Shropshire Council

Shropshire
Inequalities Plan

2022-2027

Contents

Inequalities plan

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

1. Introduction

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

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

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

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

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

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

2. Background and purpose of the Inequalities Plan

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

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

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

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

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

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

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

Section 1:
Health inequalities context

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

3. Definition of Health Inequalities and How They Are Measured

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

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

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

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

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

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

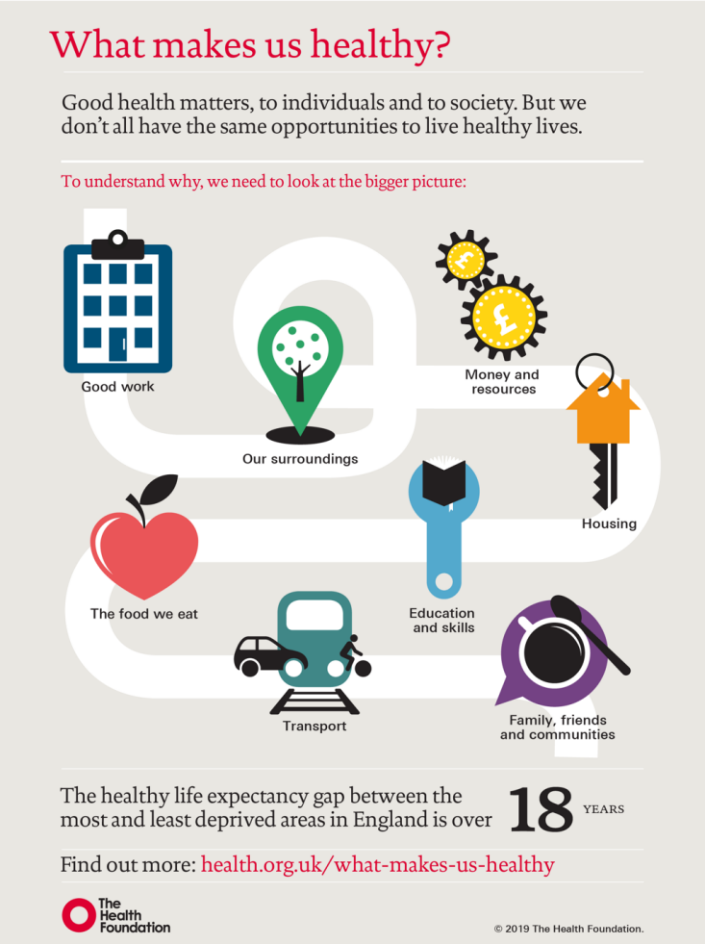
based on the type of work a person does and it too is related to health and health inequalities. For example, people in higher managerial and professional occupations are more likely to have a higher income, own their own home and enjoy better health than those in manual/low skill occupations.

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

4. Causes of Health Inequalities

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

Figure 1. What Makes Us Healthy



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

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

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

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

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

The Wider Determinants of Health

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

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

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

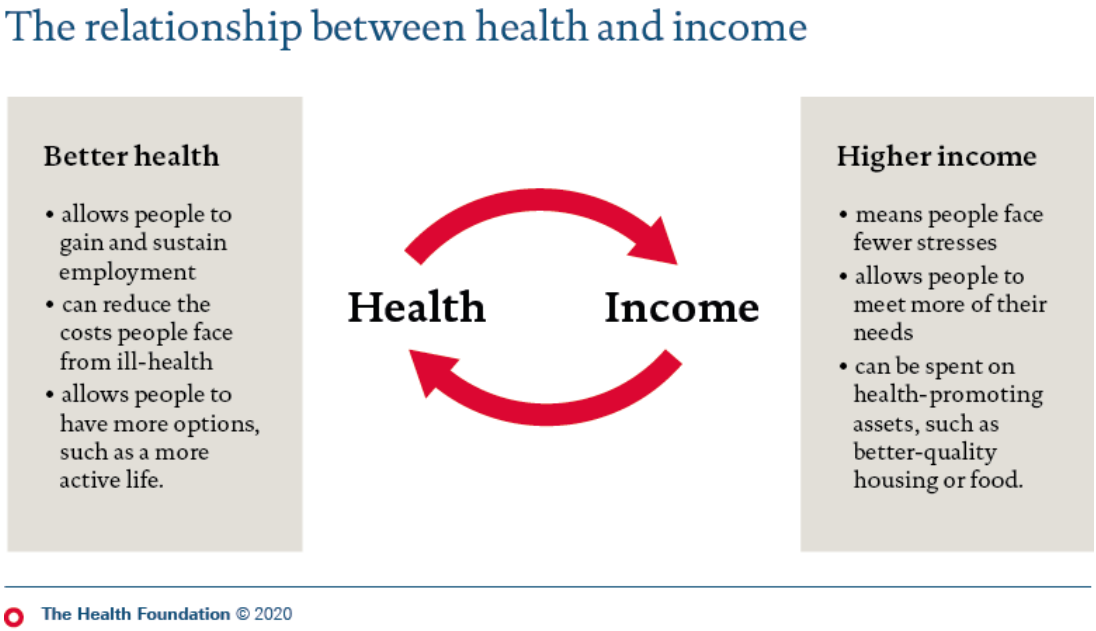
4.7 Research indicates that the wider determinants of health have a greater influence on health than health care, behaviours or genetics [4], however this evidence is not matched with the public's understanding of what influences health with a tendency for an individual's choices or behaviours, together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

Impact of Poverty

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

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

Figure 2. The Relationship Between Health and Income



Protected Characteristics

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

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

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

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

Health Inclusion Groups

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

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

Lifestyles and Health Inequalities

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

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

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

Health and Digital Literacy

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

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

Stigma and Health Inequalities

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

Impact of Rurality

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

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

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

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

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

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

Intersectionality and Health Inequality

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

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

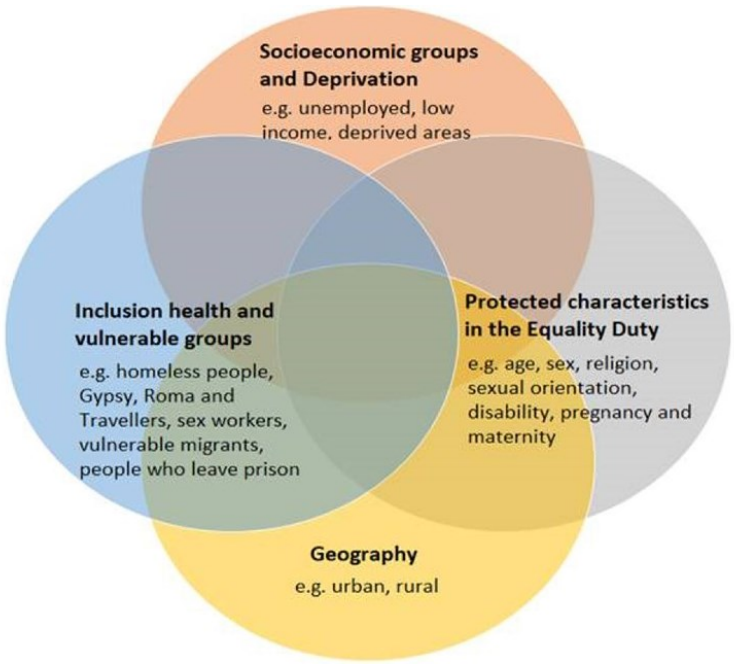
- Asian or Black pensioners
- Single female pensioners
- Pensioners with disabilities.

