excellent proxy measure of assessing the impact of the commissioning of oral health improvement programmes on the local community. Dental caries is a synonymous term for tooth decay.

In Shropshire in 2020-21, 14.6% of 5 year olds examined had at least one tooth decayed, missing or filled, a lower rate than seen nationally (23.7%) and regionally (23.8%). Shropshire's rate also fell compared to 2019-20 however the pandemic may have impacted this data.

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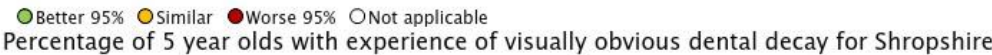
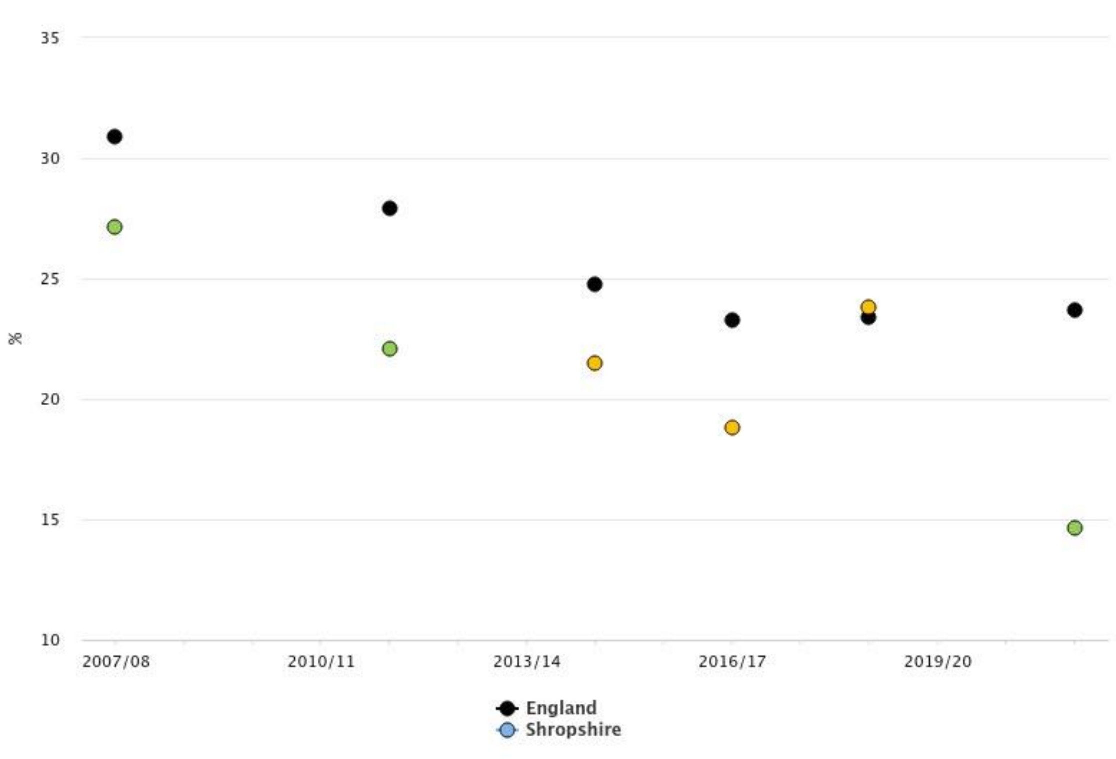
Percentage of 5 year olds with experience of visually obvious dental decay 2021/22 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	23.7	23.3	24.0
West Midlands region (statistical)	–	-	23.8	22.8	24.8
Herefordshire	–	-	38.7	33.2	44.6
Stoke-on-Trent	–	-	35.0	32.1	38.1
Coventry	–	-	34.2	29.1	39.7
Sandwell	–	-	30.0	25.3	35.1
Walsall	–	-	24.8	20.3	30.0
Birmingham	–	-	23.8	19.2	29.0
Wolverhampton	–	-	23.4	21.5	25.5
Telford and Wrekin	–	-	19.1	13.3	26.5
Warwickshire	–	-	17.7	15.9	19.7
Worcestershire	–	-	17.6	13.3	22.9
Dudley	–	-	17.3	13.5	21.9
Staffordshire	–	-	16.8	13.1	21.3
Solihull	–	-	16.4	12.0	22.0
Shropshire	–	-	14.6	10.4	20.2





Vaccination coverage

The childhood immunisation programme

Immunisations are given to babies at eight, twelve and sixteen weeks of age, with further immunisations given at one year of age [39] [40]:

Routine childhood immunisations — From September 2023

Age due	Diseases protected against	Vaccine given and trade name		Usual site[1]
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix[2]	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	Rotavirus	Rotavirus	Rotarix[2]	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB	MenB	Bexsero	Left thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMRvaxPro[3] or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Eligible paediatric age group[4]	Influenza (each year from September)	Live attenuated influenza vaccine LAIV	Fluenz Tetra[3,5]	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	dTaP/IPV	Boostrix-IPV	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMRvaxPro[3] or Priorix	Upper arm
Boys and girls aged twelve to thirteen years	Cancers and genital warts caused by specific human papillomavirus (HPV) types	HPV[6]	Gardasil 9	Upper arm
Fourteen years old (school Year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y	MenACWY	Nimenrix	Upper arm

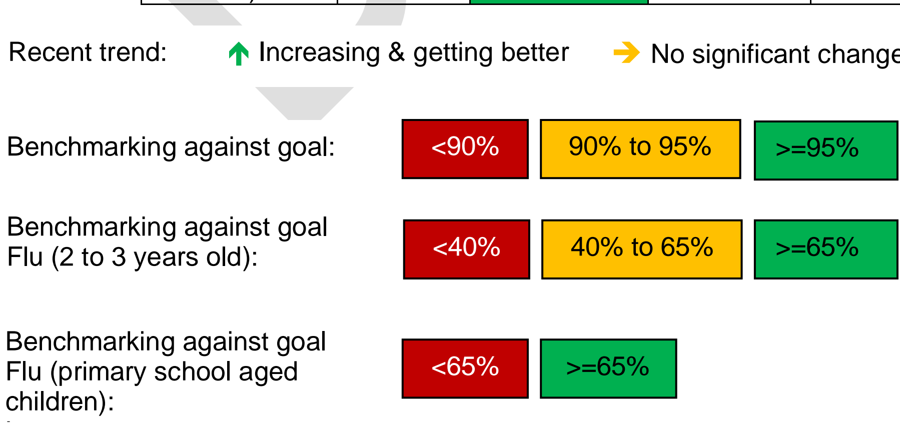
1. Intramuscular injection into deltoid muscle in upper arm or anterolateral aspect of the thigh.
2. Rotavirus vaccine should only be given after checking for SCID screening result.
3. Contains porcine gelatine.
4. See annual flu letter at: www.gov.uk/government/collections/annual-flu-programme
5. If LAIV (live attenuated influenza vaccine) is contraindicated or otherwise unsuitable use inactivated flu vaccine (check Green Book Chapter 19 for details).
6. See Green Book chapter 18a for immunising immunocompromised young people who will need 3 doses.

[39] A guide to immunisations for babies born on or after 1 January 2020
[40] Routine childhood immunisation schedule - GOV.UK (www.gov.uk)

Vaccination measures

Childhood vaccine coverage in Shropshire, including West Midlands and England comparisons, Source: PHOF, Fingertips, OHID

Vaccination coverage	Period	Shropshire	West Midlands	England	Recent trend
Dtap IPV Hib (1 year old)	2022/23	95.7	91.5	91.8	→
Men B (1 year old)	2022/23	95.8	90.6	91.0	→
Rotavirus (1 year old)	2022/23	94.1	88.3	88.7	→
PCV	2022/23	96.9	93.2	93.7	↑
Hepatitis B (2 years old	2022/23	-	-	-	-
Dtap IPV Hib (2 years old)	2022/23	96.5	92.9	92.6	→
Men B booster (2 years old)	2022/23	93.9	87.1	87.6	→
MMR – one dose (2 years old)	2022/23	94.7	88.9	89.3	→
PCV booster	2022/23	94.5	88.3	88.5	→
Flu (2 to 3 years old)	2022/23	50.8	39.1	43.7	→
Hib and MenC booster (2 years old)	2022/23	94.4	88.2	88.7	→
DTaP and IPV booster (5 years)	2022/23	89.5	82.8	83.3	→
MMR – one dose (5 years old)	2022/23	95.6	92.6	92.5	→
MMR – two doses (5 years old)	2022/23	89.8	83.7	84.5	→
Flu (primary school aged children)	2022	70.8	52.1	56.3	-



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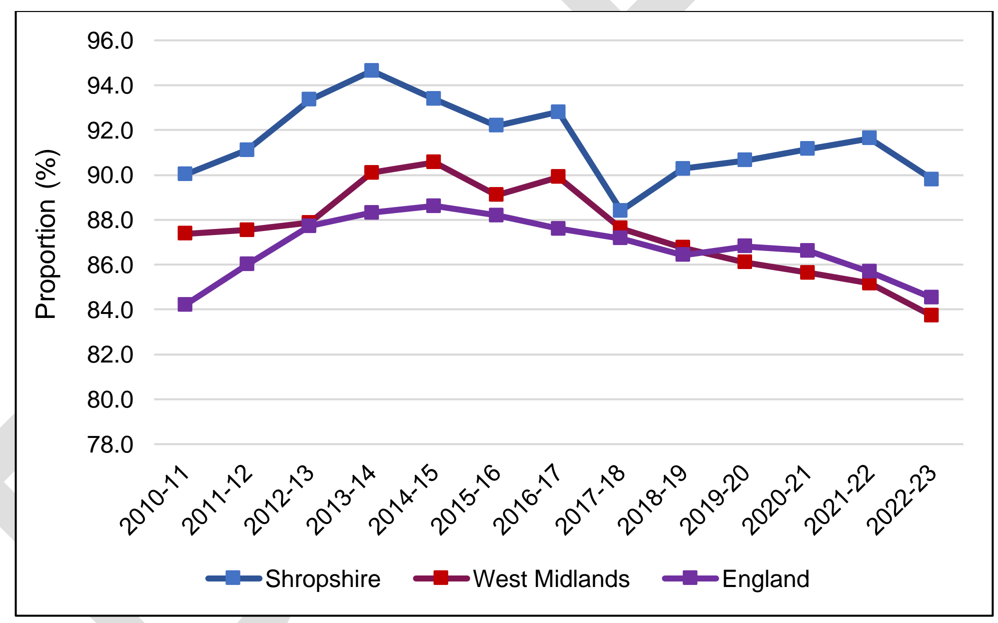
- In the period 2022/23, vaccination coverage for 1 year olds in Shropshire for Dtap IPV Hib and MenB were above the goal of >= 95% [41]. Vaccine coverage for Rotavirus for 1 year olds in 2022/23 was lower than the >=95% goal but fell between 90% and 95%.

- At 2 years, vaccine coverage was high and above the >=95%goal for Dtap IPV Hib at 96.5%, however MenB boosters, MMR first dose, and Hib and MenC coverage were lower than the >=95% goal but fell between 90% and 95%[40].

- Flu vaccination coverage at 2-3 years was lower than the goal of >=65% but fell between 40% and 65%, at 50.8%[40]. At 5 years old, coverage for Dtap and IPC boosters as well as MMR second doses were less than 90%, at 89.5% and 89.8% respectively, similar to the goal along with MMR second doses[40].

- As shown in the figure below, MMR vaccine coverage for two doses in Shropshire saw an increase between 2017-18 and 2021-22 (from 87.6% to 91.6%), after which a decrease was seen between 2021-22 and 2022-23 (from 91.6% to 89.8%).

MMR vaccine coverage for two doses (5 years old) in Shropshire, including West Midlands and England comparisons, Source: PHOF, Fingertips, OHID



[41] PHOF

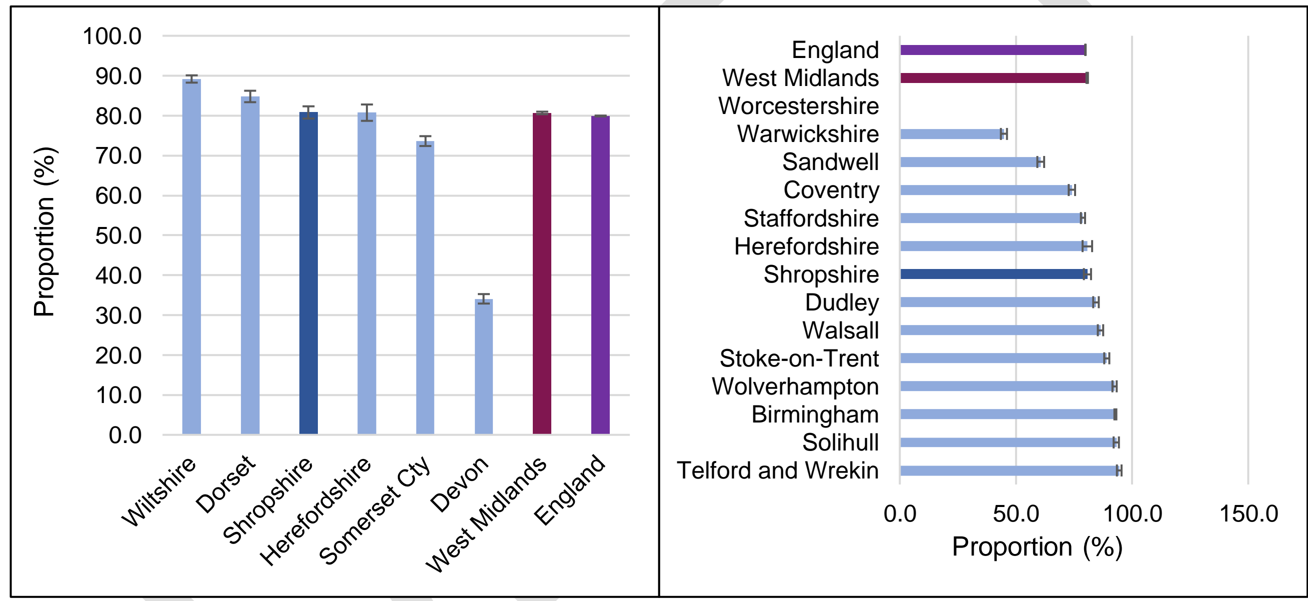
Health Visiting metrics

New birth visits within 14 days (NBV)

All infants and their families are eligible to receive a visit led by a health visitor within the first two weeks from birth. This means that any problems can be identified early, and interventions may be more successful the earlier they are put in place[42].

During 2022-23, the proportion of infants receiving a new birth visit (NBV) by a Health Visitor within 14 days in Shropshire was 80.8%, a fall compared to the 2020-21's rate of 89.3%. Shropshire's current rate is similar to the regional average of 80.7% and national average of 79.9%[43]. Shropshire's proportion was the 6th lowest regionally and 4th lowest among its statistical neighbours.

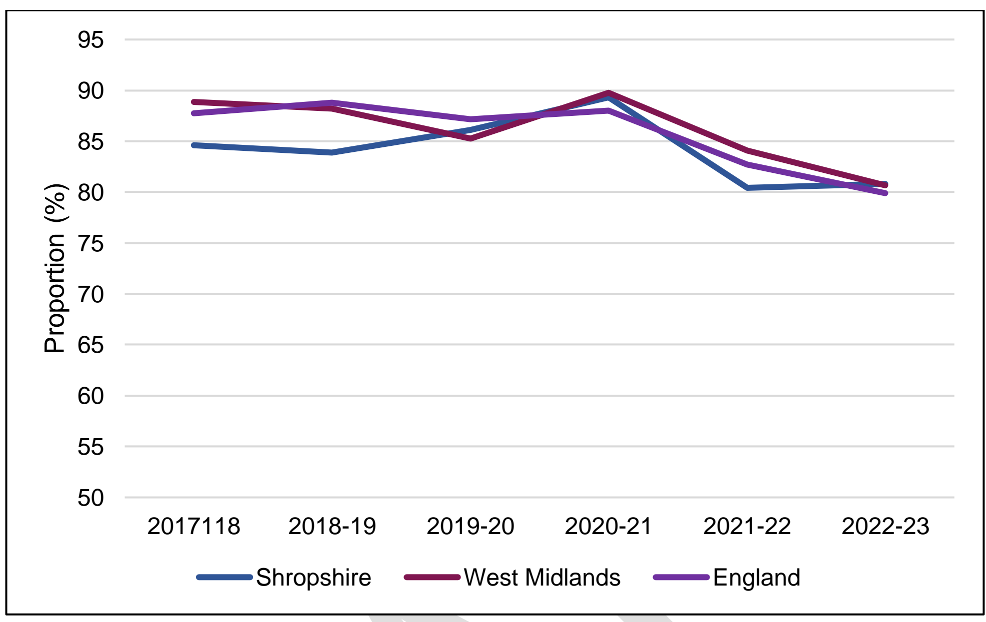
Proportion of new birth visits completed within 14 days in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Shropshire's proportion saw an increase between 2017-18 and 2020-21, after which a steady decrease was observed. Overall, regional and national proportions have been declining since 2020-21.

[42] LG inform: Health and Wellbeing in Shropshire: A Focus on Children
[43] Child and Maternal Health - Data - OHID (phe.org.uk)

Proportion of new birth visits completed within 14 days in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



6 to 8 week reviews

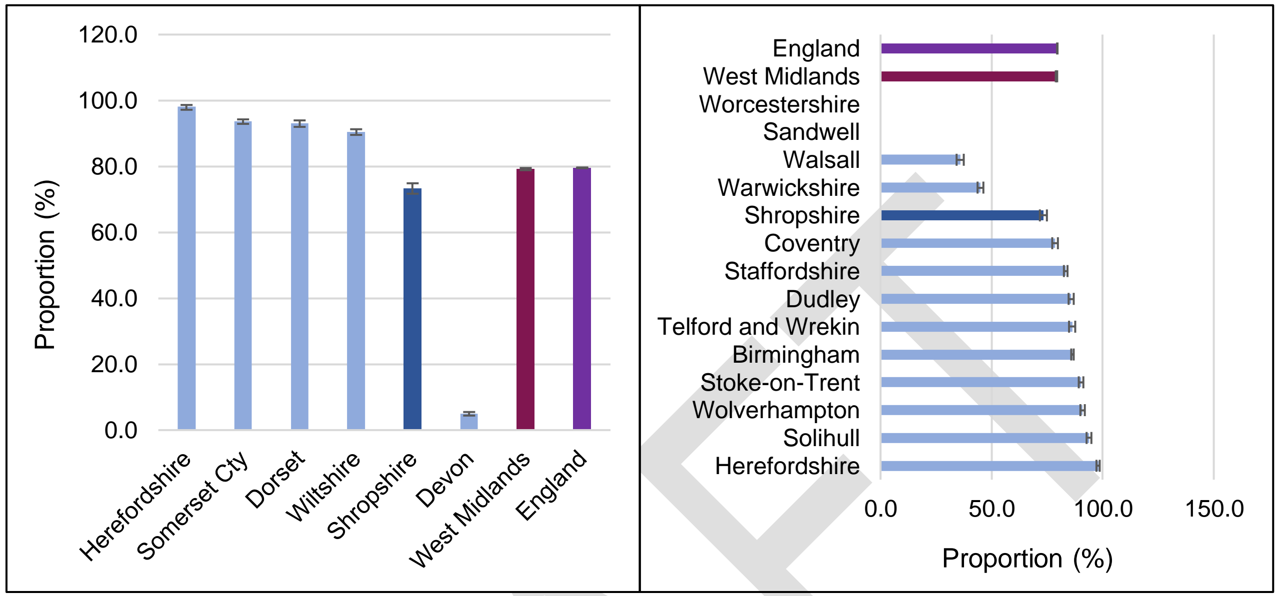
The 6 to 8 week review is an opportunity for support with breastfeeding if required, and allows an assessment of the mother's mental health, as well as reinforcing the discussions and messages from the new birth visit[44]. It is an opportunity to ensure the mother has had a six-week postnatal check, and that the infant has received the infant physical examination, as well as a reminder of the importance of the vaccinations that take place in the first few months. Any difficulties the mother has had in receiving benefits she is entitled to can be discussed and support offered.

During 2022-23, 73.3% of infants aged 6-8 weeks old received a review by the time they were 8 weeks old in Shropshire, a rise compared to 2020-21's figure of 57.6%[45]. However, Shropshire's proportion is still below the regional average of 79.2% and national average of 79.6% and ranks Shropshire third worst regionally and 2nd worst among its statistical neighbours.

This is due to mainly due to the timing that the invites are generated and parental choice. The service have made changes to the system to generate earlier appointments to ensure that these are more frequently prior to the child's first birthday.

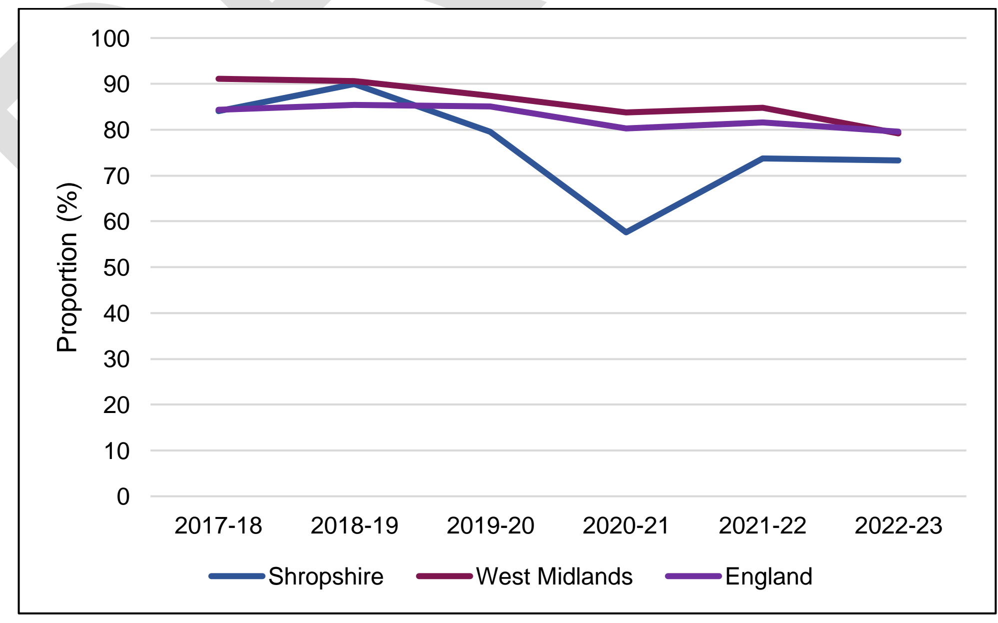
[44] Child and Maternal Health - Data - OHID (phe.org.uk)
[45] Child and Maternal Health - Data - OHID (phe.org.uk)

Proportion of children receiving 6 to 8 weeks review in Shropshire and its statistical and regional neighbours including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Shropshire's proportion saw a decrease between 2017-18 and 2020-21, after which an increase was observed. Shropshire's proportion has remained stable in the past 2 years. Overall, regional and national proportions have been declining since 2017-18.

Proportion of children receiving 6 to 8 weeks review in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

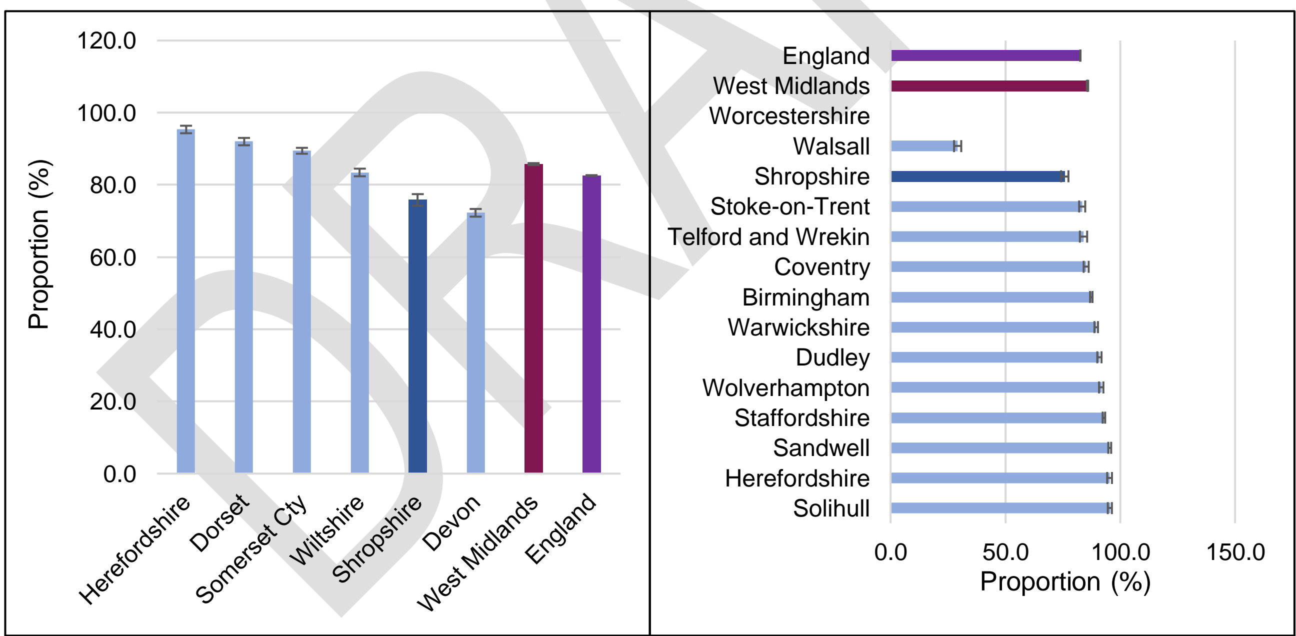


12-month reviews

All children should receive a review by a health visitor led team shortly before they turn one year. This allows for assessment of the baby's physical, emotional and social needs in the context of their family, including predictive risk factors, and provides an opportunity for both parents to talk about any concerns that they may have about their baby's health, as well as a reminder of the importance of the vaccinations at around one year. It also allows monitoring of the baby's growth, and discussions on weaning, oral health and home safety (particularly relevant as babies are now sitting independently, rolling over, and may be starting to walk). In addition, it presents an opportunity to discuss preconception health before any future pregnancy. A review between 9 and 12 months ensures any issues can be identified early and referrals made as appropriate. However, it is accepted that for many reasons these reviews may be a little late and the content is still of value. This metric therefore shows the proportion of children who have a 12-month review on time or slightly late (by 15 months) [46].

During 2022-23, 75.9% of infants aged 12 months old in Shropshire received a review by the time they were 15 months, a significant rise compared to 2020-21's figure of 13.1%[47]. However, Shropshire's proportion is still below the regional average of 85.7% and national average of 82.6% and ranks Shropshire 2nd lowest regionally and among it statistical neighbours.

Proportion of children receiving 12-month review in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



[46] Child and Maternal Health - Data - OHID (phe.org.uk)
[47] Child and Maternal Health - Data - OHID (phe.org.uk)

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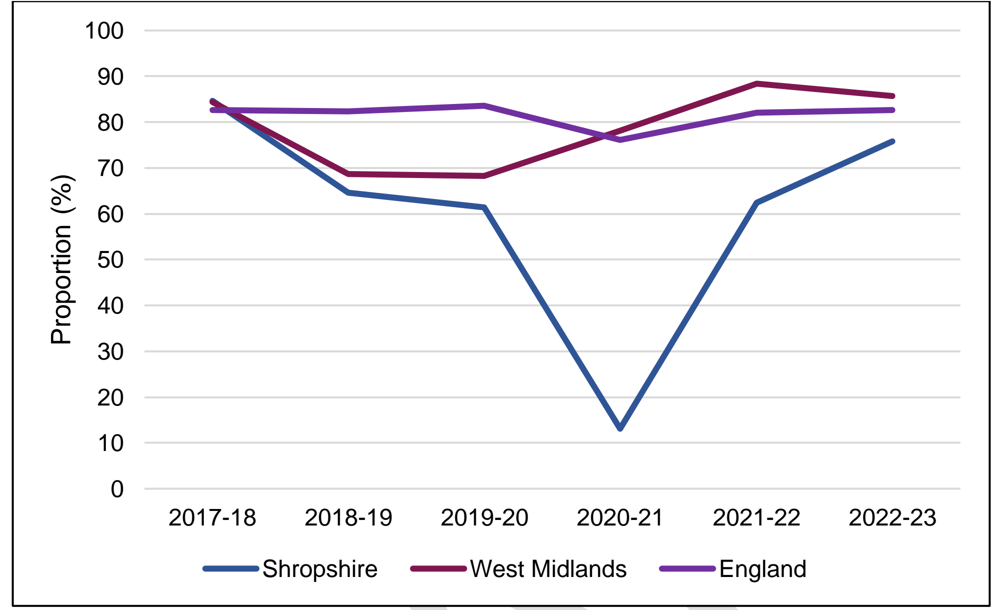
Shropshire's proportion saw a decrease between 2017-18 and 2020-21, after which a steady increase was observed. Overall, regional and national proportions have increased since 2021-22.

Proportion of children receiving 12-month review in Shropshire, including West Midlands and England comparisons, Source: Child and Maternal Health Profile, Fingertips, OHID



Child development

All children in England are eligible for a Healthy Child Programme development review, delivered as part of the universal health visitor service, around their second birthday. The Ages and Stages Questionnaire (ASQ-3) is used to generate data for a population measure of child development outcomes. The purpose is to drive improvements in outcomes at scale with a particular focus on speech, language and communication needs and school readiness[48].

Child development: percentage of children achieving a good level of development at 2 to 2½ years

During 2022-23, 64.8% of children aged 2 to 2 ½ years old achieved a good level of development, ranking Shropshire worst among its statistical neighbours and 4th worst regionally[49]. This proportion is worse than the regional average of 76.3% and national average of 79.3%.

48 LG inform: Health and Wellbeing in Shropshire: A Focus on Children
49 Child and Maternal Health - Data - OHID (phe.org.uk)

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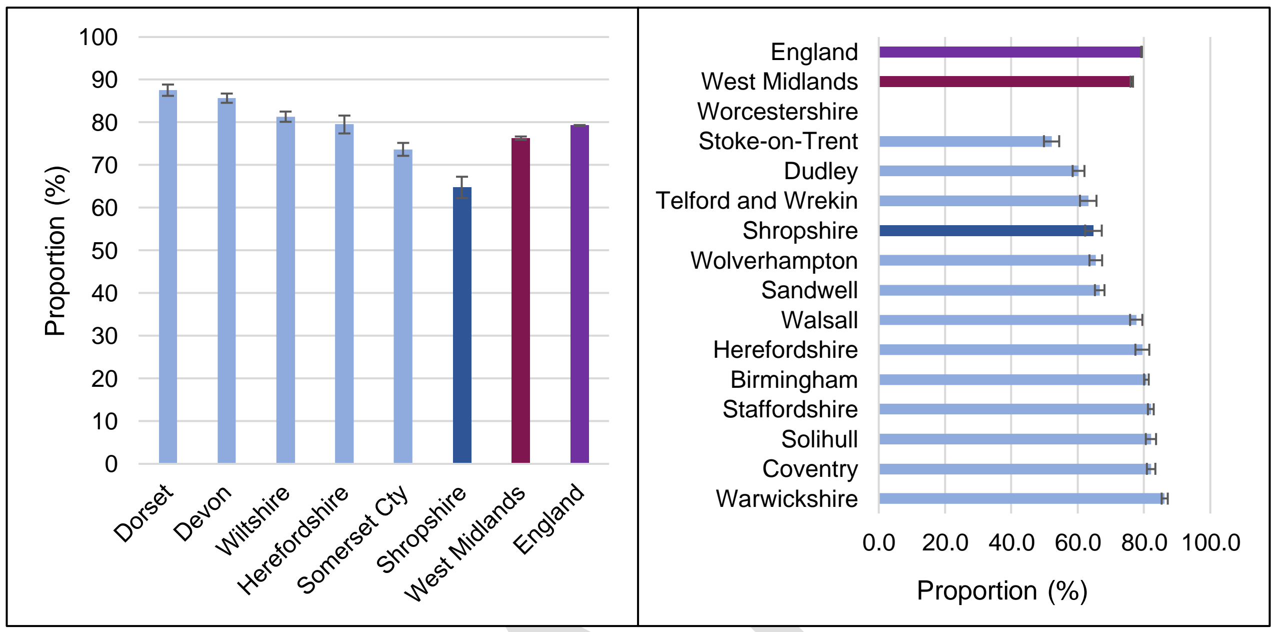
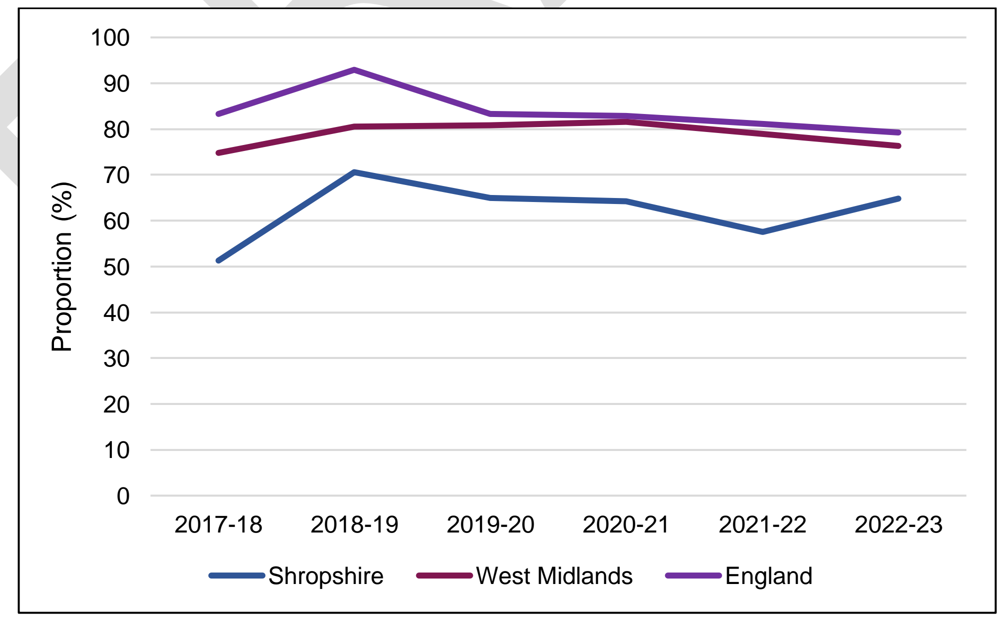
Proportion of children achieving a good level of development at 2 to 2 ½ years in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Shropshire has been below the regional and national average since 2017-18, though a slight increase was observed between 2021-22 and 2022-23. However, there are data quality concerns surrounding this data and figures should be interpreted with caution.

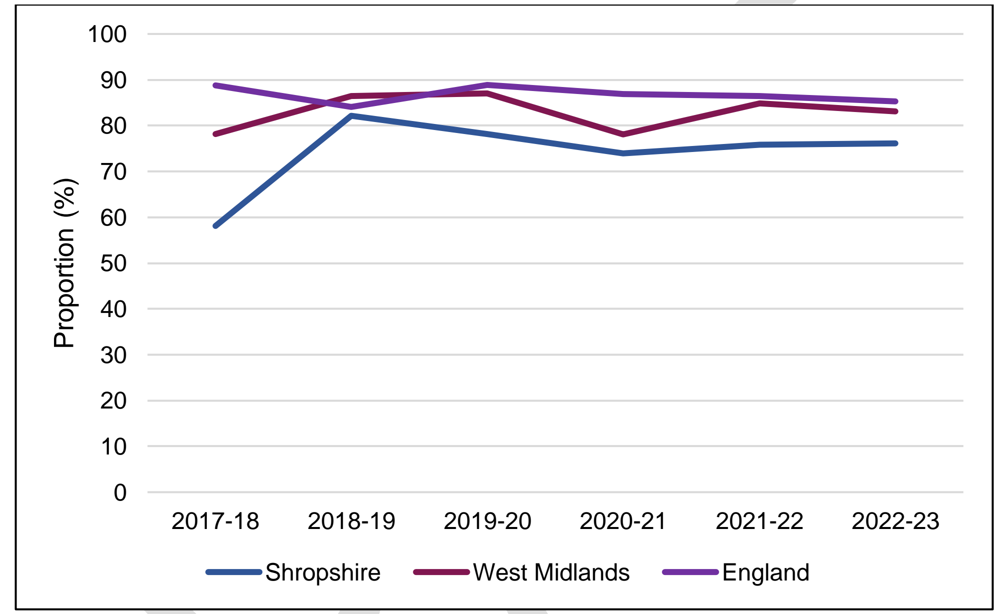
Proportion of children achieving a good level of development at 2 to 2 ½ years in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Achieving the expected level in communication skills at 2 to 2½ years

Three quarters of children in Shropshire - 76.2%, achieved the expected level of communication skills at 2 to 2 ½ years in 2022-23[50]. However, this was still lower than the regional average of 83% and national average of 85% and ranks Shropshire fourth lowest in the region and lowest among its statistical neighbours[49]. Whilst the proportion was below the national average, it has remained steady over the last three years. However, there are data quality concerns surrounding this data and figures should be interpreted with caution.

Proportion of children achieving the expected level in communication skills at 2 to 2 ½ years in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



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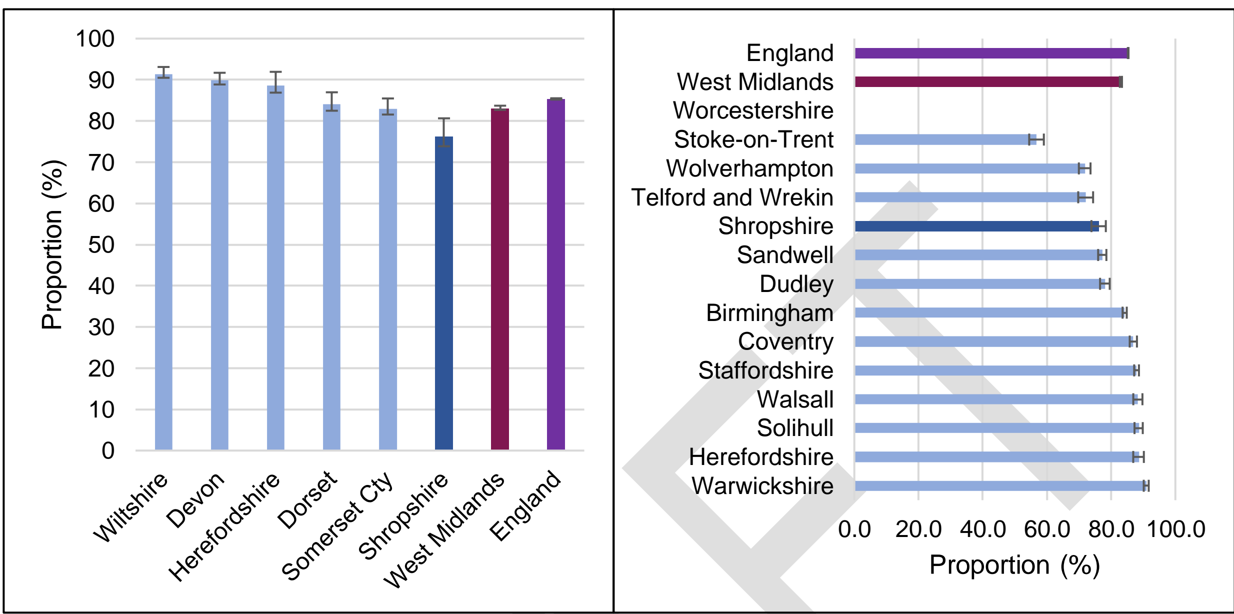
[50] Child and Maternal Health - Data - OHID (phe.org.uk)

Proportion of children achieving the expected level in communication skills at 2 to 2 ½ in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

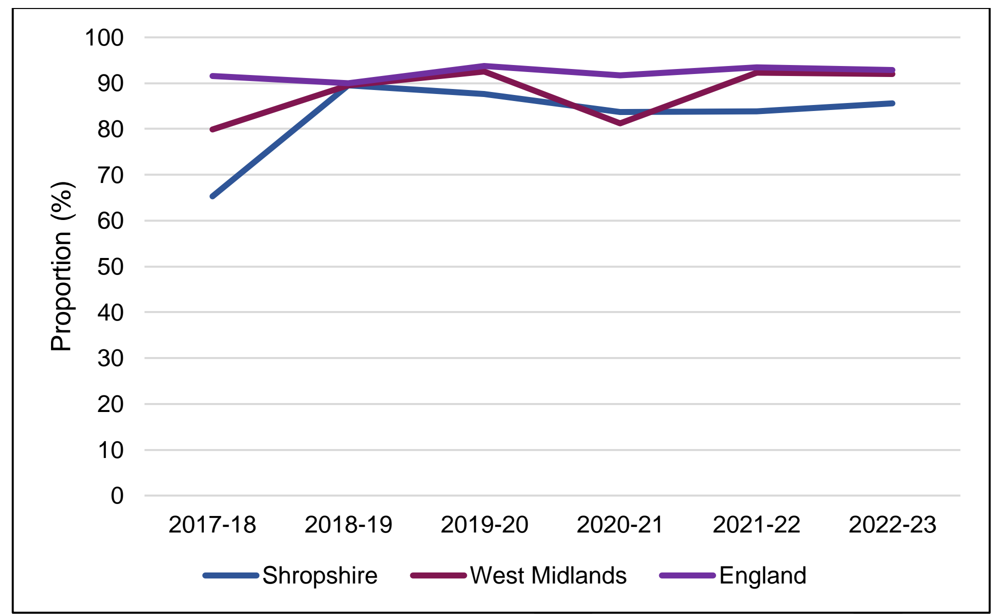


Achieving the expected level in gross motor skills at 2-2½ years

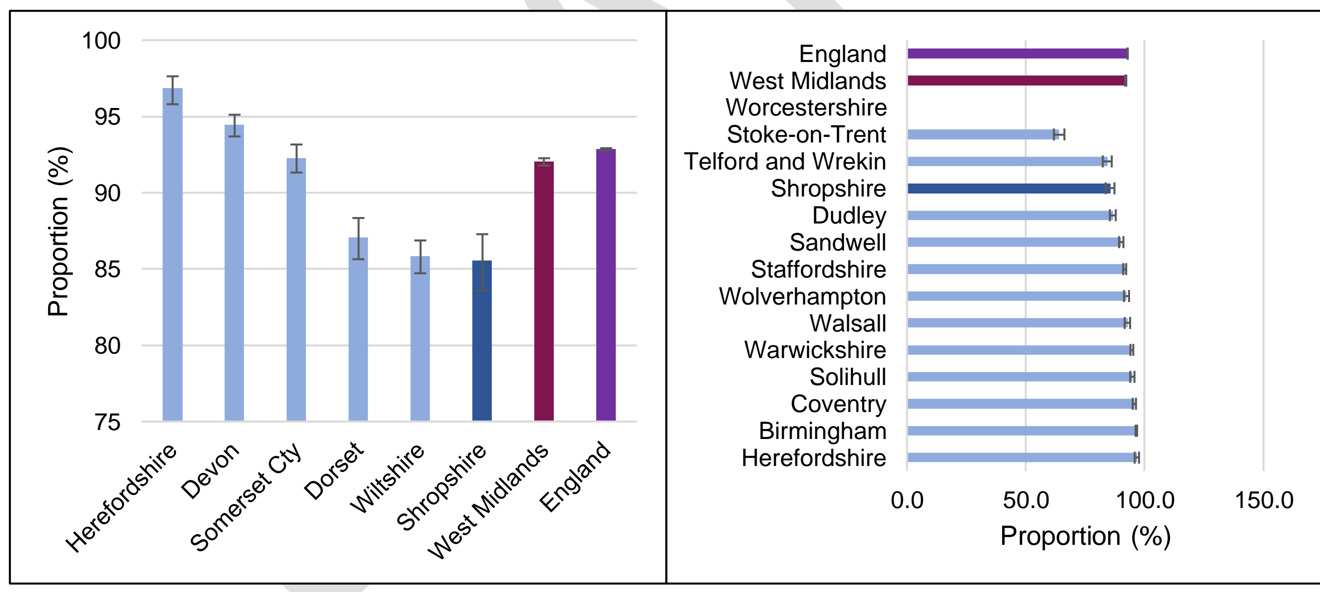
During 2022-23, 85.5% of children in Shropshire achieved the expected level of gross motor skills at 2 to 2 ½ years[51]. However, this was lower than the regional average of 92% and the national average of 92.8%[50]. This ranks Shropshire 3rd lowest in the region and lowest among its statistical neighbours. Whilst the rate is below the national average, it has remained steady over the last three years. However, there are data quality concerns surrounding this data and figures should be interpreted with caution.

