1. Agenda Item Number – Tackling Inequalities in Access, Experience and Outcomes

Meeting Name: ICB Board.
Meeting Date: Wednesday 25th June 2025
Report Presented by: Tracey Jones, Head of Healthcare Inequalities, NHS Shropshire, Telford & Wrekin.
Report Approved by: Nigel Lee, Chief Strategy Officer, NHS Shropshire, Telford & Wrekin.
Report Prepared by: Alexandra Mace, Healthcare Inequalities Partnership Lead, NHS Shropshire, Telford & Wrekin.
Action Required: For noting.

1.1. Purpose

1.1.1. The purpose of the report is to provide members of the Integrated Care Board with an update on system progress in tackling inequalities in access, experience and outcomes from healthcare services. The contents of the report specifically refers to nationally set objectives focused on addressing healthcare inequality.

1.2. Executive Summary

1.1.1. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing. Within this wider context, healthcare inequalities are about the access people have to health services and their experiences and outcomes from those services.

1.1.2. There are five strategic priorities which underpin the National Healthcare Inequalities Improvement Programme and remain recurrent in the 2025/26 Operational Planning Guidance to ensure focused action continues to take place. These priorities are otherwise known as the Health Inequalities Key Lines of Enquiry (KLOEs):

- **Restoring Services Inclusively** – using local data to plan the inclusive restoration of healthcare services, ensuring that waiting list performance reports are delineated by ethnicity and deprivation.
- **Mitigating Against Digital Exclusion** – enabling robust data collection to identify which populations are accessing face-to-face, telephone and virtual consultations (broken down by relevant protected characteristic) and ensuring the impact of digital innovation is assessed, considered and mitigated.
- **Ensuring Datasets are Complete and Timely** – to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

- **Accelerating Preventative Programmes** – driving initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.
- **Strengthening Leadership and Accountability** – ensuring named executive leads are appointed for tackling health inequalities and improving awareness and knowledge of the workforce. This also includes optimising the NHS' impact on the broader determinants of health (such as employment and environmental sustainability) by contributing to social value through our roles as Anchor Institutions.

1.1.3. In addition to the five key areas, NHS England also developed the Core20PLUS5. The Core20PLUS5 is a framework to support the NHS to make targeted and driven improvements in health and healthcare inequalities.

- **Core20** refers to people living in the 20% most deprived areas as defined by the Indices of Multiple Deprivation (IMD).
- **PLUS** refers to population groups identified by local intelligence as more likely to experience poorer health outcomes. This includes people such as those with learning disabilities or autism, drug and alcohol users and people experiencing homelessness.
- **5** refers to the five key clinical areas where evidence suggests accelerated improvement is most needed. For adults, this includes Cardiovascular Disease, which contributes to over 25% of the inequality in life expectancy we see in Shropshire, Telford & Wrekin. It also includes Cancer, Respiratory, Severe Mental Illness and Maternity.

1.1.4. Smoking is a leading cause of preventable mortality and a leading modifiable cause of health inequalities amongst Core20PLUS communities. Smoking cessation is therefore highlighted in the Core20PLUS5 as a key area of improvement which, if addressed, can lead to a positive impact across all 5 key clinical areas of the Core20PLUS5.

1.1.1. This report details the key findings of the end of year stocktake of progress against actions planned to be delivered in 2024/25.

1.1.2. Of the 20 programmes referred to and included in the Shropshire, Telford & Wrekin Healthcare Inequalities Implementation Plan, most programmes completed between 70-80% of planned work. Only 20% (the equivalent of 4 programmes) completed all planned work and very few completed less than 60%.

1.1.3. Key challenges impacting on progress in 2024/25 include the availability and completeness of data, reduced financial budgets and as a result of reduced budgets, the changing landscape and impact on staff and leadership capacity to deliver key priorities with efficient continuity.

1.1.4. Despite these significant challenges, Shropshire, Telford & Wrekin has seen a wealth of progress in areas across the programme. These examples demonstrate excellent leadership across all levels of staff, the use of evidence-based information and intelligence to target improvements in population health and the application of quality improvement approaches.

1.1.5. Due to the limitations in data availability, full conclusions regarding improvement in outcomes cannot be drawn at the time of finalising this report. Work is taking place by the STW ICB Business Intelligence Team to publish a full analysis, in line with the National Statement on Information on Health Inequalities, by the end of June 2025.

1.1.6. Data that is available shows positive changes in relation to the number of children and young people accessing mental health services, treatment rates between population groups for atrial fibrillation and cholesterol and improved rates of people with a learning disability receiving an annual health check when compared to the previous year.