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

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

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

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



Impact of COVID

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

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

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

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

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

5. The Evidence Base for Reducing Inequalities and Health Inequalities

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

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

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

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

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

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

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

SECTION 2:
Shropshire's Inequality Plan

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

6. Policy Context for Reducing Inequalities and Health Inequalities

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

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

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

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

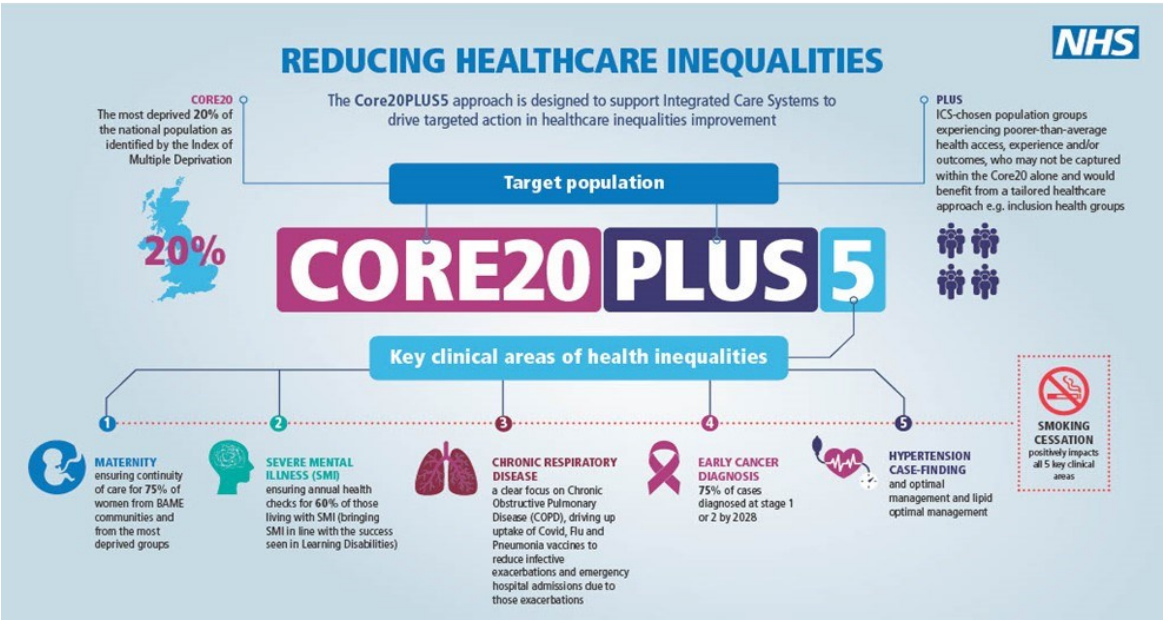
6.4 More recently Integrated Care Systems [23] have been introduced across the country with the specific purpose of bringing local partner organisations together to:

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

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

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

Figure 4. The 'Core20PLUS5' Framework



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

7. Inequalities and Health Inequalities Across Shropshire

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

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

A LSOA within the most deprived 10% in

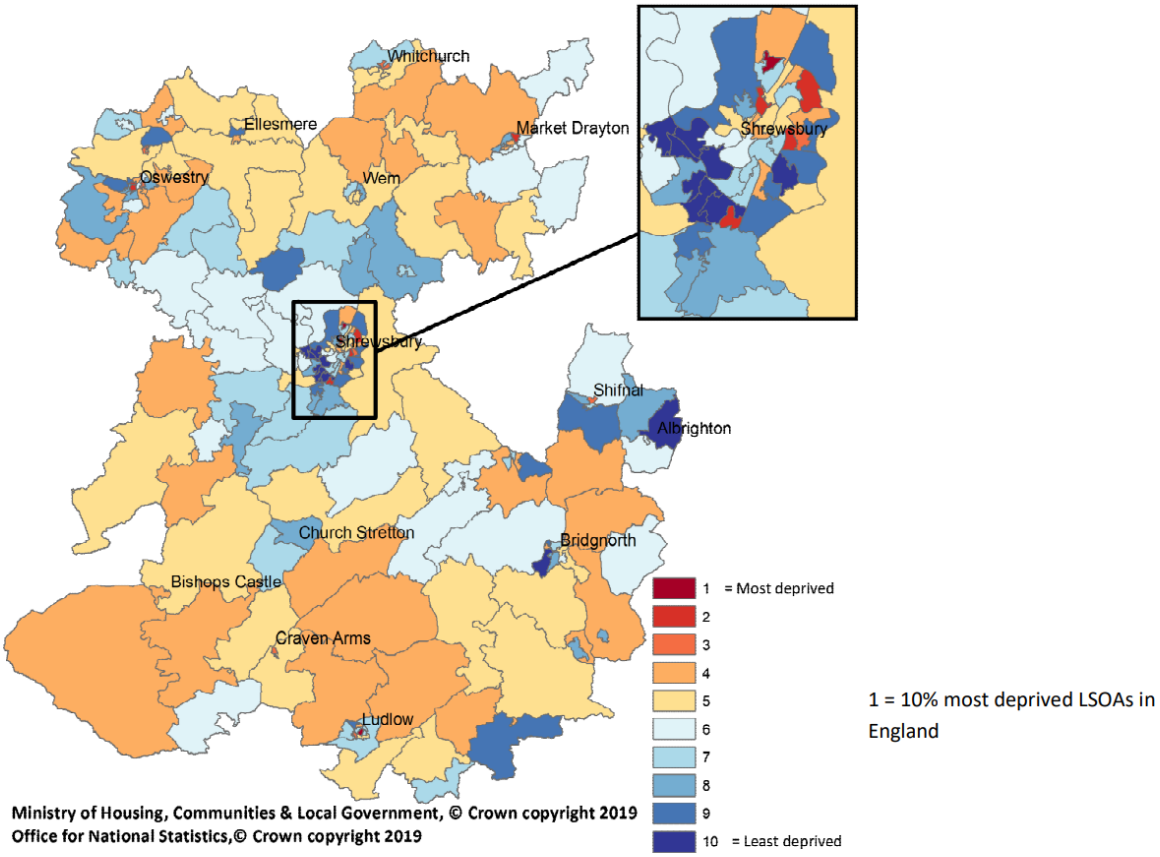
- Harlescott ward (Shrewsbury)
- Ludlow East ward

A LSOA within the most deprived 20% in

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

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

Figure 5: Map of LSOAs by Deprivation Decile



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

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

Table 1: Indicators of Inequality Across Shropshire

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

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

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

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

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

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

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

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

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

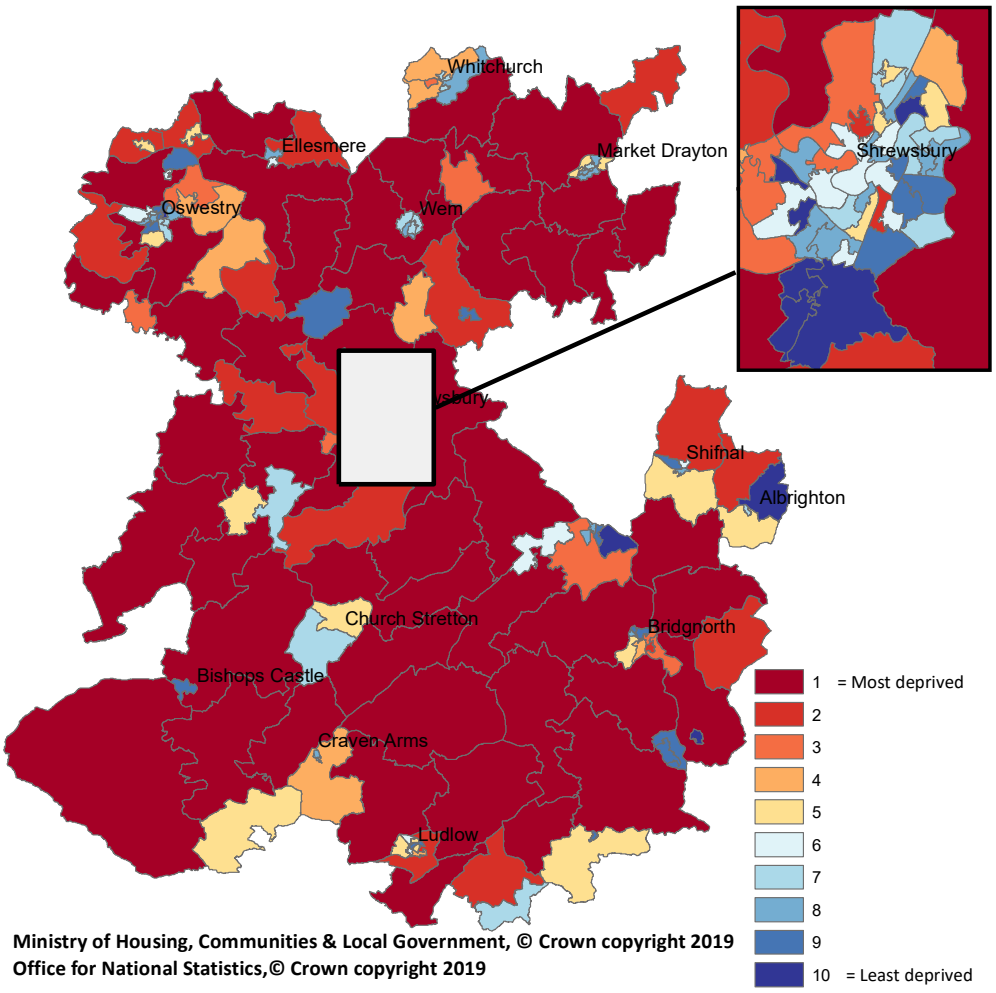
7.12 Table 2 illustrates how HLE in Shropshire compares to the England average and also provides an overall measure of inequality in HLE across the county. It can be seen that males in Shropshire have a lower HLE than the England average, whilst females in Shropshire have more years in good health than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