Proportion of children achieving the expected level in gross motor skills at 2 to 2 ½ years in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

[51] Child and Maternal Health - Data - OHID (phe.org.uk)



Proportion of children achieving the expected level in gross motor skills at 2 to 2 ½ years in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: [Child and Maternal Health Profile](), Fingertips, OHID



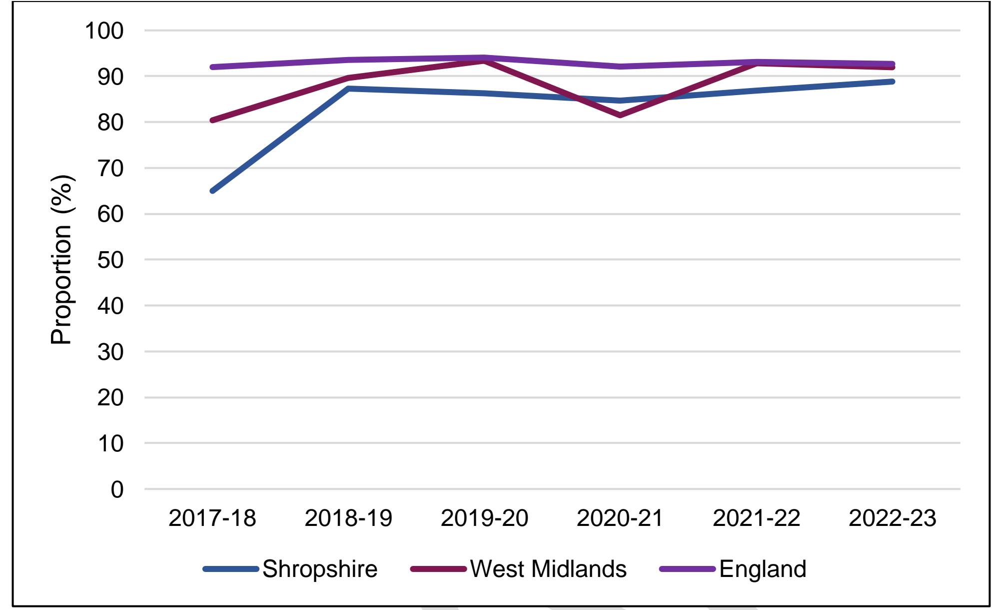
Achieving the expected level in fine motor skills at 2-2½ years

During 2022-23, 88.8% of children in Shropshire achieved the expected level of fine motor skills at 2 to 2 ½ years[52]. This was lower than the regional average of 91.9% and the national average of 92.6%. This ranks Shropshire eight lowest in the region and second lowest

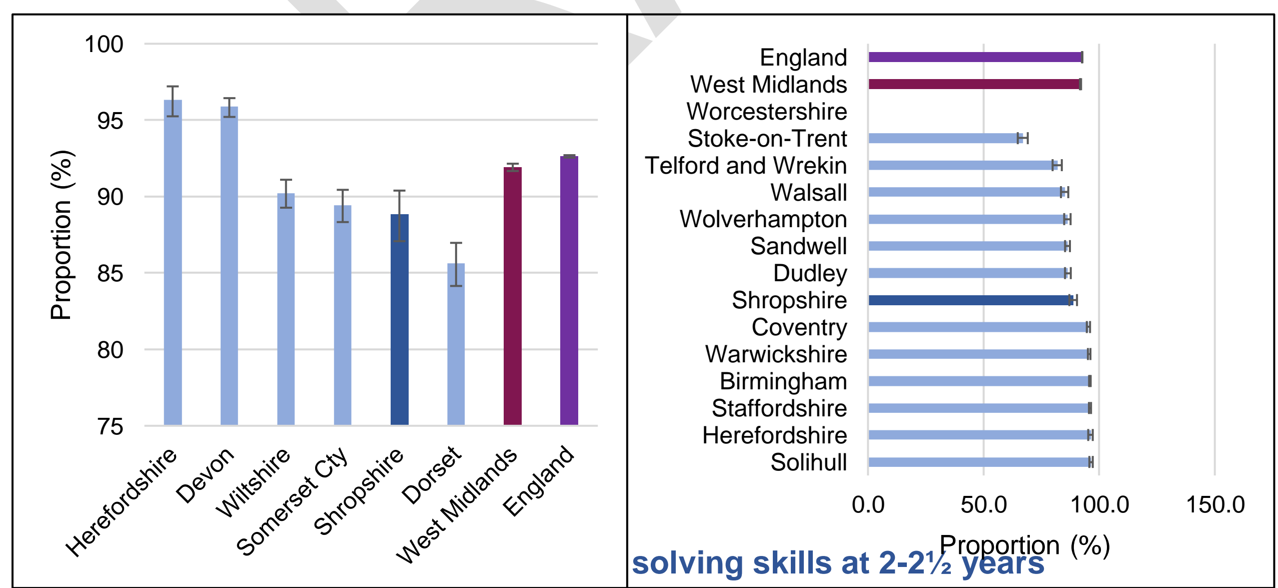
[52] Child and Maternal Health - Data - OHID (phe.org.uk)

among its statistical neighbours. Whilst the rate is below the national average, it has remained steady since 2018/19. However, there are data quality concerns surrounding this data and figures should be interpreted with caution.

Proportion of children achieving the expected level in fine motor skills at 2 to 2 ½ years in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Proportion of children achieving the expected level in fine motor skills at 2 to 2 ½ years in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

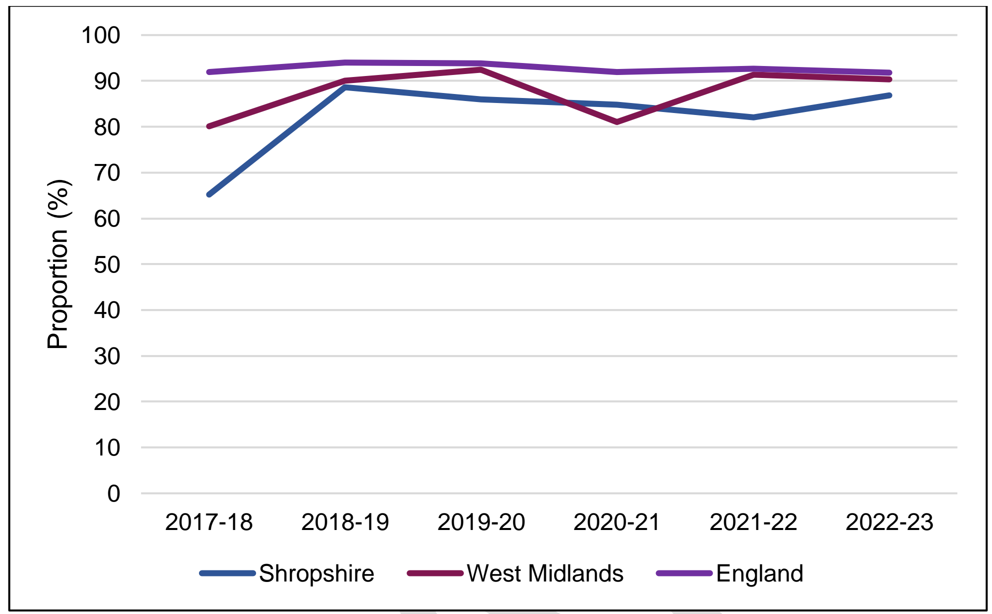


During 2022-23, 86.9% of children in Shropshire achieved the expected level in problem solving skills at 2 to 2 ½ years[53]. This is lower than the regional average of 90.2% and national average of 91.8%. This ranks Shropshire fifth lowest in the region and lowest among its statistical neighbours. Though Shropshire's proportion is lower than the national

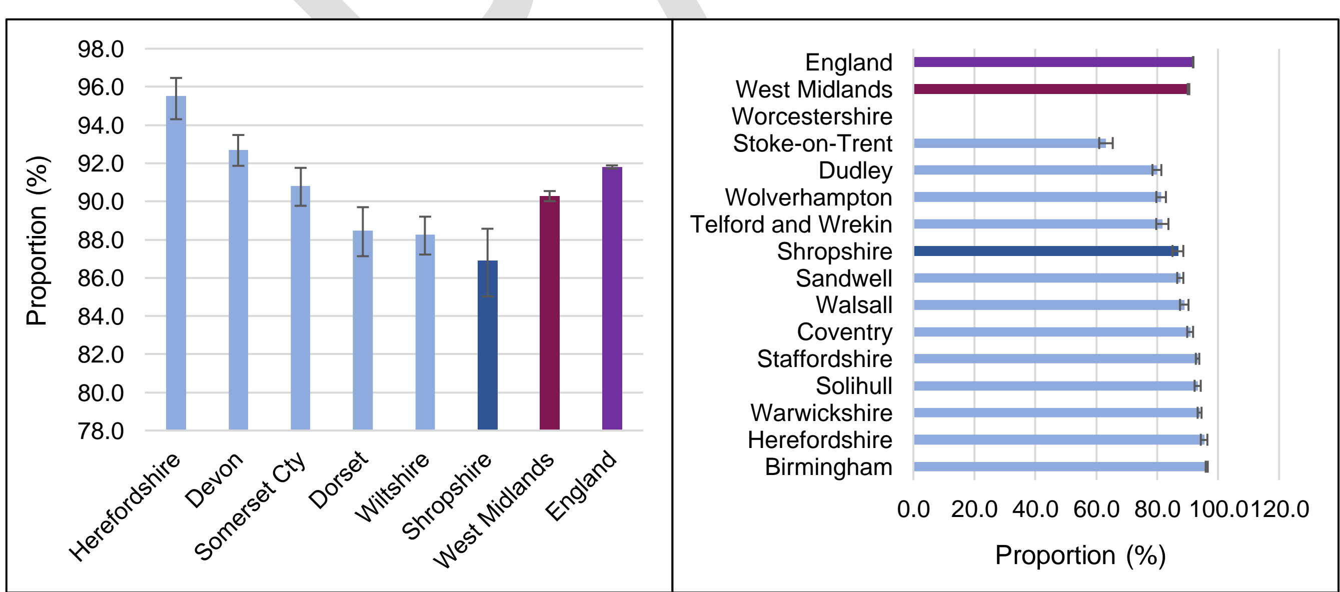
[53] Child and Maternal Health - Data - OHID (phe.org.uk)

average, a slight increase was observed between 2021-22 and 2022-23. There are data quality concerns surrounding this data and figures should be interpreted with caution.

Proportion of children achieving the expected level in problem solving skills at 2 to 2 ½ years in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



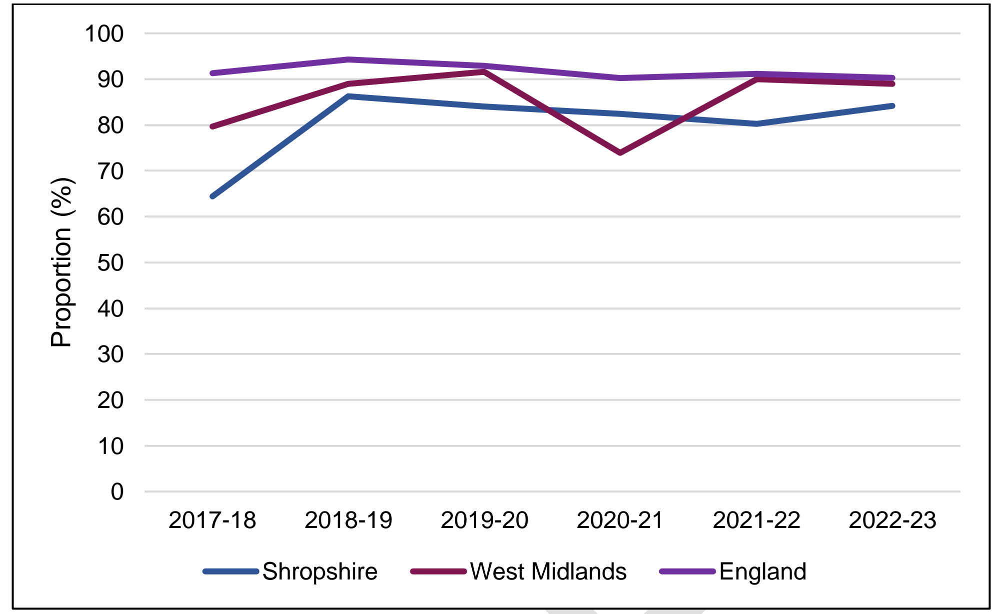
Proportion of children achieving the expected level in problem solving skills at 2 to 2 ½ years in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



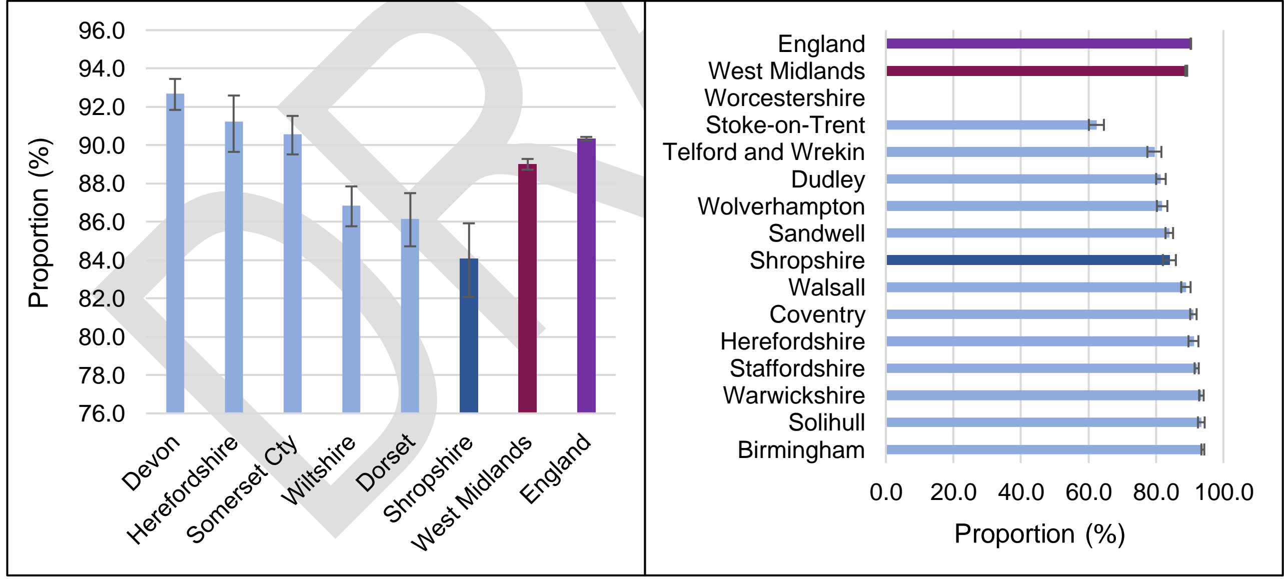
During 2022-23, 84% of children in Shropshire achieved the expected level in problem solving skills at 2 to 2 ½ years[54]. This was lower than the regional average of 89% and the national average of 90.3%. This ranks Shropshire 6th lowest regionally and lowest among its statistical neighbours.

[54] Child and Maternal Health - Data - OHID (phe.org.uk)

Proportion of children achieving the expected level in personal social skills at 2 to 2 ½ years in Shropshire, including West Midlands and England comparisons, 2017-18 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Proportion of children achieving the expected level in personal social skills at 2 to 2 ½ years in Shropshire and its statistical and regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



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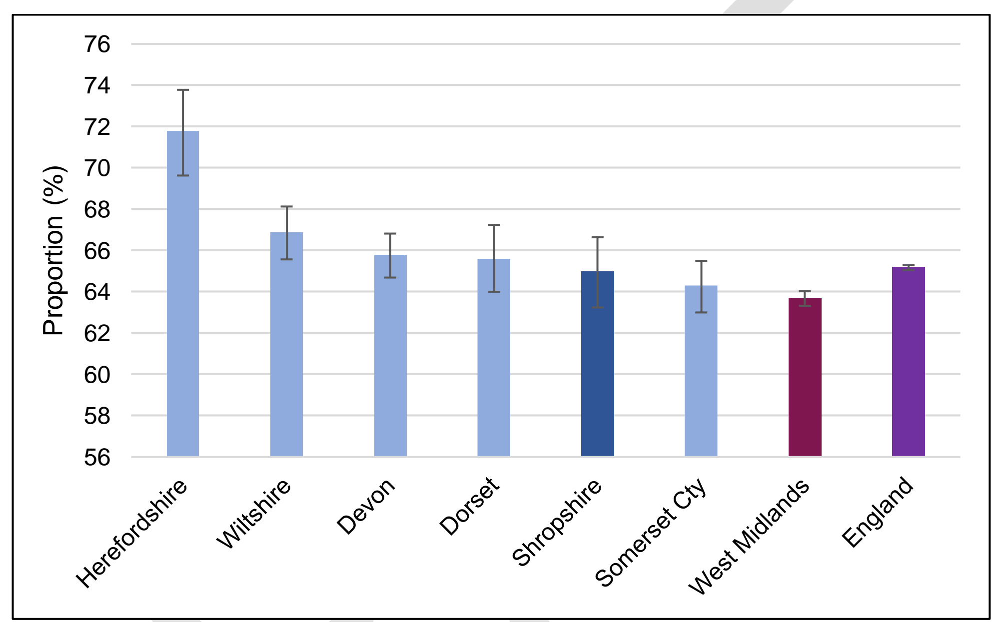
School readiness: children achieving a good level of development at the end of Reception

School readiness is improving and getting better in Shropshire. During 2021-22, 65% of children achieved a good level of development at the end of reception. Shropshire's current rate for school readiness is similar to the national average of 65.2% and regional average of 63.7%. Shropshire ranks 2nd lowest among its statistical neighbours and 6th highest in the region.

Proportion of children achieving a good level of development at the end of Reception in Shropshire and its statistical neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



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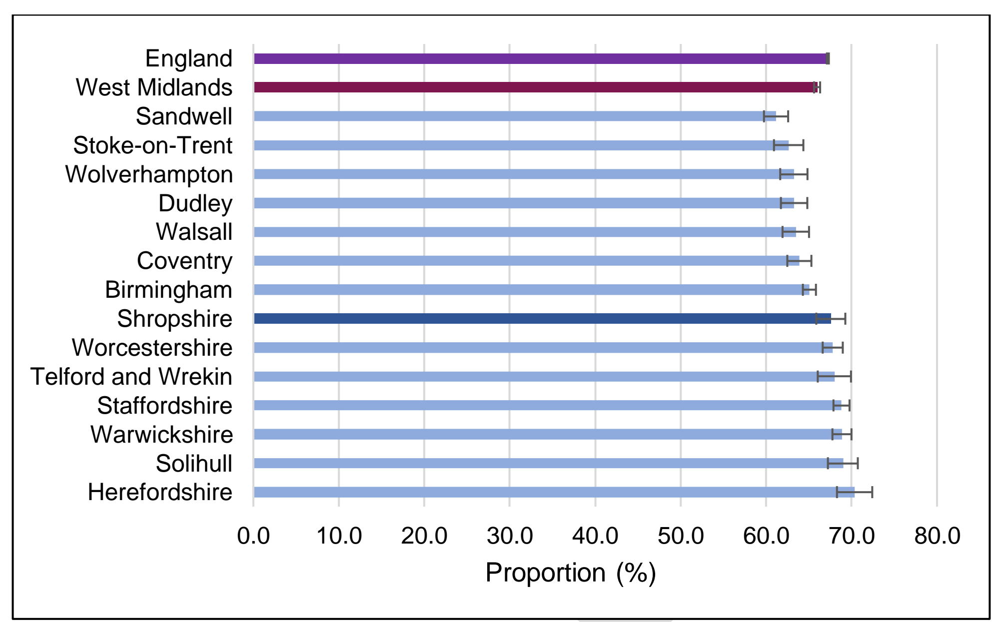
Proportion of children achieving a good level of development at the end of Reception in Shropshire and its regional neighbours, including West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



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Service provision

The Healthy Child Programme (HCP) aims to bring together health, education and other main partners to deliver an effective programme of prevention and support.

In Shropshire the public health elements of this programme are commissioned by Shropshire Council to cover children aged 0-19 years (up to age 25 for those with Special Education Needs and Disabilities (SEND)). Shropshire Community Health Trust are the commissioned providers of the Public Health Nursing Service which includes the Health Visiting Service, school nursing service and the Family Nurse Partnership.

Health Visitors provide support for families and their children aged 0-5 and are uniquely placed to reach every child in their own home and be connected to their whole family and community. They build trusting relationships with children, carers and families, to positively influence their future health outcomes. Health Visitors identify the child's health needs and strengths and deliver timely, effective, evidence-based interventions in partnership with them. Shropshire's Health Visiting service provides a universal offer that ensures support for children and families is personalised, effective, timely and proportionate.

Shropshire Council also commission the Family Nurse Partnership which is a structured, evidence based, personalised, intensive visiting programme of support for vulnerable young parents. Young mothers-to-be and their partners are supported by a specially trained Family Nurse who visits them regularly, from early pregnancy until their child is aged between one and two.

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Public Health Nursing Service Performance

Health Visiting: quarterly performance and trends

The national Child Health Programme sets out five mandatory checks which provide good proxies for how well the service is meeting the needs of children and families. Locally sourced performance data up to Q4 2023-24 is shown below. This shows the gap as of Q4 2022/23 to the national average (2022/23) as an indicator of performance improvement. Note, this data has not yet been validated by the provider but is included to give an indication of progress and trends.

Quarterly data from the provider shows an improvement in the rate of most of the mandated contacts:

New Birth visits within 14 days
Shropshire's performance for the New Birth Visits within 14 days and has been improving over time. In the latest quarter, 78% of mothers received a new birth visit within 14 days of giving birth compared to 80% on average nationally.

6-8 week review
Shropshire's rate of 6-8 week reviews by 8 weeks is now similar to the national average in the latest quarter, with 80% of mothers receiving a check by 8 weeks compared to 80% nationally.

12 month review by 12 months
The percentage of mothers receiving a 12 month review by 12 months is below the national average and requires improvement at 61% compared to 83% nationally. However, this rate is improving over time, up from 40% in Q4 of 22/23 to 61% in Q4 of 23/24.

The reason for this low rate is due to reviews taking place before 15 months, with a rate of 87%. This is mainly due to the timing that the invites are generated and parental choice. The service have made changes to the system to generate earlier appointments to ensure that these are more frequently prior to the child's first birthday.

2-2 ½ year review
In Shropshire, 70% of mothers received a 2- 2 ½ year review, lower than the national rate of 74% but improving over time.

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Health Visiting Indicators Summary - Shropshire

Indicator	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Trend over time chart	Trend compared to previous quarter	Change compared to previous quarter	National average 2022/23	Gap to national average
Number of First face to face antenatal contact	17	19	19	21	24	20	32	**38**		▲	12	-	-
% NBV within 14 days	77%	86%	81%	78%	79%	79%	80%	**78%**		▼	-2%	80%	-2%
% NBV after 14 days	20%	12%	17%	18%	19%	19%	18%	**18%**		↔	0%	-	
% 6-8 week review by 8 weeks	74%	75%	70%	73%	74%	71%	89%	**80%**		▼	-9%	80%	0%
% Breastfed at 6-8 weeks	28%	31%	31%	33%	38%	35%	40%	**49%**		▲	9%	49%	0%
% 12 month review by 12 months	22%	48%	57%	40%	37%	41%	50%	**61%**		▲	11%	83%	-22%
% 12 month review by 15 months	65%	52%	88%	96%	88%	85%	82%	**87%**		▲	5%	-	-
% 2-2½ year review	58%	51%	41%	61%	66%	61%	78%	**70%**		▼	-8%	74%	-4%
% 2-2½ year review using ASQ 3	90%	92%	90%	89%	81%	85%	**86%**	92%		▲	6%	93%	-7%
% at or above expected level in communication skills	78%	67%	72%	74%	78%	75%	**79%**	67%		▲	-12%	85%	-6%
% at or above expected level in gross motor skills	86%	78%	75%	86%	87%	84%	**89%**	78%		▲	-11%	93%	-4%
% at or above expected level in fine motor skills	88%	81%	85%	88%	92%	86%	**91%**	81%		▲	-10%	93%	-2%
% at or above expected level in problem solving skills	86%	79%	84%	85%	86%	85%	**90%**	79%		▲	-11%	92%	-2%
% at or above expected level in personal-social skills	83%	75%	79%	84%	87%	64%	**89%**	75%		▲	-14%	90%	-1%
% at or above expected level in all five areas of developm	64%	59%	63%	61%	65%	68%	**67%**	59%		▼	-8%	79%	-12%

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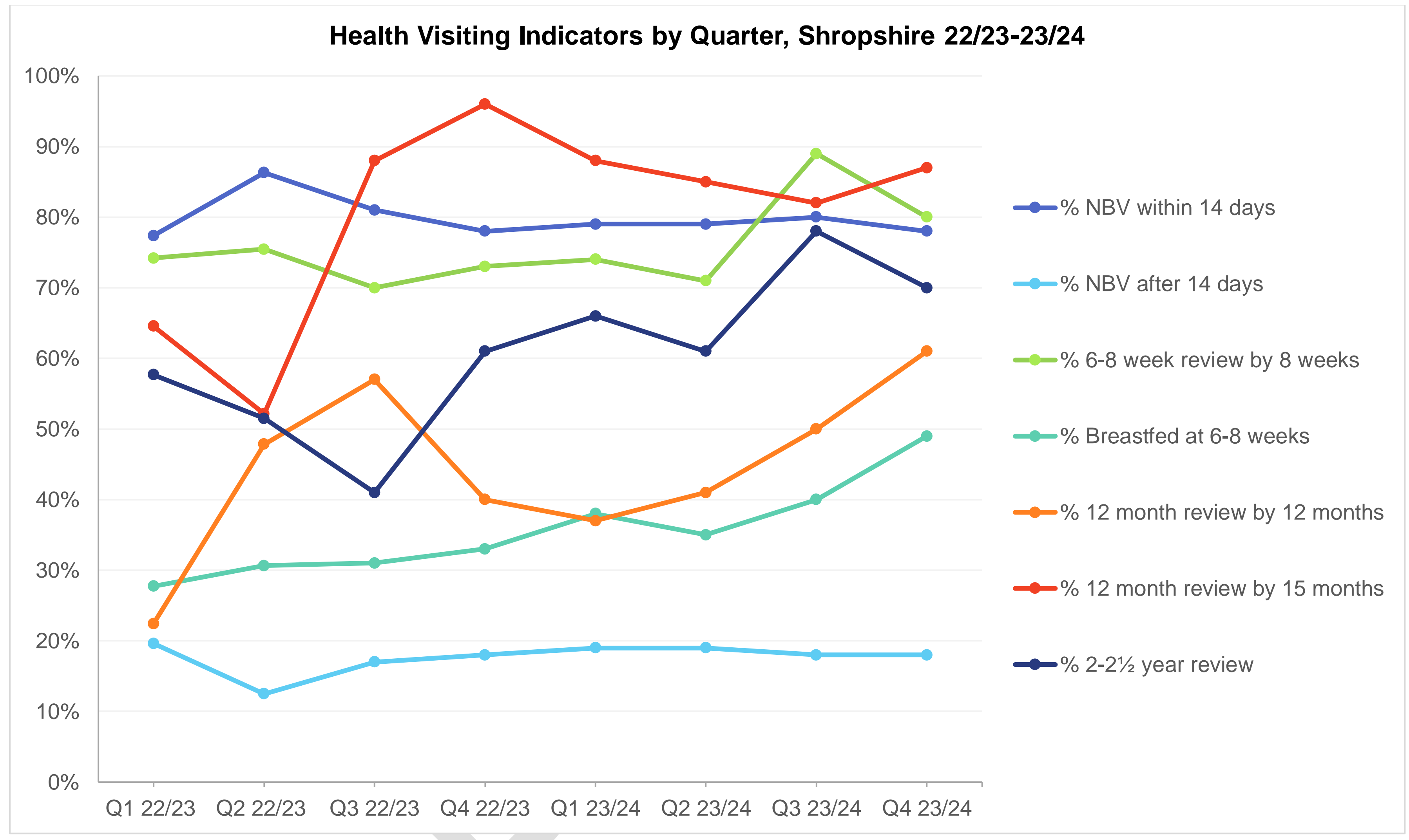

Health Visiting Indicators by Quarter, Shropshire 22/23-23/24
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q1 22/23
Q2 22/23
Q3 22/23
Q4 22/23
Q1 23/24
Q2 23/24
Q3 23/24
Q4 23/24
% NBV within 14 days
% NBV after 14 days
% 6-8 week review by 8 weeks
% Breastfed at 6-8 weeks
% 12 month review by 12 months
% 12 month review by 15 months
% 2-2½ year review

Health Visiting: annual performance and trends

Data from published 2022/23 shows Shropshire worse than the national average for all mandated contacts with the exception of New Birth Visits within 14 days, where Shropshire was similar to the national average.

However, data for 2023/24, there has been an increase year on year for all mandated contacts (in bold in table below) with the exception of New Birth Visits within 14 days which remains steady.

- The proportion of babies receiving a 6-8 week review by 8 weeks increased by 5% between 2022/23 and 2023/24.
- % Breastfed at 6-8 weeks increased by 10% in the same period.
- The proportion of children receiving a 12 month review by 12 months increased by 5% between 2022/23 and 2023/24.
- The proportion receiving 2-21/2 year reviews saw the biggest improvement, a rise of 16% compared to the previous year.

Metric	Mandated contact?	Shropshire average 22/23	Shropshire average 23/24	Year on year change	National average 2022/23	Gap to national average	Compared to national average
% NBV within 14 days	Yes	81%	79%	-2%	80%	-1%	Similar
% NBV within 30 days	No	19%	19%	0%	-	-	-
% 6-8 week review by 8 weeks	Yes	73%	79%	5%	80%	-1%	Similar
% Breastfed at 6-8 weeks	Yes	31%	41%	10%	49%	-8%	Similar
% 12 month review by 12 months	Yes	42%	47%	5%	83%	-36%	Worse
% 12 month review by 15 months	Yes	75%	86%	10%	-	-	-
% 2-2½ year review	Yes	53%	69%	16%	74%	-5%	Similar

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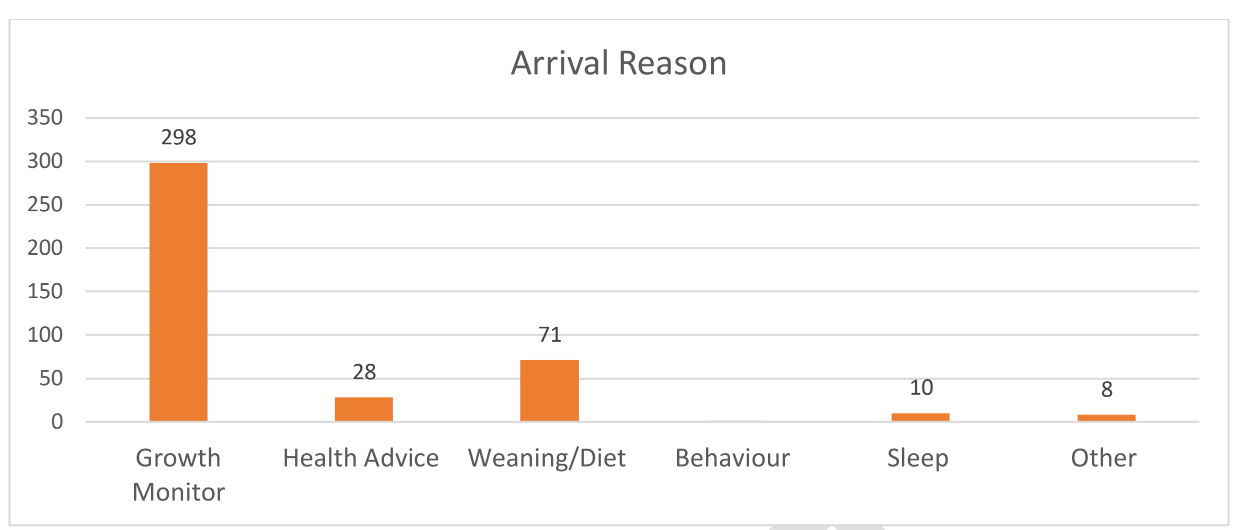
Health Visiting: Open Access Clinics

Open Access clinics are located within Community and Family hubs across the county offering families the opportunity to "drop in" to see a health visitor for advice, guidance or support related to their or their family's health and well-being.

The data below shows the additional contacts through the Health Visiting open access drop in clinics. Please note, during Q4 23/24, only Sunflower House was operating.

During Q4 of 2023/24, there were 307 attendances, with 10 visits from service users out of area. Growth monitoring was the most common arrival reason. 'Other' include; frequent stools , teething and breastfeeding.

Weight review and weaning were the most common advice given. 5 onward referrals were made following clinic visits, to GPs or paediatricians.



The 'Other' break down as follows;

- Breastfeeding
- Height
- Development
- Reflux
- Birth Reflection
- Feeding
- Head Circumference

In Q1 of 24/25, there were 353 attendances, a rise compared to the previous quarter. Two Early Help referrals were made. And four had an outcome of Targeted Early Help.

The most common advice was again, growth monitoring and diet/weaning.

Advice	Total
Behaviour	5
Breastfeeding	87

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Development	46
Diet/Weaning	145
Parental Mental Health and Well-Being	5
Growth Monitoring	342
Health Advice	67
Sleep	19
Other	36

Other' includes

- Walking
- Baby Bank
- Constipation
- Chesty Cough
- Physical Health
- Birth Reflections
- Skin irritations
- Torticollis
- Reflux
- Head Circumference/Shape
- Safety advice
- Dental Health
- Sun Safety
- Signposting to GP
- Referral to breastfeeding specialist
- Referral to Physio
- Speech

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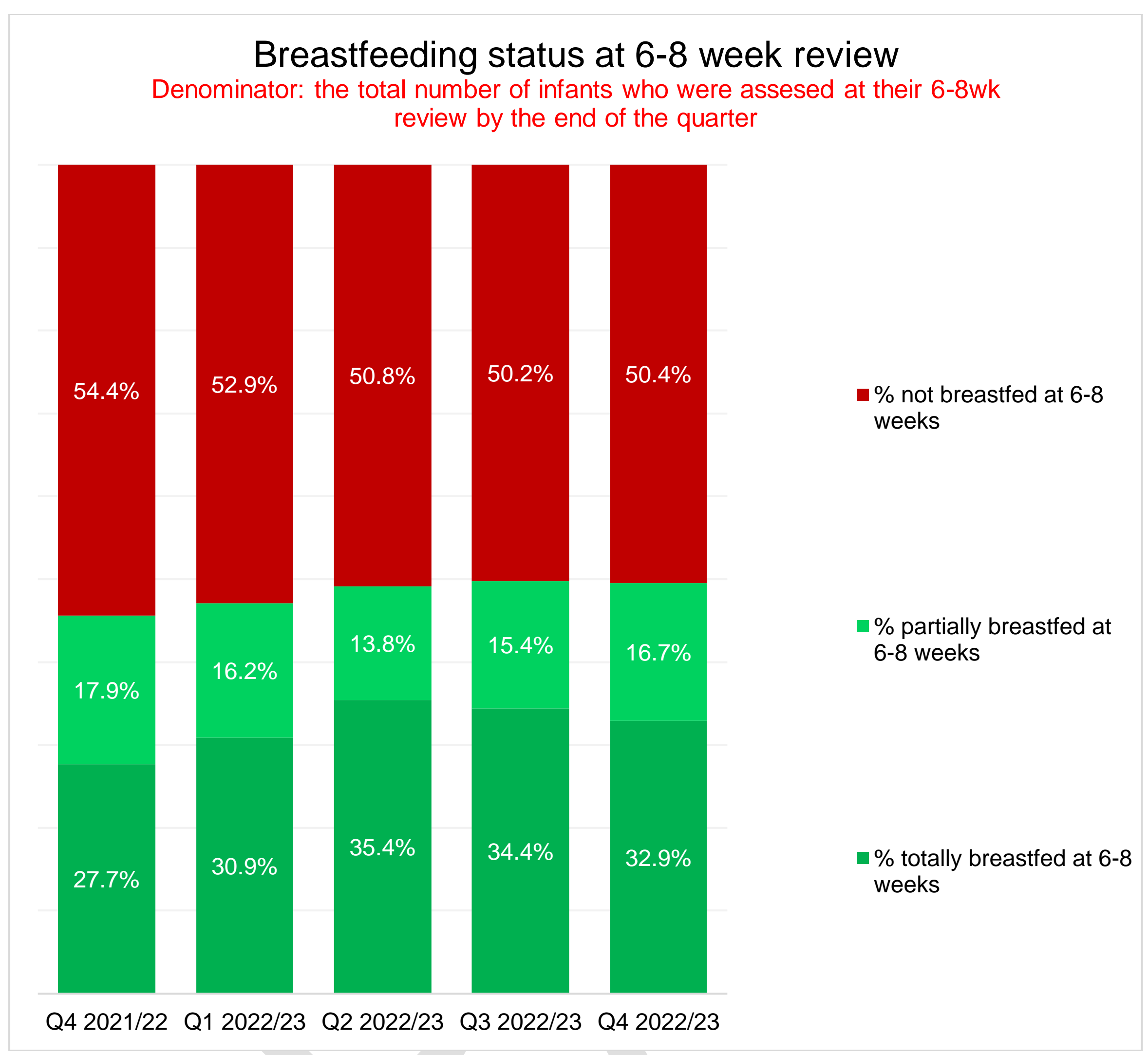
6–8-week review: breastfeeding status

Note: this data differs from data presented in the Breastfeeding Prevalence section. The denominator is the total number of infants who ***received*** *a 6–8-week review and does not include those who did not receive a visit.*

The proportion of infants partially or totally breastfed at their 6-8 week review has seen a rise over time. As of Q4 23/4, 49% of infants were recorded as breastfed at their 6-8 week review, a 14% rise since Q2 of the same year.

In Q4 of 2022/23, half (49%) of infants who were assessed at their 6–8-week review were partially or totally breastfed, 33% of which were totally breastfed.

This is an improvement compared to the previous year, up from 46% partially or totally breastfed in Q4 2021/22 to 49% in Q4 2022/23.


Breastfeeding status at 6-8 week review
Denominator: the total number of infants who were assesed at their 6-8wk review by the end of the quarter
54.4%
52.9%
50.8%
50.2%
50.4%
17.9%
16.2%
13.8%
15.4%
16.7%
27.7%
30.9%
35.4%
34.4%
32.9%
Q4 2021/22
Q1 2022/23
Q2 2022/23
Q3 2022/23
Q4 2022/23
% not breastfed at 6-8 weeks
% partially breastfed at 6-8 weeks
% totally breastfed at 6-8 weeks

Uptake of the Healthy Start Voucher Scheme

The Healthy Start scheme provides vouchers for pregnant women and parents with children under 4 years of age in receipt of certain benefits to help buy some basic foods. This important means-tested scheme provides vouchers to spend with local retailers. The scheme provides financial support to families to buy health food, milk and vitamins for pregnant women and parents of young children.

Take up in the most recent reporting period (January 2024) in Shropshire was 71% of eligible families, which was slightly below the national average of 74% [55].This is a rise over the last three years, up from 49% in January 2021. However, this still means that over a third (39%) of eligible families aren't taking up this free support for their children. The chart below right shows the number of eligible families and the number of people taking up healthy start vouchers. Both have been rising since January 2019, with a steeper rise in eligible families compared to the number of those taking up the scheme. This is also seen nationally[56].

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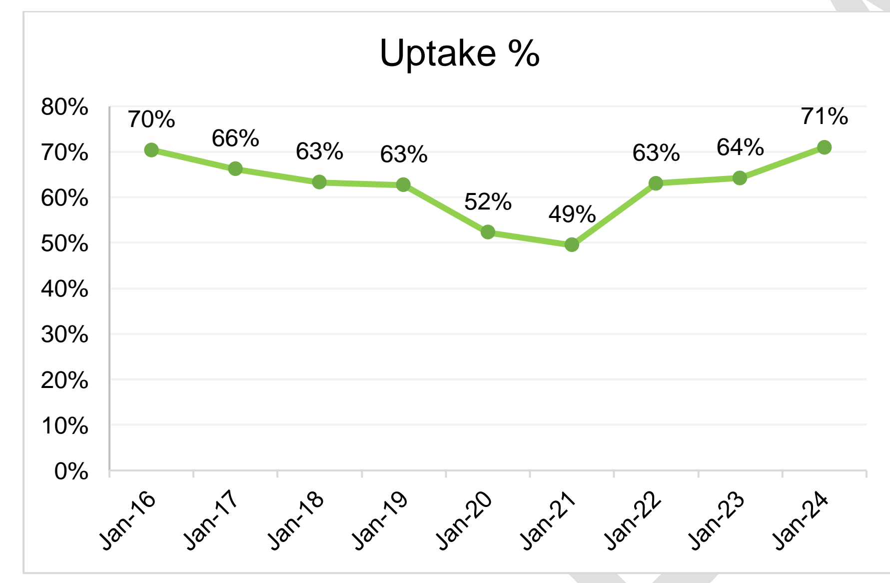

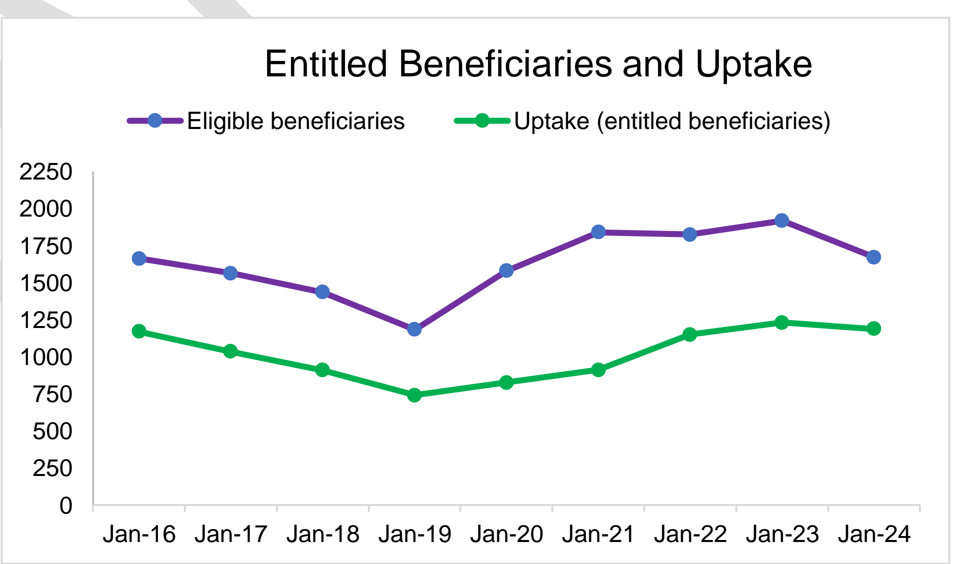

[55] https://media.nhsbsa.nhs.uk/news/nhs-healthy-start-uptake-data-released
[56] https://media.nhsbsa.nhs.uk/news/nhs-healthy-start-uptake-data-released#:~:text=National%20uptake%20is%20currently%2062.7,the%20previous%20paper%20voucher%20scheme.&text=More%20families%20are%20now%20eligible,than%2020%2C000%20since%20August%202021.