1.1.7. There are however areas requiring significant improvement. These areas have either seen no improvement throughout 2024/25, or have shown inequalities between population groups to be widening. This includes the treatment of hypertension and provision of diabetic care processes, both of which are significant contributors to unequal health outcomes and inequality in life expectancy across Shropshire, Telford & Wrekin.

1.1.8. A series of planned actions have been committed to by the Integrated Care Board (ICB) for delivery within 2025/26. These actions have been based on learning taken from 2024/25, as well as analysis undertaken to understand impact against key outcomes.

1.2. Recommendations

1.2.1. Note the contents of the report and the progress made to date.

1.2.2. Continue to support and champion progress against healthcare inequalities key priorities within your respective organisations to improve the experience and health outcomes of Core20PLUS populations.

1.2.3. Specifically promote and encourage urgent action to realise improvements in the completion and accuracy of coded demographic data, such as ethnicity and housing status, to enable successful population health management.

1.2.4. Support concerted efforts to address inequality in hypertension treatment and recover treatment levels to the national target of 80%, acknowledging that blood pressure is one of the leading risk factors in poorer outcomes

from Cardiovascular Disease. Cardiovascular Disease contributes to over 25% of the inequality in life expectancy seen between people living in the most deprived compared to those living in the least deprived areas of Shropshire, Telford & Wrekin.

1.2.5. Provide top-down, senior support to promote health inequalities as a golden thread to existing service design, commissioning, transformation and delivery and not thought of as an optional, additional task, mitigating the risk of de-prioritisation amongst competing financial and performance pressures.

1.2.6. As a system, endorse the mandatory embedding of quality improvement approaches, supporting staff to attend quality improvement training and embed quality improvement principles within project management and service improvement.

1.3. Conflicts of Interest

1.3.1. No conflicts of interest have been identified.

1.4. Links to the System Board Assurance Framework (SBAF)

1.4.1. BAF RISK 3: Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. There is a risk that with competing priorities in a challenged system, insufficient focus is given to targeted interventions for populations identified as experiencing the greatest levels of inequality i.e. CORE20+ populations.

1.5. Alignment to Integrated Care Board

1.5.1. This report aligns with the following ICB pledges:

Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	X
Delivering improvements in Mental Health and Learning Disability/Autism provision	X
Economic regeneration	
Climate change	
Leadership and Governance	X
Enhanced engagement and accountability	X
Creating system sustainability	X
Workforce	

1.6. Key Considerations

1.6.1. **Quality and Safety:** Addressing inequalities improves patient experience and effective efficient care processes

1.6.2. **Financial Implications:** Investment in and focus on health inequalities and prevention contributes to reducing overall system costs of treating later stage

illness.

1.6.3. **Workforce Implications:** Ongoing need to raise awareness of health and healthcare inequalities amongst healthcare staff and actions to reduce them.

1.6.4. **Risks and Mitigations:** There are substantial risks moving into 2025/26 in light of recent national announcements for further reductions in costs and the consistent challenges relating to insufficient capacity to deliver against national requirements.

1.6.4..1. **Risk:** Based on progress made in 2024/25 and the robustness of plans for 2025/26, there is a risk relating to the delivery of improvements in key clinical areas, such as Cardiovascular Disease and Diabetic Care.

Mitigation: Current mitigations are in place through the additional support of the STW ICB Health Inequalities Team, who will actively work with programme leads whereby accelerating improvement, specifically in relation to actions to reduce inequalities, is required within 2025/26. However, it should be noted that due to recent national announcements and subsequent recruitment pauses, capacity within the STW ICB Health Inequalities Team has been reduced.

1.6.4..2. **Risk:** There is a risk in relation to the availability and completeness of data and the capability to use this data to monitor trends in improvement against key outcome metrics and inform strategic intervention.

Mitigation: Mitigating actions include:

- The utilisation of Schedule 2N of the NHS Standard Contract to set out requirements on Trusts to focus improvements operationally in the improvement of demographic data coding.
- Enhanced oversight from data teams on the data quality and completeness of demographic information within patient records.
- The ongoing development of the STW Population Health and Health Inequalities Dashboard, to include visualisation of trends over time to demonstrate impact against key health inequality metrics. The dashboard is being produced by the STW ICB Business Intelligence Team, with an anticipated launch in Quarter 2 2025/26.

1.6.4..3. Additional programme risks may be identified in-year subject to further discussions with programme leads regarding the robustness of plans to tackle inequalities in access, experience and outcomes within programme areas. Programme risks will be

managed through existing governance structures.

1.6.5. **Engagement:** not applicable to the contents of this report.