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

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

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

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



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

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

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

See appendix 4 for data sources

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

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

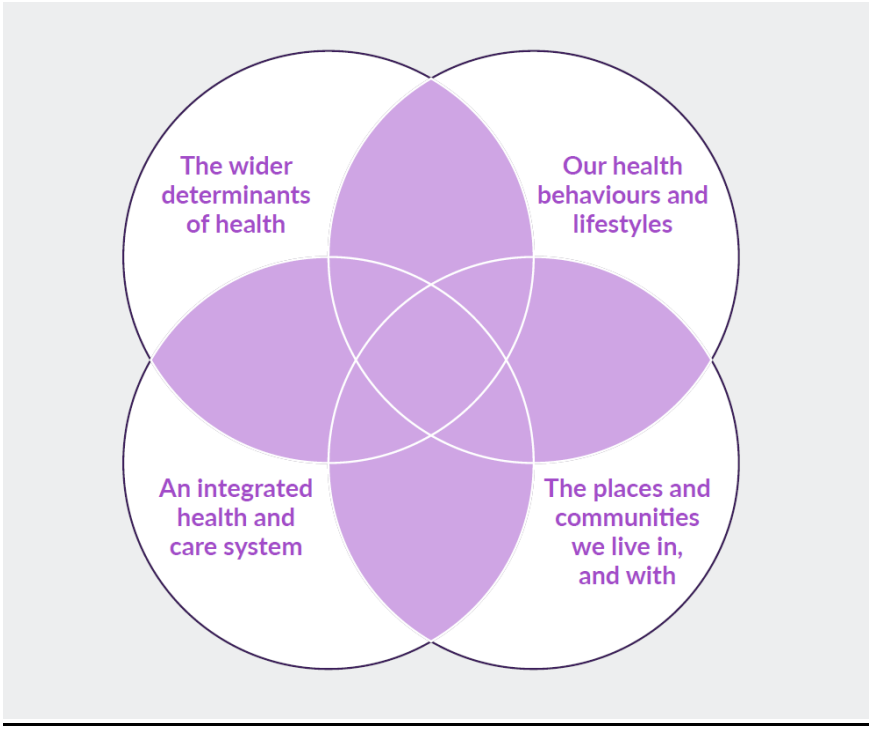
7.18 Shropshire's Joint Strategic Needs Assessment (JSNA) process will provide further insight into the health of the population at a more granular level, as will the Director of Public Health's annual report.

8. Development of the Inequalities Plan

Population Health Model

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

Figure 7: Population Health Model



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

These are:

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

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

9. Underpinning principles

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

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

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

10. Structure and Content of HI Plan

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

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

Table 4. Structure of Inequalities Plan

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

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

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

11. Additional/Core Programmes of Work

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

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

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

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

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

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

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

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

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

Working with our Voluntary, Community and Enterprise Sector

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

Early Help/Supporting Families

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

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

Delivering Social Value

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

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

The Holiday Activities and Food (HAF) Programme

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

The UK Shared Prosperity Fund (UKSPF)

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

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

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

12. Cost of Living Crisis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comprehensive Action to Reduce Smoking Rates

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

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

13.4 The report identifies 4 critical recommendations, as follows:

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

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

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

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

Reference to the Accessible Information Standard

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

14. Overriding Priorities

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

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

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

15. Governance – Monitoring Delivery of the Inequality Plan

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

16. Key Areas of Focus for Shropshire

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

Social Determinants of Health

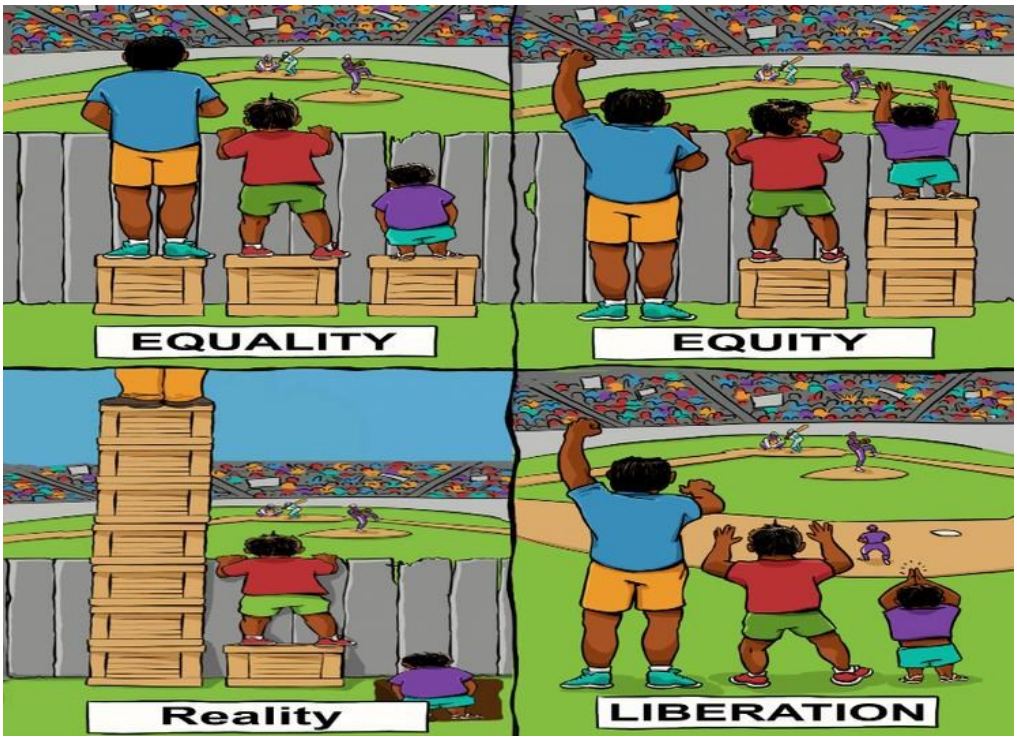
(i) It is clear that the 'wider determinants' (or social determinants) of health impact in diverse ways to influence health outcomes. These same factors affect educational, employment and other outcomes in similar detrimental ways – which go on to compound disadvantage and further undermine health living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

Figure 8: Social Determinants of Health

Proportionate Universalism

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

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



Rurality

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

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

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

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

Cost of Living Crisis (CLC)

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

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

Health in All Policies

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

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

Joint Strategic Needs Assessment (JSNA)

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

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

17. Recommendations

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

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

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

18. Shropshire's Inequalities Plan

Format of the Plan

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

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

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

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

Please note:

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

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

Table 1: Wider Determinants of Health

Population Health Domain: Wider Determinants

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

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

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

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

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

[1] Shropshire Council (2022) Invest Shropshire

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

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

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

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

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

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

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

Table 2: Healthy Lifestyles

Population Health Domain: Healthy Lifestyle Behaviours

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

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

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

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

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

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

Table 3: Healthy Places

Population Health Domain: Healthy Places and Communities

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

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

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

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

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

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

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

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

Table 4: Integrated Health and Care System

Population Health Domain: Integrated Health and Care System

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

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

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

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

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

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

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

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

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

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

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

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4.7 continued.,			A PCN must review cohort definition and extend the offer of proactive social prescribing based on an assessment of population needs and PCN capacity (March 2023) PCNs must audit a sample of the Patients current experiences of shared decision making through use of a validated tool and must document their consideration and implementation of any improvements to SDM conversations made as a result (March 2023)			