Healthy Start Voucher Scheme

Planning

December 2021- January 2022

- Explored data and refined objectives
- Recognition of pressures/limited capacity of frontline staff to promote vouchers
- Mapped existing promotion
- Planned who we needed to engage
- Explored NHS resources that could be adapted for Shropshire
- Agreed target of 5% increase
- Linked to Health Inequalities plan
- Agreed to engage with relevant staff to see what they needed to promote

Communications material produced

May - June 2022

- Leaflet for families produced adapting NHS HS resources
- Professionals poster produced with key messages for professionals to build confidence
- QR code embedded
- Healthy Start 'Ask your midwife or Health Visitor about Healthy Start' stickers- maternity agreement to stick these on all red books for pregnant women
- SWAY created for professionals with links to NHS information for professionals

Online communications campaign went live

August 2022

Online comms campaign went live- Shropshire Council social media, intranet (all relevant webpages), Family information services and organisations added SC link to webpages.

2022

49% uptake

2021

65% uptake

2023

Engagement with stakeholders and professionals

January 202-April 2022

Meetings with midwifery, public health nurses, food banks, social care, early help, parenting team, Maternity voices partnership and Shropshire Council colleagues (welfare team, public health, registrars, housing, libraries etc)

Review of feedback & funding secured

- Professionals were not confident to promote as did not feel knowledgeable. Changes to HS move to digital was another barrier as professionals were not aware of new process. Professionals felt a visual leaflet and QR code would be helpful alongside professionals information.
- Workforce group agreed messages and resources needed based on stakeholder engagement
- Costed and budget secured through Public Health/Shropshire Council for resources

Campaign went live

July 2022- August 2022

- Huge response with almost all organisations requesting printed posters
- Positive feedback received from organisations and professionals
- Additional organisations requesting resources- word of mouth

Ongoing

August 2022 to present

- Regular online and stakeholder promotion
- Review of engagement with social media comms campaigns
- Ask to the system to promote

Children aged 0-4 with SEND

Please see the Special Educational Needs and Disability (SEND) for 0-25 year olds JSNA here for data and intelligence relating to this group.

Vulnerable children

Drugs and Alcohol

Information on Parents/carers and families in substance misuse services can be found in the Population and Context Chapter of this JSNA. Please refer to the chapter for more information.

Shropshire's published Drugs and Alcohol Needs Assessment provides more detailed information here Drug and Alcohol Needs Assessment.

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Domestic abuse

Information on Parents/carers and families in substance misuse services can be found in the Population and Context Chapter of this JSNA. Please refer to the chapter for more information.

In 2022, Shropshire's Domestic Abuse Needs Assessment was published, including a section on children and young people. For more information, please see the main report here.

Child Benefits

See Population and Context chapter – Child Benefits section for detail.

In Shropshire, there were 11,260 children aged under 5 for whom benefit was received in August 2023, equating to 22% of all children for whom benefit is received in the county. This is a small decrease compared to the previous year of 3% (equating to390 children).

Total number of children for whom benefit is received by age group, West Midlands Local authorities, August 2023

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Area Name	Children: Under 5	Children: 5 to 10	Children: 11 to 15	Children: 16 and over	Total number of children
Herefordshire, County of	6,635	10,190	9,220	4,610	30,655
Shropshire	11,260	16,780	15,190	7,530	50,760
Stoke-on-Trent	13,515	19,320	17,120	7,910	57,860
Telford and Wrekin	8,860	13,055	11,750	5,745	39,415
Staffordshire	35,530	50,880	44,850	22,300	153,560
Warwickshire	22,720	33,185	29,530	14,285	99,720
Birmingham	58,830	90,140	80,550	42,140	271,660
Coventry	15,970	23,990	21,645	10,390	71,995
Dudley	15,170	21,740	18,815	9,490	65,215
Sandwell	18,060	27,170	24,410	12,420	82,060
Solihull	7,800	12,390	11,295	5,755	37,240
Walsall	15,150	22,185	19,385	9,730	66,445
Wolverhampton	13,555	20,465	18,195	9,090	61,305
Worcestershire	22,640	33,605	30,120	15,250	101,610

Area Name	Children: Under 5	Children: 5 to 10	Children: 11 to 15	Children: 16 and over	Total number of children
Herefordshire, County of	22%	33%	30%	15%	30,655
Shropshire	22%	33%	30%	15%	50,760

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Stoke-on-Trent	23%	33%	30%	14%	57,860
Telford and Wrekin	22%	33%	30%	15%	39,415
Staffordshire	23%	33%	29%	15%	153,560
Warwickshire	23%	33%	30%	14%	99,720
Birmingham	22%	33%	30%	16%	271,660
Coventry	22%	33%	30%	14%	71,995
Dudley	23%	33%	29%	15%	65,215
Sandwell	22%	33%	30%	15%	82,060
Solihull	21%	33%	30%	15%	37,240
Walsall	23%	33%	29%	15%	66,445
Wolverhampton	22%	33%	30%	15%	61,305
Worcestershire	22%	33%	30%	15%	101,610

Total number of children for whom benefit is received by age group, Shropshire, August 2022-23

Shropshire	Aug-22	Aug-23
Children: Under 5	11,650	11,260
Children: 5 to 10	17,270	16,780
Children: 11 to 15	15,145	15,190
Children: 16 and over	7,700	7,530

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Children in need

Every local authority must protect and promote the welfare of children in need in its area. To do this, it must work with the family to provide support services that will enable children to be brought up within their own families.

Who are 'children in need'

Children in need are defined in law as children who are aged under 18 and:

- need local authority services to achieve or maintain a reasonable standard of health or development
- need local authority services to prevent significant or further harm to health or development
- are disabled

Children in Need are a legally defined group of children (under the Children Act 1989), assessed as needing help and protection as a result of risks to their development or health.

This group includes children on child in need plans, children on child protection plans, children looked after by local authorities, care leavers and disabled children[57].

National picture

Source: Department for Education (DfE)

In 2023, over 403,000 children were classed as in need and just under 51,000 children were on protection plans.

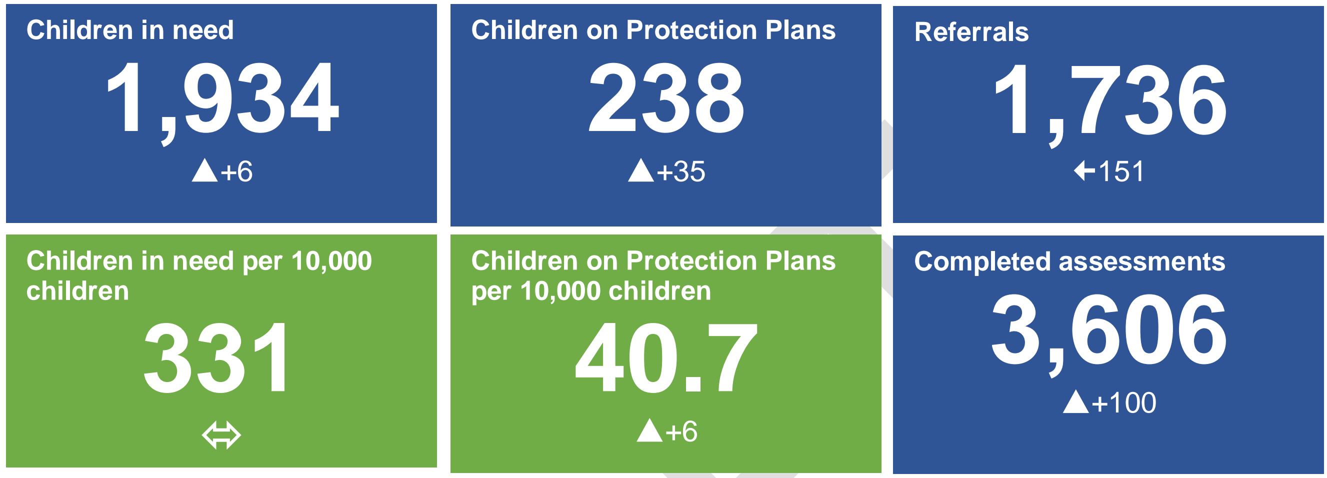
All the headline measures (apart from completed assessments) have decreased at least slightly compared with 2022. The number of children in need is higher than in 2020, which (mostly) pre-dates the COVID-19 pandemic in England. However, the number of children on protection plans, referrals and completed assessments is lower.

The latest annual decreases follow the increase in 2022, in which there was a rise in all the headline measures, likely linked to school attendance restrictions due to COVID-19 no longer being in place.

[57] Citizens Advice

In 2021, there was a fall in referrals, mainly driven by a drop in school referrals, attributable to restrictions on school attendance being in place for parts of the year. This in turn likely contributed to the falls seen in the other headline measures in that year[58].

Shropshire picture



Data at 31 March 2023: (arrows indicate change compared to 2022)
Source: Explore Education Statistics

In Shropshire, at 31 March 2023, there were 1,934 children in need (aged under 18). This equates to a rate of 331 children in need per 10,000 children which is below regional and national average but similar to our statistical neighbours. There were 238 on protection plans, equating to a rate of 40.7 per 10,000, below the national average.

The rate of children in need in Shropshire has been rising over time since 2017, rising from a rate of 199 in 2017 to 331 per 10,000 children.

The most common primary need for these children was abuse or neglect between 2013 and 2023, with 58% of children in need having this as their primary need. This rate has been steady over the last 3 years

The rate of children on child protection plans in Shropshire has been falling since 2019, however there has been a rise in the latest year, up from 34.7 per 10,000 in 2022 to 40.7 per 10,000 in 2023.

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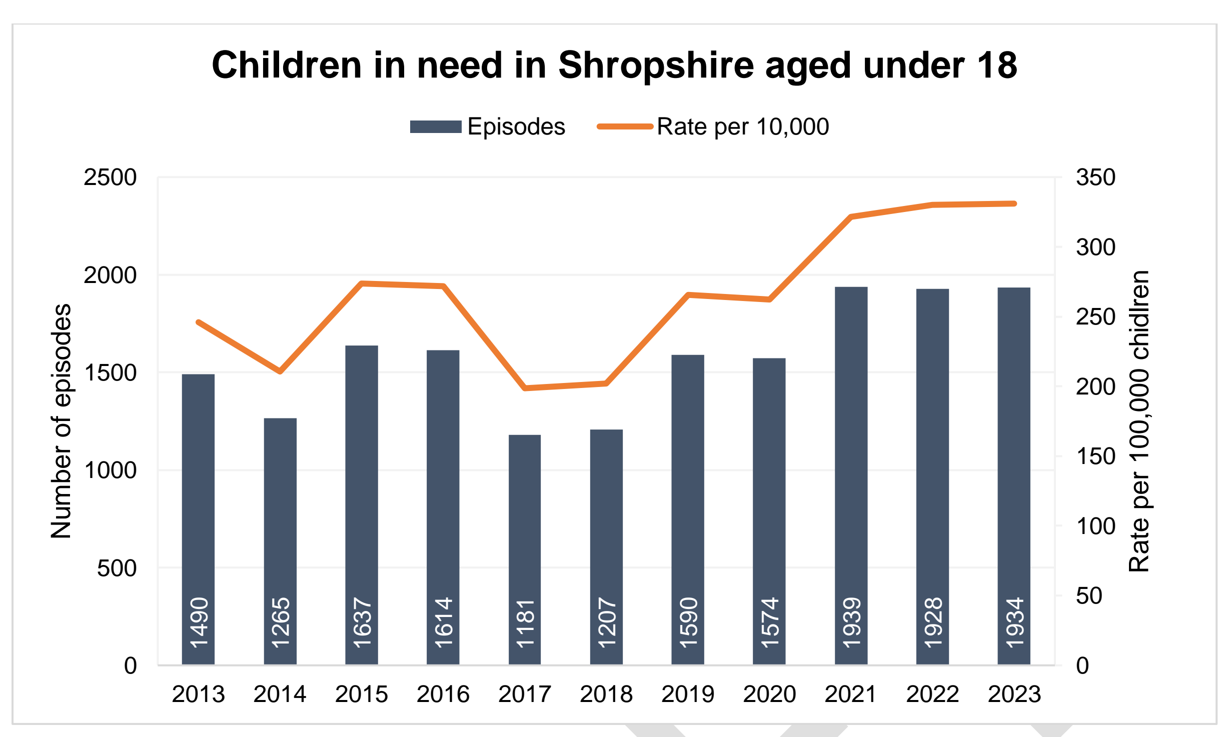
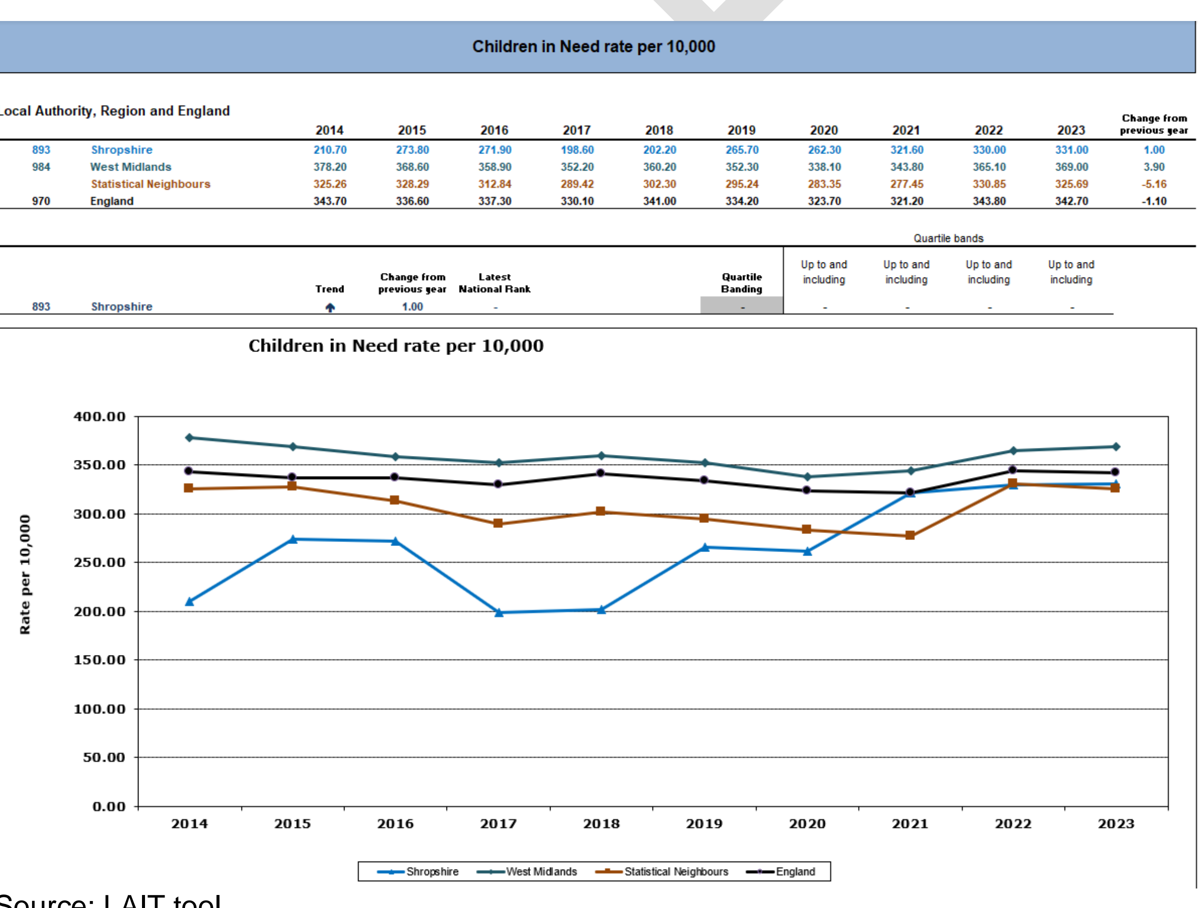
[58] Children in Need- Gov.uk https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need





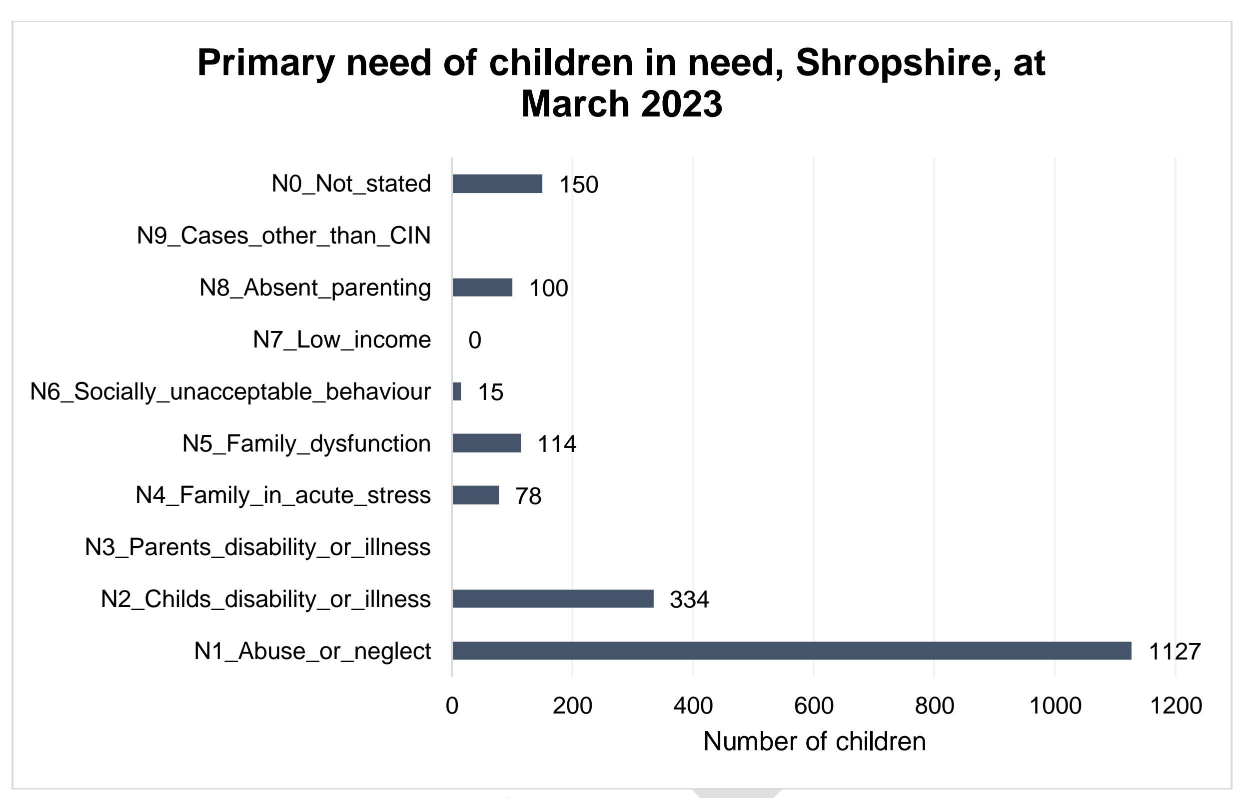
Children in Need rate per 10,000

Local Authority, Region and England

		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Change from previous year
893	Shropshire	210.70	273.80	271.90	198.60	202.20	265.70	262.30	321.60	330.00	331.00	1.00
984	West Midlands	378.20	368.60	358.90	352.20	360.20	352.30	338.10	343.80	365.10	369.00	3.90
	Statistical Neighbours	325.26	328.29	312.84	289.42	302.30	295.24	283.35	277.45	330.85	325.69	-5.16
970	England	343.70	336.60	337.30	330.10	341.00	334.20	323.70	321.20	343.80	342.70	-1.10

		Trend	Change from previous year	Latest National Rank	Quartile Banding	Quartile bands: Up to and including	Up to and including	Up to and including	Up to and including
893	Shropshire	↑	1.00	-	-	-	-	-	-

Source: LAIT tool



Outcomes for Children in Need (including Looked after Children)

Data is only published up to 31st March 2022. At this time in Shropshire, there were1,928 children in need (CIN) aged under 18.

Social Care group	Definition
CIN	Children in need
CINO	children in need, excluding children on a child protection plan and children looked after. This includes children on child in need plans as well as other types of plan or arrangements.
CPPO	children on a child protection plan, excluding children looked after.
CLA	children looked after (excludes children who are in respite care in their most recent episode during the reporting year).

Special education needs (SEN)
Special educational need and primary type of special education need for children in need (excluding children on a child protection plan and children looked after), children on a child protection plan (excluding children looked after) and children looked after.

In Shropshire, at 31st March 2022, there were 1,097 children in need who were pupils, 52% (572) of which were pupils with SEN. This compares with 49% nationally.

Of the 1,097 children in need who were pupils, 62% were children in need, excluding children on a child protection plan and children looked after, 26% were children looked after the remaining were on child protection plans. This is a similar profile to what we see nationally.

Of those CINO pupils in Shropshire, 58% were pupils with SEN, compared to 48% of children looked after and a third of children on protection plans were pupils with SEN. In England, 48% were pupils with SEN, compared to 57% of children looked after and 39% of children on protection plans were pupils with SEN.

At 31st March 2022	Social care group	Total pupils in each social care group	%	Number of pupils with no identified SEN	%	Number of pupils with SEN	%
England	CINO	139,320	66%	72,140	52%	67,180	48%
	CLA	41,940	20%	17,890	43%	24,060	57%
	CPPO	29,710	14%	18,050	61%	11,650	39%
	Total	210,970	100%	108,080	51%	102,890	49%
Shropshire	CINO	682	62%	289	42%	393	58%
	CLA	284	26%	149	52%	135	48%
	CPPO	131	12%	87	66%	44	34%
	Total	1,097	100%	525	48%	572	52%

Children looked after (children in care)

Children in care are a vulnerable group at greater risk of poor physical and emotional health outcomes than their peers. This can lead to poorer health throughout their life, and shorter life expectancy. Each local authority has a responsibility to understand a children in care's health needs and ensure that they receive the care they need.

On March 2023 in Shropshire, there were 656 children looked after, a rise of 7.5% compared the previous year[59]. Local data indicates that there will be a rise in 2024, with 719 looked after children reported as at 25 March 2024.

In 2023, there were 161 children looked after aged 0-4 years old, making up 24% of all children looked after in the county. Local data indicates that there are currently 154 looked after children aged 0-4 in Shropshire as at 25 March 2024, making up 21% of all looked after children.

[59] Education Statistics

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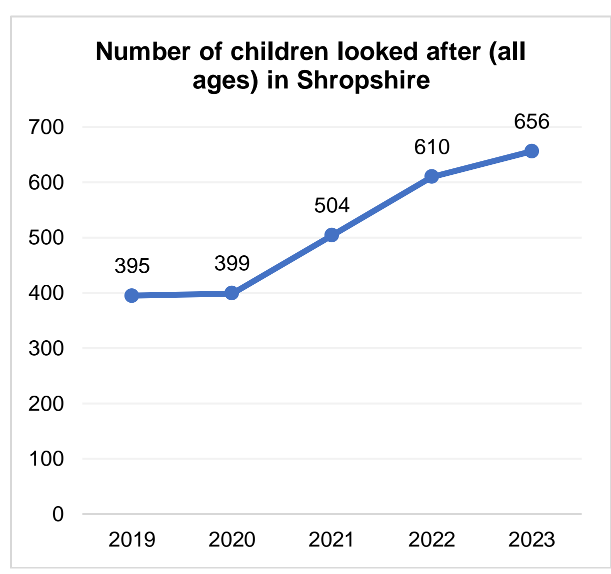

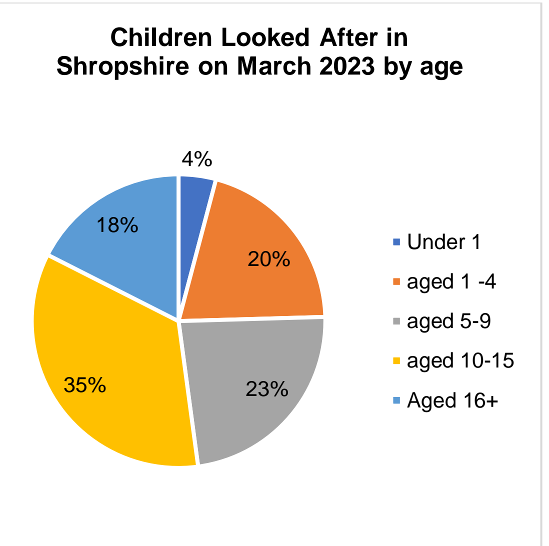

Published data showing the number of children looked after in each age group over time. Soruce: Education Statistics.

Children looked after on 31 March in each year						
Year	**Under 1**	**aged 1 -4**	**aged 5-9**	**aged 10-15**	**Aged 16+**	**Total**
2019	21	63	84	144	83	395
2020	17	71	86	149	76	399
2021	33	104	111	166	90	504
2022	41	127	133	199	110	610
2023	27	134	153	227	115	656

Table showing local data from Shropshire Children's Services at 25 March 2024

As at 25/3/24	**0-4 years**	**Total**
Full care order	67	**433**
Interim care order	57	**150**
Single period (s20)	27	**126**
Placement order	*	**9**
LA on remand		*
Total	**154**	**719**

*** Numbers under 5 have been suppressed.**

Trends

There has been a steady rise among all age groups compared to 2022, particularly in those aged 5-15. However there has been a fall among children looked after aged under 1.

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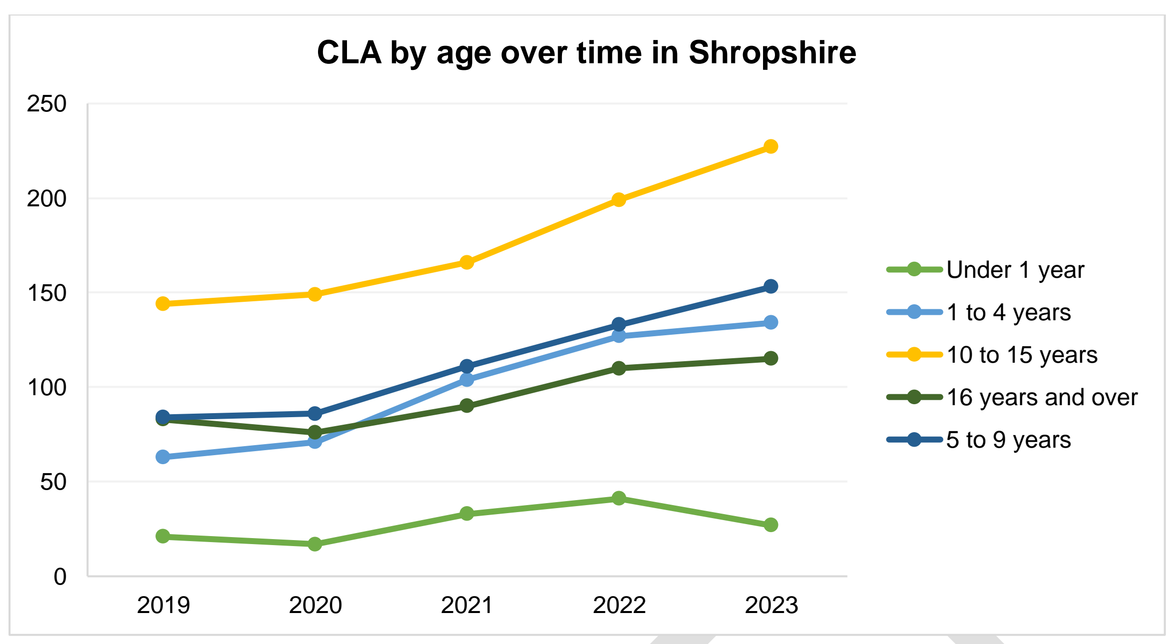
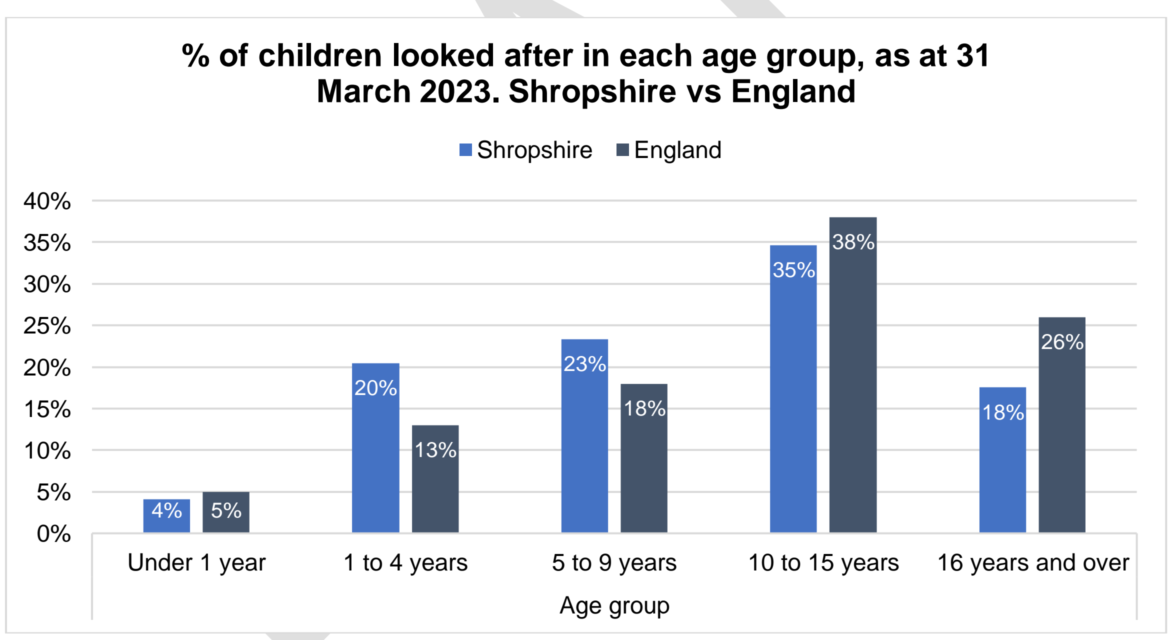


Compared to England, in 2023, Shropshire had a higher proportion of looked after children in the 1-4 year old and 5-9 year old age groups, and a lower proportion in those aged 10 and over.



Vulnerable families with 0-4 year olds

The Supporting Families Programme helps thousands of families across England to get the help they need to address multiple disadvantages through a whole family approach, delivered by keyworkers, working for local authorities and their partners.

Supporting Families launched in March 2021 and builds on the previous Troubled Families programme. As set out in 'Supporting Families 2021 to 2022 and beyond', its focus is on building the resilience of vulnerable families, and on driving system change so that every area has joined up, efficient local services which are able to identify families in need and provide the right support at the right time.
The programme has two key ambitions:

- To see vulnerable families thrive, building their resilience by providing effective, whole family support to help prevent escalation into statutory services.
- To drive system change locally and nationally, working with local authorities and their partners to create joined up local services, able to identify families in need, provide the right support at the right time, and track their outcomes in the long term

To help local authorities and their partners achieve these objectives, an outcomes framework has been developed which includes ten headline outcomes. This enables more detailed reporting on the problems families are facing, clarify what good looks like for these outcomes, and what levels of evidence would be expected when measuring these outcomes.

The 10 headline outcomes are:

1. Getting a good education
2. Good early years development
3. Improved mental and physical health
4. Promoting recovery and reducing harm from substance use
5. Improved family relationships
6. Children safe from abuse and exploitation
7. Crime prevention and tackling crime
8. Safe from domestic abuse
9. Secure housing
10. Financial stability

What are the most common problems our families with 0-4 year olds face?

The below table shows a locally collated list of metrics grouped into criteria relating to the Supporting Families Framework. This was used to identify vulnerable children and their families in Shropshire, the common problems families face and to measure the impact of the Supporting Families programme.

The following were matched by people and property:

- Social Care (Adults and Children's)
- Education Management
- Housing Options
- Early Years census
- School census
- Police domestic abuse and violence
- Youth offending
- Universal credit
- Drug and alcohol abuse (in progress)

Table showing metrics grouped into criteria relating to the Supporting Families Framework used to identify vulnerable families

Criteria ***(Supporting families outcome)***	**Metric**

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Children Safeguarding *(Children safe from abuse and exploitation; Improved family relationships)*	Child Looked After Episode
	CIN Plan
	Contacts
	Child Sexual Exploitation or at risk of
	Early Help Episode of support (with consent)
	Child Missing from Home or Care Episode
	Child on a Child Protection Plan
	Open case on LCS - open referral and CIN at national level. Closed when services are closed.
	S47 Assessment
Crime *(Crime prevention and tackling crime)*	Self-reported issues with crime recorded on Housing Application Form. Do you or anyone else in the household have a Criminal Conviction/ ASBO or a Conviction for a sexual offence
	Child Criminal Exploitation or at risk of
	Accused and convicted of Crime Incident
	Youth Offending Service Involvement
	Anti-Social Behaviour interventions through housing or evicted due to Anti-Social Behaviour
Domestic Abuse *(Safe from domestic abuse)*	A crime incident involving emotional, physical & financial domestic abuse. Includes all victim/suspect type roles associated with each crime incident. Where blame cannot be apportioned all parties recorded against the offence (including dependants of the nominals involved in the DA incident) will be recorded as an involved party.
	Accused and convicted of Crime Incident with a Domestic Violence marker or similar
Early Years *(Good early years development)*	Their children are eligible for 24U Funding (15 hours of free childcare) but are not taking this up.
	Child is eligible for Disability Access Fund-a one-off payment of £615 per child per year to the provider nominated by the parent (for parents receiving Disability Living Allowance for their child)
	Child is eligible for Pupil Premium which is paid to provider to help with child's education if parent is on specified benefits or child is looked after or has left care through adoption, special guardianship order or a childs arrangement order
	Child is recorded as having Special Educational Needs (in Early Years setting)
Education *(Getting a good education)*	Child recorded on Liquid Logic as having Special Educational Needs
	Child has more than 10% absence
	Child has had an exclusion from school
	Primary Special Educational Need recorded
	Secondary Special Educational Need recorded
Financial *(Financial stability)*	Self-reported financial issues recorded on Housing Application Form. Are you or anyone else in the household in Debt, have Debts or Loans or is either Unemployed, Unable to work or Neither of the potential household members are employed.
	Claiming Benefits
	Rent arrears (having issues with rent)
	Child has free school meals
Health *(Improved mental and physical health)*	Self-reported health issues recorded on Housing Application Form. Do you or anyone else in the household identify as having a Medical Condition, Mental Health Issues or is receiving Medical Benefits
Housing *(Secure Housing)*	Is homeless (gained from the Housing register application)
	On Housing Register
	On the Emergency Accommodation list

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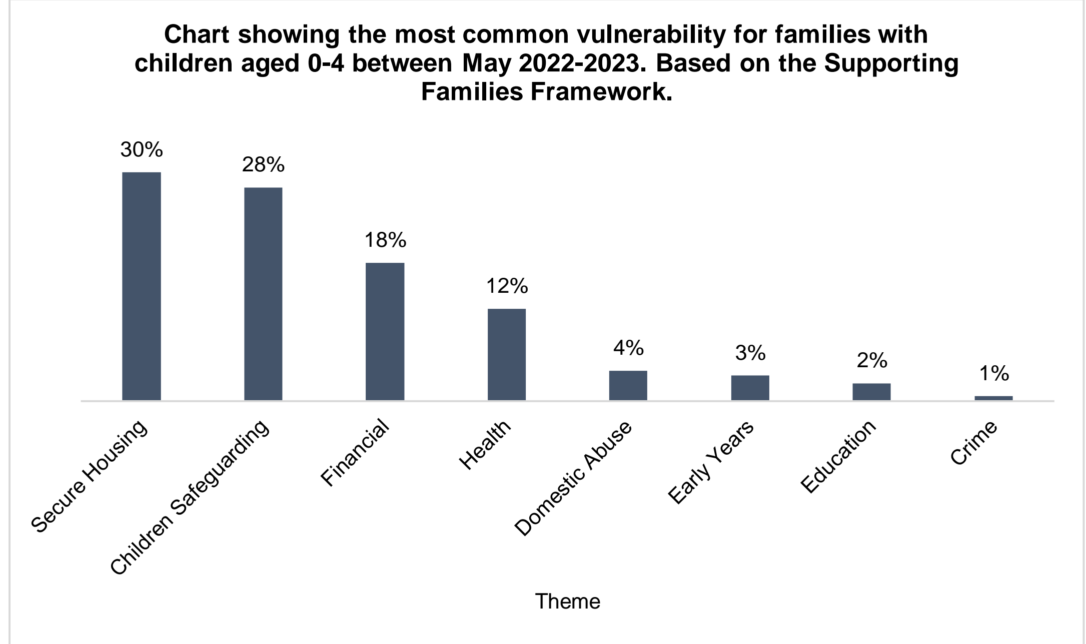
Note: Substance misuse data is currently missing due to information governance issues as this analysis required patient identifiable data. You can find information on parents/carers in drug and alcohol treatment in the Population and Context Chapter.

Data was filtered to identify the number of 0-4 year olds for each metric. Between May 2022 and May 2023 in Shropshire, there were 10,541 records of activity in total:

- Of these 10,541 records, secure housing was the most common problem families with 0-4 year olds were facing with 30% on a housing register, emergency accommodation list or registered as homeless
- Child safeguarding was identified in 28% of all records
- Financial issues were identified in 18% of all records, indicating this as another common issue

Note, one child can have records across multiple metrics.



Identifying our most vulnerable children and their families

Children/families with records across multiple criteria are our most vulnerable families in Shropshire. This work has been undertaken to determine:

- Is Early Help working with the right families?
- Are we engaging the hardest to reach families?

For example: a child/family with a 0-4 year old could be on the housing register, have a family member with health issues and a family member with a criminal record, therefore having vulnerabilities across Housing, Health and Crime.

How many families with 0-4 year olds had records across three or more criteria?

There were 3,869 0-4 year olds in 3,421 properties known to Shropshire Council in the last 12 months (from 8 June 2024). These children where identified to have activity in one or more of the eight criteria:

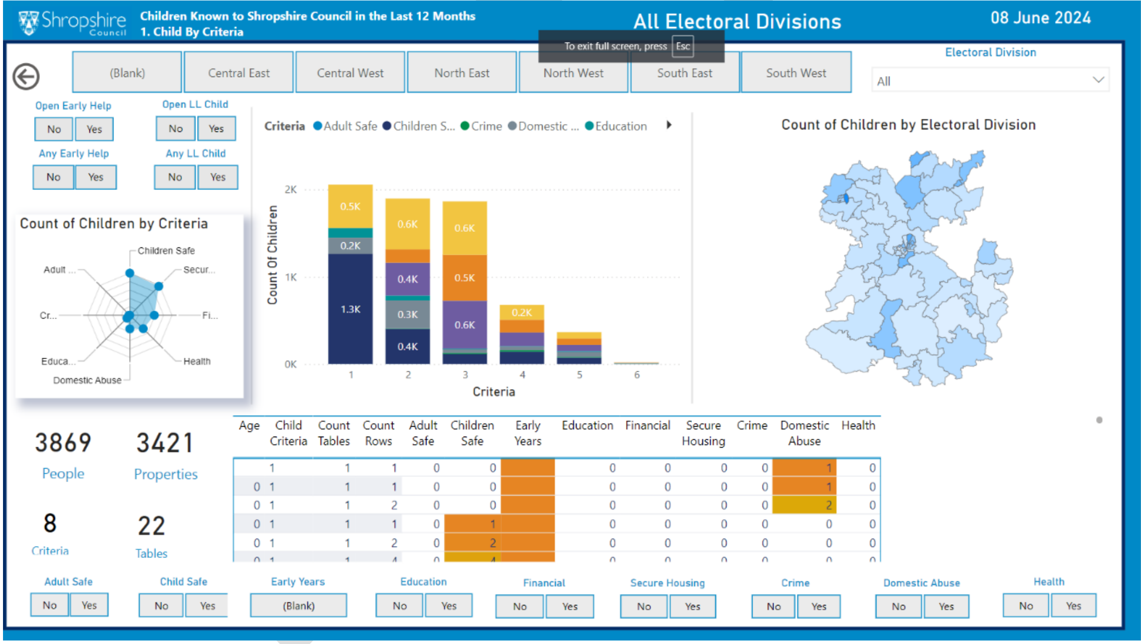
- Adult Safeguarding
- Children Safeguarding

- Crime
- Housing
- Education
- Finance
- Health
- Domestic abuse

Majority (93%) of 0-4 year olds had activity in 1-3 criteria, with over half having activity in one criteria. Children Safeguarding and housing were the two most common criteria in this age group.