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

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

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

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

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

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

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

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

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

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

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

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4.14 continued.,			targeting of those at risk (December 2022)	Increase in beneficiaries of X-pert including increased numbers from people from ethnic minority backgrounds Increase in beneficiaries of Daphne including increased numbers from people from ethnic minority backgrounds Increase in treatment targets reached (BP, Cholesterol, HbA1c)		
			Education course established for the housebound (April 2023) Education course established for those with a Learning Disability (April 2023)	Increase in number of housebound in receipt of education Increase in number with LD in receipt of education		

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

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

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

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

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

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

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

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

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

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4.20 continued.,					Projects developed and implemented that support reduction in domestic violence, improve maternal mental health, Reduce child exclusions, improves CYP mental health, improve access to food and access to local services Partner engagement and commitment across NHS, Fire and Rescue, Police, to support the development	
4.21 Complex need – focuses on those who experience multiple disadvantage. This may be linked to substance misuse, domestic abuse, social problems, housing/ homelessness, debt or other issues	Improved life expectancy for those with Serious Mental Illness (SMI)	Gordon Kochane Reporting to Health and Wellbeing Board	Post of Population Health Fellow to support the development of a Complex Needs Assessment & Strategy Date: In post (October 2022)	Needs Assessment complete by 30.09.22 Strategy complete: 30.09.22	Improved life expectancy of those with Serious Mental Illness (SMI) Better joined up working and understanding of how to support those with complex need	TBD

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

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

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

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

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

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

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

Table 5: Social Inclusion Groups

Social Inclusion Groups

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

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

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

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

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

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

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

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

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

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

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

Table 6: Primary Care Network Health Inequality Plans

Tackling neighbourhood health inequalities

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

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

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

19. References

1. What are health inequalities? | The King's Fund (kingsfund.org.uk)
2. PowerPoint Presentation (publishing.service.gov.uk)
3. What are health inequalities? | The King's Fund (kingsfund.org.uk)
4. Wider Determinants of Health - OHID (phe.org.uk)
5. https://www.health.org.uk/publications/long-reads/building-public-understanding-of-health-and-health-inequalities
6. Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)
7. Inclusion Health: Applying All Our Health - GOV.UK (www.gov.uk)
8. https://www.health.org.uk/publications/reports/addressing-the-leading-risk-factors-for-ill-health
9. https://www2.deloitte.com/content/dam/Deloitte/uk/Documents/life-sciences-health-care/deloitte-uk-foph-negating-the-gap.pdf
10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/
11. APPG Rural Health and Care | NCRHC
12. Poverty dynamics in Rural Britain 1991–2008: Did Labour's social policy reforms make a difference? - ScienceDirect
13. Food Insecurity Project: South-West Shropshire | Healthwatch Shropshire
14. APPG Rural Health and Care | NCRHC
15. Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

References continued.,

16. WP202201-Inequality-and-the-Covid-crisis-in-the-United-Kingdom.pdf (ifs.org.uk)

17. Reducing inequalities in health: towards a brave old world? | The King's Fund (kingsfund.org.uk)

18. Fair Society Healthy Lives full report (parliament.uk)

19. Marmot Review 10 Years On - IHE (instituteofhealthequity.org)

20. Levelling up white paper aims to address health inequalities (gmjournal.co.uk)

21. Health and Social Care Act 2012 (legislation.gov.uk).

22. NHS Long Term Plan v1.2 August 2019

23. NHS England » What are integrated care systems?

24. core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

25. NHS England » Network Contract DES

26. Microsoft Word - Census Table First Results- Rounded (shropshire.gov.uk)

27. Shropshire's profile | Shropshire Council

28. IMD_Overall_2019.pub (shropshire.gov.uk)

29. The English Indices of Deprivation 2019 (publishing.service.gov.uk)

30. health-all-policies-hiap--8df.pdf (local.gov.uk)

31. Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

References continued.,

32. 'Supporting Families 2021 to 2022 and beyond'

33. 1b_Social_value-Briefing.pdf (publishing.service.gov.uk)

34. 23.4 million people unable to afford the cost of living this spring | New Economics Foundation

35. Household income inequality, UK - Office for National Statistics (ons.gov.uk)

36. Millions of low-income households pulled under by arrears as living costs rise - Credit Connect (credit-connect.co.uk)

37. Financial hardship and economic vulnerability in England | LG Inform (local.gov.uk)

38. United Kingdom Food Security Report 2021: Theme 4: Food Security at Household Level - GOV.UK (www.gov.uk).

39. https://lginform.local.gov.uk/reports/view/lga-research/ficlga-research-report-financial-hardship-and-economic-vulnerability?mod-area=E92000001&mod-group=AllRegions_England&mod-type=namedComparisonGroupFinancial hardship and economic vulnerability in England | LG Inform (local.gov.uk)

40. Disability Price Tag | Disability charity Scope UK

41. it-doesnt-add-up---campaign-report.pdf (ageuk.org.uk)

42 Making smoking obsolete: summary - GOV.UK (www.gov.uk)

43 Sexual orientation, UK - Office for National Statistics (ons.gov.uk)

44. National LGBT Survey: Summary Report - GOV.UK (www.gov.uk)

45. LGBTQ+ facts and figures | Stonewall.

46. NHS England » Accessible Information Standard – Overview 2017/2018

47. Accessible Information Standards Survey - Deafinate Matters CIC

20. Appendix 1

Membership of Inequalities Plan Steering Group

Berni Lee	Consultant in Public Health, Health Improvement – Shropshire Council
Val Cross	Health and Wellbeing Strategic Manager – Shropshire Council
Sarah Dodds	Feedback Insight Team Leader Communications & Engagement – Shropshire Council
Sarah Hampson	Insight Officer Communications & Engagements – Shropshire Council
Jane Trethewey	Assistant Director Homes & Communities – Shropshire Council
Tracy Darke	Assistant Director Economy & Place – Shropshire Council
Tracey Jones	Deputy Director Partnerships – Shropshire Telford & Wrekin Commissioning Groups
Lois Dale	Rurality and Equalities Specialist, Resources Directorate – Shropshire Council
Alice Sheppard	GP Trainee/Population Health Fellow – Shropshire Council
Melanie Holland	Strategy & Development Manager, Homes & Communications – Shropshire Council
Penny Bason	Head of Service – Joint Partnerships – Shropshire Partnership
Lynn Cawley	Chief Officer – Healthwatch Shropshire
Heather Osbourne	Chief Executive – Age UK Shropshire Telford & Wrekin

21. Appendix 2

Life Expectancy for Males by Electoral Ward

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	79.7	79.6	79.7
Shropshire	-	80.5	80.2	80.8
Copthorne	-	85.8	83.2	88.4
Burnell	-	85.1	82.6	87.6
Harlescott	-	83.9	76.8	91.0
Loton	-	83.6	81.0	86.3
Clun	-	83.4	80.7	86.1
Radbrook	-	83.3	81.0	85.5
Llanymynech	-	83.2	81.1	85.3
Abbey	-	83.1	81.2	84.9
Bagley	-	83.0	81.2	84.7
Clee	-	82.9	80.8	85.0
The Meres	-	82.6	80.4	84.9
St Oswald	-	82.5	80.5	84.5
Alveley and Claverley	-	82.5	80.1	85.0
Corvedale	-	82.3	79.8	84.9
Ruyton and Baschurch	-	82.3	79.4	85.2
Bridgnorth West and Tasley	-	82.0	80.0	84.0
Bayston Hill, Column and Sutton	-	82.0	80.6	83.4
Prees	-	82.0	79.9	84.0
Whitchurch South	-	81.8	79.8	83.9
Longden	-	81.8	78.1	85.6
Shifnal South and Cosford	-	81.8	79.5	84.1
Shifnal North	-	81.6	78.7	84.4
Shawbury	-	81.4	79.5	83.4
Church Stretton and Craven Arms	-	81.4	79.7	83.1
Hodnet	-	81.4	79.6	83.2
Porthill	-	81.1	79.2	83.0
Ellesmere Urban	-	81.1	78.7	83.5
Oswestry South	-	81.0	78.7	83.3
Ludlow South	-	81.0	78.7	83.3
Broseley	-	80.9	79.3	82.5
Market Drayton East	-	80.8	78.7	83.0
Wem	-	80.4	78.6	82.3
Battlefield	-	80.4	78.0	82.8
Brown Clee	-	80.3	78.6	82.1
Severn Valley	-	80.3	77.6	83.0
Bishop's Castle	-	80.3	77.5	83.1
Belle Vue	-	80.3	78.2	82.3
Chirbury and Worthen	-	80.2	76.2	84.2
Albrighton	-	80.2	77.9	82.5
Gobowen, Selattyn and Weston Rhyn	-	80.1	78.2	82.0
Cheswardine	-	80.1	77.9	82.3
Monkmoor	-	79.9	77.8	81.9
Highley	-	79.8	76.9	82.6
Much Wenlock	-	79.7	76.1	83.3
Rea Valley	-	79.6	77.1	82.1
Whittington	-	79.3	77.3	81.3
Cleobury Mortimer	-	79.0	76.6	81.4
Bridgnorth East and Astley Abbotts	-	78.8	76.7	81.0
Worfield	-	78.8	76.8	80.7
Oswestry West	-	78.7	76.2	81.2
Ludlow East	-	78.5	75.6	81.3
St Martin's	-	78.5	75.7	81.2
Underdale	-	78.4	75.3	81.4
Market Drayton West	-	78.3	76.2	80.3
Tern	-	78.1	75.9	80.4
Bowbrook	-	78.1	75.4	80.8
Meole	-	78.0	75.2	80.9
Castlefields and Ditherington	-	77.7	75.0	80.4
Oswestry East	-	77.6	75.9	79.3
Ludlow North	-	77.5	72.6	82.3
Quarry and Coton Hill	-	76.7	74.2	79.3
Whitchurch North	-	76.6	74.7	78.5
Sundorne	-	75.3	72.7	77.9

Life expectancy for Females by Electoral Ward

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	83.2	83.2	83.3
Shropshire	-	83.6	83.3	83.9
Clun	-	89.6	86.7	92.4
Llanymynech	-	89.3	86.0	92.7
Bishop's Castle	-	88.1	86.0	90.2
Copthorne	-	87.7	84.9	90.5
Longden	-	86.9	84.0	89.9
Burnell	-	86.9	84.9	88.8
Bridgnorth West and Tasley	-	86.6	84.9	88.2
Ludlow South	-	86.5	84.6	88.4
Loton	-	85.7	81.9	89.6
Clee	-	85.7	82.7	88.7
Alveley and Claverley	-	85.6	83.7	87.6
Oswestry West	-	85.6	83.5	87.7
Belle Vue	-	85.5	83.6	87.3
Shifnal South and Cosford	-	85.4	83.4	87.3
Shifnal North	-	85.2	83.5	86.8
Ellesmere Urban	-	85.2	83.3	87.0
Chirbury and Worthen	-	85.0	81.5	88.4
Ruyton and Baschurch	-	84.9	82.7	87.1
Bagley	-	84.9	83.2	86.6
Oswestry South	-	84.8	82.7	87.0
Corvedale	-	84.7	80.3	89.1
Church Stretton and Craven Arms	-	84.6	83.1	86.0
Radbrook	-	84.4	82.2	86.7
Bowbrook	-	84.4	82.0	86.9
Battlefield	-	84.4	81.1	87.6
Albrighton	-	84.3	82.2	86.4
Prees	-	84.2	81.6	86.8
Porthill	-	84.0	81.3	86.7
Bayston Hill, Column and Sutton	-	84.0	82.5	85.5
Highley	-	83.9	81.2	86.6
Severn Valley	-	83.8	80.7	86.9
Much Wenlock	-	83.8	81.2	86.5
Rea Valley	-	83.7	82.0	85.3
Hodnet	-	83.6	81.6	85.6
Whitchurch North	-	83.5	82.2	84.8
Broseley	-	83.3	81.2	85.4
Gobowen, Selattyn and Weston Rhyn	-	83.3	81.7	84.9
Wem	-	83.2	81.4	85.1
Cleobury Mortimer	-	83.2	81.4	85.0
Shawbury	-	83.0	81.1	84.9
Harlescott	-	82.9	80.8	85.0
Whitchurch South	-	82.8	81.0	84.7
Market Drayton West	-	82.8	80.9	84.8
The Meres	-	82.8	79.5	86.1
Abbey	-	82.6	79.4	85.8
Ludlow East	-	82.6	80.7	84.5
Whittington	-	82.6	80.8	84.4
Ludlow North	-	82.4	80.2	84.5
Bridgnorth East and Astley Abbotts	-	82.3	80.7	83.9
Meole	-	82.3	79.8	84.8
Market Drayton East	-	82.1	79.8	84.5
Monkmoor	-	82.1	80.0	84.3
Cheswardine	-	82.0	79.9	84.2
Underdale	-	82.0	79.4	84.6
Brown Clee	-	81.8	79.4	84.1
Castlefields and Ditherington	-	81.7	79.1	84.3
Oswestry East	-	81.3	79.5	83.1
St Martin's	-	81.2	78.5	84.0
St Oswald	-	80.8	77.1	84.4
Worfield	-	80.2	77.2	83.2
Quarry and Coton Hill	-	79.7	76.7	82.6
Sundorne	-	79.6	76.6	82.7
Tern	-	79.5	75.9	83.0

22. Appendix 3 Deaths from causes considered preventable, under 75 years, SMR

Area	Count	Value	95% Lower CI	95% Upper CI
England	342,988	100.0	99.7	100.3
Shropshire	2,033	85.7	82.0	89.5
Sundorne	39	160.6	113.9	220.0
Underdale	42	151.8	109.2	205.5
Castlefields and Ditherington	42	147.1	105.8	199.3
St Martin's	46	135.9	99.5	181.3
Highley	38	128.1	90.6	175.9
Oswestry West	33	126.2	86.8	177.2
Quarry and Coton Hill	38	124.5	87.9	171.2
Harlescott	36	120.8	84.6	167.2
Ludlow East	35	117.6	81.7	164.0
Bridgnorth East and Astley Abbotts	69	116.8	90.8	148.0
Market Drayton West	69	112.9	87.8	143.0
Battlefield	30	109.6	73.9	156.5
Bowbrook	32	109.1	74.3	154.4
Whitchurch North	56	108.9	82.3	141.5
Tern	40	107.6	76.7	146.7
Oswestry East	65	106.8	82.4	136.1
Monkmoor	32	101.0	69.0	142.5
Oswestry South	31	99.7	67.7	141.5
Ludlow North	33	97.8	67.1	137.7
Wem	62	96.5	73.9	123.9
Whittington	31	95.9	64.9	136.6
Chirbury and Worthen	25	92.9	60.1	137.1
Severn Valley	32	89.8	61.2	127.1
Market Drayton East	37	88.4	62.2	121.9
Meole	27	86.9	57.3	126.4
Brown Clee	30	86.3	58.0	123.6
St Oswald	30	85.3	57.6	121.8
Gobowen, Selattyn and Weston Rhyn	43	84.3	61.0	113.5
Broseley	34	83.5	57.8	116.6
Ludlow South	26	82.2	53.5	121.0
Hodnet	26	81.5	53.0	119.9
Rea Valley	27	80.0	52.7	116.4
Shifnal North	30	79.9	53.9	114.1
Cleobury Mortimer	53	78.9	59.0	103.4
Bridgnorth West and Tasley	42	77.6	55.8	105.1
Belle Vue	24	77.3	49.5	115.0
Much Wenlock	28	77.3	51.1	112.0
Worfield	24	76.9	49.3	114.4
Porthill	22	76.3	47.8	115.5
Albrighton	25	73.7	47.7	108.8
Whitchurch South	25	73.1	47.3	107.9
Bayston Hill, Column and Sutton	72	72.7	56.9	91.5
Shawbury	24	72.4	46.4	107.8
Abbey	23	71.9	45.3	108.3
Ellesmere Urban	21	69.3	42.9	105.9
Shifnal South and Cosford	25	69.1	44.7	102.1
Ruyton and Baschurch	20	68.3	41.7	105.4
Alveley and Claverley	25	66.5	43.0	98.2
Loton	21	65.6	40.4	100.9
Bishop's Castle	22	65.4	40.8	99.6
The Meres	25	63.0	40.6	93.4
Radbrook	20	62.4	38.1	96.4
Clee	24	62.1	39.8	92.3
Llanymynech	22	59.6	37.1	90.7
Longden	19	58.6	35.3	91.6
Copthorne	17	58.0	33.4	93.4
Church Stretton and Craven Arms	46	57.5	42.1	76.7
Cheswardine	17	56.5	32.9	90.4
Prees	21	55.5	34.4	84.9
Clun	21	54.9	33.8	84.4
Burnell	20	54.5	33.1	84.7
Bagley	16	49.7	28.1	81.4
Corvedale	17	48.2	27.8	77.7