Number of criteria	Number of 0-4 year old%	% of 0-4 year olds
1	2,105	54%
2	861	22%
3	640	17%
4	214	6%
5	47	1%
6	*	*
Total	**3,869**	**100%**

Early Help Hub dashboard



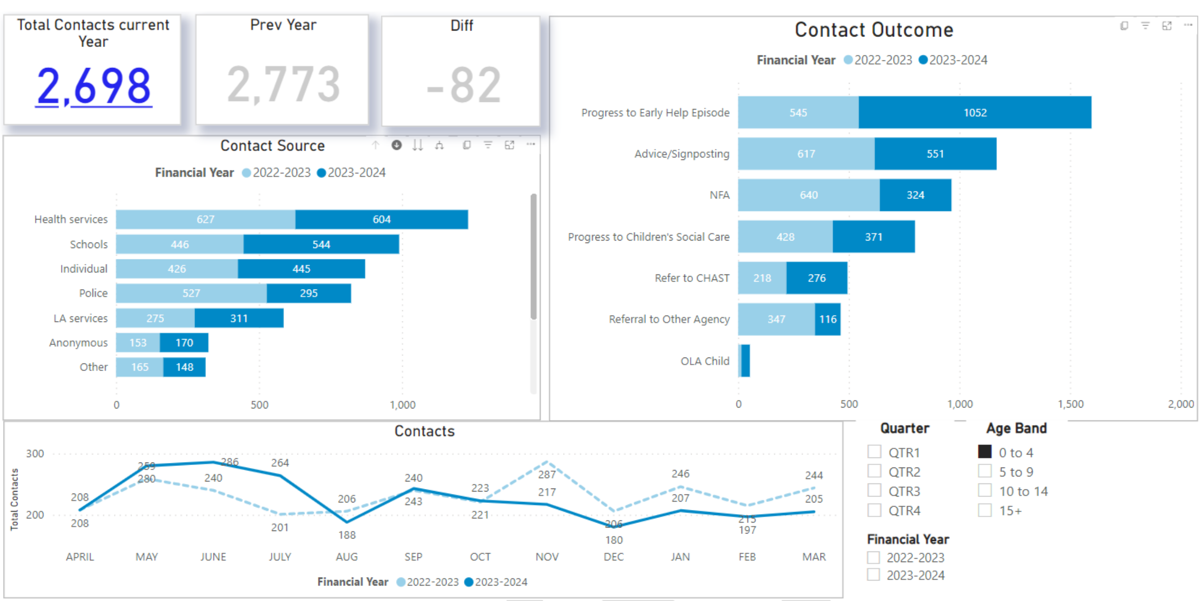
Children's Social Care Contacts and referrals

Contacts

In Shropshire in 2023-24, there were 2,698 Children's Social Care contacts with babies, infants and children aged 0-4, a fall of 82 contacts compared to the previous year. There was a higher number of contacts for this age group between May and July 2023 compared to the same period in 2022 however for the remainder of the financial year, numbers of contacts were similar, with some months of 2023-24 being slightly lower than the same period in 2022-23.

The highest number of contacts were from a health services and school source over the last two years. Compared to 2022-23, there has been a rise in contacts with babies, infants and children aged 0-4 in Shropshire where the source of contact was schools, individuals, and LA services. The number of contacts where the source was health services remains steady, however there has been a rise in contacts from A&E.

Dashboard showing Children's social care contacts for 0-4 year olds. Source: Shropshire Children's services



Referrals

In Shropshire during 2023-24, there were 408 Children's Social Care referrals of babies, infants and children aged 0-4, a fall of 28 referrals compared to the previous year.

The highest number of referrals were from Health Services and LA services in 2023-24, with Police making most referrals in 2022-23 for 0-4 year olds.

Within health services referrals, midwives and ambulances made the most referrals in 2023-24. The number of referrals from midwives, ambulances, consultants and A&E doubled compared to 2022-23, with a large fall seen in referrals made by primary health services.

Dashboard showing Children's social care referrals for 0-4 year olds. Source: Shropshire Children's services

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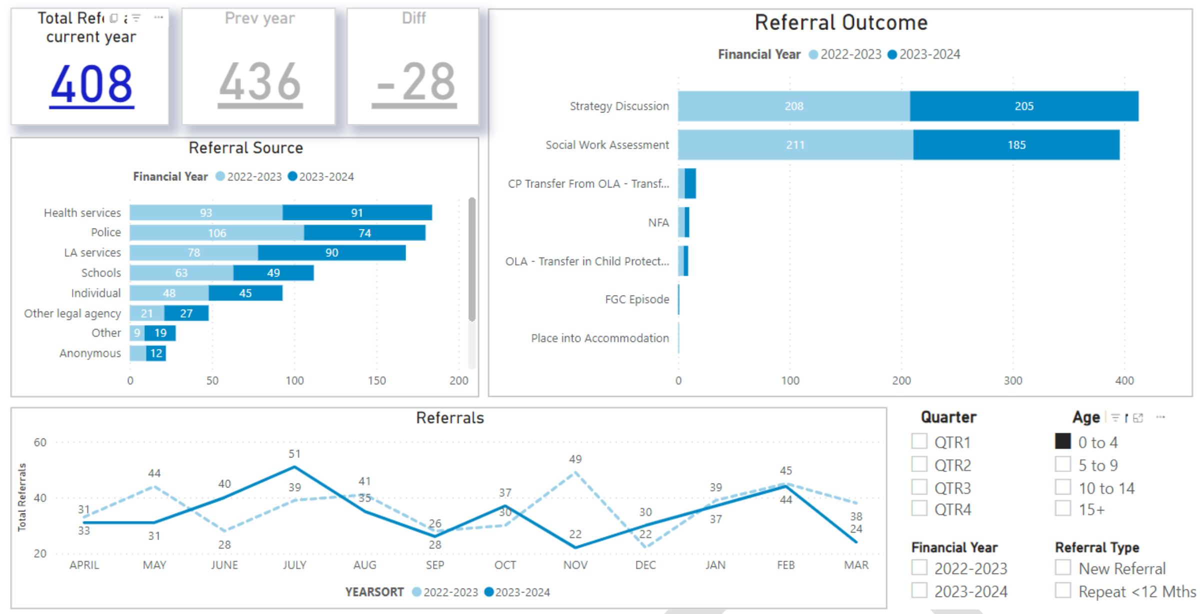

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Case study: COMPASS Help and Support Team (CHAST)

The CHAST offer aims to address demand and capacity issues into Children's Social Care in Shropshire and to ensure parents and families access support and help to meet their needs at the earliest opportunity. CHAST support is important as Early help can offer children the support needed to reach their full potential (EIF, 2021). It can improve the quality of a child's home and family life, enable them to perform better at school and support their mental health (EIF, 2021). Research suggests that early help can:

- protect children from harm
- reduce the need for a referral to child protection services
- improve children's long-term outcomes (Haynes et al, 2015)

The COMPASS Help and Support Team data shows that between September 2022 and March 2023, 74 babies, infants and children were supported by the team, 65% of which were aged 2-4. This data includes unborn babies. These were children largely from household compositions of 1-2 children (76%). Half (53%) of those supported were males, 43% were females with the remainder were unknown. Majority of babies, infants and children supported were White British (68%). Referrals came from a wide number of sources, for example ambulances, schools, and the police. The most common presenting issues were domestic abuse (16%), parenting difficulties (13%) and neglect (12%). The most common barriers to access were not needing support previously (38%), declining support (23%) or being known to children's services previously (18%).

Table showing the top 6 presenting issues to CHAST, September 2022 to March 2023,

Source: COMPASS Help and Support Team

Presenting issue	Count	Proportion
Domestic abuse	18	16%
Parenting Difficulties	15	13%
Neglect	14	12%
Adult mental health	11	10%
Parental acrimony	10	9%
Adult substance misuse	9	8%

* Figures under 5 have been suppressed for confidentiality reasons.

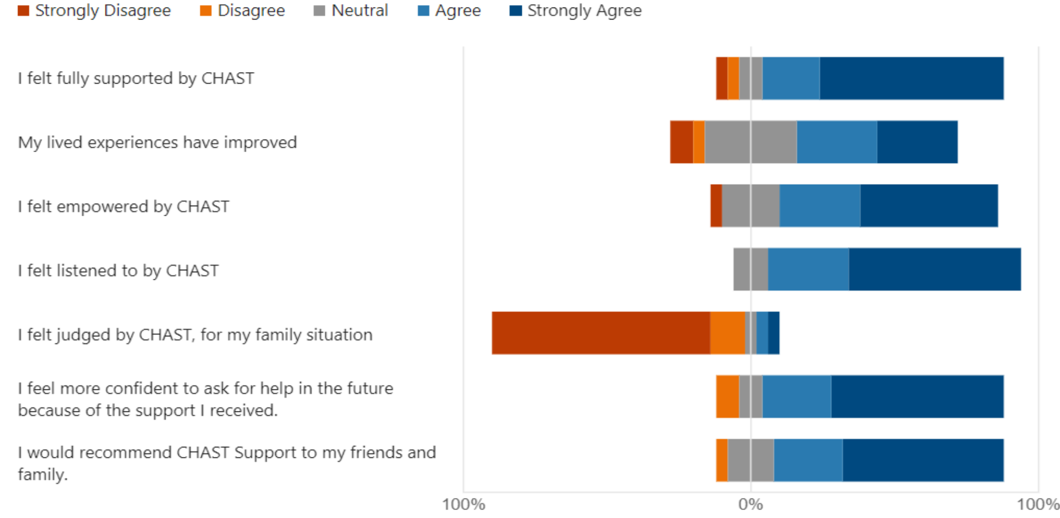
Table showing Early Help outcomes, September 2022 to March 2023, Source: COMPASS Help and Support Team

Early Help Outcome	Count	Proportion
None as no support given	24	19%
Due to decline	23	18%
Keeping children safe from abuse and exploitation	16	13%
Improved mental and physical health	15	12%
Safe from domestic abuse	8	6%
Improved family relationships	8	6%
Secure housing	8	6%
No data	8	6%
Early years development	7	6%
Getting a good education	*	*
Promoting recovery and reducing substance misuse	*	*
Financial stability	*	*

* Figures under 5 have been suppressed for confidentiality reasons.

Impact of CHAST on Children and Families from their perspective

Feedback was collected from all families with children aged 0-18 engaged with the team during the first three months of operation. Families rated CHAST 8.80 out of 10 for the support they received, with majority feeling their lived experiences had improved, they were empowered, listened to and approached in a non-judgemental way. This included 49 babies, infants and children aged 0-4 years (out of a total of 179). The feedback received stated our children and families felt more confident to ask for help in the future and would recommend CHAST to their friends and family.



Only those families who need social work intervention are being identified at front door, this ensures help to families at the right time, at the right level.

Impact of CHAST on Children and Families from their perspective.

It was a very quick turnaround, and with our experience of dealing with BEEU, the difference, was amazing. It felt like before, we were a forgotten family. However, with the support from Jill and CHAST, we felt as though we existed, for the first time in a long time. It was the first time, that we were dealt with as a family and not just me.

Knowing that there are agencies out there, and there are things that I can access to support me and my family. CHAST put me in touch with lots of support, that I can access myself, and gave reassurance that there was help. It helped me to identify problems that the situation could be, and things I had not considered before

you have amazed me Jill, you have been here for half an hour, and I feel better than I have felt for twenty years.

It has increased my confidence in my ability to move past the issues, that I felt I was facing. I did not feel so alone, in the problems that I was experiencing. I felt the safety of my family was very much the point of concern, without any fault of blame being proportioned to myself.

we have spent years of people not listening to us, and I feel now, that we are going to get some support, and you have been really kind, it's a life line

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CHAST Service-Improvements and the way forward to 6-month Review.

Service improvements from the feedback received from CHAST have already started to be undertaken. Examples are:

- Feedback was given around children and families being sign-posted, to services, but not having hands on support to make referrals. CHAST responded to this, by disseminating new guidance to family support workers around a hand-holding approach and more hands on help and support.
- Feedback was also given, around a lack of knowledge in support service arena's for different presenting issues. CHAST responded to this, and now have weekly catch-up meetings where partners are invited to discuss their service, and referral pathway to support the knowledge of front-line family support workers in CHAST.
- Waiting times when CHAST became busy, were also raised. CHAST is in the process of responding to this, with an advert for two further family support workers to meet the current demand on the COMPASS Help and Support Team.

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Early Years Settings

Early years settings provide a caring, supportive environment where children can learn and develop. Early years settings such as nurseries, pre-schools and childminders support parents and deliver crucial care and education for our youngest children.

Starting from April 2024, existing childcare support will be expanded in phases. By September 2025, most working families with children under the age of 5 will be entitled to 30 hours of childcare support.

The changes are being introduced gradually to make sure that providers can meet the needs of more families. This means that:

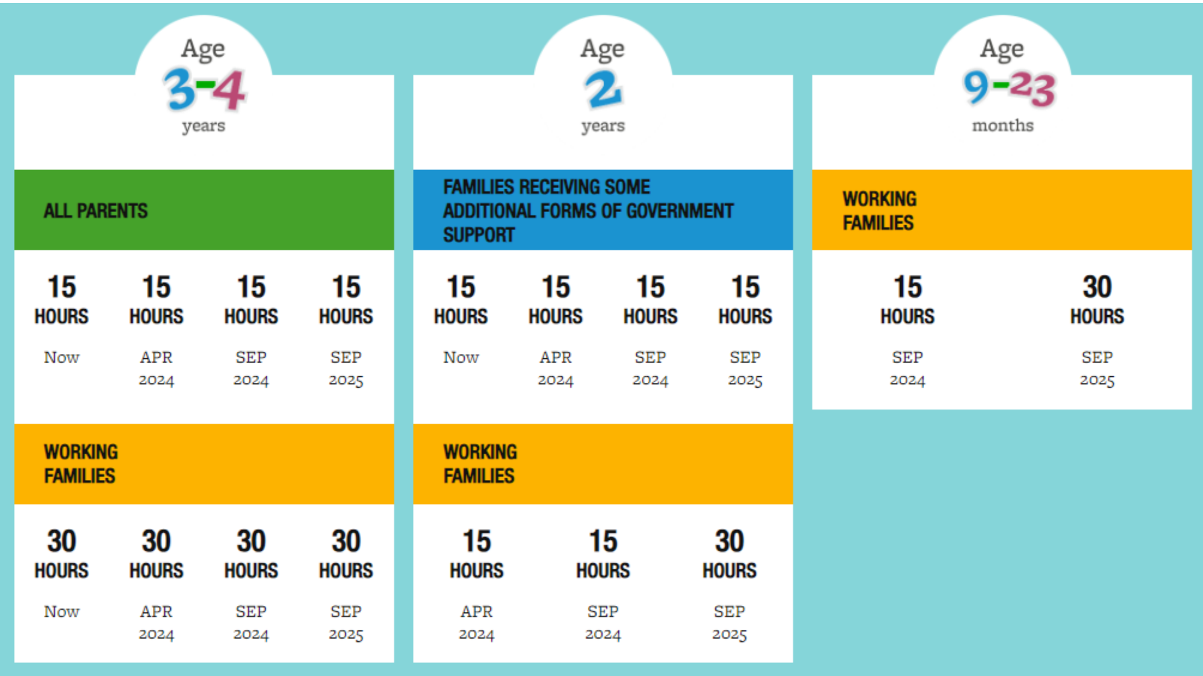
From April 2024, eligible working parents of 2-year-olds will be able to access 15 hours childcare support.

From September 2024, 15 hours childcare support will be extended to eligible working parents of children from the age of 9 months to 3-year-olds.

From September 2025, eligible working parents with a child from 9 months old up to school age will be entitled to 30 hours of childcare a week.

Like the existing offer, depending on your provider, these hours can be used over 38 weeks of the year or up to 52 weeks if you use fewer than your total hours per week.

Sign up for more details about the upcoming expansion from April 2024, as well as how and when to register for support with childcare costs.



Source: Child Care Choices - https://www.childcarechoices.gov.uk/upcoming-changes-to-childcare-support/

Where are the Early Years settings in Shropshire in relation to areas of deprivation?

As of May 2024, in Shropshire, there were 99 Early Years settings and 97 childminders located across the county (see map below). Many settings are concentrated in the Shrewsbury area and Oswestry. Reassuringly, settings are well-placed in relation to areas with high levels of income deprivation affecting children (purple heat map below).

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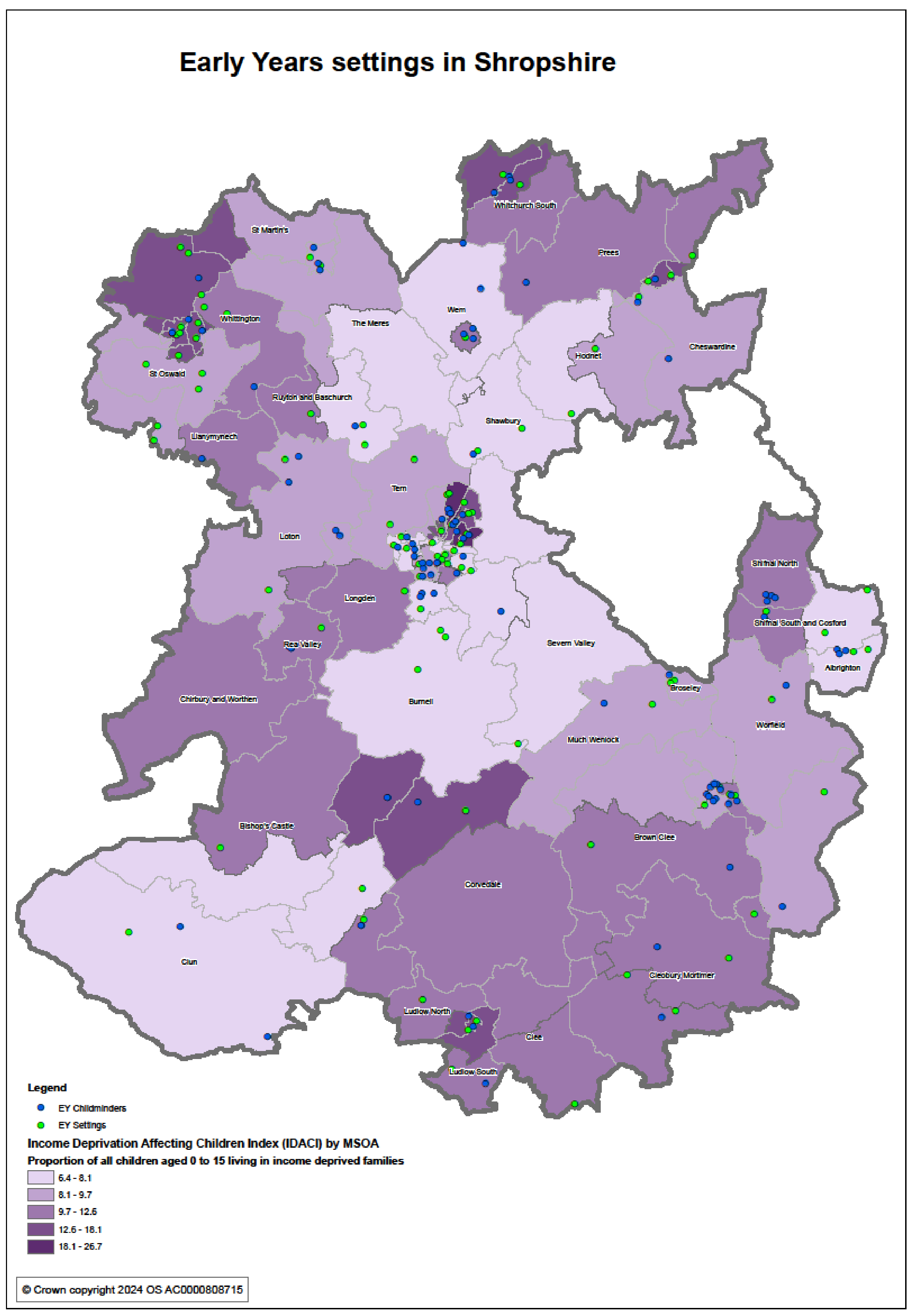
Early Years settings in Shropshire
Whitchurch South
St Martin's
Prees
Wem
The Meres
Whittington
Cheswardine
Hodnet
St Oswald
Ruyton and Baschurch
Shawbury
Llanymynech
Tern
Loton
Shifnal North
Longden
Shifnal South and Cosford
Rea Valley
Severn Valley
Albrighton
Broseley
Chirbury and Worthen
Burnell
Worfeld
Much Wenlock
Bishop's Castle
Brown Clee
Corvedale
Clun
Cleobury Mortimer
Ludlow North
Clee
Ludlow South
Legend
EY Childminders
EY Settings
Income Deprivation Affecting Children Index (IDACI) by MSOA
Proportion of all children aged 0 to 15 living in income deprived families
6.4 - 8.1
8.1 - 9.7
9.7 - 12.6
12.6 - 18.1
18.1 - 26.7
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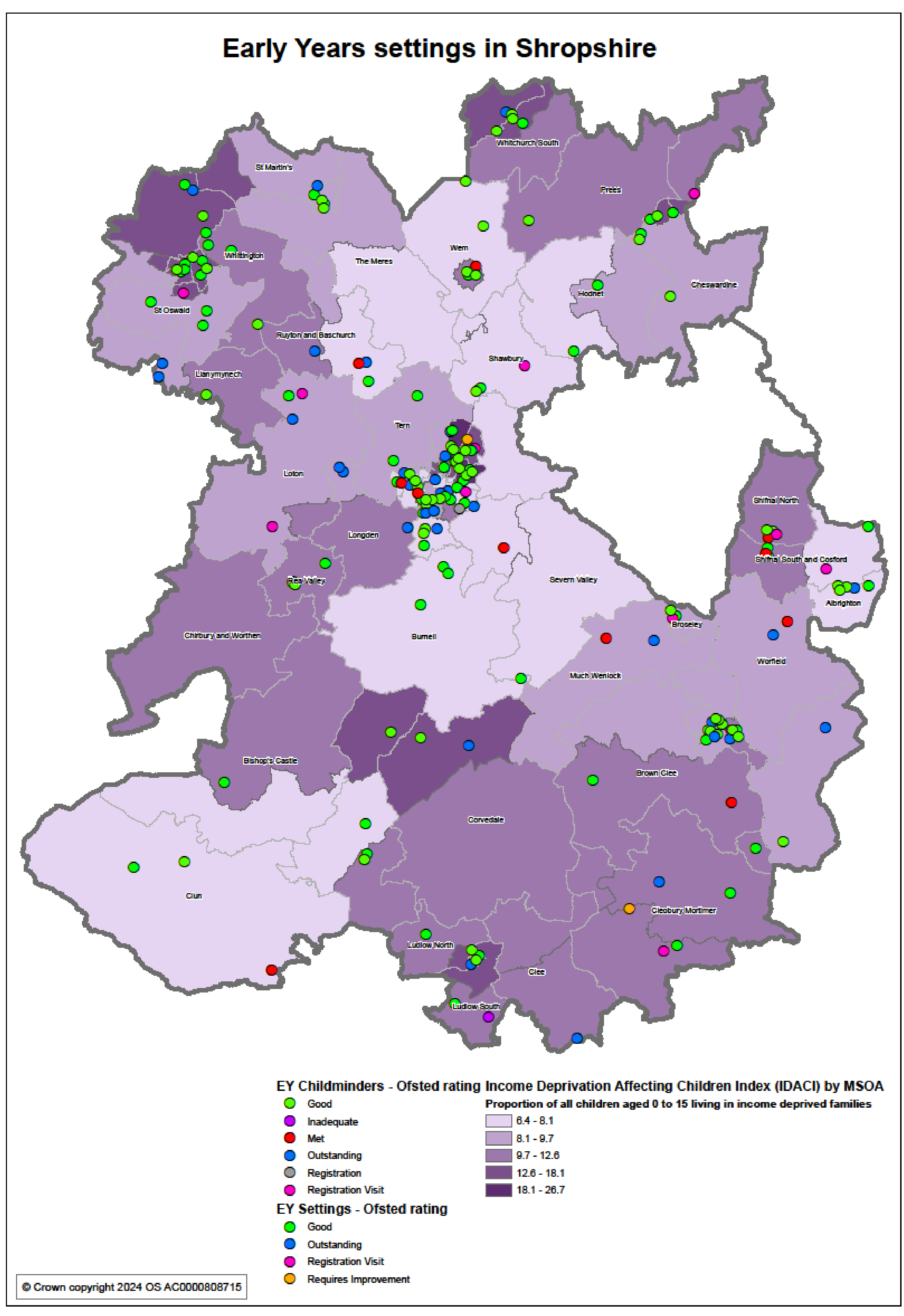

Early Years settings in Shropshire
Whitchurch South
St Martin's
Prees
Whittington
The Meres
Wem
Hodnet
Cheswardine
St Oswald
Ruyton and Baschurch
Shawbury
Llanymynech
Tern
Loton
Shifnal North
Longden
Shifnal South and Cosford
Rea Valley
Severn Valley
Albrighton
Chirbury and Worthen
Burnell
Broseley
Worfield
Much Wenlock
Bishop's Castle
Brown Clee
Corvedale
Clun
Cleobury Mortimer
Ludlow North
Clee
Ludlow South
EY Childminders - Ofsted rating
Good
Inadequate
Met
Outstanding
Registration
Registration Visit
Income Deprivation Affecting Children Index (IDACI) by MSOA
Proportion of all children aged 0 to 15 living in income deprived families
6.4 - 8.1
8.1 - 9.7
9.7 - 12.6
12.6 - 18.1
18.1 - 26.7
EY Settings - Ofsted rating
Good
Outstanding
Registration Visit
Requires Improvement
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Two thirds (67%) of Early Years settings received a 'Good' Ofsted outcome, with 1 in 4 (23%) receiving an 'outstanding' outcome.

Ofsted outcome	**Number of Early Years settings**	**Proportion**
Outstanding	22	23%
Good	65	67%
Requires improvement	2	2%
Registration visit	8	8%
Total	**97**	**100%**

Two thirds (68%) of Childminders received a 'Good' Ofsted outcome, with 13% receiving an 'outstanding' outcome and 11% 'Met'..

Ofsted outcome	**Number of Childminders**	**Proportion**
Outstanding	13	13%
Good	66	68%
Met	11	11%
Inadequate	1	1%
Registration visit	6	6%
Total	**97**	**100%**

Voluntary and Community sector offer

The Shropshire Community Directory has been developed by Shropshire Libraries to provide a comprehensive database of up-to-date information on community groups, clubs, societies and organisations.

The Shropshire Family Information Directory has a list of activities and groups available to families with children 0-4 years olds. There is currently a piece of work underway to enhance this offer regularly adding new groups that become available across the whole of Shropshire and just over the borders.

Details can be found via the website under the 'Things to do' section, and can then be filtered by area or age group.

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Childcare

SEND Local Offer

Domestic abuse

Education and learning

Family support

Health and wellbeing

Money matters

Safety

Things to do

Young people

Shropshire Family Information Service (FIS) has developed this on-line directory featuring local and national organisations and services that exist to support children, young people and families.

The directory contains information on groups which can offer advice and support on some of the issues or concerns any family may encounter. It can also help you find activities in your local area for children and young people to take part in where they can learn new skills and make new friends.

If you are part of a group or service that isn't yet included in the service directory contact Shropshire Family Information Service to add your details free of charge.

Stakeholder engagement

We asked stakeholders to work with us to identify and provide us with the relevant data, intelligence, and evidence to inform the JSNA:

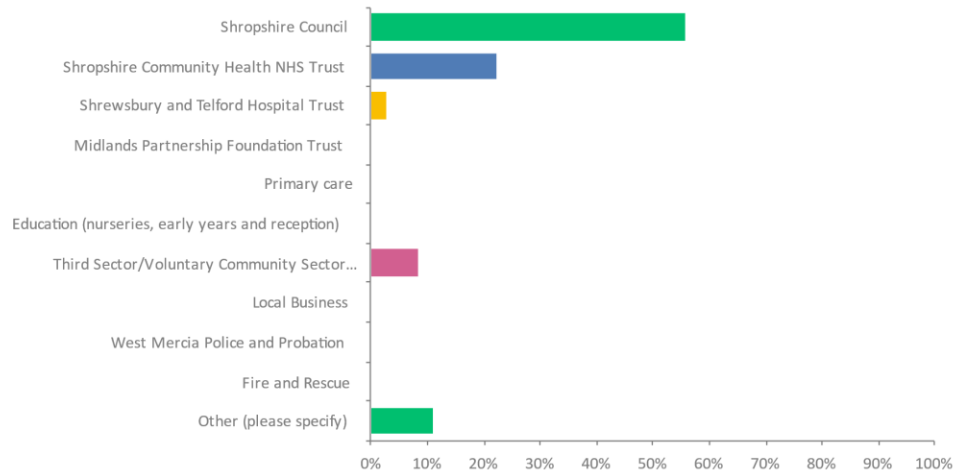
- To identify subjects which should be spotlighted and explored in more depth (Spotlight JSNAs)
- To inform us of your outreach and engagement work with children, young people and families in Shropshire
- To provide their views on key opportunities, challenges, and assets to be included in the JSNA
- Once developed, to use the Children and Young Peoples JSNA to inform service development and delivery

We engaged stakeholders and professionals using an online questionnaire through the SurveyMonkey platform. The questionnaire was developed to capture the views of all services and organisations that support babies, infants and children and their families (age 0-4).

Responses were collected between 31 March 2023 and 1 May 2023. In total, 36 responses were received. Over half (56%) of respondents were Shropshire Council employees, 22% were Shropshire Community Health NHS Trust employees, 11% were from Other organisations (e.g. NHS Shropshire Telford & Wrekin ICB and Town Councils) and 8% from Third Sector/Voluntary Community Sector Enterprises/Charities:

Q1: Which organisation do you work for?

Answered: 36 Skipped: 0



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Which service area do you work in?

Organisation and Service area	Number of respondents
Shropshire Council	**20**
Children's Social Care	3
Culture Leisure and Tourism	1
Early Help	8
Emergency planning biodiversity and public health	1
Housing Services	1
Learning and skills	2
Libraries	1
Public Health	2
Shropshire Museums and Archives	1
Shropshire Community Health NHS Trust	**8**
Community children's nursing	1
Community Paediatrics	1
Family Nurse Partnership	1
Health Visiting	2
PHNS	1
School Nursing	2
Other (please specify)	**4**
Designated Safeguarding Team	1
Education	1
Maternity & Neonatal	1
Town Councillor	1
Third Sector/Voluntary Community Sector Enterprises/Charities	**3**
Autism specific support for families	1

Breastfeeding Support	1
Children's Social Care	1
Shrewsbury and Telford Hospital Trust	**1**
Midwifery	1
Total	**36**

Of the 20 responses from Shropshire Council, majority were from the Early Help service. 16 stakeholders from outside Shropshire Council also responded, half of which were from the Shropshire Community Health NHS Trust.

Collectively supporting families to meet the needs of babies, infants and children (aged 0-4)

Across the system, respondents rated Shropshire collectively supporting families to meet the needs of babies, infants and children (aged 0-4) at 2.9, where 1 was not at all and 5 was extremely well.

Some service areas felt that the system is collectively supporting families to meet the needs of babies, infants and children (aged 0-4) very and extremely well (average rating of 4-5), for example: Community children's nursing, the Family Nurse Partnership, Housing and the Museum.

Other respondents such as those working in service areas of Breastfeeding Support, Education, Community Paediatrics, Maternity & Neonatal, Town Councillor, Designated Safeguarding Team and the PHNS, reported room for improvement with an average rating of 2.

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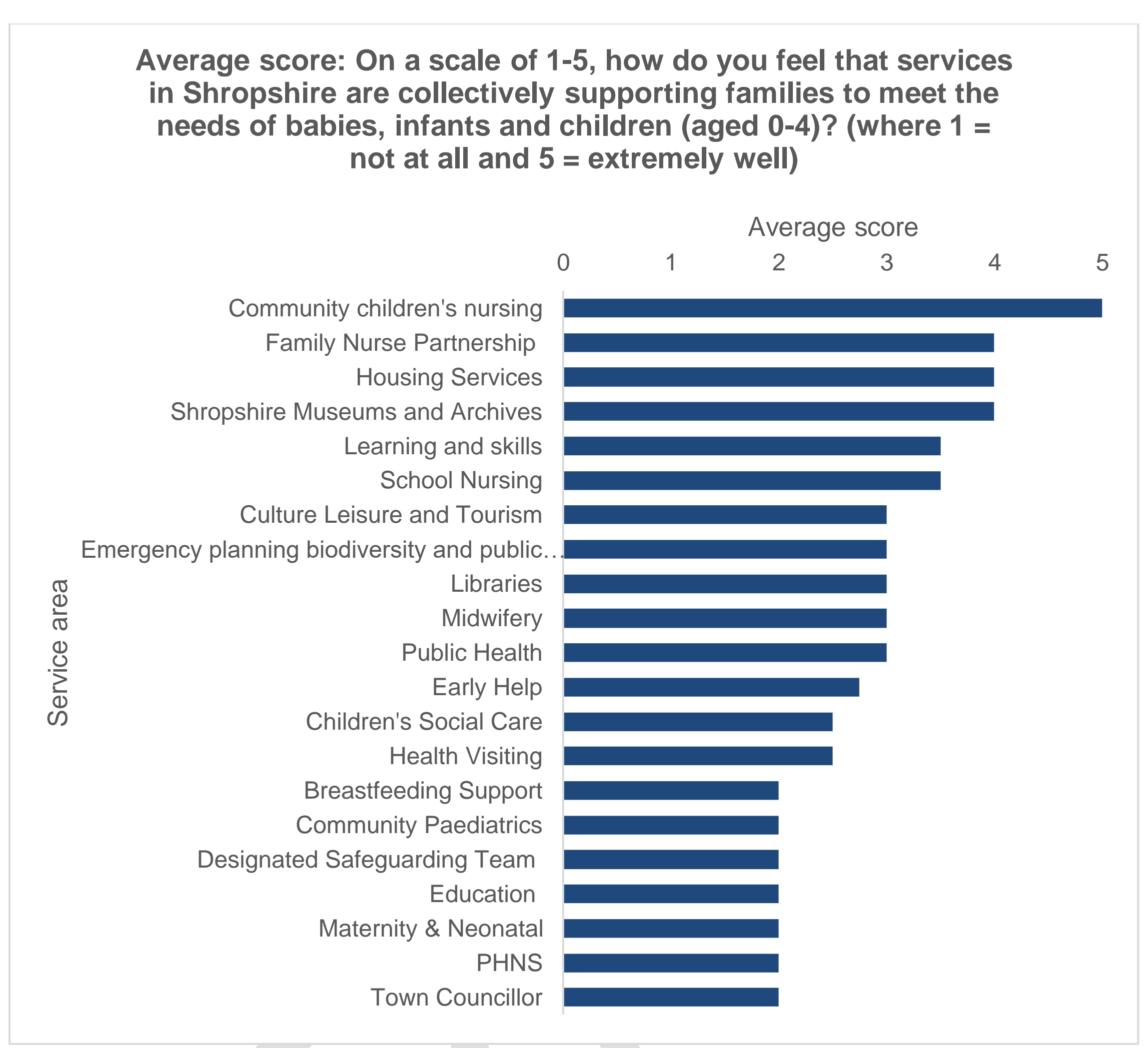

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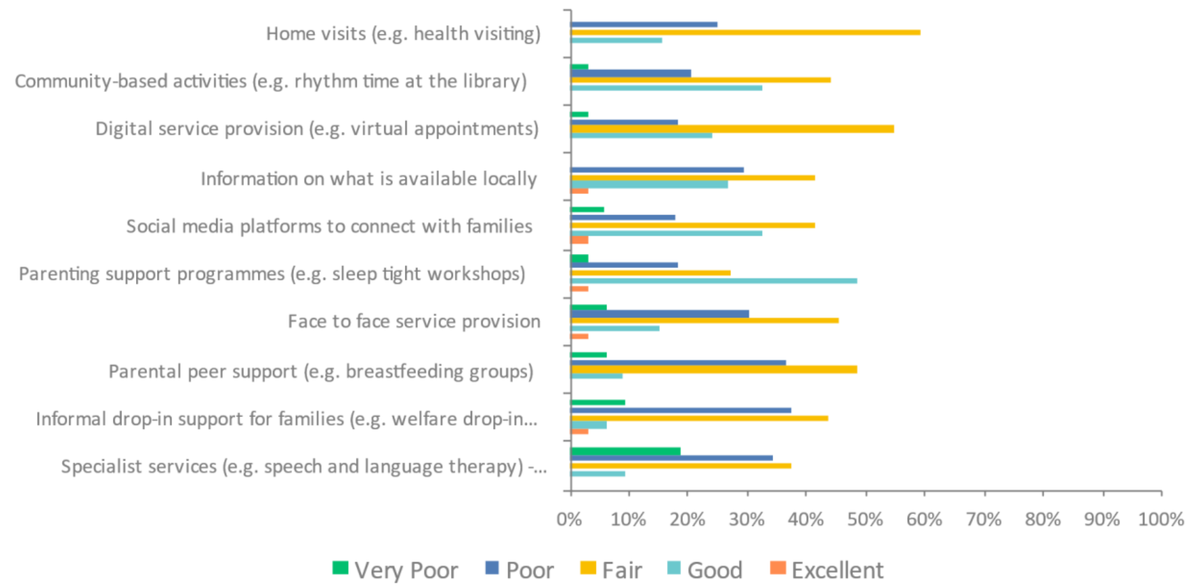
Areas doing well or areas for improvement in Shropshire:

The below charts indicate how respondents feel we are doing around the availability and accessibility of services and information; engagement and co-production and organisational development and partnership working.

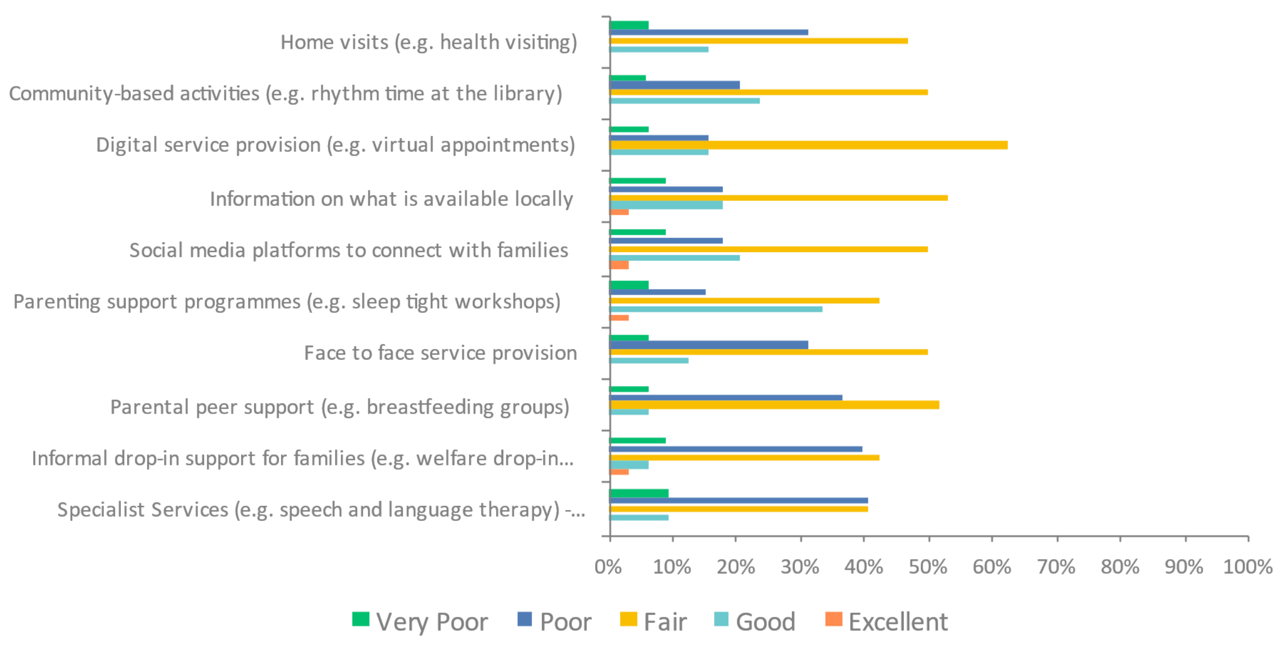
Q4: Availability of services and information

Answered: 34 Skipped: 2



Q5: Accessibility of services and information

Answered: 35 Skipped: 1



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Q6: Engagement and co -production

Answered: 34 Skipped: 2

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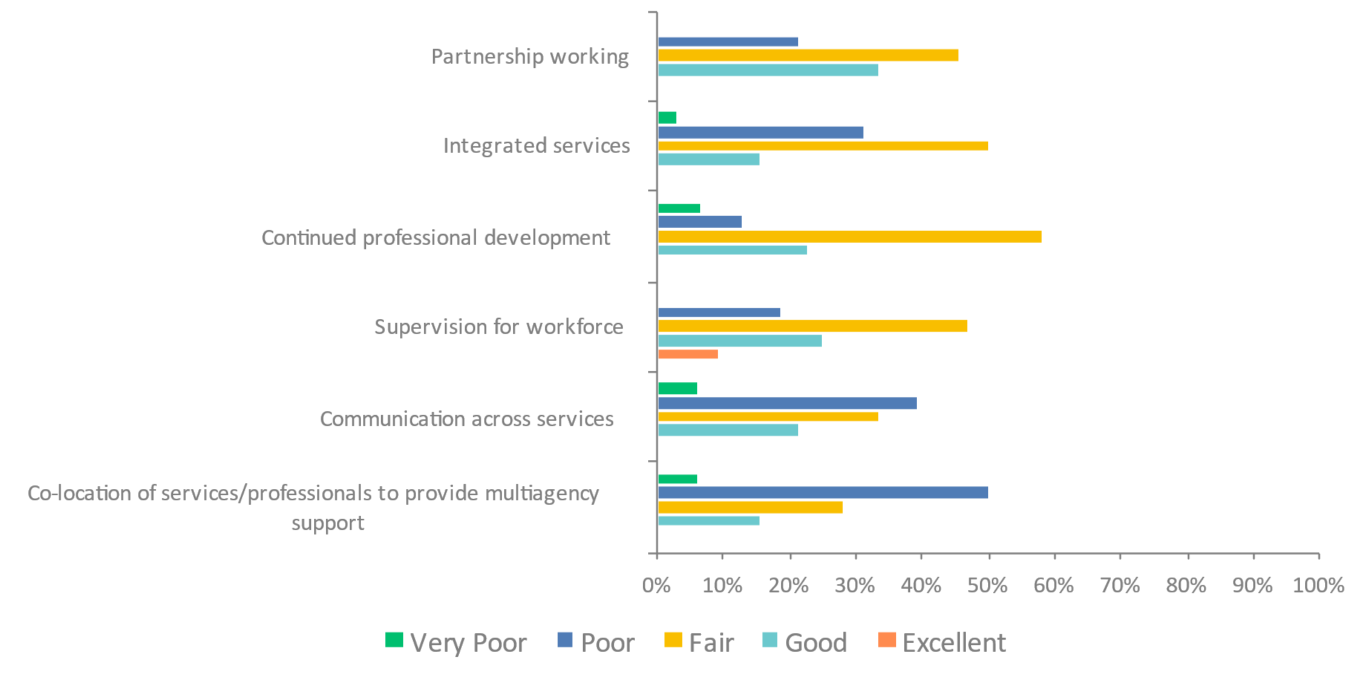
Q7: Organisational development and partnership working:

Answered: 33 Skipped: 3



Availability of services and information	Very Poor	Poor	Fair	Good	Excellent

	Very Poor	Poor	Fair	Good	Excellent
Home visits (e.g. health visiting)	0%	26%	58%	16%	0%
Community-based activities (e.g. rhythm time at the library)	3%	18%	45%	33%	0%
Digital service provision (e.g. virtual appointments)	3%	19%	53%	25%	0%
Information on what is available locally	0%	27%	42%	27%	3%
Social media platforms to connect with families	6%	15%	42%	33%	3%
Parenting support programmes (e.g. sleep tight workshops)	3%	16%	28%	50%	3%
Face to face service provision	6%	31%	44%	16%	3%
Parental peer support (e.g. breastfeeding groups)	6%	38%	47%	9%	0%
Informal drop-in support for families (e.g. welfare drop-in clinics)	10%	39%	42%	6%	3%
Specialist services (e.g. speech and language therapy) - Please state	19%	35%	35%	10%	0%

Accessibility of services and information	**Very Poor**	**Poor**	**Fair**	**Good**	**Excellent**
Home visits (e.g. health visiting)	6%	32%	45%	16%	0%
Community-based activities (e.g. rhythm time at the library)	6%	21%	48%	24%	0%
Digital service provision (e.g. virtual appointments)	6%	13%	65%	16%	0%
Information on what is available locally	9%	15%	55%	18%	3%
Social media platforms to connect with families	9%	15%	52%	21%	3%
Parenting support programmes (e.g. sleep tight workshops)	6%	13%	45%	32%	3%
Face to face service provision	6%	32%	48%	13%	0%
Parental peer support (e.g. breastfeeding groups)	6%	38%	50%	6%	0%
Informal drop-in support for families (e.g. welfare drop-in clinics)	9%	41%	41%	6%	3%
Specialist services (e.g. speech and language therapy) - Please state	10%	42%	39%	10%	0%

Engagement and Co-production	**Very Poor**	**Poor**	**Fair**	**Good**	**Excellent**
Actively involving parents in service development	16%	38%	38%	9%	0%
Voice of the child – gaining wishes, thoughts and feelings of children	9%	41%	38%	13%	0%
Collating service user feedback (e.g. feedback forms)	9%	33%	42%	15%	0%
Access data on children and young people (i.e. Do you have access to the data you need?)	12%	27%	39%	21%	0%
Using data to inform service planning and delivery	13%	16%	47%	22%	3%
Sharing of information between agencies (e.g. multiagency meetings)	13%	34%	22%	31%	0%

Organisational development and partnership working	**Very Poor**	**Poor**	**Fair**	**Good**	**Excellent**
Partnership working	0%	22%	44%	34%	0%
Integrated services	3%	29%	52%	16%	0%
Continued professional development	7%	13%	57%	23%	0%
Supervision for workforce	0%	19%	45%	26%	10%

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Communication across services	6%	41%	31%	22%	0%
Co-location of services/professionals to provide multiagency support	6%	48%	29%	16%	0%

Availability of services and information

50% of respondents felt that there is good availability of parenting support programmes in Shropshire. Areas of need are also highlighted, for example: 39% of respondents felt that there is poor availability of informal drop-in support for families and a further 42% felt availability was "fair". One in five respondents also reported that there is very poor availability of specialist services in the county, particularly for speech and language and pre and post-natal care. Waiting times around specialise services was also highlighted as poor.

Accessibility of services and information

32% of respondents felt that there is good availability of parenting support programmes. However, 32% of respondents feel that there is poor accessibility of face-to-face service provision and another 32% feel that there is poor accessibility to home visits". One in ten respondents feel that there is very poor availability of specialist services, especially for rural communities.

Engagement and co-production

38% of respondents reported poor co-production with parents in service development with a further 38% reporting "fair". 41% reported poor co-production with the voice of the child, highlighting a need for improvement. 34% feel that there is poor sharing of information between agencies, however a further third feel that there is good information sharing between agencies.

Organisational development and partnership working

Almost half of respondents (48%) felt that co-location of services is "poor" and 41% reported communication across services as "poor". On the other hand, 34% reported good partnership working.

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lack-of-transport
disabled-children-support
short-break-activities
antenatal-services
sure-start-centres
parenting-groups
face-to-face
integrated-support
infant-feeding-support
breastfeeding-support
perinatal-mental-health-support
drop-ins
rurality
home-visits
healthy-eating-support
waiting-lists
health-visitor-capacity

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Detailed responses:

- "There is a lack of drop-in, face-to-face support for families, like they used to get with the Sure Start Children's Centres. The Short Break activities are very limited in certain parts of the county."
- "No face to face health visiting service for Bishops Castle. Parents can have phone calls or travel to Ludlow. Public Transport links are poor. Sure Start filled all the gaps and now we are seeing the legacy ."
- "Gaps in provision of All In short breaks for this age group, also geographical gaps in wider provision around the county. Information sharing between partners needs to improve about the service provision available, most is unknown and not promoted enough. Better use of the Family Information Service central online database of services should be encouraged."

Areas doing well in the service provision for families, babies, infants and children aged 0-4

early-help
sleep-support
fnp-programme
community-based-activities
online-support
drop-ins
family-information-service
multi-agency-working
home-visiting
health-visiting

- “Family Information Service is a great source and accessible on many different levels”
- “The work that is being completed in Oswestry is a good example of integrated working “
- “Early Help team do an excellent job.”
- “Use of libraries to deliver and support provision Delivery of speech and language intervention programmes -EY Talkboost Speech and Language website, ST&W, is very informative and supportive”

What you think are the key challenges for children (0-4) in Shropshire:

Respondents highlighted parental mental health as the key challenges for children aged 0-4, with 11 out of 34 respondents highlighting this as the key challenge. Child development and neglect were the other two areas reported to be areas of need for 0-4s in Shropshire.

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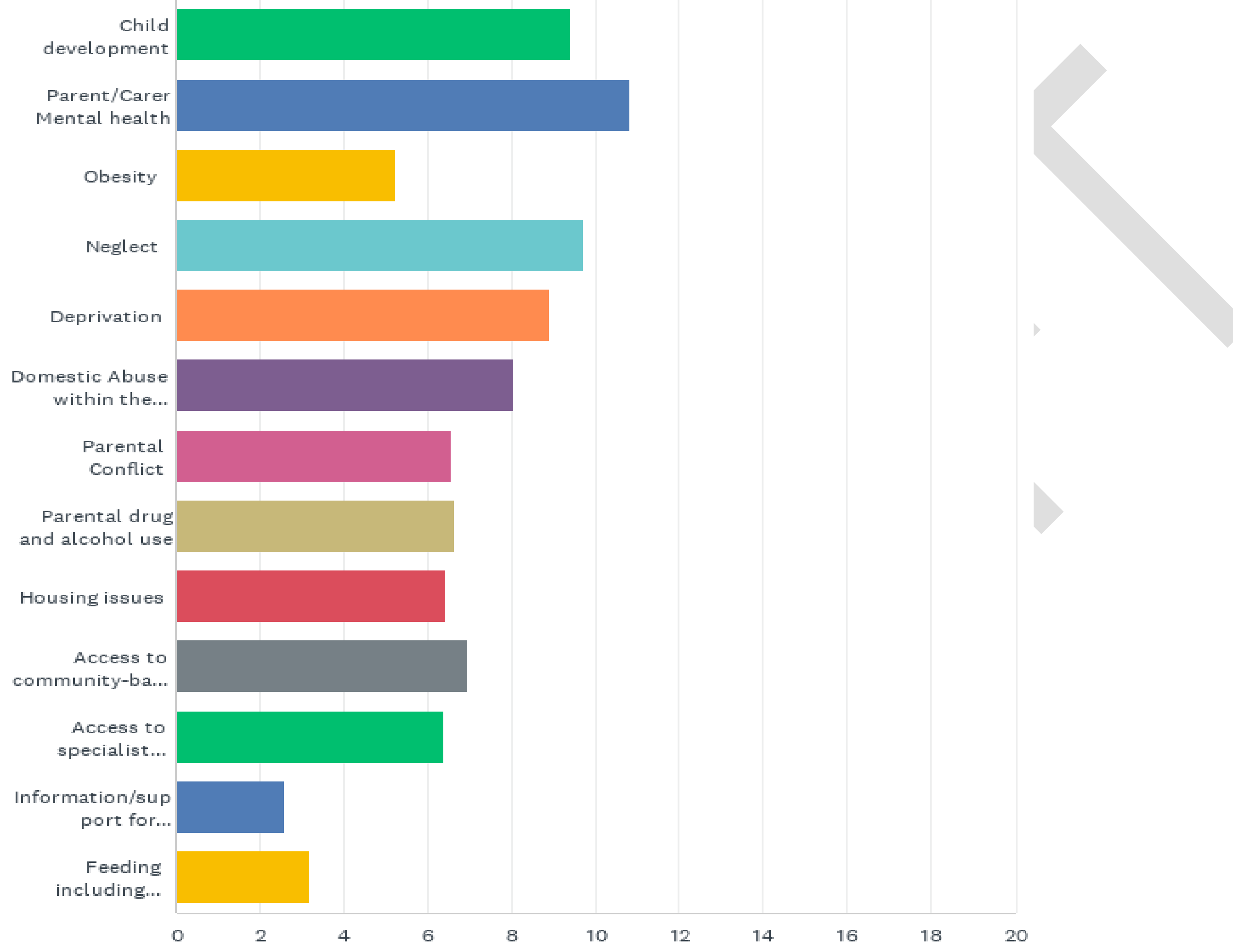

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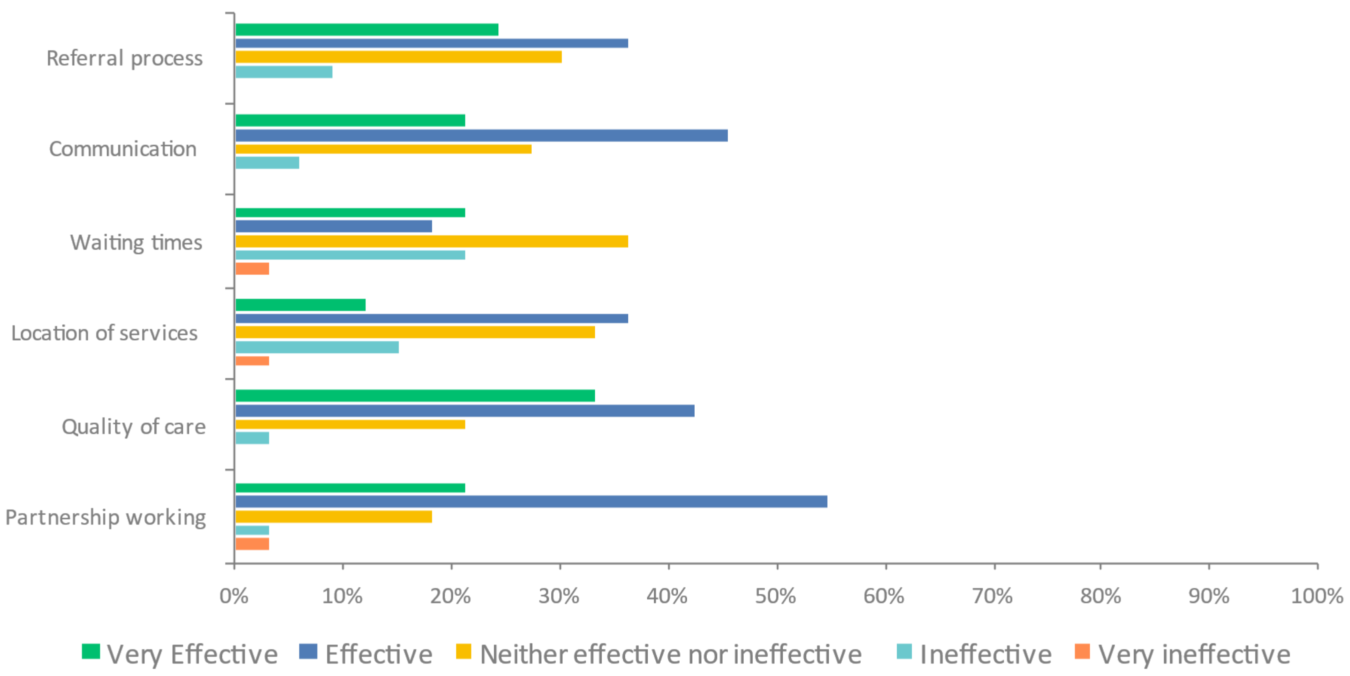
How your service operating?

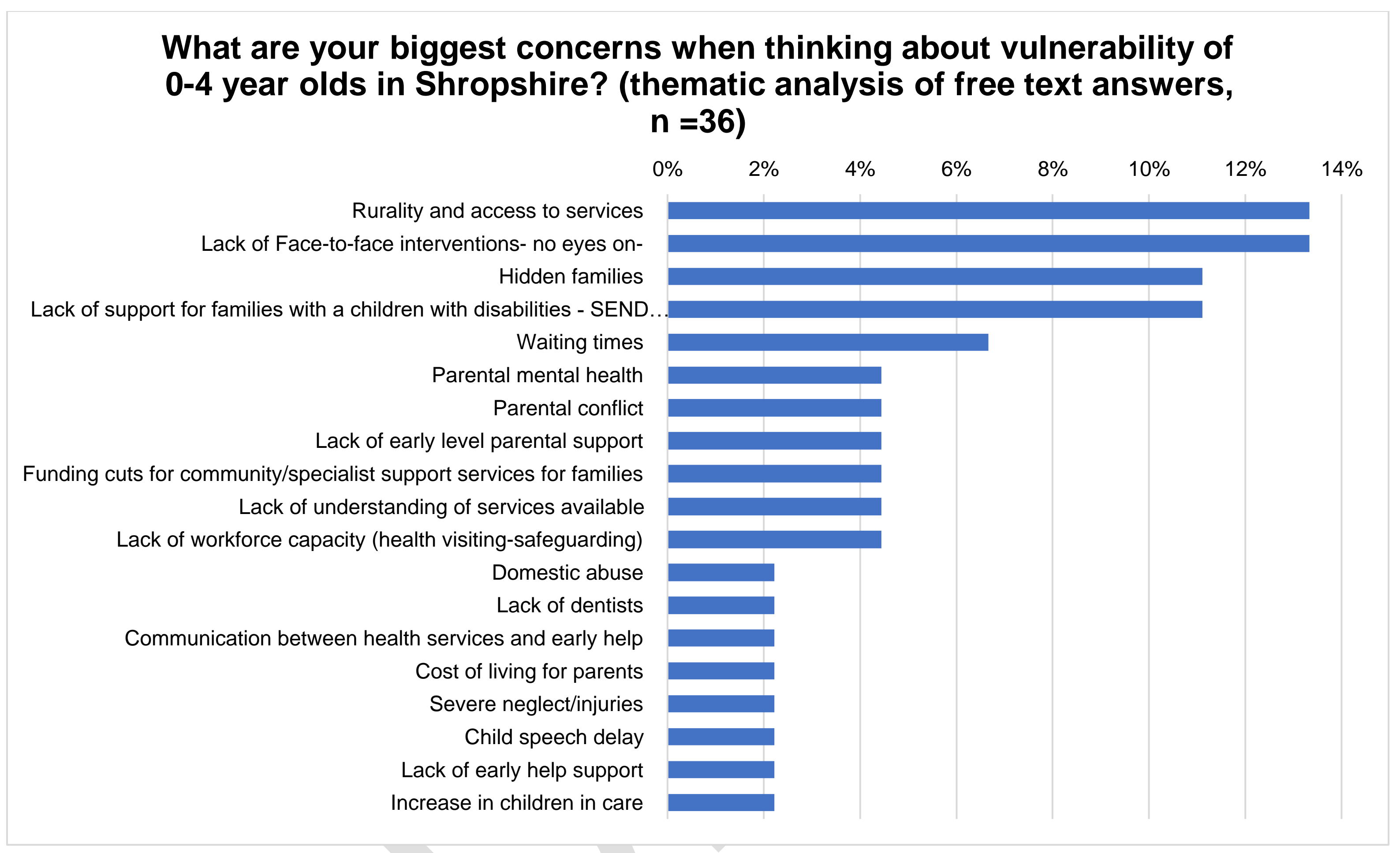
Q11: Please rate the following aspects of how effective you feel your service area is operating:

Answered: 33 Skipped: 3



What are your biggest concerns when thinking about vulnerability of 0-4 year olds in Shropshire?

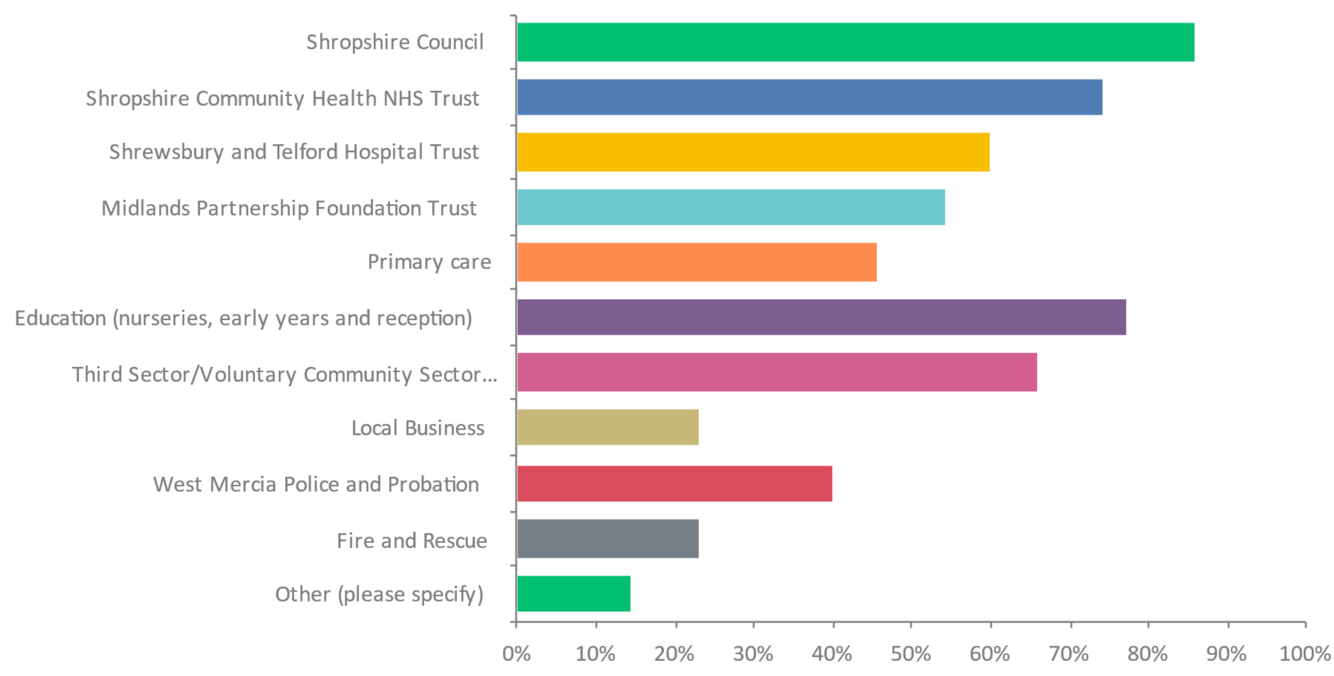
This was an open text question. The below chart presents the frequency of key themes emerging from responses.


What are your biggest concerns when thinking about vulnerability of 0-4 year olds in Shropshire? (thematic analysis of free text answers, n =36)
0%
2%
4%
6%
8%
10%
12%
14%
Rurality and access to services
Lack of Face-to-face interventions- no eyes on-
Hidden families
Lack of support for families with a children with disabilities - SEND…
Waiting times
Parental mental health
Parental conflict
Lack of early level parental support
Funding cuts for community/specialist support services for families
Lack of understanding of services available
Lack of workforce capacity (health visiting-safeguarding)
Domestic abuse
Lack of dentists
Communication between health services and early help
Cost of living for parents
Severe neglect/injuries
Child speech delay
Lack of early help support
Increase in children in care

Partnership working opportunities.

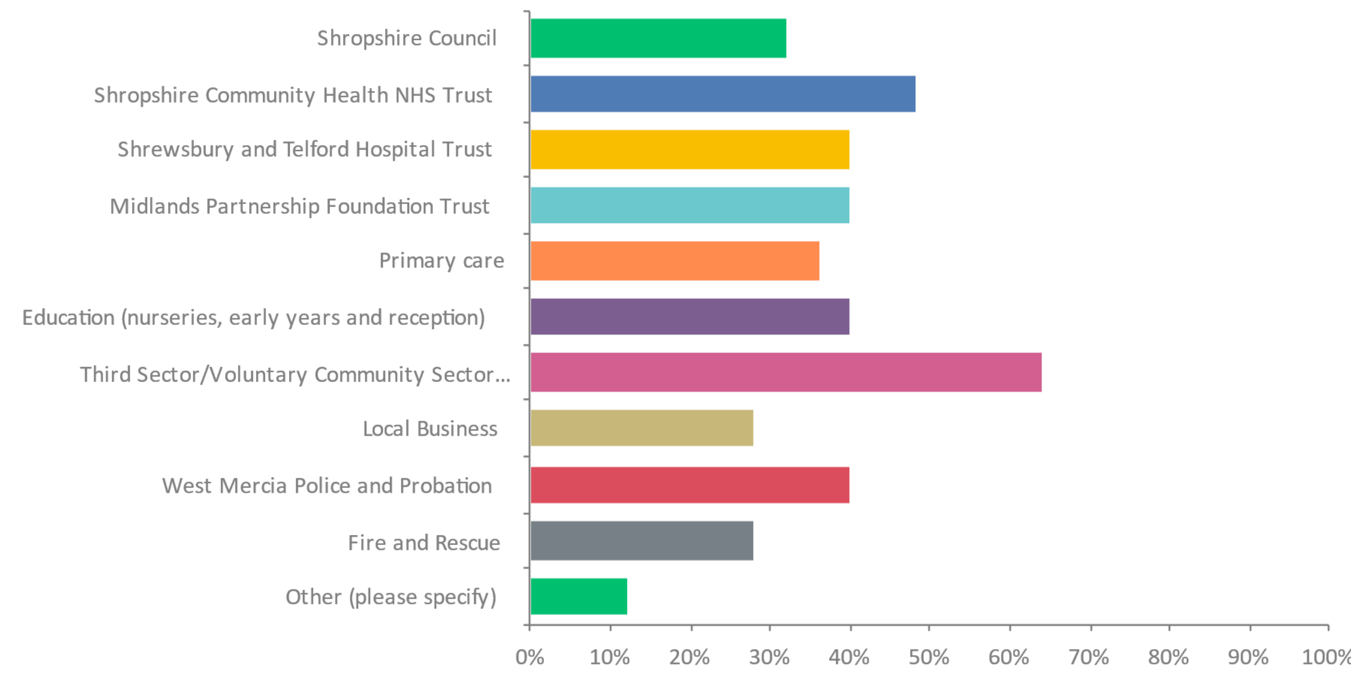
Q15: Which services do you regularly work in partnership with? (select all that apply)

Answered: 35 Skipped: 1



Q16: Which service areas would you like to work more closely with? (select all that apply)

Answered: 25 Skipped: 11



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Parents and carers engagement

As part of the CYP JSNA, a best start of life early years parents and cares survey was conducted. Parents and carers of children aged 0-5 were targeted to assess their experiences of accessing services and support in Shropshire (including parent and carers of children with Special Education Needs and Disability).

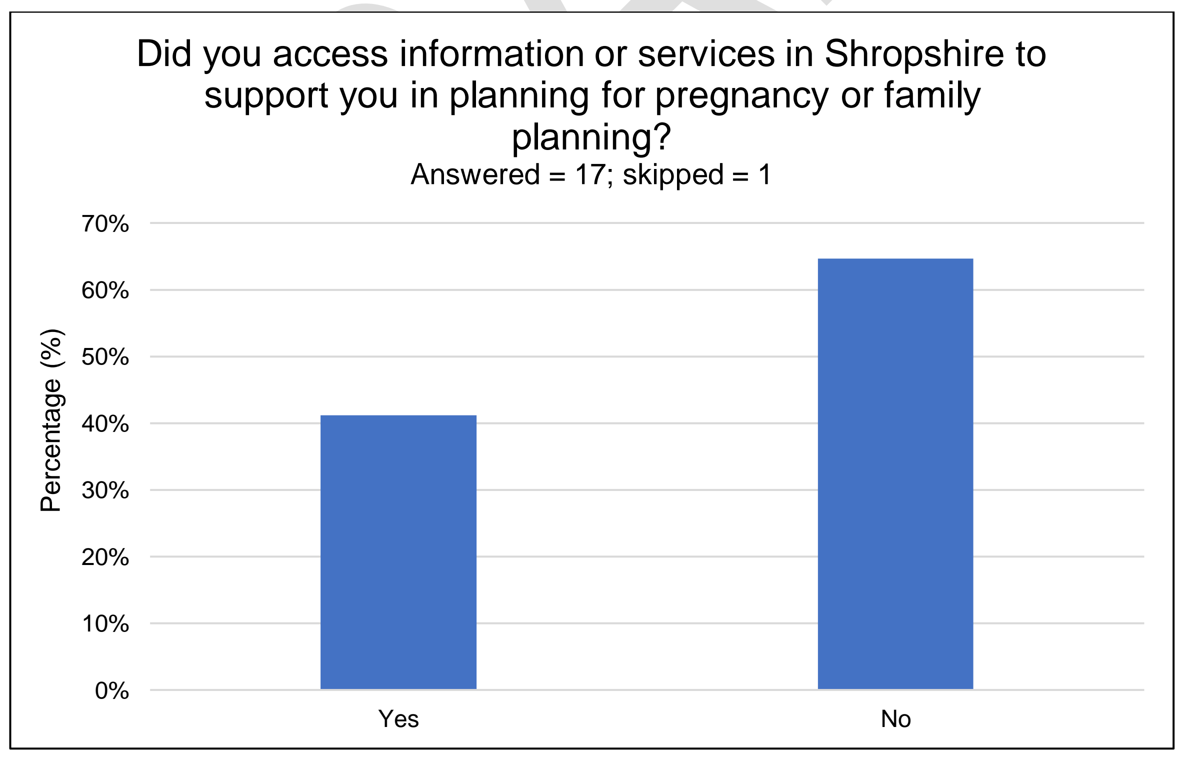
We engaged parents/carers of 0-4 year olds using an online questionnaire through the Survey Monkey platform. The survey was distributed at a parents and carers event via a QR code. Survey responses were collected between 26 October 2023 and 29 November 2023. Unfortunately, we received a very low response rate with 18 responses were received.

Of the respondents, 71% had parent or caregiving responsibilities for more than 2 children and 36% indicated that they had a child or children with an additional need or disability.

Access to information

When asked if they had accessed information or services to support in pregnancy or family planning, 65% of respondents indicated that they did not. Parents and carers were asked which information or services they accessed in a free text question. Respondents who accessed information or services on pregnancy or family planning indicated that they accessed the following:

- 15 free hours childcare
- Midwife support post miscarriage
- Maternity services



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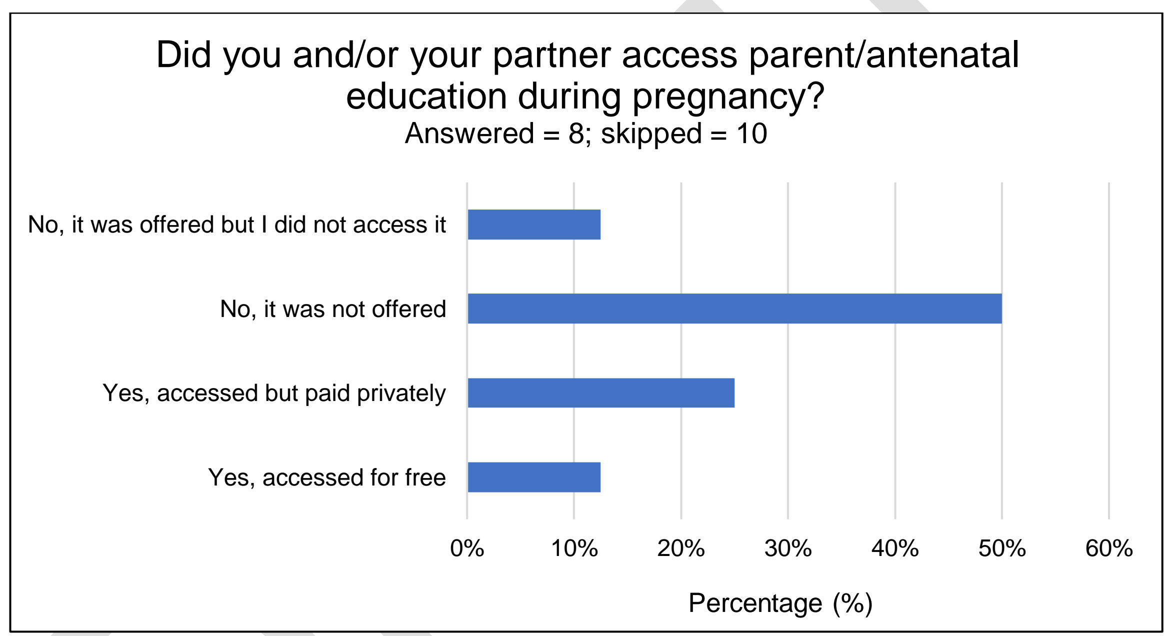
Of those who accessed information or services on pregnancy or family planning, 57% had a very good or excellent experience with the information or services accessed. However, there was a very low response rate of 5 respondents. Service users indicated that:

''There should be more help for women/families who go through pregnancy loss''
''Maternity services were not great and there was little support with regards to antenatal care and postnatal care, particularly with breastfeeding''

Antenatal education

Parents and carers were asked if either them or their partner accessed parent or antenatal education during pregnancy. 38% of respondents accessed parent or antenatal education (13% accessed it for free and 25% accessed it privately). 50% of respondents indicated that this service was not offered to them. However, there was a very low response rate of 8 respondents



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Health visiting benefits

Respondents were asked where they felt they would have most and least benefitted from the support of a health visitor. For each category, 7 respondents answered the question.

- 57% felt they most benefitted from a health visitor during pregnancy,
- 57% indicated in the first 14 days after childbirth,
- 43% indicated when the child is aged between 12 months to 2 years,
- 43% indicated when the child is aged between 3 to 5 years.

Experiences	0 = Least benefitted	1	2	3	4	5 = Most benefitted
During pregnancy	29%	0%	0%	0%	14%	57%
In the first 14 days following childbirth	0%	14%	14%	0%	14%	57%
Between 14 and 30 days following childbirth	0%	0%	29%	29%	14%	29%
Baby aged 6-8 weeks	0%	0%	43%	29%	14%	14%
Baby aged 3-6 months	0%	14%	43%	14%	14%	14%
aged 12 months-2 years	14%	14%	14%	14%	0%	43%
child 2 to 3 years	14%	0%	29%	29%	0%	29%
child 3 to 5 years	14%	14%	0%	14%	14%	43%

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As a parent/carer of child (ren) aged 0-5, what are the most important considerations to you, to help you look after your child's health and wellbeing?

Respondents indicated the following when asked what the most important considerations were when looking after their child's health and wellbeing:

''Access to healthcare without a long wait''

''Being able to access services for information and support without delays''

''Physical health and nutrition, followed by mental wellbeing of child and how to support''
''Regular check ins with health professionals for reassurance''

Is there anything else you would like to tell us about your family's experiences of health services you used in Shropshire?

''Increased focus should be placed on maternal postnatal health. Wasn't offered 6 week postnatal check or further support about physical healing after birth''

''Long wait times in a&e and for appointments''

''My middle child has Autism. The follow on care since we moved to Shropshire in April has been difficult to obtain. Services and information are not linked and shared. It's had to know what's available if someone doesn't advise you. Doctors don't always know the correct paths and paediatrician will end you back to doctor and it takes a long time to get issues resolved''

''My first pregnancy ended in miscarriage, there is absolutely no help or support out there for ladies and families who have been through loss. The mental impact is horrific, but as soon as you've passed the foetus/baby you are forgotten about, and no contact is made with support or follow up doctor appointment to check health/mental health''

Recommendations

Recommendations are based on the Areas of Need

1. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.
2. To continue to monitor **child and infant mortality**, adjusting action plans as required to ensure appropriate mitigations are in place.
3. To improve the recording to show the accurate position of **emergency admissions of 0-4s,** distinct from 0-4s who required same day emergency care. To monitor the level of emergency admissions of 0-4s and take appropriate action.
4. To increase uptake of pregnancy and childhood **immunisations** to provide protection and reduce the risks associated with these illnesses.
5. To continue to increase **breastfeeding rates** at 6-8 weeks to achieve at least the national average.
6. To continue to increase and monitor the number of families **accessing the mandated contacts** offered by the health visiting service.
7. To ensure the **cost of living** support and support for health and wellbeing is well promoted through all services, including promoting the take up of **healthy start vouchers**
8. To reduce the number of 0-4 year olds whose **parents use drugs and alcohol** who become looked after and to increase the number of parents receiving **appropriate support at the earliest opportunity.**
9. To reduce the number of 0-4s **living in households where domestic abuse** occurs by supporting the workforce to **identify perpetrators** and support them to **behaviour change programmes**
10. For all health and social care agencies to ensure they appropriately assess the **mental health** needs of the child, mother and family and signpost to relevant services and intervention.
11. To develop **Women's Health Hubs** across Shropshire aligning with development of **Community & Family Hubs** to improve outcomes for women & children aged 0-4.
12. To publish the **Best Start for Life offer** to enable families to access information about services and support to increase visibility and accessibility of services and improve child outcomes.
13. To continue to increase **awareness of early help and prevention offers** to support families and prevent escalation.
14. To continue to monitor the level of children who are **overweight or obese at reception** and to deliver on the Early Years actions of the Healthier Weight Strategy
15. To engage with **stakeholders to inform recommendations**.

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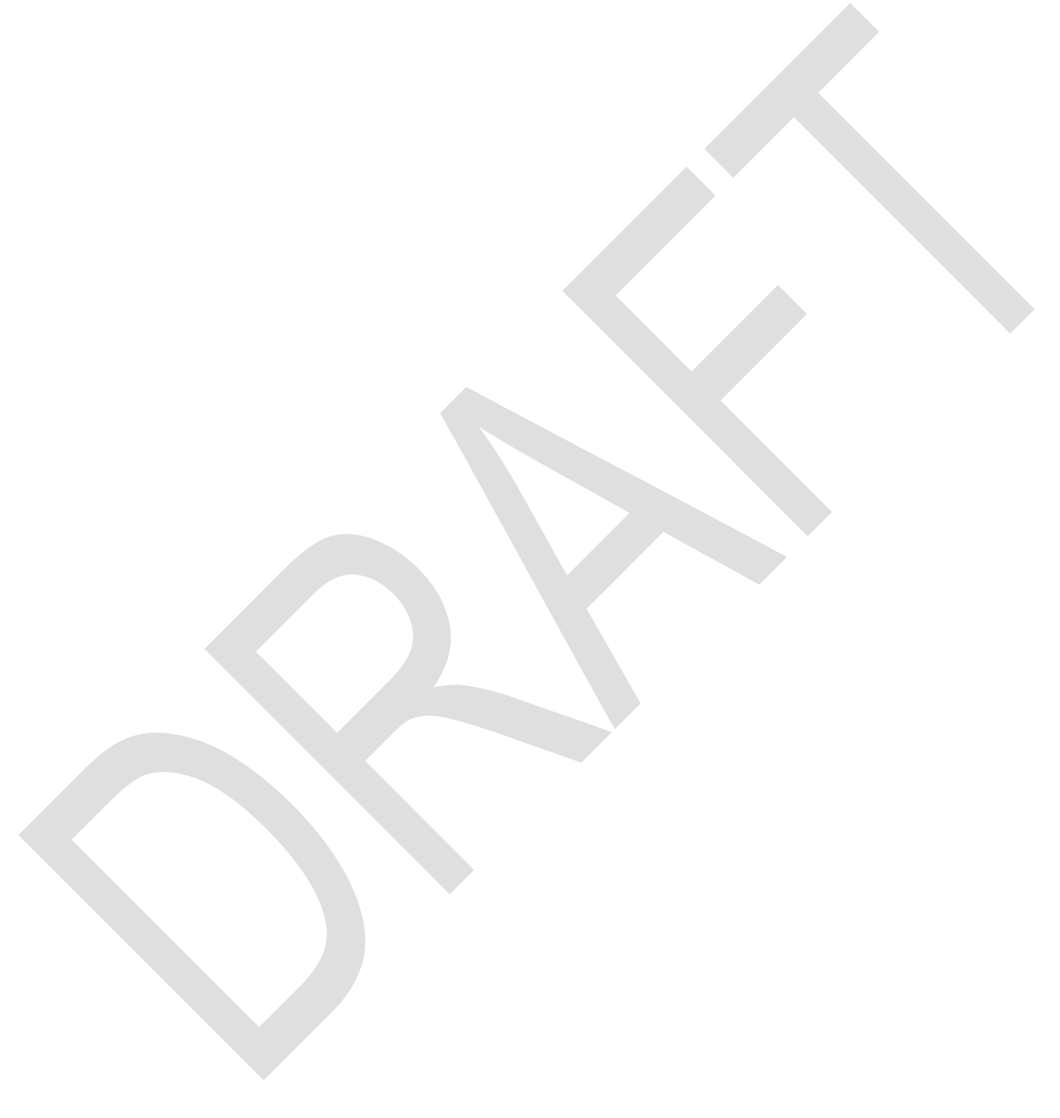

Area of need	Mitigation (What are we doing now)	Recommendation (What we are intending to do and how)	Governance (Where does this recommendation sit)
1. Smoking status at time of delivery	• Healthy Pregnancy service in SATH maternity offering smoking cessation support • Health Lives Advisors offering behavioural support for smoking cession • Expansion of smoking cessation offer • Community and family hub development to increase available support • Tobacco Dependency treatment pathways	• To decrease the number of pregnant women smoking at time of delivery to England average	LMNS Health and Wellbeing Board
2. Infant mortality	• Cascading learning from infant deaths (CDOP reviews) • System wide Infant and Child Mortality workshops • Increasing awareness of Safer Sleep advice • Community and family hub development to increase available support • Dashboard in development to STW monitor trends and identify modifiable factors	• To decrease the number of infant deaths by addressing modifiable factors • Learning from previous deaths • Identifying any local themes	ICS System Quality Group LMNS
3. Emergency admissions (under 1s and 0-4s)	• Increased awareness of asthma and inhaler use • School nursing service have trained school staff and also implemented Asthma Friendly Schools programme. • GP practices audited blue inhaler prescriptions. • Community and family hub development to increase available support e.g. Health Visiting drop in clinics opening across county • Priority focus of the infant mortality workstream • Accident prevention awareness	• Reduce the number of 0-4's being admitted from A&E by increasing awareness of early identification and treatment • Increasing awareness of appropriate management of acute and long-term conditions • Learning from case reviews • Embed paediatric Same Day Emergency Care in the community and monitor activity	ICS System Quality Group LMNS System Urgent and Emergency care CYP Oversight Group
4. Population Vaccination coverage: MMR two doses (5 years old)	• Increased circulation of resources to raise awareness of the importance of immunisations through EY settings, schools, higher education, social media, staff newsletters. • GP practices offering catch up appointments to improve coverage. • Community and family hub development to increase available support	• Increase vaccination coverage to 95% by continued awareness of reasons for vaccination • Identify groups with lower uptake and target messaging and work with these communities to increase uptake.	Health Protection Quality Assurance Board
5. Breastfeeding prevalence at 6-8 weeks	• STW Infant feeding strategy • Breastfeeding peer support groups • Additional breastfeeding training to PHNS • Online Antenatal/Postnatal Solihull Training • Baby Buddy App • Introduced open access HV clinics • HV single point of access and texting service • Community and family hub development • Provider is working on improving the data inputting as hasn't been as robust in recent years but is now improving as staff have been made aware and are encouraged to complete it.	• Improve referral pathways for complex breastfeeding support • Raise awareness of breastfeeding peer support groups and HV open access clinics • Improve reporting mechanisms. • Introduction of Womens' Health Hub	LMNS PHNS contract monitoring
6.Uptake of Healthy Start vouchers	• Increased awareness through media • Awareness though Baby Buddy App • Increased training and information to professionals supporting pregnant women and families • Community and family hub development to increase available support • Provider is currently looking at the process for being able to offer HS vouchers in clinic	• Continue to raise awareness • Increase availability of vitamins	Public Health – linking with national team

Area of need	Mitigation (What are we doing now)	Recommendations (What we are intending to do)	Governance (Where does this sit)
7. Proportion of children receiving a 12 month review by 12 months	• Increased awareness of reviews to parents and families • Altered booking system to generate appointments early • Introduced open access HV clinics • HV single point of access and texting service • Community and family hub development to increase available support • 2 year integrated review in the early year's settings (2 year development) and the open access clinics (emergency admissions/minor illness management, breastfeeding, healthy start vouchers).	• Continue to increase number of reviews at 12 months and monitor • Continue to raise awareness • Changing the way in which appointments are sent to meet timescales • Increase availability of HV open access clinics	ICS System Quality Group PHNS contract monitoring
8. Percentage of children achieving a good level of development at 2 to 2½ years	• Piloting integrated 2-year reviews with EY settings • Increase awareness of reviews and encourage parents to take up. • HV single point of access and texting service • Introduced open access clinics • Community and family hub development to increase available support • Physical activity is a key area within early years as part of a child's development. We will continue to work with our Early Years setting to implement the CMO's recommendations regarding physical activity and encourage them to use innovative ways to integrate those across the early year's curriculum	• Roll out integrated 2-year reviews with EY settings • Continue to raise awareness on effective interactions that improve child development. • Roll out of the school readiness leaflet • Introduction and roll out of HV open access clinics for parents/carers to access support	ICS System Quality Group PHNS contract monitoring Health and Wellbeing Board
9. Child development: percentage of children achieving the expected level in communication skills, gross motor skills, fine motor skills, problem solving skills and personal social skills at 2 to 2½ years	• Introduced Early Talk boost and Talk boost to increase speech and language development • Produced school readiness leaflet with information on how to support child development. • Raised awareness of child development. • Increase access to HV service for support. • HV open access clinics • HV single point of access and texting service • Increase uptake of early education • Community and family hub development to increase available support • Physical activity is a key area within early years as part of a child's development. We will continue to work with our Early Years setting to implement the CMO's recommendations regarding physical activity and encourage them to use innovative ways to integrate those across the early years curriculum	• Publishing Best Start for Life offer • Roll out of school readiness leaflet • Online Solihull programmes • To increase awareness of effective interactions from bump- toddlers to improve development. • Introduction and roll out of HV open access clinics for parents/ cares to access support.	ICS System Quality Group PHNS contract monitoring
10. Stakeholders report transport/access and face to face provision is a barrier for health visiting	• Introduced open access clinics • Increased HV recruitment to vacant posts • HV single point of access and texting service • Restored face to face contacts • HV training places • Community and family hub development to increase available support	• Continue to recruit to vacant posts • HV training places increasing • Publicise service offer • Introduction and roll out of HV open access clinics	PHNS contract monitoring
11. Looked after children, 0-4 year olds making up 24% of all children looked after in the county (2023)	• Actions developed and implemented as a result of the Children's summit (2023) • Transformation of Targeted Early Help, Re-launch of the EH Partnership Board and launch of Early Help Strategy, • Community and Family hubs and Integration panels • Communication on how to seek support particularly during school holidays and times of increased pressure • Best Start in Life programme which includes the introduction of Family Foundations Course and information on support available to first time parents/co-parents • Actions included within the Drug and Alcohol Partnership Plan	• Reduce the number of 0-4's becoming looked after by • Increasing professional curiosity • Increasing awareness of professionals and families of early help to support families and prevent escalation • Increasing number of families accessing early help • Improve identification of families in need • Continued audit of cases and learning cascaded and acted upon	Shropshire Safeguarding Community Partnership Health and Wellbeing Board