23. Appendix 4

Data Sources for Vulnerable Groups in Shropshire

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

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

a. **Children in absolute low-income families** Children in absolute low-income households (20/21) https://stat-xplore.dwp.gov.uk

b. **Children in relative low-income families** Children in Relative low-income households (20/21) https://stat-xplore.dwp.gov.uk

c. **Children in care (fingertips 2020)**

d. **Free school meals known to be eligible for free school meals** https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics

e. **Number of excluded pupils (fingertips)**

f. **Number of NEETs(fingertips 2020)**

g. **Number claiming UC in employment April 2022** https://stat-xplore.dwp.gov.uk

h. **Number claiming UC not in employment April 2022** https://stat-xplore.dwp.gov.uk

i. **Number on PIP payments PIP Cases with entitlement, Caseload by local authority** https://stat-xplore.dwp.gov.uk

j. **Number of carers claiming carers allowance** https://stat-xplore.dwp.gov.uk

k. **Number homeless** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072068/Statutory_Homelessness_Stats_Release_Oct-Dec_2021.pdf

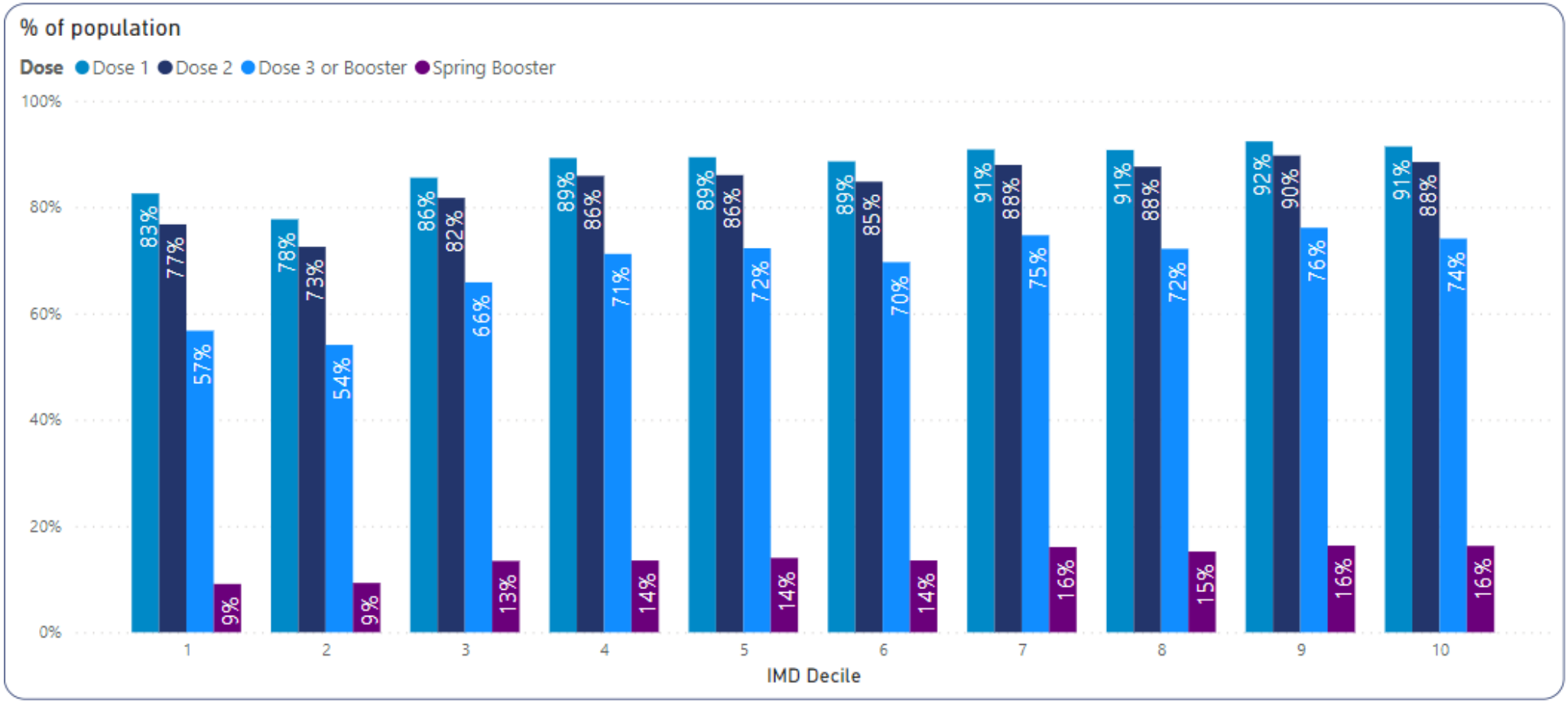
l. **Number living in fuel poverty** 16.5% of households identified as being in fuel poverty in 2020
Financial hardship and economic vulnerability in Shropshire | LG Inform (local.gov.uk)
Housing and households | Shropshire Council

m. **SMI register (QoF data)** QOF 2020-21 | NHS Digital

n. **LD register (QoF data)** QOF 2020-21 | NHS Digital

24. Appendix 5

Vaccination coverage by IMD Decile to 30/06/22



25. Appendix 6

Source of Priorities for Inequalities Plan

NHS Planning Guidance [Report template - NHSI website (england.nhs.uk)]	
Priority	**Explanation/rationale from source**
Restore NHS services inclusively (to include 20% most deprived LSOAs and ethnic minorities)	It is critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.
Mitigate digital exclusion	Systems are asked to ensure that: • providers offer face-to-face care to patients who cannot use remote services • more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups • they take account of their assessment of the impact of digital consultation channels on patient access
Datasets are complete	Systems are asked to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, eg for people experiencing post- COVID syndrome. Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.
Strengthen leadership and accountability	Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme.

Priority	Explanation/rationale from source
Accelerate Prevention Programmes that proactively engage those at greatest risk of poor health outcomes	Uptake of the **COVID and flu vaccination**. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021. Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including: • Ongoing management of **long-term conditions • Annual health checks for people with a learning disability.** • **Annual health checks for people with serious mental illness** • In maternity care, implementing **continuity of carer** for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.
Population Health Management (i.e. not one of the specified 5 priorities but mentioned)	The development of primary and community services and implementation of population health management will be led at place level, with Primary Care Networks as the building blocks of local healthcare integration.
NHS LTP Prevention Priorities NHS Long Term Plan v1.2 August 2019	
Smoking	By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. The model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments. A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings

Priority	Explanation/rationale from source
Obesity/Diabetes	The NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity) By 2022/23, we also expect to **treat up to a further 1,000 children a year for severe complications related to their obesity**, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. The NHS Diabetes Prevention Programme supports those at high risk of type 2 diabetes to reduce their risk. We are now committing to fund a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option to widen patient choice and target inequality. Expanding the Diabetes Prevention Programme is a key vehicle for tackling health inequalities, with a significantly higher take up from BAME groups than the general population. We will also continue to support local health systems to address inequality of access to multidisciplinary foot care teams and specialist nursing support for people who have diabetes. Medical research has shown that some people with type 2 diabetes can achieve remission through adoption of a very low-calorie diet. This allowed nearly half of patients to stop taking anti-diabetic drugs and still achieve non-diabetic range glucose levels. We will therefore test an NHS programme supporting very low-calorie diets for obese people with type 2 diabetes. The NHS will continue to take action on healthy NHS premises. All trusts will be required by the NHS standard contract to deliver against the hospital food standards (2019).
Alcohol	Over the next five years, those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs using funding from their clinical commissioning groups (CCGs) health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services.
Air Pollution	The NHS will work to reduce air pollution from all sources. Specifically, we will cut business mileages and fleet air pollutant emissions by 20% by 2023/24.