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END OF REPORT

Shropshire Council

Children and Young People JSNA

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Early Years (0-4s) Chapter Summary

August 2024

Aims & objectives

This JSNA chapter will provide a **detailed understanding of the needs of children aged 0-4 and their families in Shropshire to inform the direction and development of local services**, with a view to reducing health inequalities through identification, prevention and early intervention

Given the broad range of needs and services for children under 5 years, this report is not an in depth review of any one specific service, but instead aims to:

- describe the **population profile** of children under 5 and their families in Shropshire- please also see the Population and Context chapter
- identify **risk factors** that impact on infant and child health outcomes - please also see the Population and Context chapter
- provide an overview of the **wider determinants** of health and their impact on the under 5s and their families- please also see the Population and Context chapter
- identify relevant **national guidance and local policy** in relation to early years
- provide an **overview of the health and wellbeing of under 5s**
- provide an overview of **current service provision** and assessment of outcomes including gaps in relation to domains impacting on early childhood outcomes; physical, psychosocial and emotional, cognitive and language development
- identify **vulnerable children,** and/or at risk groups
- identify **gaps, barriers, and unmet needs** in current service provision
- provide evidence-based **recommendations** to ensure that the needs of 0-4 year olds are met in Shropshire

Contents

The early years indicators offer information about the health of children under 5 including:

- birth outcomes and associated risk factors
- accidents and injuries
- breastfeeding
- obesity
- health visiting services
- child development and school readiness

Additionally, there are early years supplementary indicators, including information on:

- hospital admissions
- vaccination rates
- Homelessness
- Safeguarding and vulnerable children

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Policy & Guidance

Best start for life

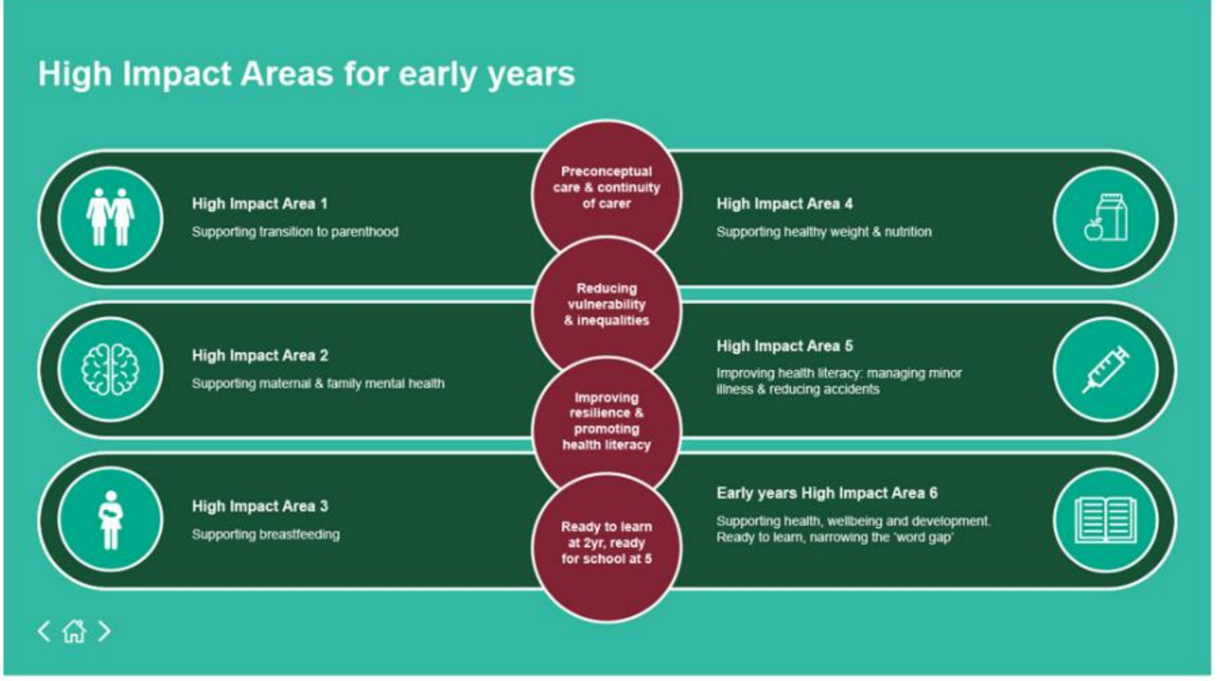
Goal is to ensure the best support throughout those 1,001 critical days, setting babies up to maximise their potential for lifelong emotional and physical wellbeing. To achieve this, we will focus on six **Action Areas**:

Action Areas

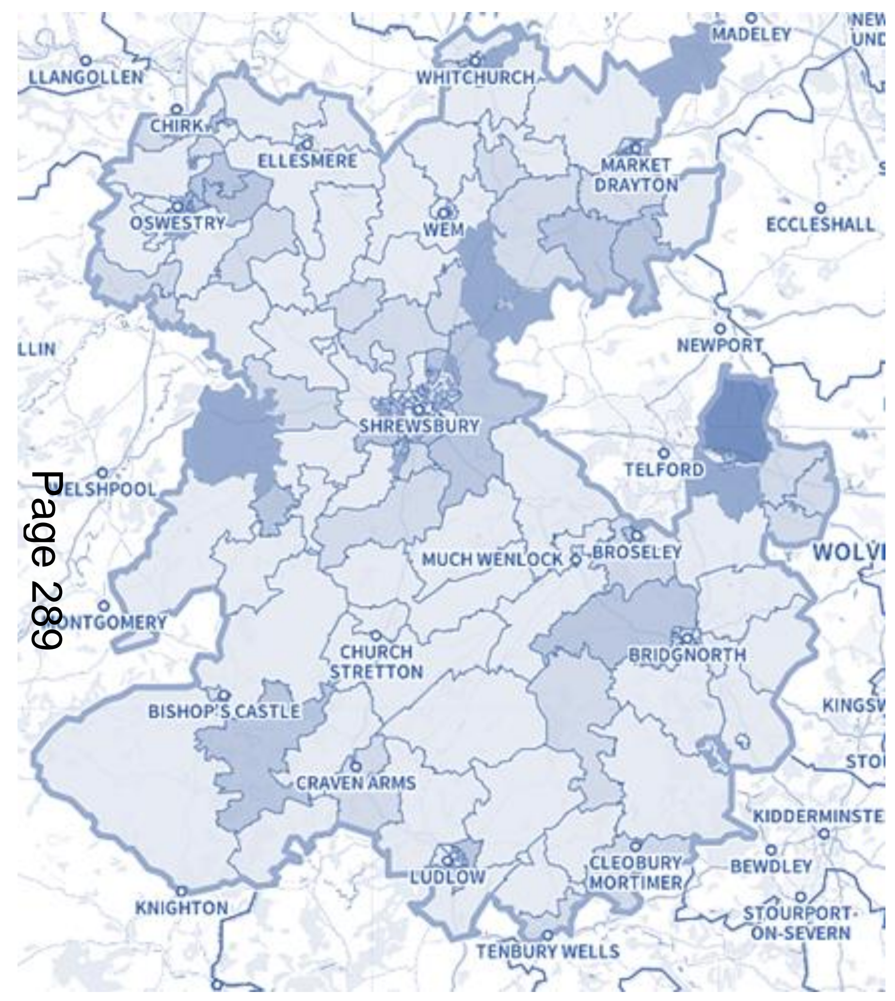
Ensuring families have access to the services they need
1. **Seamless support for families:** a coherent joined up Start for Life offer available to all families.
2. **A welcoming hub for families:** Family Hubs as a place for families to access Start for Life services.
3. **The information families need when they need it:** designing digital, virtual and telephone offers around the needs of the family.
Ensuring the Start for Life system is working together to give families the support they need
4. **An empowered Start for Life workforce:** developing a modern skilled workforce to meet the changing needs of families.
5. **Continually improving the Start for Life offer:** improving data, evaluation, outcomes and proportionate inspection.
6. **Leadership for change:** ensuring local and national accountability and building the economic case.

Healthy Child Programme

Health visitors lead the Healthy Child Programme 0 to 5.
Below are the **6 high impact areas** for early years and how they relate to the 4 overarching aims for early years:



Early Years 0-4s Shropshire



Where do 0-4s live?

The colours represent the quintiles:

- 7% to 28%: 10 areas
- 6% to 7%: 22 areas
- 5% to 6%: 39 areas
- 4% to 5%: 40 areas
- 0% to 4%: 82 areas

14,423 aged 0-4 in 2021, **an 8% fall** from 2011 (England 7% fall)

4.5% aged 0-4 **of Shropshire's population** (England 5.4%)

2,567 live births in Shropshire (2022)

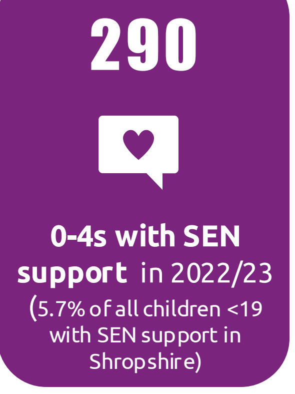
37 infant deaths during 2020-22, rate of 4.8 per 1,000 births

43 babies had **low birth weight** in 2021, 1.8% of all births

Overall deprivation is low in Shropshire. 513 or 3.6% of babies, infants and children aged 0-4 live in the top 5 most deprived areas (LSOAs) of Shropshire: Harlescott, Ludlow East, central Oswestry, Monkmoor and Meole Brace.

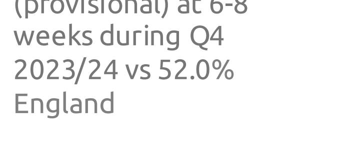
51% Male **49%** Female

3.6% **0-4s from ethnic minority groups** in 2011, 567 children



290 **0-4s with SEN support** in 2022/23 (5.7% of all children <19 with SEN support in Shropshire)

2,033 new birth visits by 14 days, 80.8% vs England 79.9% (2022/23)



49.0% infants breastfed (provisional) at 6-8 weeks during Q4 2023/24 vs 52.0% England

105 hospital admissions for unintentional and deliberate injuries (0 to 4 years), 74 per 1k compared to 92 in England (2022/23)

2,690 per 1,000 emergency admissions (0-4 years) 189 per 1k compared to 158 in England (2022/23)

68% achieving good level of development at the end of reception in Shropshire, 67% England (2022/23)

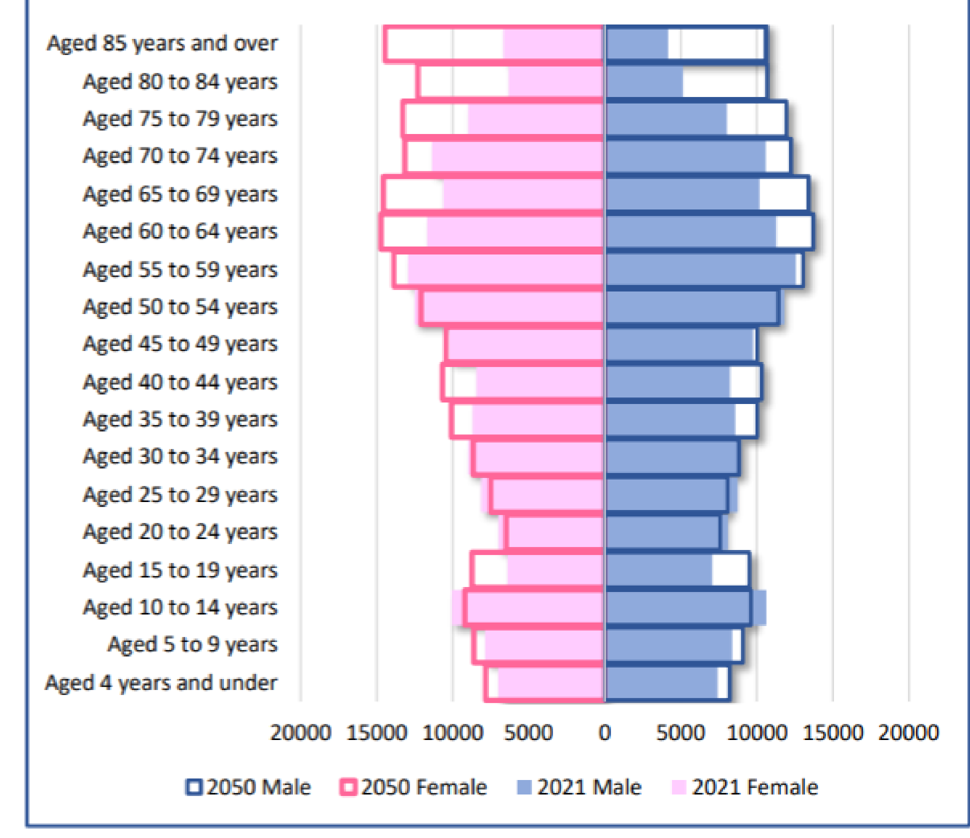
22.1% reception aged children (4–5-year-olds) **overweight or obese,** England 21.3%

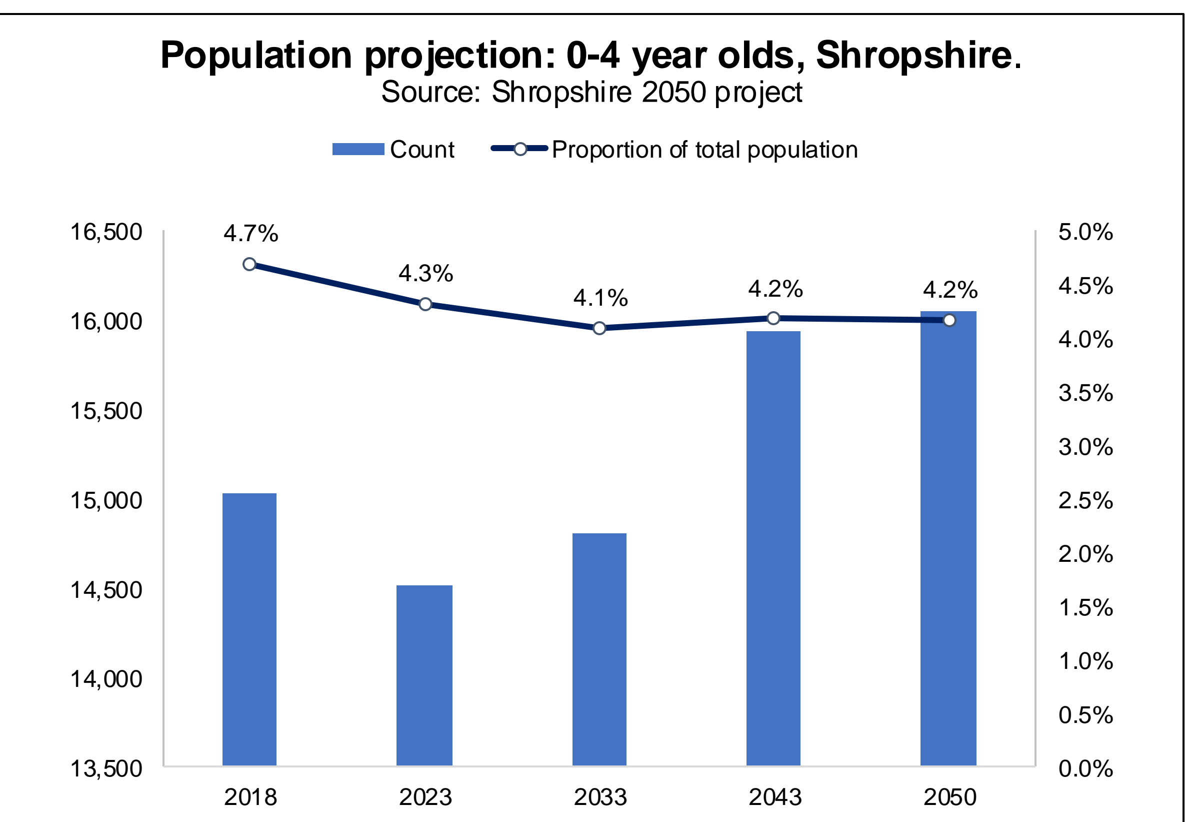
89.8% MMR vaccine coverage two doses in 2022/23, target =>95%

Future trends

Shropshire Council

Charts showing population projections for 0–4-year-olds in Shropshire, 2021-2050 (left) and 2018-2050 (right). Projections are SNPP to 2043, then rolled on to 2050 using PopGroup.





Rise of 1,293 babies and children aged 0-4 by 2050

Early Years metrics

Targets are the national average.

See the full report document for trends and comparator information for each of these metrics.

Better 95% | Similar | Worse 95% | Not applicable

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Shropshire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18s conception rate / 1,000	2021	–	65	12.5	15.2	13.1	31.5		2.7
Smoking status at time of delivery New data	2022/23	→	283	11.4%	9.1%	8.8%	19.4%		3.4%
Low birth weight of term babies	2021	→	43	1.8%	3.0%	2.8%	5.0%		1.5%
Infant mortality rate New data	2020 - 22	–	37	4.8	5.6	3.9	7.6		1.4
Breastfeeding prevalence at 6 to 8 weeks - current method New data	2022/23	–	917	*	*	49.2%*	-	*Insufficient number of values for a spine chart*	
Reception prevalence of overweight (including obesity) (4-5 yrs) New data	2022/23	→	565	22.1%	22.2%	21.3%	29.6%		4%
A&E attendances (0 to 4 years) New data	2022/23	–	8,765	617.3	837.7	797.3	1,928.9		414.7
Emergency admissions (0 to 4 years)	2021/22	–	2,595	180.8	171.7	161.5	328.3		63.0
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years) New data	2021/22	–	125	87.2	100.0	103.6	204.4		42.0
Children with one or more decayed, missing or filled teeth	2016/17	–	-	18.8%	25.7%	23.3%	47.1%		12.9%
Population vaccination coverage: MMR for two doses (5 years old) New data; <90% / 90% to 95% / ≥95%	2022/23	→	2,763	89.8%	83.7%	84.5%	56.3%		94.4%
Proportion of New Birth Visits (NBVs) completed within 14 days New data	2022/23	↓	2,033	80.8%	80.7%	79.9%*	13.3%		99.0%
Proportion of infants receiving a 6 to 8 week review New data	2022/23	↓	2,186	73.3%	79.2%	79.6%*	4.9%		98.5%
Proportion of children receiving a 12-month review New data	2022/23	→	2,085	75.9%	85.8%	82.6%*	22.9%		99.0%
Proportion of children who received a 2 to 2½ year review New data	2022/23	→	1,519	52.9%	77.0%	73.6%*	5.3%		98.0%
Proportion of children aged 2 to 2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review New data	2022/23	↑	1,389	91.4%	94.4%	92.5%*	43.7%		100%
Child development: percentage of children achieving a good level of development at 2 to 2 and a half years New data	2022/23	↓	900	64.8%	76.3%	79.2%*	4.1%		94.4%
Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years New data	2022/23	↓	1,058	76.2%	83.0%	85.3%*	12.0%		95.9%
Child development: percentage of children achieving the expected level in gross motor skills at 2 to 2½ years New data	2022/23	↓	1,188	85.5%	92.0%	92.8%*	13.3%		98.8%
Child development: percentage of children achieving the expected level in fine motor skills at 2 to 2½ years New data	2022/23	→	1,234	88.8%	91.9%	92.6%*	13.8%		99.1%
Child development: percentage of children achieving the expected level in problem solving skills at 2 to 2½ years New data	2022/23	→	1,207	86.9%	90.3%	91.8%*	11.3%		98.3%
Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years New data	2022/23	→	1,168	84.1%	89.0%	90.3%*	13.7%		97.2%
School readiness: percentage of children achieving a good level of development at the end of Reception New data	2022/23	–	1,973	67.6%	66.0%	67.2%	58.5%		
School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception New data	2022/23	–	2,432	83.3%	78.1%	79.7%	69.7%		%
School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception New data	2022/23	–	2,031	69.6%	67.4%	68.8%	59.4%		%

Early Years metrics continued

Targets are the national average.

See the full JSNA Chapter document for trends and comparator information for each of these metrics.

Better 95% | Similar | Worse 95% | Lower 95% | Similar | Higher 95% | Not applicable

Recent trends: – Could not be calculated | ➡ No significant change | ⬆ Increasing & getting worse | ⬆ Increasing & getting better | ⬇ Decreasing & getting worse | ⬇ Decreasing & getting better | ⬆ Increasing | ⬇ Decreasing

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Shropshire			Regions (statistical)	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
A&E attendances (under 1 year) New data	2022/23	–	2,135	798.1	1,196.8	1,132.3	2,613.3		505.9
Emergency admissions (under 1 year) New data	2022/23	➡	1,205	450.5	411.3	375.4	831.1		131.8
Emergency admissions (0 to 4 years) New data	2022/23	➡	2,690	189.4	172.7	158.0	340.1		57.4
Neonatal mortality rate New data	2020 - 22	–	28	3.6	4.5	2.9	5.8		0.9
Post-neonatal mortality rate New data	2020 - 22	–	9	1.2	1.2	1.1	2.8		0.0
Hospital admissions for dental caries (0 to 5 years) New data	2020/21 - 22/23	–	120	228.4	98.0	178.8	0.0		900.9
Admissions for asthma (0 to 9 years) New data	2022/23	➡	80	261.9	195.7	154.7	483.1		52.4
Admissions for diabetes (0 to 9 years) New data	2022/23	➡	10	32.7	36.9	32.5	94.8		0.0
Admissions for epilepsy (0 to 9 years) New data	2022/23	➡	15	49.1	105.7	92.9	272.9		0.0
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act New data	2022/23	–	401	11.9	15.9	16.1	35.8		7.5
Population vaccination coverage: Hepatitis B (1 year old)	2022/23	–	4	100%	*	*	-	-	-
Population vaccination coverage: Dtap IPV Hib HepB (1 year old) <90% 90% to 95% ≥95%	2022/23	➡	2,620	95.7%	91.5%	91.8%	67.8%		97.6%
Population vaccination coverage: Hepatitis B (2 years old)	2022/23	–	-	*	*	*	-	-	-
Population vaccination coverage: Dtap IPV Hib HepB (2 years old) <90% 90% to 95% ≥95%	2022/23	➡	2,673	96.5%	92.9%	92.6%	70.8%		98.5%
Population vaccination coverage: Hib and MenC booster (2 years old) <90% 90% to 95% ≥95%	2022/23	➡	2,616	94.4%	88.2%	88.7%	63.4%		97.2%
Population vaccination coverage: PCV booster <90% 90% to 95% ≥95%	2022/23	➡	2,617	94.5%	88.3%	88.5%	67.7%		97.0%
Population vaccination coverage: MMR for one dose (5 years old) <90% 90% to 95% ≥95%	2022/23	➡	2,941	95.6%	92.6%	92.5%	81.2%		97.4%
Population vaccination coverage: MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2022/23	➡	2,763	89.8%	83.7%	84.5%	56.3%		94.4%
Low birth weight of all babies	2021	➡	140	5.3%	7.9%	6.8%	11.0%		3.6%
Very low birth weight of all babies	2021	➡	20	0.8%	1.4%	1.0%	2.0%		0.2%
Children aged 5 and under killed or seriously injured in road traffic accidents New data	2020 - 22	–	2	3.8	6.9	7.5	29.9		0.0
Population vaccination coverage: MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2022/23	➡	2,622	94.7%	88.9%	89.3%	68.1%		97.3%
Newborn Blood Spot Screening: Coverage	2017/18	–	-	-	98.1%*	96.7%*	-	*Insufficient number of values for a spine chart*	-
Newborn Hearing Screening: Coverage	2022/23	➡	2,242	98.4%	98.7%*	98.5%*	87.9%		99.8%

Areas of need for 0-4s

1. Smoking status at time of delivery
2. Infant mortality – not red, local rise – work in progress through child mortality
3. Emergency admissions (0-4s) and under 1s, admissions for asthma (0-9s)
4. Population Vaccination coverage: MMR two doses (5 years old)
5. Breastfeeding prevalence
6. Uptake of healthy start vouchers
7. % of children receiving a 12 month review by 12 months
8. Child development: % of children achieving a good level of development at 2 to 2½ years
9. Child development: % of children achieving the expected level in communication skills, gross motor skills, fine motor skills, problem solving skills and personal social skills at 2 to 2½ years
10. Transport/access and face to face provision is a barrier for health visiting
11. Looked after children

More detail can be found in the full report.

Emergency admissions 0-4s

Deep dive example

- In 2022/23, more than two thirds of 0-4 emergency admissions were for three reasons:
  - **Diseases of the respiratory system** (43%)
  - **Certain infectious and parasitic diseases** (16%)
  - **Symptoms, signs and abnormal clinical and laboratory findings,** not elsewhere classified (includes fevers, febrile illness, nausea and vomiting) (11%)
- Breaking these reasons down, showed acute **upper respiratory infection**, **viral infections** and **fevers** as key drivers
- However, across Shropshire, Telford and Wrekin, half (53%) of 0-4 admissions recorded during the 2022/23 period had a zero length of stay.
- **This is due to the paediatric assessment unit referring babies and children into hospital for tests and monitoring followed by a same day discharge. Shropshire does not have a Same Day Emergency Care (SDEC) offer which, if in place, could reduce the rate of emergency admissions.**
- Seasonal pattern to the respiration admissions in persons aged 0-4, with activity peaking around December each year.

Shropshire trend analysis (January 2021-February 2024) of emergency admissions (aged 0-4) recorded under the following ICD-10 disease chapters
:

Diseases of the respiratory system
Certain infectious and parasitic diseases
Symptoms, signs and abnormal clinic

Crude rate per 1,000

200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 0

Diseases of the respiratory system

Certain infectious and parasitic diseases

Symptoms, signs and abnormal clinical and laboratory findings, not…

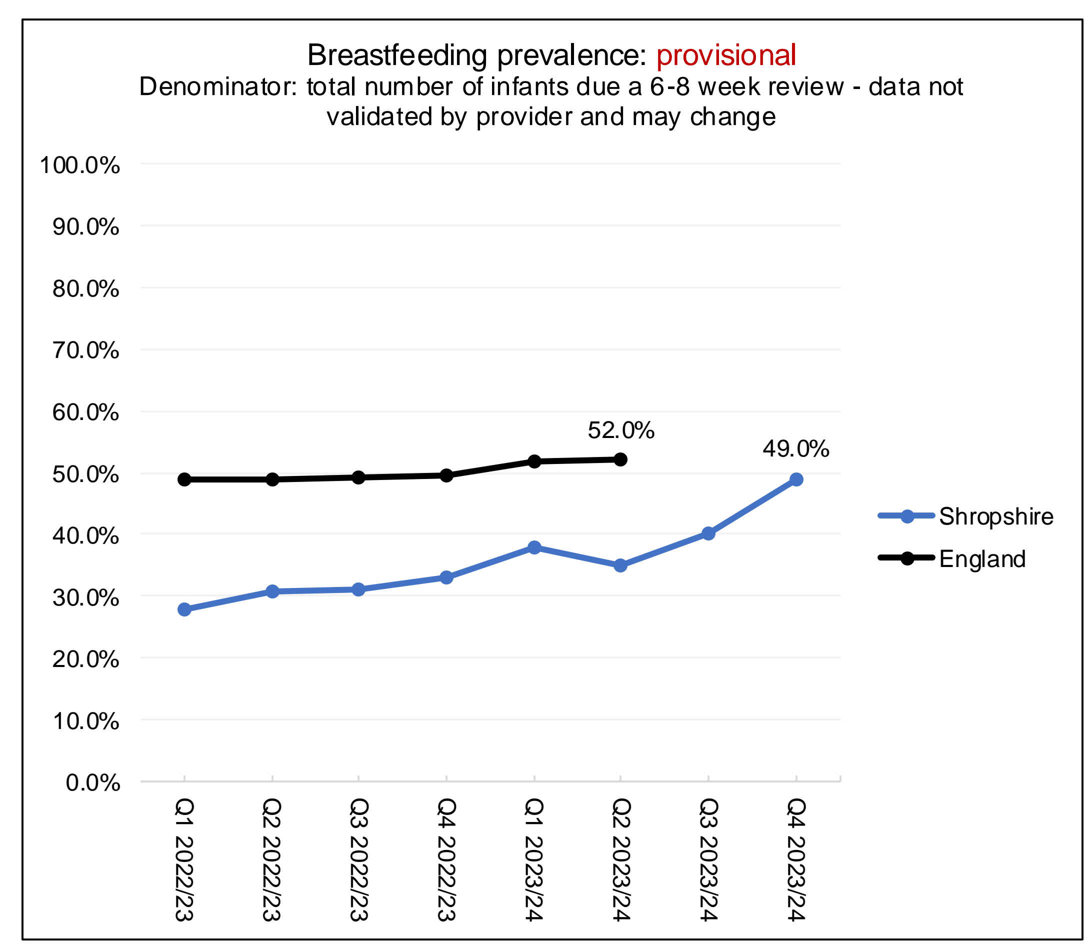
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec | Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec | Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec | Jan

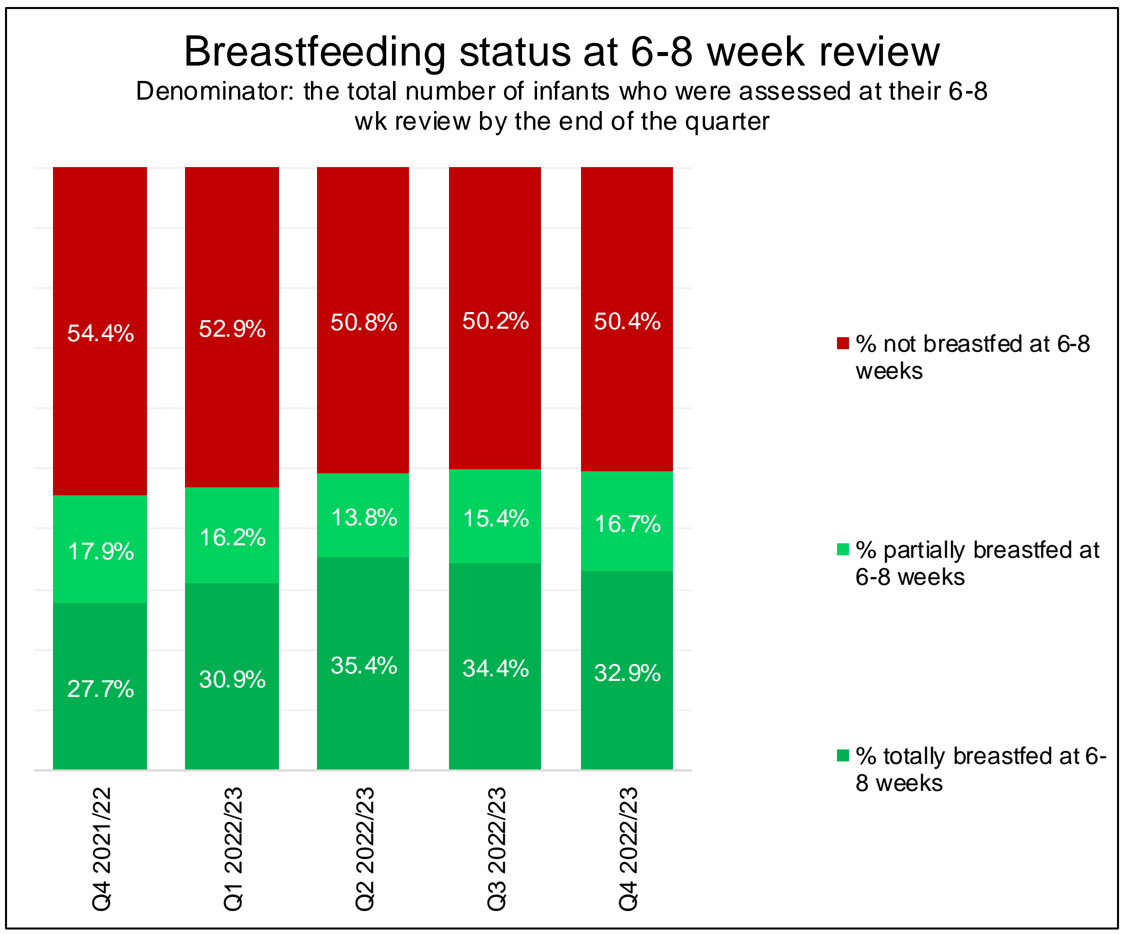
2021 | 2022 | 2023 | 2024

Definition: Emergency admissions via A&E, GPs, Consultant outpatient clinic, Mental Health Services or Baby born at home as intended

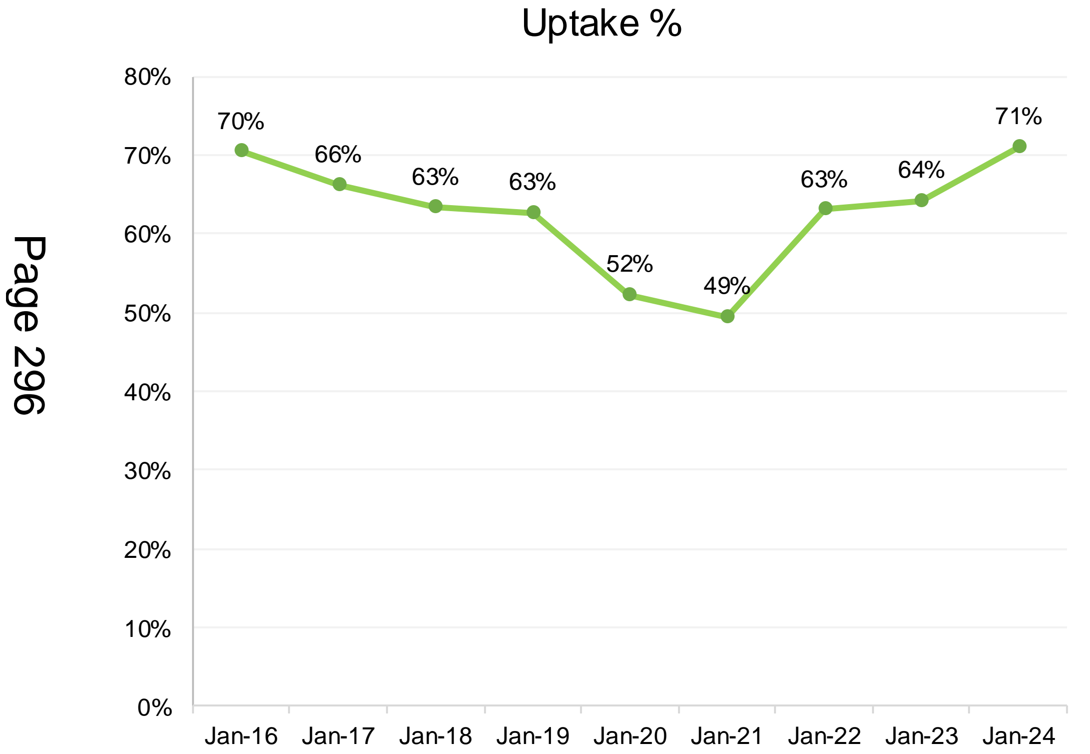
Service performance: Breastfeeding

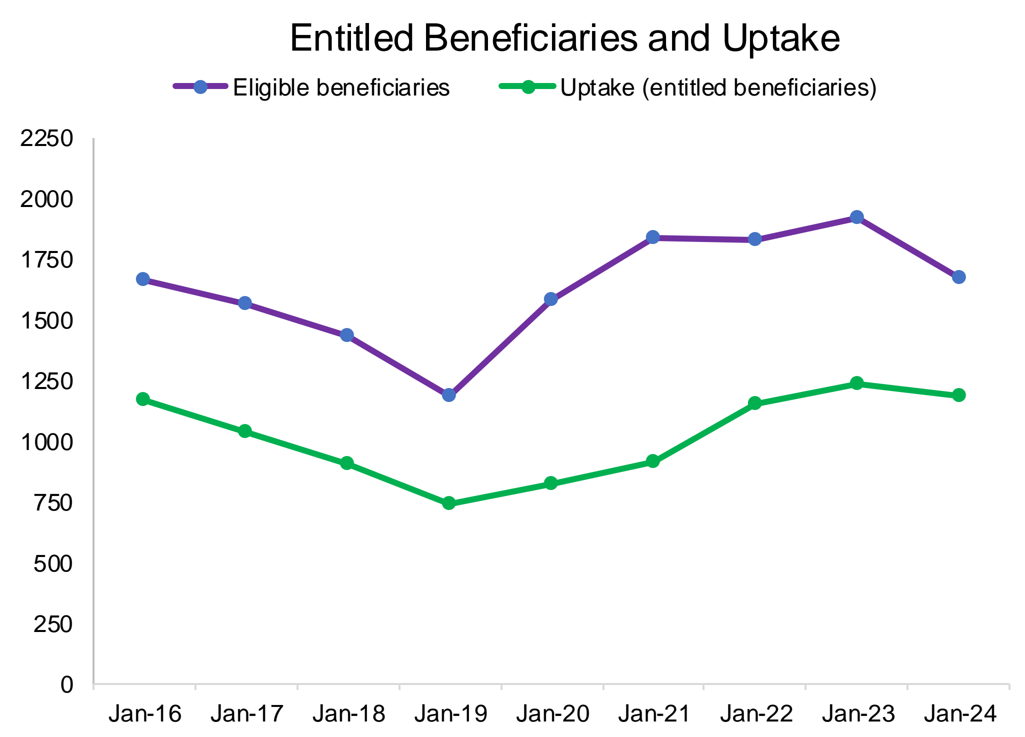
During Q4 2023/24, **49% infants totally or partially breastfed** at 6-8 weeks in Shropshire.





Service performance: Healthy Start vouchers





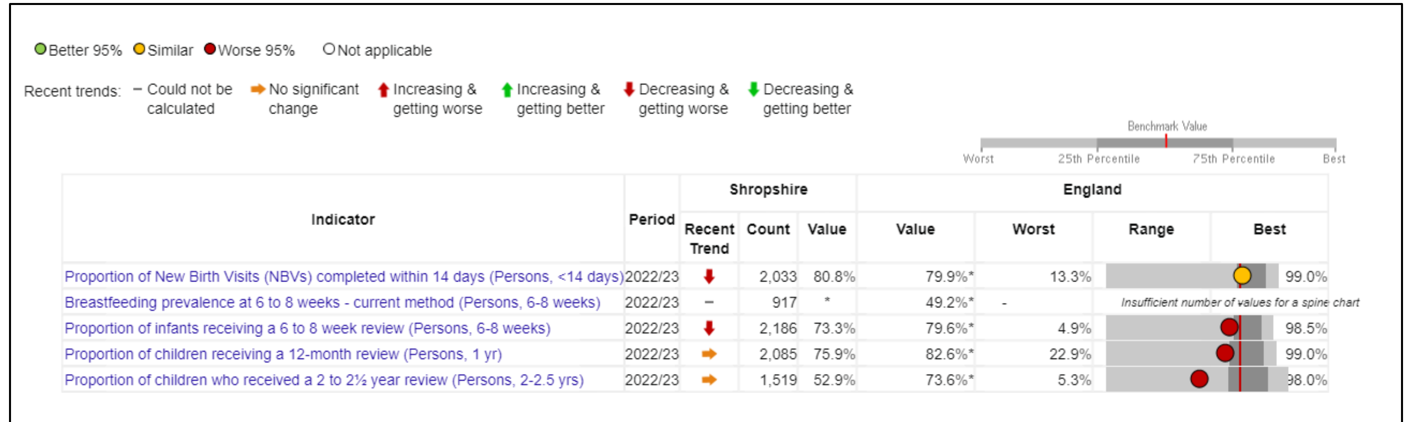
Similar to national average of 74% as of Jan 2024

Service performance: Health visiting

During 2022/23, Shropshire's health visiting rates were worse than the national average however, more **recent data indicates an improvement in rates**.

Published metrics 2022/23

Source: Fingertips



Better 95% | Similar | Worse 95% | Not applicable

Recent trends: – Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Indicator	Period	Shropshire Recent Trend	Shropshire Count	Shropshire Value	England Value	England Worst	England Range	England Best
Proportion of New Birth Visits (NBVs) completed within 14 days (Persons, <14 days)	2022/23	↓	2,033	80.8%	79.9%*	13.3%		99.0%
Breastfeeding prevalence at 6 to 8 weeks - current method (Persons, 6-8 weeks)	2022/23	–	917	*	49.2%*	-	Insufficient number of values for a spine chart	
Proportion of infants receiving a 6 to 8 week review (Persons, 6-8 weeks)	2022/23	↓	2,186	73.3%	79.6%*	4.9%		98.5%
Proportion of children receiving a 12-month review (Persons, 1 yr)	2022/23	→	2,085	75.9%	82.6%*	22.9%		99.0%
Proportion of children who received a 2 to 2½ year review (Persons, 2-2.5 yrs)	2022/23	→	1,519	52.9%	73.6%*	5.3%		98.0%

Provisional metrics 2023/24

Source: SHROPCOM

Note this is comparing Shropshire 2023/24 data with the published 22/23 national average.

This data has not yet been validated by the provider but is included to give an indication of progress and trends.

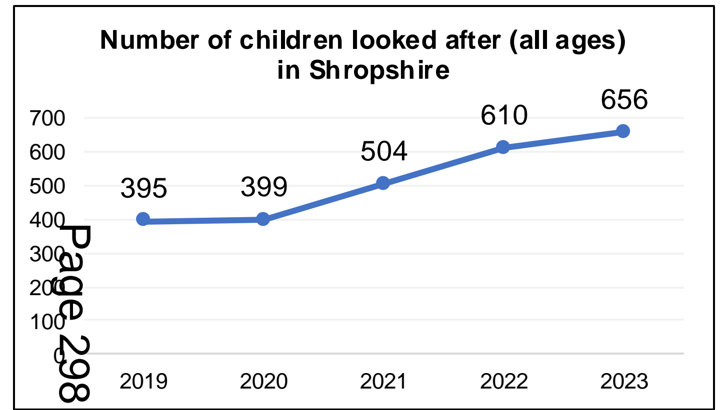
Metric	Shropshire average 22/23	Shropshire average 23/24	Year on year change	National average 2022/23	Gap to national average	Compared to national average
% NBV within 14 days	81%	79%	-2%	80%	-1%	
% NBV within 30 days	19%	19%	0%	-	-	-
% 6-8 week review by 8 weeks	73%	79%	5%	80%	-1%	
% Breastfed at 6-8 weeks	31%	41%	10%	49%	-8%	
% 12 month review by 12 months	42%	47%	5%	83%	-36%	
% 12 month review by 15 months	75%	86%	10%	-	-	-
% 2-2½ year review	53%	69%	16%	74%	-5%	

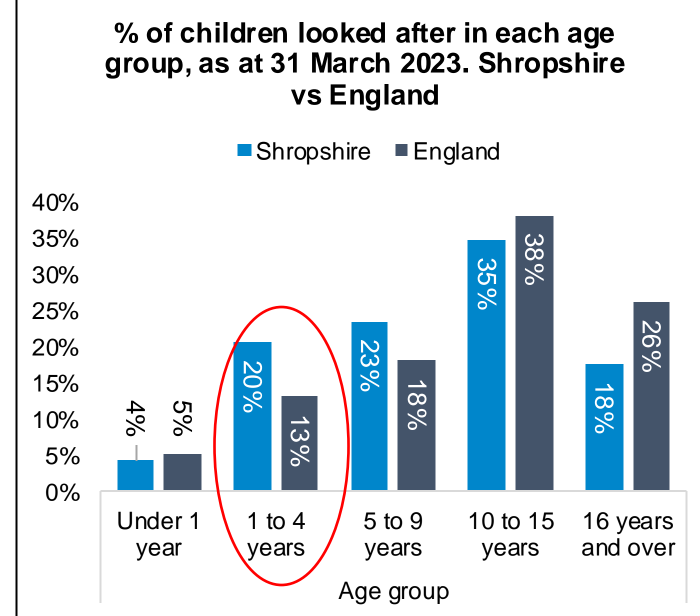
Mitigation:
The reason for the low 12 month review rate is due to reviews taking place before 15 months, with a rate of 86%. This is due to the **timing that the invites are generated and parental choice**. The service have made changes to the system to generate earlier appointments to ensure that these are more frequently prior to the child's first birthday.