Priority	Explanation/rationale from source
The following are included in the LTP but were not identified as 'must do's' for ICSs	
Antimicrobial resistance	*The health service will continue to support implementation and delivery of the government's new five-year action plan on Antimicrobial Resistance.*
Homelessness	*People affected by homelessness die, on average, around 30 years earlier than the general population. 31% of people affected by homelessness have complex needs, and additional financial, interpersonal, and emotional needs that make engagement with mainstream services difficult. 50% of people sleeping rough have mental health needs, but many parts of the country with large numbers of rough sleepers do not have specialist mental health support and access to mainstream services is challenging. We will invest up to £30 million extra on meeting the needs of rough sleepers,* ***to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support****, integrated with existing outreach services.*
Carers and Young Carers	*Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, finance concerns, stress, and social isolation. Quality marks for carer-friendly GP practices, developed with the Care Quality Commission (CQC), will help carers identify GP services that can accommodate their needs. We will encourage the national adoption of carer's passports and set out guidelines for their use based on trials in Manchester and Bristol. These will be complemented by developments to electronic health records that allow people to share their caring status with healthcare professionals wherever they present.* *Carers should not have to deal with emergencies on their own. We will ensure that more carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it. Up to 100,000 carers will benefit from 'contingency planning' conversations and have their plans included in Summary Care Records, so that professionals know when and how to call those plans into action when they are needed.* *Young carers feel say they feel invisible and often in distress, with up to 40% reporting mental health problems arising from their experience of caring. Young Carers should not feel they are struggling to cope on their own. The NHS will roll out 'top tips' for general practice which have been developed by Young Carers, which include access to preventive health and social prescribing, and timely referral to local support services. Up to 20,000 Young Carers will benefit from this more proactive approach by 23/24.*

Priority	Explanation/rationale from source
Gambling	*We will invest in expanding NHS specialist clinics to help more people with serious gambling problems. Over 400,000 people in England are problem gamblers and two million people are at risk, but current treatment only reaches a small number through one national clinic. We will therefore expand geographical coverage of NHS services for people with serious gambling problems, and work with partners to tackle the problem at source*
Partner with local VCS	*The NHS will continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups.*
Sept 30th Operational Guidance C1400-2122-priorites-and-operational-planning-guidance-oct21-march21.pdf (england.nhs.uk)	
Update on March Guidance	We will also continue the focus on the five priority areas for tackling health inequalities and redouble our efforts to see sustained progress across the areas detailed in the NHS Long Term Plan, including: • early cancer diagnosis, • hypertension detection, • respiratory disease, • annual health checks for people with severe mental illness, • continuity of maternity carer, and • improvements in the care of children and young people. To support this, we are improving the quality and presentation of health inequalities data and will shortly set out further details of our approach. We are also asking that all NHS Board performance reports include reporting by deprivation and ethnicity Continue to ensure health inequalities are considered within elective recovery plans and progress is tracked through board level performance reports. Systems are also asked to support their PCNs to work closely with local communities to address health inequalities.

Core20Plus5 core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)	
Priority	**Explanation/rationale from source**
Core 20	The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).
Plus	ICS-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. NB: For Shropshire this is defined as 'Rurality'
5 clinical groups	1. **Maternity:** ensuring continuity of care for **75% of women from BAME** communities and from the most deprived groups 2. **Severe Mental Illness** (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities) 3. **Chronic Respiratory Disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) **driving up uptake of Covid, Flu and Pneumonia vaccines** to reduce infective exacerbations and emergency hospital admissions due to those exacerbations 4. **Early Cancer Diagnosis**: 75% of cases diagnosed at stage 1 or 2 by 2028 5. **Hypertension Case-Finding**: to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke

Priority	Explanation/rationale from source
Local ICS Priorities	
Integrated health equity and equality assessment framework	The intention is to develop one standardised overarching framework for delivering a variety of assessments that all fall under the umbrella of an Integrated Impact Assessment (IIA). The plan is to standardise the way this process is completed across the system (a measurable, gold standard approach), but also recognise that projects differ in size and resources and not all elements are relevant to every project. The IIA framework is intended to encompass the following elements: • Social Inclusion • Equality - across the 9 protected characteristics and also e.g. deprivation, carers, dementia, refugees (we need a mechanism to determine which other characteristics are relevant to a project) • Health Inequalities (as part of broader Health and Wellbeing?) • Quality (including clinical effectiveness, patient safety and user experience) • Climate Change • Economic Impact
Complex need	This will involve population level data analysis of prevalence of certain diagnoses and social determinants associated with high risk of developing complex needs. There will be a focus on making best use of local resources, targeting a population who have low, moderate, or serious mental illness, who experience multiple disadvantage and have complex lives. This disadvantage may take the form of (but not limited to) substance misuse, domestic abuse, social problems, housing/ homelessness, debt, or other issues. The life expectancy gap between those with Severe Mental Illness and the rest of the population is one of the worst nationally. Key anticipated outcomes include: ○ improved individual emotional and mental health and wellbeing ○ improved physical health of those with complex needs ○ reduced homelessness ○ better joined up services, and service offer ○ improved asset-based approaches to supporting people in local communities ○ Reduce impact on services (health, social care)

Priority	Explanation/rationale from source
Personalisation (if this is separate to Population Health Management)	Personalised care means people having choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. This means a shift in power and decision-making, to enable people to have a voice, to be heard and be connected to each other and their communities. The following need to be enabled: • Care and support planning and shared decision-making – ensuring person-centred conversations with people about their life to inform their care plan • Personal health budgets and choice – to put people in control of their care • Social Prescribing – connecting people to communities, and the necessity of investing in and working with communities to ensure they have the capacity to support each other • Support for self-management – to help people better manage their health and wellbeing, through self-management education, health coaching and peer support
Shropshire Health and Well Being Board Priorities hwbb-draft-strategy-22-27.pdf (shropshire.gov.uk)	
Joined up working	The local System will work together and have joint understanding of health being social and economic, not just absence of disease. Partnership Boards will work more closely together to reduce duplication and make the best use of the skills and knowledge of people within them, and to engage with people who use our services.
Improving Population Health	Using a population health approach, we will aim to improve the health of the entire Shropshire population. This will include action: to reduce the occurrence of ill health; to deliver appropriate health and care services; on the wider determinants of health; and primary prevention as well as support (secondary prevention) for those currently on long waiting lists for procedures.
Working with and building strong and vibrant communities	Shropshire has a strong, vibrant community, many which have their own proud identity. We will work with our communities to reduce inequalities, promote prevention, increase access to social support and influence positive health behaviours. We will also pool information and resource to support people in our communities.

Priority	Explanation/rationale from source
Reduce Inequalities	We will have a clear and focused approach to health inequalities, including targeted work, and help give everyone in Shropshire a fair chance to live their life well, no matter where they live. Medical treatment alone cannot tackle inequalities and the biggest impact on our health and wellbeing includes having a job and income, access to education, and a decent home to live in
Focus 1: Workforce	During COVID many people have lost their job or had to take lower paid and less stable employment. We will work to make Shropshire workplaces fair, happy and healthy places for people to work in and promote wellbeing for all, no matter where they are employed.
Focus 2: Mental Health	The 5-year Mental Health Strategy for Shropshire and Telford & Wrekin will guide our ambitions over the next five years. This strategy has a 'life course' approach from pregnancy to childhood to older age.
Focus 3: C&YP	COVID has had a huge impact on many families, and particular focus will be CYP mental health and wellbeing. In addition, plans to create a Trauma Informed workforce will be implemented. This will enable understanding of certain behaviours and help promote resilience for our young people.
Focus 4: Healthy Weight and Physical Activity	Our ambition is to reduce levels of obesity in Shropshire across all ages. This priority will be linked to alcohol, smoking and mental health, through preventative work around Musculoskeletal (MSK) conditions, respiratory health, Cardio-vascular disease (CVD), and cancer risk; food insecurity and reasons around obesity will all be included.
Other Priorities	
Social Prescribing	Social Prescribing will remain a HWBB priority, and a pilot to expand the programme for children and young people in south-west Shropshire has commenced.
Alcohol	An estimated 35,319 adults in Shropshire aged 18-65 drink more than the Chief Medical Officer's guidelines of 14 units per week. Children affected by parental alcohol misuse are more likely to have physical, psychological, and behavioural problems, and alcohol is the 3rd leading risk factor for death and disability after smoking and obesity. PHE data for KSI on roads shows alcohol related collisions in Shropshire are significantly higher than the rest of England and the West Midlands, and successful alcohol treatment as lower than the rest of England. We will monitor this through the Alcohol Strategy and reporting to HWBB.

Priority	Explanation/rationale from source
Domestic Abuse	Domestic abuse affects all communities regardless of gender, age, race, religion, sexuality, disability, mental health, social and financial status. Domestic abuse is coercive, controlling, abusive and violent behaviour. Such violence can also be directed towards children, other family members or friends of the victim. Some 30,475 women in Shropshire will experience domestic abuse during their lifetime
County Lines	County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and adults (including those with care and support needs) to move, [locally supply] and store the drugs and money. They will often use coercion, intimidation, violence (including sexual violence) and weapons. Shropshire Safeguarding Partnership report annually to the HWBB.
Smoking in Pregnancy	Babies born to mothers who smoke are more likely to suffer from respiratory disease as well as being at greater risk of sudden infant death. For mothers there is an increased risk of miscarriage, stillbirth, premature delivery and having a low-birth-weight baby. Rates of smoking in early pregnancy remain higher in Shropshire compared to the England average. The HWBB will continue to have smoking in pregnancy as a priority until rates decrease further.
Food Insecurity	Food insecurity has a physical and mental impact on the wellbeing of everyone experiencing it. Food insecurity remains a HWBB priority, and the developing Healthy Weight Strategy and our partnership with Shropshire Food Poverty Alliance to help address this issue will continue.
Suicide Prevention	Shropshire and Telford & Wrekin Suicide Prevention Network have launched a wallet sized Z-Card providing brief advice for anyone contemplating suicide or who is worried about someone else, along with primary contact numbers for immediate support. A targeted approach to upskill the workforce on suicide risk and awareness of how to intervene has been taken with the launch of a Suicide Prevention training programme in Shropshire.
Killed or Seriously Injured on Roads	More accidents occur on rural roads compared to urban roads in Shropshire and there are a similar proportion of traffic accidents on both urban roads and rural roads with a 30mph limit. Although COVID-19 has reduced traffic on Shropshire roads and thus those KSI, the risks will increase as the pandemic declines. Thus, KSI on roads will remain a HWBB priority

Priority	Explanation/rationale from source
Air Quality	Shropshire Council's 2020 Air Quality Annual Status Report (ASR) report that Air pollution is associated with a number of adverse health impacts. It is recognised as a contributing factor in the onset of heart disease and cancer. Additionally, air pollution particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions. There is also often a strong correlation with equalities issues because areas with poor air quality are also often the less affluent areas. Shropshire Council has a Climate Strategy and Action Plan and Shropshire, Telford & Wrekin ICS has climate change as a pledge.

26. Appendix 7

Core Work Programmes with Impact on Health Inequalities

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

Working with our Voluntary, Community and Enterprise Sector

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

More widely the Integrated Care System recognises that prevention of ill health and a focus on inequalities is fundamental to longer-term sustainability of the system. Coproducing solutions with our communities, in partnership with the VCSE, is fundamental to both harnessing community ability and capacity, as well as improving population health. Strategically and operationally, the VCSE is an important partner in improving health, wellbeing, and care outcomes.

Consequently, the ICS has been developing its relationship with the sector and has recently signed a Memorandum of Understanding to clarify how all parties will work together. Despite these good working relationships, learning from Covid indicates that we have much more to do, and the public sector must consider how it supports the sustainability and growth of the VCSE if we are to address current and future health challenges.

Early Help/Supporting Families

The council delivers specific Early Help services including Targeted Early Help, Parenting, Family Information Service, and support for schools. The Council partners with schools, health services (including the Healthy Child Programme) and others to deliver a multi-agency offer to improve outcomes for children and families.

Shropshire Council, with system partners is creating a new vision and way of working with CYP and families based on a stronger and wider prevention offer which brings together service areas and programmes. This supports the integrated approach across people, place, wellbeing and health and provides a multiplicity of opportunities to enhance service offers and connections between service areas.

For families, children, and young people this builds on the work of Early Help, the Strengthening Families programme, (launched in 2021) bringing in the public health programmes and different commissioned services.

The results of these changes will ensure there is a re-emphasis on the importance of the first 1001 days of a child's life, enhancement of family help services through the creation of a network of family hubs, investment in infant and parental mental health, breastfeeding support, parenting programmes, speech and language development and delivering on key recommendations from the Early Years Healthy Development review , and the continuation of the Supporting Families programme, targeting support to Shropshire's most vulnerable children and families. The work will also build on the developing local evidence base around CYP Social Prescribing and drive forward prevention programmes based on community activity and partnerships with the NHS and our voluntary and community sector.

Delivering Social Value

The Social Value Act 2012 requires the public sector to ensure that the money it spends on services or goods creates the greatest possible economic, social, and environmental value for local communities. 1b_Social_value-Briefing.pdf (publishing.service.gov.uk) Implementing Social Value involves making procurement decisions in a way that ensures wider benefits are considered throughout the commissioning cycle. Examples of the type of Social Value that might be achieved could be a commitment from a contractor to pay a living wage to their employees or to employ target groups such as young unemployed people, alongside delivering the service being commissioned. As such implementing Social Value approaches can positively support other local efforts to reduce health inequalities.

Shropshire Council has a well-developed strategic approach to achieving Social Value through commissioning with guidance and support for commissioners and agreed priority areas that should be considered in seeking Social Value. More recently the development of a Social Value Fund has been piloted whereby contractors can take up the option of making a cash contribution in lieu of delivering Social Value through a contract. This offers the potential for a more flexible approach to securing Social Value that will be further evaluated over the coming months. There could be scope to secure additional benefits through Social Value by working collaboratively with other public sector commissioners and providers across the ICS, but this would require further exploration.

The Holiday Activities and Food (HAF) Programme

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

years. It has been nationally funded because of a recognition that children from low-income households are:

- less likely to access organised out-of-school activities
- more likely to experience 'unhealthy holidays' in terms of nutrition and physical health
- more likely to experience social isolation

A dynamic comprehensive HAF programme is being delivered across Shropshire benefiting children and young people in receipt of FSMs as well as other groups such as

- children assessed as being in need, at risk or vulnerable
- young carers
- looked-after children or previously looked after children
- children with an education, health and care (EHC) plan
- children who have low attendance rates at school or who are at risk of exclusion
- children living in areas of high deprivation or from low-income households who are not in receipt of FSMs

The Shropshire HAF programme is being delivered by the council in partnership with schools, voluntary and community organisations, and childcare providers across the county. The programme has been shown to hugely benefit the children and young people who live in the most challenging circumstances and continues to achieve a range of positive outcomes. Shropshire HAF celebration and feedback | Shropshire Council

The UK Shared Prosperity Fund (UKSPF)

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

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

27. Appendix 8

Social Task Force Action Plan to Address Cost of Living Crisis

Working together the Forum, through the Poverty and Hardship sub-group, have developed an action plan, the most significant gaps currently are the need to:

1) Review capacity across the system to support people in Shropshire with the cost-of-living crisis. Consider which resources and skills are available. Triage and offer specialist support for those in need.

2) Improved information sharing between partners in relation to the cost-of-living crisis to ensure that partner organisations are kept informed of up-to-date information on assistance available so they can cascade to the people they support (eg, Household support fund, HAF scheme).

3) Joint working to create protocols around more common debts.

4) Workforce training/Improved signposting information for frontline staff and volunteers to boost their knowledge of support available and increase confidence to hold difficult conversations around the increases in the cost of living.

5) Data & Insight. Continue to review what insight is held on groups most likely to be impacted by the cost-of-living crisis. Plan an event to learn what data is available. Do community organisations have case studies or insight which might help to identify the best way to support the groups identified in this plan? Can we target those at greatest risk?

6) Work with Stakeholders to review the Household Support Fund allocation to date. What worked well? How can we target better to vulnerable groups identified?

7) Joint communications on the cost-of-living crisis highlighting help available, including panels on Shropshire Radio. Key messages include: encouraging householders to contact Marches Energy Agency (MEA) now for help with energy efficiency measures over the summer to help householders get ready for Autumn/Winter & Energy advice; communications around how to make best use of the £650 government support payment and promotion of Breathing Space to prevent government support payments being allocated to overdraft/debt repayments/rent arrears.

8) Assessment of the impact of the cost-of-living crisis on the workforce, including how it will impact their ability to effectively do their jobs. A key focus on workers on lower incomes, particularly the impact on carers.

Shropshire Council