Vulnerable children in Shropshire

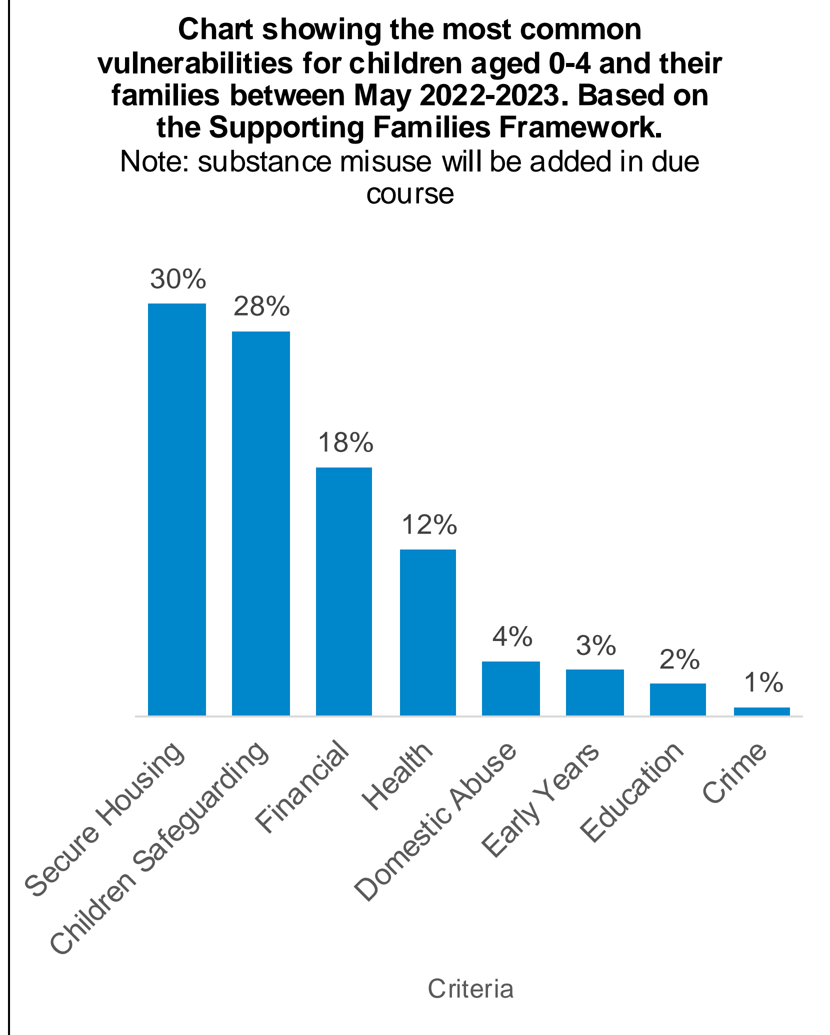
NOTE This slide is still in development and data is likely to change. E.g. COMPASS is now EHAST

Looked after children





Supporting families



COMPASS Help and Support Team

Shropshire's front door for children's social care

74 babies, infants and children aged 0-4 were supported by the team between September 2022 and March 2023 (6 months).

Top 6 presenting issues:

Table showing presenting issue to CHAST, September 2022 to March 2023,

Source: COMPASS Help and Support Team

Presenting issue	Count	Proportion
Domestic abuse	18	16%
Parenting Difficulties	15	13%
Neglect	14	12%
Adult mental health	11	10%
Parental acrimony	10	9%
Adult substance misuse	9	8%

DRAFT

Early Years settings

As of June 2024 in Shropshire, there were 97 Early Years settings and 97 childminders located across the county. Many settings are concentrated in the Shrewsbury area and Oswestry.

Reassuringly, settings are **well-placed in relation to areas with high levels of income deprivation affecting children**.

Early Years settings in Shropshire

EY Childminders - Ofsted rating
- Good
- Inadequate
- Met
- Outstanding
- Registration
- Registration Visit

EY Settings - Ofsted rating
- Good
- Outstanding
- Registration Visit
- Requires Improvement

Income Deprivation Affecting Children Index (IDACI) by MSOA

Proportion of all children aged 0 to 15 living in income deprived families
- 6.4 - 8.1
- 8.1 - 9.7
- 9.7 - 12.6
- 12.6 - 18.1
- 18.1 - 26.7

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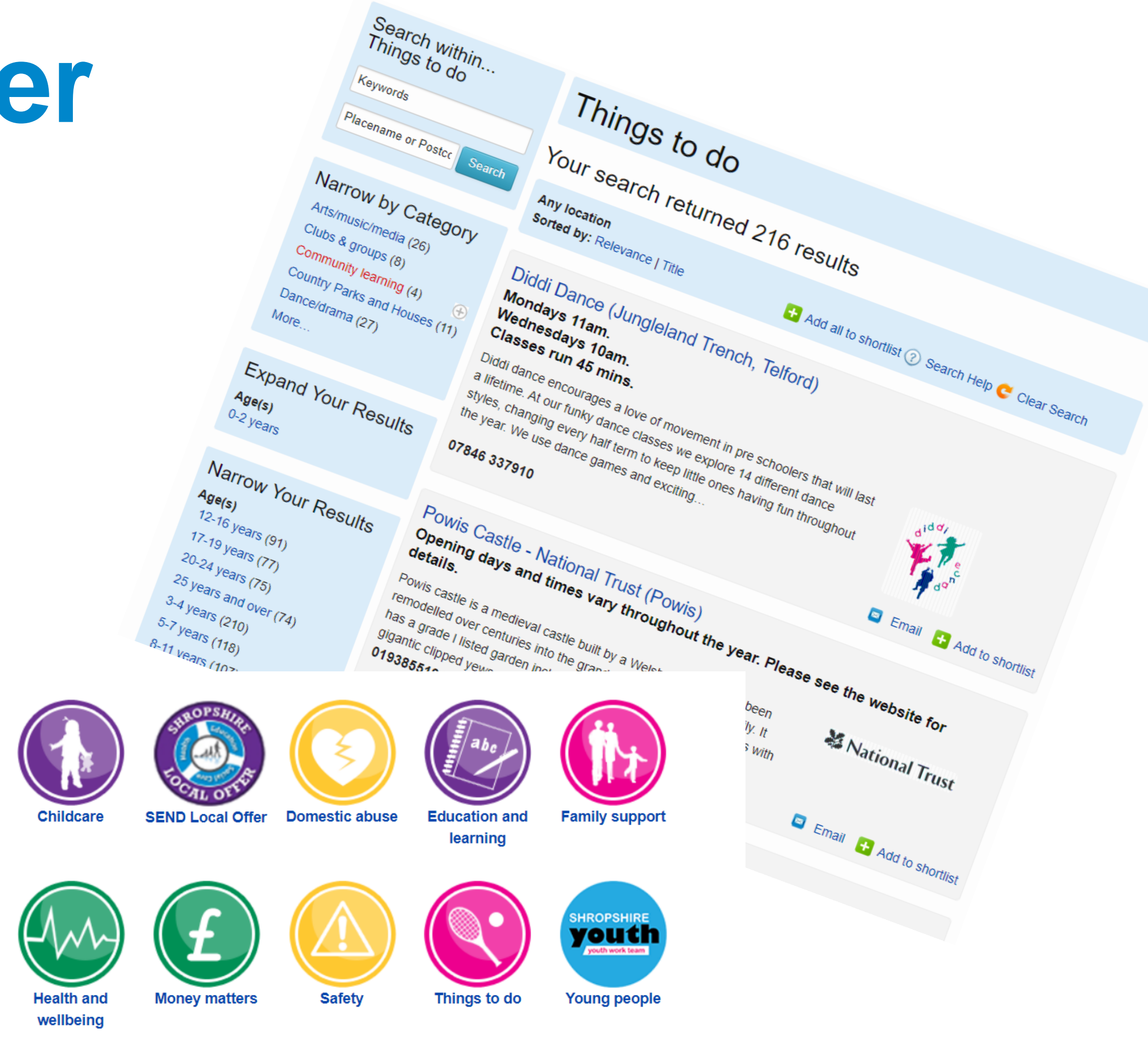
VSCE offer



The Shropshire [Family Information Directory]() has a list of activities and groups available to families with children 0-4 years olds.

There is currently a piece of work underway to enhance this offer regularly adding new groups that become available across the whole of Shropshire and just over the borders.

Shropshire Family Information Service (FIS) has developed this on-line directory featuring local and national organisations and services that exist to support children, young people and families.

The directory contains information on groups which can offer advice and support on some of the issues or concerns any family may encounter. It can also help you find activities in your local area for children and young people to take part in where they can learn new skills and make new friends.

If you are part of a group or service that isn't yet included in the service directory contact Shropshire Family Information Service to add your details free of charge.

Stakeholder engagement

36 responses

We engaged stakeholders and professionals using an online questionnaire. The questionnaire was developed to capture the views of all services and organisations that support babies, infants and children and their families (age 0-4).

Strengths

early-help
sleep-support
fnp-programme
community-based-activities
online-support
drop-ins
family-information-service
multi-agency-working
home-visiting
health-visiting

Gaps

lack-of-transport
disabled-children-support
short-break-activities
antenatal-services
sure-start-centres
parenting-groups
face-to-face
integrated-support
infant-feeding-support
breastfeeding-support
perinatal-mental-health-support
drop-ins
rurality
home-visits
healthy-eating-support
waiting-lists
health-visitor-capacity

Shropshire Council

Parents/carers engagement

We engaged parents/carers of 0-4 year olds using an online questionnaire. The survey was distributed at a parents and carers event via a QR code. Survey responses were collected between 26 October 2023 and 29 November 2023.

Response rate n=18

When would you have most and least benefitted from the support of a health visitor?

Least ... Most

Experiences	0	1	2	3	4	5
During pregnancy	29%	0%	0%	0%	14%	57%
In the first 14 days following childbirth	0%	14%	14%	0%	14%	57%
Between 14- and 30-days following childbirth	0%	0%	29%	29%	14%	29%
Baby aged 6-8 weeks	0%	0%	43%	29%	14%	14%
Baby aged 3-6 months	0%	14%	43%	14%	14%	14%
aged 12 months-2 years	14%	14%	14%	14%	0%	43%
child 2 to 3 years	14%	0%	29%	29%	0%	29%
child 3 to 5 years	14%	14%	0%	14%	14%	43%

As a parent/carer of child (ren) aged 0-5, what are the most important considerations to you, to help you look after your child's health and wellbeing?

"Access to healthcare without a long wait"

"Being able to access services for information and support without delays"

"Physical health and nutrition, followed by mental wellbeing of child and how to support"

"Regular check ins with health professionals for reassurance"

Recommendations

Based on the Areas of Need highlighted on slide 10

Area of need	Mitigation (What are we doing now)	Recommendation (What we are intending to do and how)	Governance (Where does this recommendation sit)
1. Smoking status at time of delivery	• Healthy Pregnancy service in SATH maternity offering smoking cessation support • Health Lives Advisors offering behavioural support for smoking cession • Expansion of smoking cessation offer • Community and family hub development to increase available support • Tobacco Dependency treatment pathways	• To decrease the number of pregnant women smoking at time of delivery to England average	LMNS Health and Wellbeing Board
2. Infant mortality	• Cascading learning from infant deaths (CDOP reviews) • System wide Infant and Child Mortality workshops • Increasing awareness of Safer Sleep advice • Community and family hub development to increase available support • Dashboard in development to STW monitor trends and identify modifiable factors	• To decrease the number of infant deaths by addressing modifiable factors • Learning from previous deaths • Identifying any local themes	ICS System Quality Group LMNS
3. Emergency admissions (under 1s and 0-4s)	• Increased awareness of asthma and inhaler use • School nursing service have trained school staff and also implemented Asthma Friendly Schools programme. • GP practices audited blue inhaler prescriptions. • Community and family hub development to increase available support e.g. Health Visiting drop in clinics opening across county • Priority focus of the infant mortality workstream • Accident prevention awareness	• Reduce the number of 0-4's being admitted from A&E by increasing awareness of early identification and treatment • Increasing awareness of appropriate management of acute and long-term conditions • Learning from case reviews • Embed paediatric Same Day Emergency Care in the community and monitor activity	ICS System Quality Group LMNS System Urgent and Emergency care CYP Oversight Group
4. Population Vaccination coverage: MMR two doses (5 years old)	• Increased circulation of resources to raise awareness of the importance of immunisations through EY settings, schools, higher education, social media, staff newsletters. • GP practices offering catch up appointments to improve coverage. • Community and family hub development to increase available support	• Increase vaccination coverage to 95% by continued awareness of reasons for vaccination • Identify groups with lower uptake and target messaging and work with these communities to increase uptake.	Health Protection Quality Assurance Board
5. Breastfeeding prevalence at 6-8 weeks	• STW Infant feeding strategy • Breastfeeding peer support groups • Additional breastfeeding training to PHNS • Online Antenatal/Postnatal Solihull Training • Baby Buddy App • Introduced open access HV clinics • HV single point of access and texting service • Community and family hub development • Provider is working on improving the data inputting as hasn't been as robust in recent years but is now improving as staff have been made aware and are encouraged to complete it.	• Improve referral pathways for complex breastfeeding support • Raise awareness of breastfeeding peer support groups and HV open access clinics • Improve reporting mechanisms. • Introduction of Womens' Health Hub	LMNS PHNS contract monitoring
6.Uptake of Healthy Start vouchers	• Increased awareness through media • Awareness though Baby Buddy App • Increased training and information to professionals supporting pregnant women and families • Community and family hub development to increase available support • Provider is currently looking at the process for being able to offer HS vouchers in clinic	• Continue to raise awareness • Increase availability of vitamins	Public Health – linking with national team

Area of need	Mitigation (What are we doing now)	Recommendations (What we are intending to do)	Governance (Where does this sit)
7. Proportion of children receiving a 12 month review by 12 months	• Increased awareness of reviews to parents and families • Altered booking system to generate appointments early • Introduced open access HV clinics • HV single point of access and texting service • Community and family hub development to increase available support • 2 year integrated review in the early year's settings (2 year development) and the open access clinics (emergency admissions/minor illness management, breastfeeding, healthy start vouchers).	• Continue to increase number of reviews at 12 months and monitor • Continue to raise awareness • Changing the way in which appointments are sent to meet timescales • Increase availability of HV open access clinics	ICS System Quality Group PHNS contract monitoring
8. Percentage of children achieving a good level of development at 2 to 2½ years	• Piloting integrated 2-year reviews with EY settings • Increase awareness of reviews and encourage parents to take up. • HV single point of access and texting service • Introduced open access clinics • Community and family hub development to increase available support • Physical activity is a key area within early years as part of a child's development. We will continue to work with our Early Years setting to implement the CMO's recommendations regarding physical activity and encourage them to use innovative ways to integrate those across the early year's curriculum	• Roll out integrated 2-year reviews with EY settings • Continue to raise awareness on effective interactions that improve child development. • Roll out of the school readiness leaflet • Introduction and roll out of HV open access clinics for parents/carers to access support	ICS System Quality Group PHNS contract monitoring Health and Wellbeing Board
9. Child development: percentage of children achieving the expected level in communication skills, gross motor skills, fine motor skills, problem solving skills and personal social skills at 2 to 2½ years	• Introduced Early Talk boost and Talk boost to increase speech and language development • Produced school readiness leaflet with information on how to support child development. • Raised awareness of child development. • Increase access to HV service for support. • HV open access clinics • HV single point of access and texting service • Increase uptake of early education • Community and family hub development to increase available support • Physical activity is a key area within early years as part of a child's development. We will continue to work with our Early Years setting to implement the CMO's recommendations regarding physical activity and encourage them to use innovative ways to integrate those across the early years curriculum	• Publishing Best Start for Life offer • Roll out of school readiness leaflet • Online Solihull programmes • To increase awareness of effective interactions from bump- toddlers to improve development. • Introduction and roll out of HV open access clinics for parents/ cares to access support.	ICS System Quality Group PHNS contract monitoring
10. Stakeholders report transport/access and face to face provision is a barrier for health visiting	• Introduced open access clinics • Increased HV recruitment to vacant posts • HV single point of access and texting service • Restored face to face contacts • HV training places • Community and family hub development to increase available support	• Continue to recruit to vacant posts • HV training places increasing • Publicise service offer • Introduction and roll out of HV open access clinics	PHNS contract monitoring
11. Looked after children, 0-4 year olds making up 24% of all children looked after in the county (2023)	• Actions developed and implemented as a result of the Children's summit (2023) • Transformation of Targeted Early Help, Re-launch of the EH Partnership Board and launch of Early Help Strategy, • Community and Family hubs and Integration panels • Communication on how to seek support particularly during school holidays and times of increased pressure • Best Start in Life programme which includes the introduction of Family Foundations Course and information on support available to first time parents/co-parents • Actions included within the Drug and Alcohol Partnership Plan	• Reduce the number of 0-4's becoming looked after by • Increasing professional curiosity • Increasing awareness of professionals and families of early help to support families and prevent escalation • Increasing number of families accessing early help • Improve identification of families in need • Continued audit of cases and learning cascaded and acted upon	Shropshire Safeguarding Community Partnership Health and Wellbeing Board

Summary of DRAFT recommendations

1. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.
2. To continue to monitor **child and infant mortality**, adjusting action plans as required to ensure appropriate mitigations are in place.
3. To improve the recording to show the accurate position of **emergency admissions of 0-4s,** distinct from 0-4s who required same day emergency care. To monitor the level of emergency admissions of 0-4s and take appropriate action.
4. To increase uptake of pregnancy and childhood **immunisations** to provide protection and reduce the risks associated with these illnesses.
5. To continue to increase **breastfeeding rates** at 6-8 weeks to achieve at least the national average.
6. To continue to increase and monitor the number of families **accessing the mandated contacts** offered by the health visiting service.
7. To ensure the **cost of living** support and support for health and wellbeing is well promoted through all services, including promoting the take up of **healthy start vouchers**
8. To reduce the number of 0-4 year olds whose **parents use drugs and alcohol** who become looked after and to increase the number of parents receiving **appropriate support at the earliest opportunity.**
9. To reduce the number of 0-4s **living in households where domestic abuse** occurs by supporting the workforce to **identify perpetrators** and support them to **behaviour change programmes**
10. For all health and social care agencies to ensure they appropriately assess the **mental health** needs of the child, mother and family and signpost to relevant services and intervention.
11. To develop **Women's Health Hubs** across Shropshire aligning with development of **Community & Family Hubs** to improve outcomes for women & children aged 0-4.
12. To publish the **Best Start for Life offer** to enable families to access information about services and support to increase visibility and accessibility of services and improve child outcomes.
13. To continue to increase **awareness of early help and prevention offers** to support families and prevent escalation.
14. To continue to monitor the level of children who are **overweight or obese at reception** and to deliver on the Early Years actions of the Healthier Weight Strategy
15. To engage with **stakeholders to inform recommendations**.

Shropshire Council

Review, feedback and next steps:

- ✓ HWBB- draft April 2024
- ✓ EH Partnership board – 27 June 2024
- ✓ SHROPCOM
- ✓ Children's Safeguarding Oversight Group- March 2024
- ✓ ShIPP- July 2024 – feedback by 2 Aug 2024
- ✓ Further engagement with stakeholders to inform recommendations, target setting exercise and comms plan.
- ❑ HWBB- September 2024
- ❑ How do we promote this product? Webinars?

For feedback and queries, please contact Jess Edwards
Public Health Intelligence Manager
jess.edwards@shropshire.gov.uk

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SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	19 September 2024					
Title of report	Cost of Living - Dashboard					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	x	Information only (No recommendations)	
Reporting Officer & email	Rachel.robinson@shropshire.gov.uk					

Which Joint Health & Wellbeing Strategy priorities does this report 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	x
	Workforce	x	Reduce inequalities (see below)	x
What inequalities does this report address?	Inequalities arising from factors affecting the cost of living among our residents, such as fuel costs, income, employment and house and rent prices.			

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

1. Executive Summary

This report presents to the Health and Wellbeing Board an update on Shropshire's Cost of Living dashboard, progress to date, future direction, and timescales.

2. Report

The Shropshire Cost of living interactive dashboard can be found here:
https://app.powerbi.com/Redirect?action=OpenApp&appId=c36bab57-92cf-4323-b55d-d23d5152b2d4&ctid=b6c13011-372d-438b-bc82-67e4c7966e89

The Cost of Living project started before Christmas 2023 and is based on the Suffolk County Council's Cost of Living dashboard.

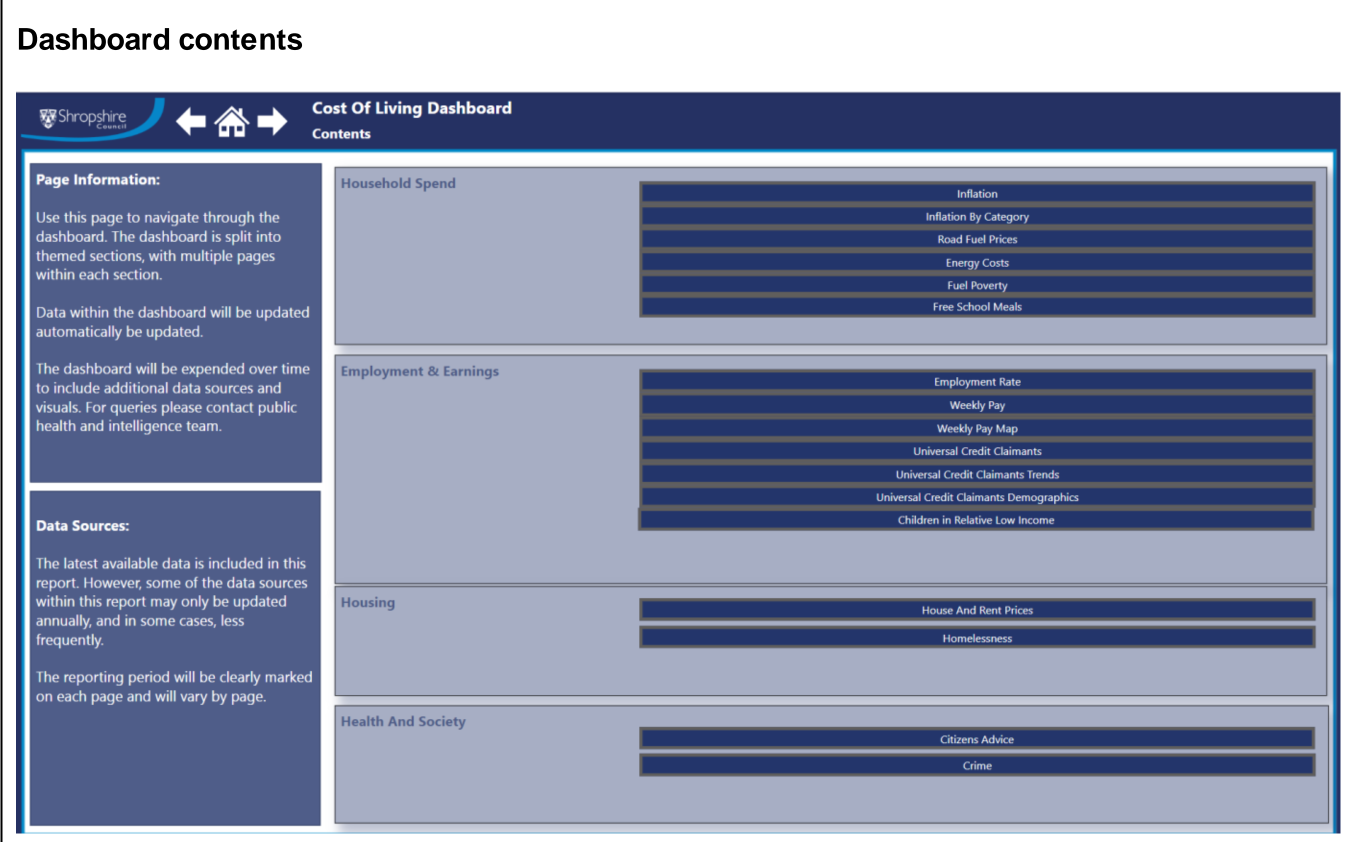
Shropshire's Cost of Living dashboard includes data from various public sources such as DWP (Department for Work and Pensions), ONS (Office for National Statistics), Education statistics and data from local partner organisations, such as Citizens Advice.

The dashboard includes the following sections:

- Household Spend
- Employment and Earnings
- Housing
- Health and Society

The dashboard went for comment to the Poverty and Hardship group in February 2024, involving statutory and VCSE (Voluntary, Charity and Social Enterprise) partners working to support people in hardship and poverty in Shropshire. This group feeds into the Social Taskforce. The dashboard was then reviewed by the Social Task Force Group in March and was circulated in August 2024, receiving positive feedback and interest. We are still waiting for data from other partners to incorporate into the tool, it will be an iterative intelligence product, and more data will be added as it becomes available.

Dashboard contents



Examples of reports by section:

Household spend: Fuel Poverty

Shropshire Council

Household Spend

Fuel Poverty

Page Information:
Fuel poverty in England is measured using the Low Income Low Energy Efficiency (LILEE) indicator. A household is considered to be fuel poor if they are living in a property with a fuel poverty energy efficiency rating of band D or below, and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line. The most recent sub regional data was published in 2024 using 2022 data.

LA Name	Number of households	Number of households in fuel poverty
Shropshire	142,625	25,730

Proportion of households per area which were fuel poor in 2021

Area	%
West Midlands (Me...	20.6%
Walsall	19.7%
East Staffordshire	18.1%
Shropshire	18.0%
Staffordshire Moorl...	18.0%
Newcastle-under-Ly...	18.0%
Dudley	17.4%
Staffordshire	15.8%
Cannock Chase	15.7%
Stafford	15.3%
Telford and Wrekin	14.9%
South Staffordshire	13.7%
Tamworth	13.6%
Lichfield	13.3%
England	13.1%
Solihull	12.7%

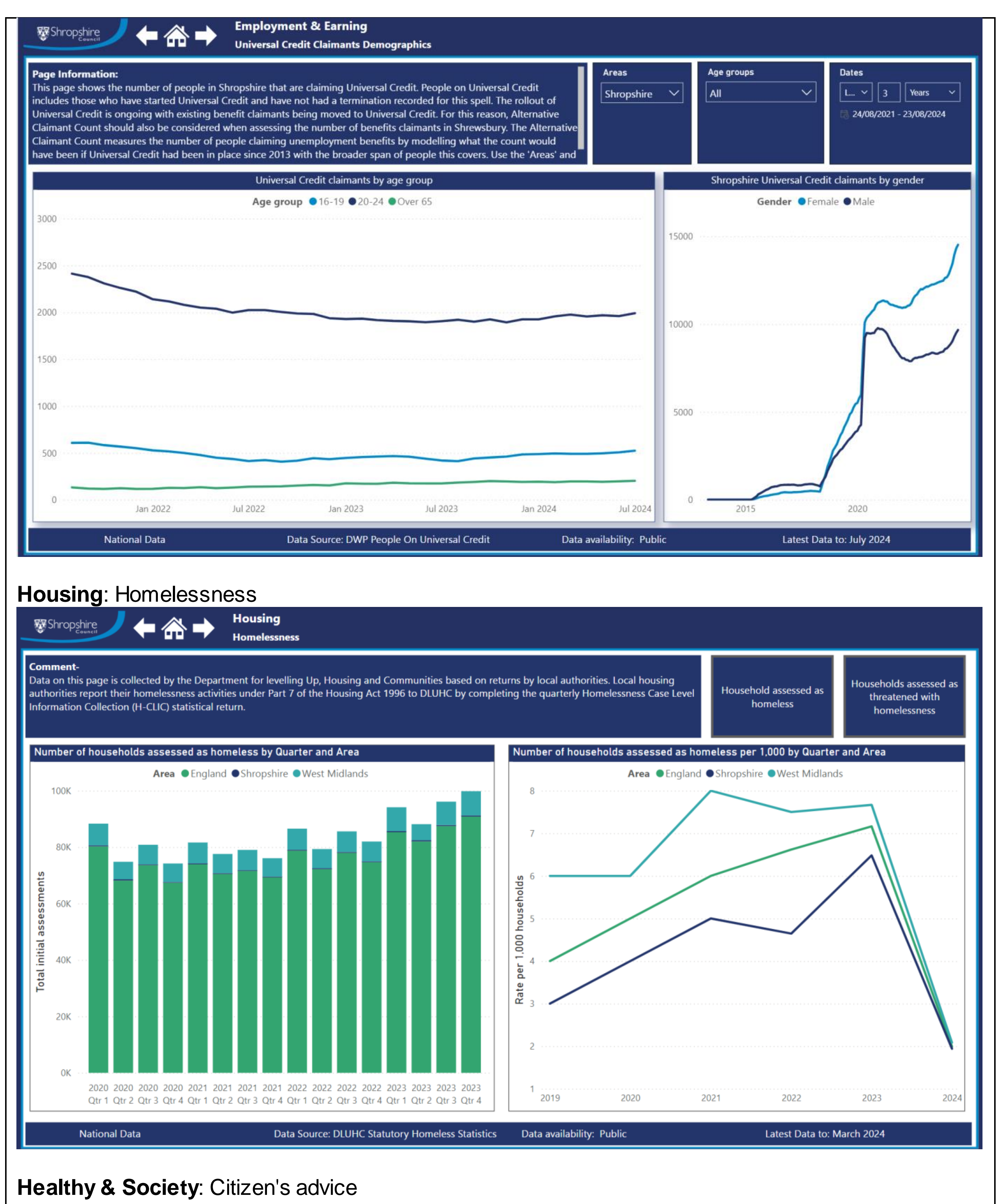
0% 5% 10% 15% 20%

Proportion of households at LSOA Level

Note: The darker the gradient colour on the map, the higher the proportion of households in that

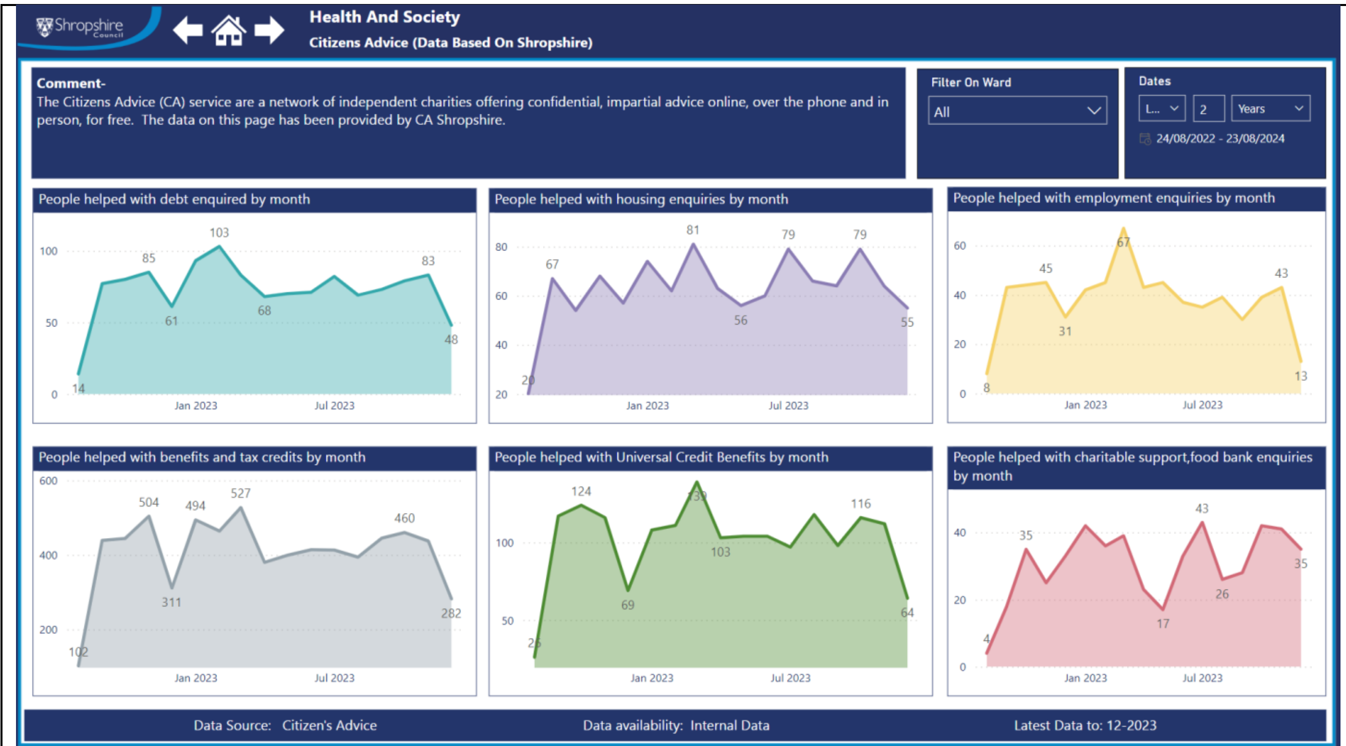
National Data | Data Source: BEIS Fuel Poverty SUb-regional Statistics | Data availability: Public | Latest Data to: 2022, published in 2024

Employment and Earning: Universal Credit claimants



Housing: Homelessness

Healthy & Society: Citizen's advice



Work continues with the integration of partner data, for example from VSCE partners. We aim to publish this tool on the public facing Shropshire Council website alongside the Economy dashboard to provide a set of tools to inform planning and decision making.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences, and other Consultation)	None	
Financial implications (Any financial implications of note)	None	
Climate Change Appraisal as applicable	None	
Where else has the paper been presented?	System Partnership Boards	Social Taskforce
	Voluntary Sector	Social Taskforce
	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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Cecilia Motley		
Appendices (Please include as appropriate)		

<table>
<tr><td colspan="7">SHROPSHIRE HEALTH AND WELLBEING BOARD
Report</td></tr>
<tr><td>Meeting Date</td><td colspan="6">19 September 2024</td></tr>
<tr><td>Title of report</td><td colspan="6">Integrated Care Partnership (ICP) KPI and performance outcome monitoring update</td></tr>
<tr><td>This report is for
(You will have been advised which applies)</td><td>Discussion and agreement of recommendations</td><td></td><td>Approval of recommendations (With discussion by exception)</td><td>x</td><td>Information only (No recommendations)</td><td></td></tr>
<tr><td>Reporting Officer & email</td><td colspan="6">Rachel Robinson
Rachel.robinson@shropshire.gov.uk</td></tr>
<tr><td rowspan="4">Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply</td><td>Children & Young People</td><td>x</td><td colspan="3">Joined up working</td><td>x</td></tr>
<tr><td>Mental Health</td><td>x</td><td colspan="3">Improving Population Health</td><td>x</td></tr>
<tr><td>Healthy Weight & Physical Activity</td><td>x</td><td colspan="3">Working with and building strong and vibrant communities</td><td>x</td></tr>
<tr><td>Workforce</td><td>x</td><td colspan="3">Reduce inequalities (see below)</td><td>x</td></tr>
<tr><td>What inequalities does this report address?</td><td colspan="6"></td></tr>
</table>

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

1. **Executive Summary**

This report provides an overview of the approach to Population Health Managment (PHM) across the Intergrated Care System. This report then specifically provides an update of the KPI and Performance Monitoring element of the work programme and specifically those metrics that relate to the Integrated Care Strategy which build on the Health and Wellbeing Board and SHIPP Metrics.

2. **Recommendations**

- That the Board review and comment on the outcome metrics including in this report
- That the Board note the progress to date against the Integrated Care Strategy and Health and Wellbeing Board Strategy Outcomes and consider any additional or amended outcomes for consideration within the framework at the Board

3. **Report**

Background

Population Health Management (PHM) is a way of working to understand current health and care needs and predict what local people will need in the future. It helps shape evidence-based actions to address these needs. This is used to inform and define commissioning intentions and planning of future services/ required outcomes for strategic planning/commissioning. It can also support those on the frontline, our local communities and teams to understand and support actions to improve outcomes for example through local action planning and pathway redesign.

PHM uses historical and current data to understand what factors are driving poor outcomes in different population groups. The use of joined up data across local health and care partners and techniques like population segmentation and risk stratification can offer deeper insight into the holistic needs of different population groups and the drivers of health inequalities. Alongside the use of qualitative data sources and ad hoc research and evaluation as required.

At an Integrated Care System level, a Population Health Management Group has been established to oversee the work programme to deliver a population health management approach across the system. It is chaired by the Director of Public Health for Shropshire and membership is comprised of the strategic lead and analytical lead for each partner organisation to drive the work forward.

Specifically, the purpose of the PHM group is to:

- To establish a system approach to embedding and leading Population Health Management approaches across all programmes of work and to co-ordinate the delivery of key programmes of work across the system including the prevention and inequalities

- To use all data (qualitative and quantitative and information, evidence of best practice to develop intelligence and insight in a systematic way to better understand, plan, deliver and ultimately improve our populations health and care whilst making best use of all available resources. This includes specifically informing strategy development and linking back into strategic plans

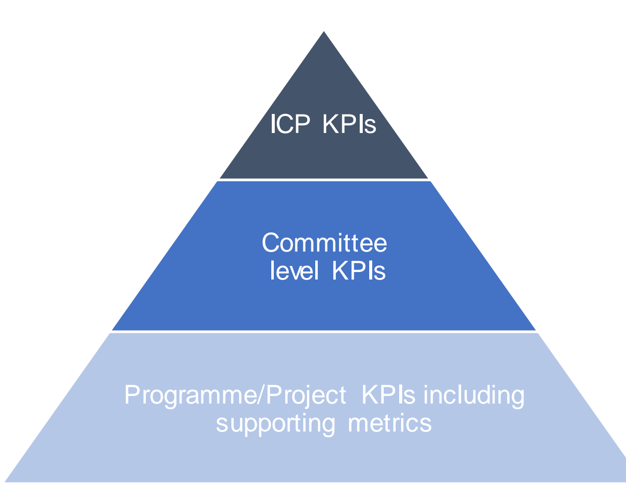
- To lead the approach across the system to benefits realisation, evaluation and monitoring of outcomes and impact

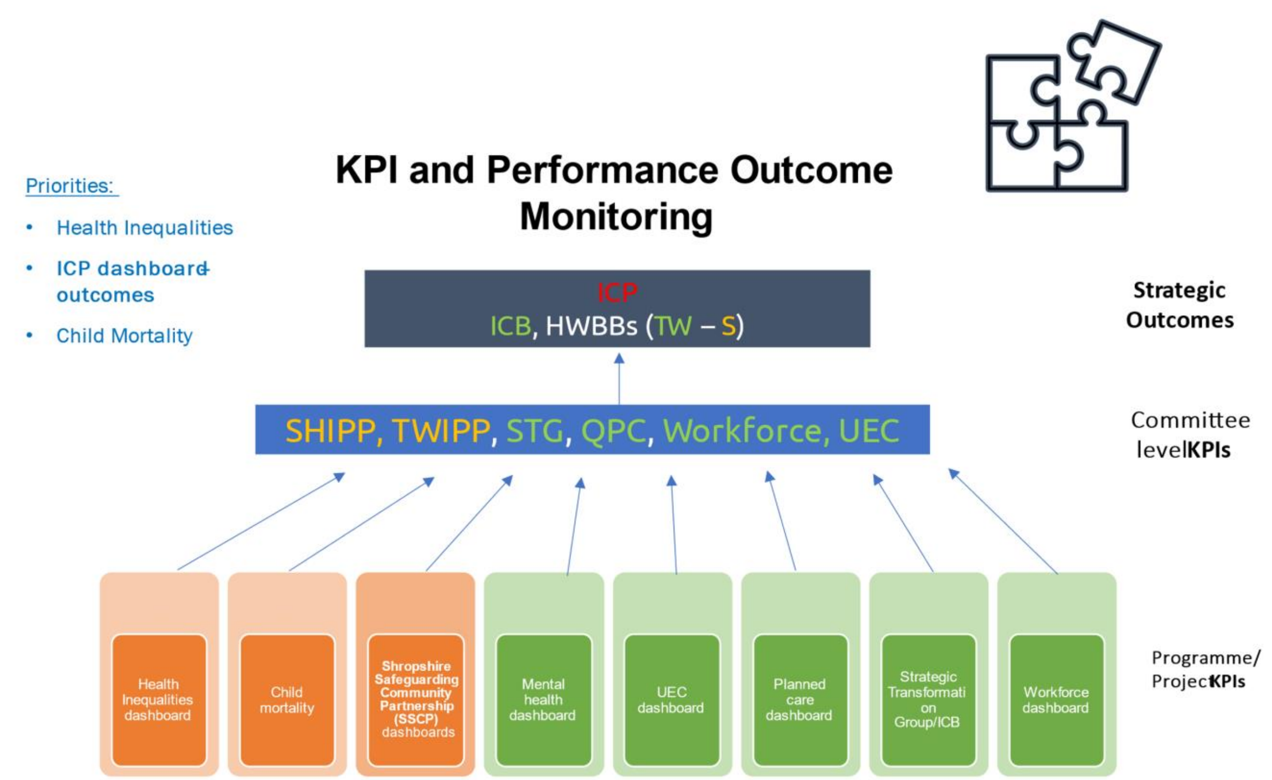
The PHM work programme is split into the following headings;

- Programme population health intelligence
- Health needs assessments
- Elective recovery
- KPI and performance outcome monitoring
- Modelling and forecasting
- Infrastructure

This report provides an update on the **KPI and performance outcome monitoring** element of the work programme and specifically the development of a framework for monitoring committee and Board level KPIs and outcomes.

KPIs and Monitoring including the Intergrated Care Partnership Outcomes
A pyramid approach has been taken to monitor performance and impact of the Population Health Management programme. Multiple dashboards monitor programme delivery through key performance indicators and outcome measures. Key KPIs from programme dashboards will feed up to committee level and to the Integrated Care Partnership. The below infographics demonstrate this.





To determine a list of KPIs for reporting to the ICP Board, a long list of KPIs were collated from the:

- Shropshire Health and Wellbeing Board KPIs
- Telford and Wrekin Health and Wellbeing board KPIs
- ShIPP KPIs
- TWIPP KPIs
- Integrated strategy (owned by the Integrated Care Partnership)

The list of metrics would be taken to each Board and Committee for consideration in draft before the final version would be signed off by the Integrated Care Partnership

The Population Health Management Planning Group considered and agreed a short list of key performance indicators to report to the ICP board, as shown below.

Suggested ICP Board metrics

ICP Planning group met in June 2024. Agreed a short list of high-level metrics from a long list collated from both HWBBs, SHIPP, TWIPP and the Integrated strategy metrics

	KPI	Where from?	Metric
1	Increase healthy life expectancy in all people	Shropshire HWB strategy/ TW HW strategy/ Integrated Strategy	Healthy life expectancy at birth (male and female)
2	Improve life expectancy at birth and 65+ years	TW HWB Strategy	Life expectancy at birth and 65+ years (male and female)
3	Narrow the gaps in life expectancy and healthy life expectancy.	TW HWB Strategy/Integrated Strategy	Inequality in LE and HLE
4	Increase healthy life expectancy for those with Severe Mental Illness (SMI)	Shropshire HWB strategy/SHIPP/ Integrated Strategy/ TW HW Strategy	Premature mortality in adults with severe mental illness (SMI) and Excess under 75 mortality rate in adults with severe mental illness (SMI)
5	16-17s not in education, employment or training	Shropshire HWB strategy/SHIPP/ Integrated Strategy	16-17s not in education, employment or training
6	Excess under 75 mortality rate in adults with Severe Mental Illness (SMI)	Shropshire HWB strategy	Excess under 75 mortality for people with SMI
7	Improve infant and maternal health outcomes	TWC HW Strategy - Integrated neighbourhood health and care	Smoking status at the Time of Delivery
8	Improve infant and maternal health outcomes	SHIPP	Infant mortality rate
9	Diabetes treatment outcomes	Integrated Strategy	Treatment outcomes - diabetes care processes
10	Reduce preventable mortality	TWC HW Strategy - Protect, prevent and detect early	Under 75 mortality rate from cardiovascular diseases considered preventable
11	Reduce preventable mortality	TWC HW Strategy - Protect, prevent and detect early	Under 75 mortality rate from cancer considered preventable
12	Reduce preventable mortality	TWC HW Strategy - Protect, prevent and detect early	Under 75 mortality rate from causes considered preventable
13	E04b – Under 75 mortality rate from Cardiovascular diseases seen as preventable (2019 definition, 1 year range)	SHIPP	Under 75 mortality rate from Cardiovascular diseases seen as preventable (1 year range)
14	Reduce impact of ACEs on our communities	Integrated Strategy	Report at Place. Overarching position ICP level.
15	Increase the number of residents describing their community as a healthy, safe and positive place to live	Integrated Strategy	Number of residents describing their community as a healthy, safe and positive place to live
16	Increase the % of residents who report that they are able to access services they need, when they need them	Integrated Strategy	Tbc
17	Reduce carbon footprint generated through travel by patients to our services	Integrated Strategy	Carbon footprint of patients travelling to services
18	Early diagnosis and treatment for cancer	SHIPP	% cancers diagnosed at stage 1 and 2

The expectation is to produce a first draft of the outcomes framework by October 2024 for the Integrated Care Partnership to review. However, the framework and the KPIs/Outcome metrics will be an ongoing development with senior leaders and members. Targets, tolerance and benchmarks will be set and clarified over the coming months with where possible, regular updates. This will be developed into a dashboard and published on the Intergrated Care System website. This will be the main source of performance information enabling greater insight, transparency and scrutiny of the ICS performance and delivery of its outcomes as set in the Integrated Care Strategy.

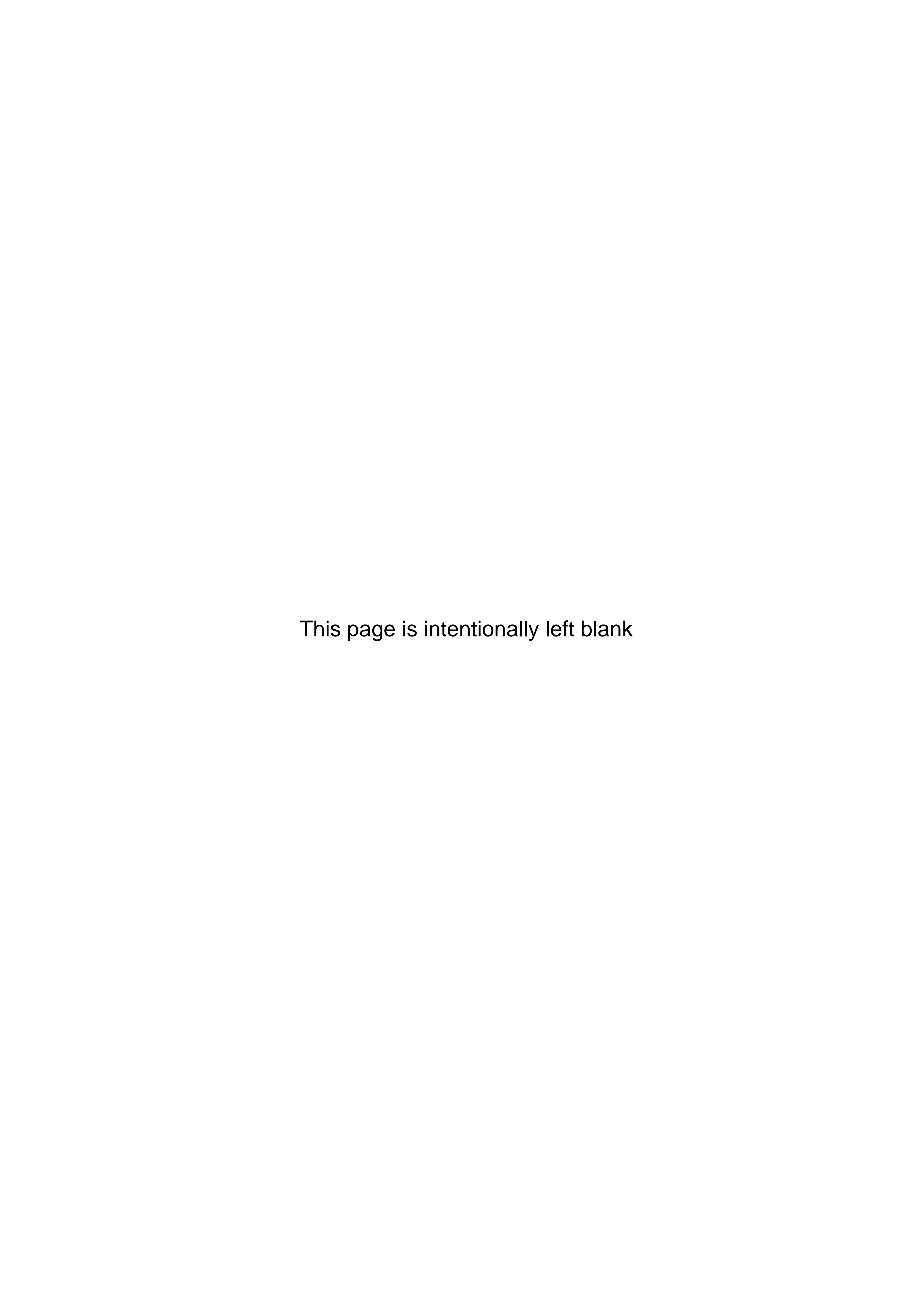
Next Steps

To move the work forward our next steps involve:

- Seeking endorsement of metrics from Shropshire Health and Wellbeing Board and Telford and Wrekin Health and Wellbeing Board
- Seeking endorsement of metrics from ShIPP and TWIPP
- Ensuring metrics still align with Integrated strategy and JFP
- The Dashboard build – commence September 2024
- A draft of the metrics to be shared with the Integrated Care Partnership for review comment and amendments
- For programmes of work to be continuously reviewed and amended in the pyramid
- Each metric to be mapped to a programme of work at the bottom of the pyramid.
- If there are exceptions or areas of need, a deep dive will follow and a report will be presented to the ICP board.
- Final first version of the framework to be published

Risk assessment and opportunities appraisal	None

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)		
Financial implications (Any financial implications of note)	None	
Climate Change Appraisal as applicable	None	
Where else has the paper been presented?	System Partnership Boards	ShIPP 19 September (as August cancelled)
	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) Portfolio holders can be found here **or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead** Cllr Cecilia Motley		
Appendices Appendix A. ICP KPI's and Dashboard update – presentation		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ICP KPIs and Dashboard update

Purpose and approach

The KPIs were collated from the:

- Shropshire Health and Wellbeing Board KPIs
- Telford and Wrekin Health and Wellbeing board KPIs
- ShIPP
- TWIPP
- Integrated strategy

The PHM planning group met, considered and agreed a long list of metrics to monitor impact of the PHM work programme

A pyramid approach

- Multiple dashboards monitor programme delivery through KPIs and outcome measures

- Key KPIs feed up to committee level and to ICP level

- Two levels of performance monitoring

ICP KPIs

Committee level KPIs

Programme/Project KPIs including supporting metrics

KPI & Performance Outcome Monitoring

- Priorities:
- Health Inequalities
- **ICP dashboard – outcomes**
- Child Mortality

ICP
ICB, HWBBs (TW – S)

Strategic Outcomes

ShIPP, TWIPP, STG, QPC, Workforce, UEC

Committee level **KPIs**

Health Inequalities dashboard

Child mortality

Shropshire Safeguarding Community Partnership (SSCP) dashboards

Mental health dashboard

UEC dashboard

Planned care dashboard

Strategic Transformation Group/ICB

Workforce dashboard

Programme/ Project **KPIs**

Suggested ICP Board Metrics

ICP Planning group met in June 2024. Agreed a short list of high-level metrics from a long list collated from both HWBBs, ShIPP, TWIPP and the Integrated strategy metrics. These are high level outcome performance measures – the detail will be reported via the relevant committee and board. These aim to provide oversight and assurance to the ICP

	KPI	Where from?	Metric
1	Increase healthy life expectancy in all people	Shropshire HWB strategy/ TW HW strategy/ Integrated Strategy	Healthy life expectancy at birth (male and female)
2	Improve life expectancy at birth and 65+ years	TW HWB Strategy	Life expectancy at birth and 65+ years (male and female)
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16	Increase the % of residents who report that they are able to access services they need, when they need them	Integrated Strategy	Tbc
17	Reduce carbon footprint generated through travel by patients to our services	Integrated Strategy	Carbon footprint of patients travelling to services
18	Early diagnosis and treatment for cancer	ShIPP	% cancers diagnosed at stage 1 and 2

Next Steps

KPI and Performance Outcome Monitoring

Priorities:

- Health Inequalities
- ICP dashboard – outcomes – by Sept
- Child Mortality

ICP
ICB, HWBBs (TW – S)
Strategic Outcomes

SHIPP, TWIPP, IDC, QPC, Workforce, UEC
Committee level KPIs

Health Inequalities dashboard
Child mortality
Shropshire Safeguarding Community Partnership (SSCP) dashboards
Mental health dashboard
UEC dashboard
Planned care dashboard
Integrated Delivery Committee/ICB
Workforce dashboard
Programme/ Project KPIs

- Endorsement of metrics
- Ensure metrics still align with Integrated strategy and JFP
- Dashboard build – commence August
- Share draft Dashboard to ICP board – October 2024
- Share draft Dashboard with HWBBs and ShIPP/TWIPP
    - 18th September -TW HWBB and TWIPP
    - 19th September- Shropshire HWBB and ShIPP
- Programmes of work will continuously be reviewed and amended in the pyramid
- Each metric will be mapped to a programme of work at the bottom of the pyramid.
- If there are exceptions or areas of need, a deep dive will follow and feed into ICP board

NHS

Integrated Strategy KPIs

Outcome Focus – potential high level outcomes

The health of our population will be improve through a focus on….	Our Outcomes
The health of our STAFF	1. We will improve our ability to attract, recruit and retain our staff 2. We will improve staff training and development opportunities across all our partners 3. We will improve self-reported health and wellbeing amongst our staff 4. We will increase Equality and Diversity workforce measures in all organisations
The health of our COMMUNITIES	1. We will reduce the impact of poverty on our communities 2. We will reduce levels of domestic violence and abuse 3. We will reduce the impact of alcohol on our communities 4. We will reduce the impact of Adverse Childhood Experiences (ACEs) on our communities 5. We will reduce the number of young people not in education, training or employment 6. We will increase the number of our residents describing their community as a healthy, safe and positive place to live
The health of our ENVIRONMENT	1. We will increase the proportion of energy used by the estates of our partner organisations from renewable sources 2. We will reduce the total carbon footprint generated through travel of patients using our services 3. We will increase the use of active travel, public transport and other sustainable transport by our staff, service users and communities

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Integrated Strategy KPIs

Outcome Focus – potential high level outcomes

The health of our population will be improved through a focus on….	Our Outcomes
The health of our RESIDENTS	1. We will increase healthy life expectancy across STW and narrow the gap between different population groups 2. We will reduce early deaths from preventable causes – cardiovascular and respiratory conditions, cancers and liver disease – focussing on those communities which currently have the poorest outcomes 3. We will improve life expectancy of those with Serious Mental Illness 4. We will increase the proportion of people in STW with a healthy weight 5. We will improve self-reported mental wellbeing 6. We will reduce the number of children & young people who self-harm 7. We will reduce alcohol related hospital admissions 8. We will reduce the proportion of pregnant women who smoke 9. We will lower the burden and minimise the impact of infectious disease in all population groups
The health of our SERVICES	1. We will increase the proportion of our residents who report that they are able to find information about health and care services easily 2. We will increase the proportion of our residents who report that they are able to access the services they need, when they need them 3. We will increase the proportion of our residents who report that their health and care is delivered through joined up services as close to home as possible

SHROPSHIRE HEALTH AND WELLBEING BOARD Report						
Meeting Date	**19th September 2024**					
Title of report	**Women's Health Hubs: Shropshire, Telford & Wrekin**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations		Approval of recommendations (With discussion by exception)	X	Information only (No recommendations)	
Reporting Officer & email	Naomi Roche: Public Health Principal - Healthy Population Lead & Women's Health Hubs Lead STW naomi.roche@shropshire.gov.uk					

Which Joint Health & Wellbeing Strategy priorities does this report 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 report address?	The work has reducing inequalities at its core. Person Centred approaches and personalising care ensures active consideration of the needs of different communities. As described in the Women's Health Strategy, 51% of the population faces obstacles when it comes to getting the care they need. Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-represented when it comes to important clinical trials. This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact them in different ways. As the national directive says, the impact of failing to put women at the heart of health services has been clear to see through the number of recent high-profile independent reports and inquiries. This has included the: • report of the Independent Medicines and Medical Devices Safety Review (IMMDS review), which considered how the health system in England responds to reports from patients about side effects from treatments. • report of the independent inquiry into the issues raised by convicted breast surgeon Ian Paterson • recent final report of the Ockenden review, which was an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust			

	As these independent reports have shown, too often it is women whom the healthcare system fails to keep safe and fails to listen to. There are specific actions in the Ockenden Report requiring the local system to improve support for women's health, including pre-conception care. ***The LMNS, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy. Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.*** The trust has referral process in place to manage pre-existing disorders and multiple pregnancies however, there is a gap regarding ensuring women have access to pre-conception care in general as this is not a specific commissioned pathway. As a priority theme for the women's hub steering group with links to LMNS health pregnancy and healthy families workstreams. This also links in with reducing infant mortality, preventing stillbirth, and prevention of many other congenital issues including foetal alcohol syndrome, spina bifida and others. Additionally, the T&W Child Sexual Exploitation Inquiry Report highlights long and extensive exploitation of young women in the area, with numerous recommendations of collaborative working to prevent exploitation in the future. Health services are a key part of this. By improving joint working with Public Health Nursing Services, Sexual health, pre-conception support, parenting support (as part of the offer), we can improve the visibility of young women in our communities and reduce CSE.

Report content -

1. **Executive Summary**

In response to the National (Women's Health Strategy) and Local Drivers (including the Ockenden Report, local Joint Strategic Needs Assessments, Child Sexual Exploitation Inquiry, and a range of community engagement results highlighting the distinct and increasing need of health, care and community support for women, in particular), collaborative and joint working is underway to deliver women's health and wellbeing hubs.

The work encompasses specific needs of women and young women, with a focus on inequalities and rural inequalities. This includes sustainable, community-based Women's Health Hubs, ensuring equitable access to clinical and non-clinical support by building on

family & community hubs within PCN areas and other clinical offers informed by the JSNAs, population health and clinical data.

2. **Recommendations**
   - Note: the content and programme updates and reflect on the progress to date.
   - Note: the first programme delivery milestone was successfully met.
   - Note: the work reflects the delivery area of Shropshire, Telford, and Wrekin.
   - Endorsement of the approach and discussion.

3. **Report**

The recently published 2024/25 Operational Planning Guidance asks ICBs to "establish and develop at least one women's health hub in every ICB by the end of December 2024 in line with the core specification, improving access, experience and quality of care" and sets the expectation that at least 75% of ICBs have a hub in place by July 2024 that meets minimum requirements.

- menstrual problems assessment and treatment, including but not limited to care. for heavy, painful or irregular menstrual bleeding, and care for conditions such as endometriosis and polycystic ovary syndrome contraceptive counselling and provision of the full range of contraceptive methods including LARC fitting for both contraceptive and gynaecological purposes (for example, LARC for heavy menstrual bleeding and menopause), and LARC removal, and emergency hormonal contraception.
- preconception care
- breast pain assessment and care
- pessary fitting and removal.
- cervical screening
- screening and treatment for sexually transmitted infections (STIs), and HIV screening
- menopause assessment and treatment

This guidance was issued with a supporting letter by Dame Ruth May, Chief Nursing Officer, England & Ed Waller Deputy Chief Financial Officer, Strategic Finance to all ICB Chief Executives with a clear expectation that the year 2 allocation could only be used for the implementation of each system's women's health hubs plans to take into consideration the core specification.

"The funding allocated to each ICB for hubs must be spent only for this purpose and any ICB underspend against this funding will be adjusted for in month 12 2024/25. Each ICB is encouraged to make full use of their funding allocation to accelerate progress, noting that they will not be expected to incur costs implementing a model that is not recurrently affordable".

Key programme milestone successfully achieved:

The first Women's Health Hub went live in Highley at the Severn Centre in July 2024, delivering 2 core specifications of the programme:

- Sexual health outreach support including the C-card, STI testing and contraception advice and guidance (core specification).
- Menopause education and support by way of a GP led menopause talk with group discussion and Q&A. Supported by blood pressure and cancer care champions and local VCS organisations (core specification).

The enhanced offers in Highley meeting STW Womens Health Hub ambitions include:

- Health Visitor open access clinics to support child development, health and parental health, including mental wellbeing.
- Early Help partnership working with health visitors.
- Family and Community information drop-in sessions where information, advice and guidance can be obtained from various health and wider determinant focused partners.
- Social Prescribing
- Themed Library information displays
- Food share
- Stay and play

Key updates, highlights, and activities:

Sexual Health & Family Nurse Partnership (FNP) joint working and collaboration including:

- Sexual Health Services providing updates to FNP on contraception and sexually transmitted infections. Sharing and discussing case studies and best practice to develop, improve and evaluate services.
- The formulation a FNP antenatal sexual health pathway and exploration of a direct phone line to a sexual health nurse for young people to access more timely information regarding their sexual health.
- The aim is to forge strong links to enable FNP clients in Shrewsbury to better access the sexual health service at Severn Fields and for all FNP clients to have access to information regarding contraception and every opportunity to access Long-acting reservable contraception (LARC) fitting.

Community & Family hubs alignment, development and collaboration including:

- Shrewsbury PCN Cancer Care Coordinator delivering monthly information & guidance drop-in sessions in collaboration with Health Visitor Open Access Clinics & Early Help Family Information Drop in at Sunflower House, Shrewsbury.
- Exploring the possibility of cervical screening clinics at Sunflower House Community & Family Hubs
- Multi organisation meeting set up with SATH, ShropCom, South West PCN, MPFT Sexual Health Services, Targeted Early Help & Public Health to explore development and collaboration opportunities specific to Women's Health for South West Shropshire Thursday 26th September.
- Public Health School Nursing exploring improving pathways for emergency contraception with Sexual Health Services building on work with FNP.
- Developing plans for menopause awareness month in October including working with libraries across STW to support information sessions and a spotlight on raising profile and awareness of women's health hubs work and resources.
- Discussions in relation to support for migrant and refugee women & girls living in STW with Shropshire Supports Refugees and Shropshire Community Health Trust. Exploring the opportunity to run a series of education sharing sessions delivered by women to health care professionals focusing on culture, health beliefs and barriers.

Ongoing engagement & collaboration with Telford & Wrekin most notably

  - Family Hubs – connections to GP Practices (Donnington, Dawley & Woodside)
  - Public Health commissioned services, Sexual Health & PHNS collaborative working
  - Teenage Conception Steering Group
  - FASD Task & Finish Group

- Perinatal Mental Health

With the support of the ICS Women's Health Hub Steering Group and Clinical Design Forum the following key developments have been made.

- SLT approved programme budget.
- Delivering the ambition of STW to focus on the approach of sustainable, community-based Women's Health Hubs, ensuring equitable access to clinical and non-clinical support by building on family & community hubs, PCN areas and other clinical offers informed by JSNA, population health and clinical data.
- Establishment of a Clinical Design Forum Chaired by Dr Priya George, Clinical Lead for Womens Health Hubs. The forum meets monthly and has representation from Primary & Secondary Care as well as Community Services, including pharmacy.
- Establishment of an ICS Women's Health Hub Steering Group. The forum meets monthly and has representation from Primary & Secondary Care as well as Community Services, including pharmacy.
- Developing funding application process for STW PCN's to support collaborative working towards the development of Womens Health Hubs focusing on inequalities, meeting population health needs and improving experiences for women and girls.
- Developing a training plan in collaboration with the Training Hub & and Clinical Forum with input from GPs, nursing, and secondary care consultants
- Developing an approach to group menopause consultations collaboratively with GP and community pharmacy with a view to replicating across PCNs.
- Supported to set up and delivery of the first STW Womens' Health Hub in Highley.
    - Partner working and collaboration to deliver joined up services in one location at the same time to aid ease of access to residents. E.g., Health Visiting Open Access sessions, Early Help family support worker and Sexual Health Outreach support worker.
    - Stepped approach to the introduction of a group menopause offer across the Southeast PCN. The first of these being specific to Menopause linked to the GP led menopause talk at Highley.
    - Developing approaches to creating clear signposting and pathways for women & girls

Submission of key NHSE reporting including regular update meetings with NHSE Midlands team

- System Maturity Matrix
- System Hubs Delivery Plan Review
- Quarterly returns – moved to monthly from June 2024

Aligned key program activities with system transformation programs including:

- LMNS – Perinatal Mental Health
- Cancer – Cervical Screening
- Shropshire – Community & Children's Hubs
- Telford & Wrekin –Family & Children's Hubs

<table>
<tr><td colspan="3"></td></tr>
<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">Risks to the delivery of this programme are highlighted in the EQIA. Without sufficient investment many elements will not be available to deliver, namely:
Response to the Ockenden Report requiring the local system to improve support for women’s health, including pre-conception care.
Sustainability - training and backfill to develop skills, confidence, and capacity within the workforce to support women’s health.
The provision of any sustainable, equitable woman’s health offer significantly impacts on health inequalities.
STW’s ability to safeguard women and children, as outlined in the CSE Inquiry.
STW’s ability to provide access to a broad range of vital preventative integrated services.</td></tr>
<tr><td>Financial implications
(Any financial implications of note)</td><td colspan="2">None directly related to this report.</td></tr>
<tr><td>Climate Change Appraisal as applicable</td><td colspan="2">N/A</td></tr>
<tr><td rowspan="3">Where else has the paper been presented?</td><td>System Partnership Boards</td><td>ShIPP</td></tr>
<tr><td>Voluntary Sector</td><td></td></tr>
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<tr><td colspan="3">Cabinet Member (Portfolio Holder) Portfolio holders can be found here or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead
Cllr Cecilia Motley, Portfolio Holder for Adult Social Care, Public Health & Communities
Dr Priya George, Clinical Lead for Women’s Health Hubs.</td></tr>
<tr><td colspan="3">Appendices
Appendix A. Women’s Health Hubs – presentation</td></tr>
</table>

Women's Health Hubs

August Update

Highley Women's Health Hub

0-5 YEARS DROP-IN CLINIC - HIGHLEY

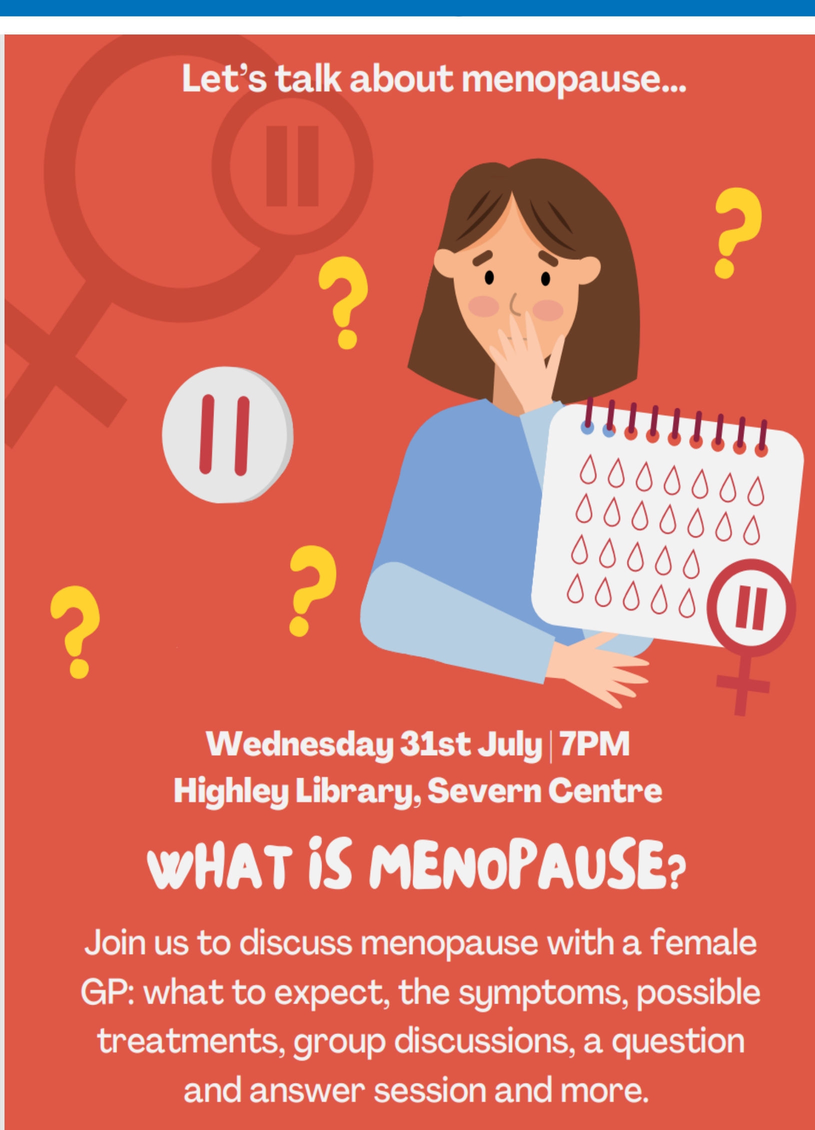
TUESDAY 23rd JULY 1:30 - 4pm
Severn Centre, Highley, WV16 6HG
(Community/Family Hub)

Come along to our drop-in clinic for health advice, information and support for you and your baby/child. No appointment needed.

- EMOTIONAL HEALTH & WELLBEING
- GROWTH/WEIGHT REVIEW & HEALTH ADVICE
- INFANT FEEDING & WEANING SUPPORT
- DEVELOPMENT, BEHAVIOUR & SLEEP SUPPORT

NHS
Shropshire Community Health
NHS Trust

Call: 0333 3583654 Text: 07520 635212



Highley Womens Health Hub

What topics would be helpful for next time?

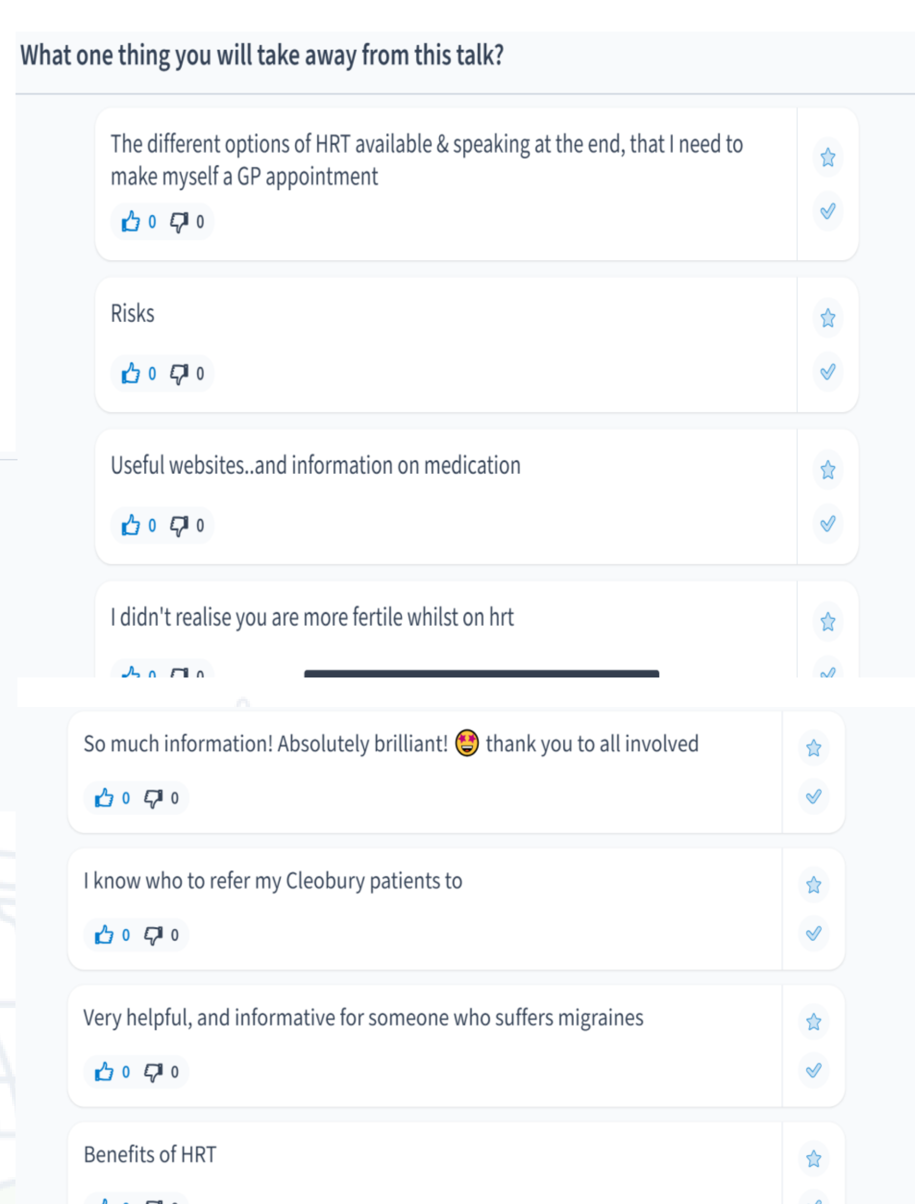
- Teenage mental health — 0 0
- Mental health — 0 0
- Dementia — 0 0
- Menopausal mental health, how to dodge cancer, holistic mental health, support for carers.
- Nutrition — 0 0
- All covered — 0 0
- IBS — 0 0
- Unsure — 0 0

Have you found this talk helpful?

Answer	%
Yes	100%
No	0%

Did the talk cover the topics you expected?

Answer	%
Yes	100%
No	0%



Other activity – Sexual Health & FNP Partnership Working

- Sexual Health Services providing updates to FNP on contraception and sexually transmitted infections. We had a great interactive morning discussing case studies and sharing best practice together.
- We are formulating a FNP antenatal sexual health pathway and looking at a direct phone line being available to a sexual health nurse for our young people who need more timely information regarding their sexual health.
- Our aim is to forge strong links so that FNP clients in Shrewsbury can access the sexual health service at Severn Fields more easily and all FNP clients will have access to information regarding contraception and every opportunity to access LARC.

Key Highlights & other activity

- NHSE return for 31/7 completed demonstrating core specification activity with a developing approach to creating clear signposting and pathways as well as a stepped approach to menopause support and treatment.
- Approval to move forward with PCN funding allocation to support collaborative working towards the development of Womens Health Hubs. EOI will be sent out week ending 7/9.
- Ongoing engagement & collaboration with Telford & Wrekin most notably
  - Family Hubs – connections to GP Practices (Donnington, Dawley & Woodside)
  - Public Health commissioned services, Sexual Health & PHNS collaborative working
  - Teenage Conception Steering Group
  - FASD Task & Finish Group
  - Perinatal Mental Health
- Training plan shared for review & prioritisation
  - Womens Health Training Co-ordinator Post ECF completed and awaiting approval

Key Highlights & other activity

- Shrewsbury PCN Cancer Care Coordinator delivering monthly information & guidance drop-in sessions in collaboration with Health Visitor Open Access Clinics & Early Help Family Information Drop in at Sunflower House, Shrewsbury commencing on Tuesday 20th August.
  - Exploring the possibility of cervical screening clinics at the Shrewsbury Community & Family Hubs
- Multi organisation meeting set up with SATH, ShropCom, South West PCN, MPFT Sexual Health Services, Targeted Early Help & Public Health to explore development and collaboration opportunities specific to Womens Health for South West Shropshire – Thursday 26th September.
- Public Health School Nursing exploring improving pathways for emergency contraception with Sexual Health Services building on work with FNP.
- Developing plans for menopause awareness month in October including working with libraries across STW to support information sessions and a spotlight on resources.
- Discussions in relation to support for migrant and refugee women & girls living in STW with Shropshire Supports Refugees and Shropshire Community Health Trust – exploring the opportunity to run a series of education sharing sessions delivered by women to health care professionals focusing on culture and health beliefs.

Key Programme Enablers

- Shropshire Telford & Wrekin System Steering Group
- Clinical Design Forum
- ICB Training Hub
- Alignment of key program activities with system transformation programs including.
  - LMNS
  - Cancer – Cervical Screening, PMD
  - Extended Community Pharmacy Pathfinder
  - Shropshire – development of Community & Children's Hubs
  - Telford & Wrekin – development of Family & Children's Hubs
- Collaboration with existing commissioned and noncommissioned providers including but not limited to
  - Sexual Health Services
  - Public Health Nursing Services
  - Drug & Alcohol Services
- Local population health data, focus on inequalities
- NHSE Midlands
- Womens Health Champion National Network

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<table>
<tr><td colspan="7">SHROPSHIRE HEALTH AND WELLBEING BOARD
Report</td></tr>
<tr><td>Meeting Date</td><td colspan="6">19.09.24</td></tr>
<tr><td>Title of report</td><td colspan="6">Shropshire Integrated Place Partnership (ShIPP) Update</td></tr>
<tr><td>This report is for
(You will have been advised which applies)</td><td>Discussion and agreement of recommendations</td><td></td><td>Approval of recommendations (With discussion by exception)</td><td></td><td>Information only (No recommendations)</td><td>x</td></tr>
<tr><td>Reporting Officer & email</td><td colspan="6">Penny Bason
Penny.Bason@shropshire.gov.uk</td></tr>
<tr><td rowspan="4">Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply</td><td>Children & Young People</td><td>x</td><td colspan="3">Joined up working</td><td>x</td></tr>
<tr><td>Mental Health</td><td>x</td><td colspan="3">Improving Population Health</td><td>x</td></tr>
<tr><td>Healthy Weight & Physical Activity</td><td></td><td colspan="3">Working with and building strong and vibrant communities</td><td>x</td></tr>
<tr><td>Workforce</td><td>x</td><td colspan="3">Reduce inequalities (see below)</td><td>x</td></tr>
<tr><td>What inequalities does this report address?</td><td colspan="6">The ShIPP Board works to reduce inequalities and encourage all programmes and providers to support those most in need.</td></tr>
</table>

Report content

1. Executive Summary

The purpose of Shropshire Integrated Place Partnership (ShIPP) is Shropshire's Place Partnership Board.
It is a partnership with shared collaborative leadership and responsibility, enabled by ICS governance and decision-making processes. Clinical/care leadership is central to the partnership, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities.
It is expected that through the programmes of ShIPP, and routine involvement and coproduction local people and workforce can feed ideas and information to inform and influence system strategy and priority development. The new governance of the ICB has named ShIPP as a formal subcommittee of the ICB Board. The governance will be developed over the coming months.

2. Recommendations

That the HWBB note the progress and actions of ShIPP

3. Report

The ShIPP Board meeting of 18th July 2024 was well attended and there was good discussion and engagement across the membership, Rachel Robinson chaired the meeting as deputy for Andy Begley.

Children & Young People's Mental Health: i-Thrive Model – Vicky Jones & Penny Bason
Vicky & Penny presented the i-thrive model for children and young people's mental health and asked for feedback on the leadership, risks and prevention aspects. There was discussion about:

- GP's issues in the treatment of children and young people and connections with social prescribers and muti agency teams.
- The importance of prevention
- Early Help Partnership Board acting as place-based leadership for i-thrive service in Shropshire
- data work should have ongoing links into the population health management system.

JSNA Update - CYP JSNA Early Years chapter for comment – Jess Edwards
Jess gave an overview of the population context chapter of the JSNA for children and young people, highlighting the trends, inequalities and health outcomes. Jess and Paula shared the early years chapter of the JSNA for children and young people, identifying the areas of need, the mitigations and the draft recommendations.
There was discussion about:

- Emergency admissions data for children – management and interpretation of data
- connecting the metrics for the Children & Family Hubs and Early Help Partnership Board to avoid duplication - a dashboard for common use.

Housing & Health Workshop update and action plan – Laura Fisher & Penny Bason
a housing paper brought to the health and well-being board led to joint workshops aimed at improving health through housing and reducing inequalities.

Two workshops held in April focused on case studies and collaborative discussions. The first workshop identified key areas and gaps in the system, while the Local Government Association provided a framework and action plan that aligned well with local findings. Discussions highlighted issues like mould and housing conditions and identified early planning as crucial for communities with greater needs. The second workshop used the LGA template to outline an action plan, recognising the need for continued collaboration across partnership boards to implement key areas of focus.

Links and opportunities for further development were discussed, a subgroup to manage the resulting action plan was proposed.

Women's Health Hubs update – Naomi Roche
Naomi updated the group on the progress of the women's health hubs programme, outlining the national and local ambitions, the key highlights and the enablers.

Naomi thanked colleagues from primary care and across they system that have worked so collaboratively in developing this work.

Links with community pharmacy and support for young people at the start of menstruation were discussed.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	N/A
Financial implications	There are none associated directly with this report.

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<tr><td>(Any financial implications of note)</td><td colspan="2"></td></tr>
<tr><td>Climate Change Appraisal as applicable</td><td colspan="2">N/A</td></tr>
<tr><td rowspan="3">Where else has the paper been presented?</td><td>System Partnership Boards</td><td>ICB</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)
N/A</td></tr>
<tr><td colspan="3">Cabinet Member (Portfolio Holder) Portfolio holders can be found here or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead

Cllr Cecilia Motley – Portfolio Holder for Adult Social Care, Public Health & Communities
Rachel Robinson – Executive Director, Health, Wellbeing and Prevention</td></tr>
<tr><td colspan="3">Appendices

None</td></tr>
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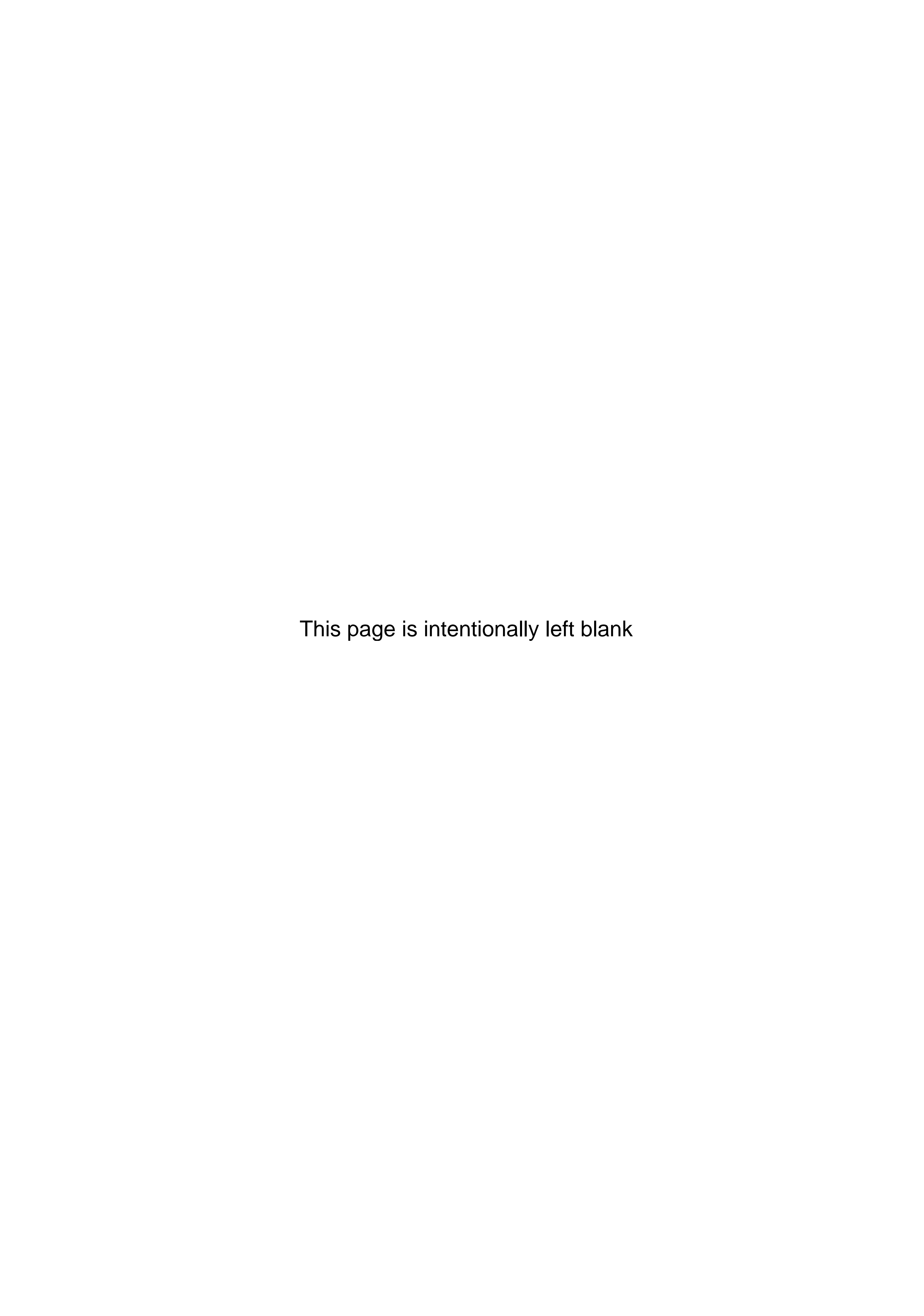

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