1.6.6. **Supporting Data and Analysis:** supporting information has been included by way of **Appendix 1.** This appendix provides an overview of progress throughout 2024/25, provided by programme leads, relating to key programmes and projects within the Healthcare Inequalities Implementation Plan. Further analysis against a subset of key health inequality outcome measures, as set by the National Statement on Information on Health Inequalities, has been included within this report. Please note that at the time of finalising this report, not all data was available. Shropshire, Telford & Wrekin's full response to the statement will be published, in line with NHS England's requirements, on the Health Inequalities Page of the ICB's website by the end of June 2025, at which time additional data will be available to publish a full report against all key metrics outlined in the statement, including a small set of additionally agreed local metrics.

1.1.1. **Legal, Regulatory, and Equality:** There is a legal and statutory duty to have due regard to consider health inequalities and for Integrated Care Boards (ICBs) and Foundation/Trusts to collect, analyse, publish and use information on health inequalities under Section 13SA of the National Health Service Act 2006. Supporting the importance of delivery of differential and targeted care for Core20PLUS is integral to the ICBs promotion and commitment to the Equality, Diversity and Inclusion workforce and wider community agenda.

1.2. Impact Assessments

1.2.1. **Has a Data Protection Impact Assessment been undertaken?** Not applicable.

1.2.2. **Has an Integrated Impact Assessment been undertaken?** Not applicable.

1.3. Attachments

1.3.1. **Appendix 1** – Quarter 4 2025/26 Programme Highlight Reports

1.3.2. **Appendix 2** – 2025/26 Summary of Planned Action

2. Main Report

2.1. Introduction

2.1.1. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing. Within this wider context, healthcare inequalities are about the access people have to health services and their experiences and outcomes from those services.

2.1.2. Research shows that people living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from inclusion health groups, for example the homeless, are most at risk of experiencing health inequalities.

2.1.3. Tackling inequalities in outcomes, experience and access of healthcare services is one of four key purposes of Integrated Care Systems (ICSs) and should be central to everything we should do.

2.1.4. In addition to this, addressing health inequalities positively contributes to all four of the key purposes. By committing to the use of targeted, evidenced based approaches alongside fully optimising our roles as Anchor Institutions to have a broader impact on social and economic development within the community, we will improve our populations health outcomes, enhance our productivity and subsequently improve value for money across the system.

2.1.5. Deprivation is measured using the national Index of Multiple Deprivation (IMD). The IMD ranks each small area in England from most (decile 1) to least deprived (decile 10) based on a combination of seven different factors including income, employment, education, health, crime, barriers to hosing and services and living environment.

2.1.6. Life expectancy is lowest in the most deprived 20% of areas (deciles 1 & 2 below) and there is a gradient in life expectancy by deprivation in both Telford & Wrekin and Shropshire. The gap in life expectancy between people living in the most deprived and the least deprived areas is greater in Telford & Wrekin compared to Shropshire and life expectancy in Telford & Wrekin is lower than life expectancy across England a whole.

Information on inequalities between Shropshire and Telford and Wrekin and England as a whole, 2020 to 2021

	Shropshire		Telford & Wrekin	
	Male	Female	Male	Female
Life expectancy **(local)**	79.7	83.9	77.8	81.6
Life expectancy in **England**	78.7	82.7	78.7	82.7
Gap (years)	-1.0	-1.2	0.9	1.0

Information on inequalities between the most and least deprived quintile of Shropshire and Telford and Wrekin, 2020 to 2021

	Shropshire		Telford & Wrekin	
	Male	Female	Male	Female
Life expectancy – **most** deprived quintile	77.2	82.7	74.2	78.9
Life expectancy – **least** deprived quintile	81.4	85.5	81.4	83.8
Gap (years)	4.2	2.7	7.3	4.9

2.1.7. According to the 2021 Census, there are 60,100 people living in the 20% most deprived areas nationally in Shropshire, Telford & Wrekin, of which 45,400 live in Telford & Wrekin and 14,700 live in Shropshire. These areas are those to which the National 'Core20' approach to target improvements in health and healthcare inequalities is targeted. There are also a range of other excluded groups that we have considered locally as part of this approach, for example, those with Learning Disability and households at risk of digital and/or rural exclusion and isolation.

2.2. Background

2.2.1. There are five strategic priorities which underpin the National Healthcare Inequalities Improvement Programme and remain recurrent in the 2025/26 Operational Planning Guidance to ensure focused action continues to take place. These priorities are otherwise known as the Health Inequalities Key Lines of Enquiry (KLOEs):

- **Restoring Services Inclusively** – using local data to plan the inclusive restoration of healthcare services, ensuring that waiting list performance reports are delineated by ethnicity and deprivation.
- **Mitigating Against Digital Exclusion** – enabling robust data collection to identify which populations are accessing face-to-face, telephone and virtual consultations (broken down by relevant protected characteristic) and ensuring the impact of digital innovation is assessed, considered and mitigated.
- **Ensuring Datasets are Complete and Timely** – to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.
- **Accelerating Preventative Programmes** – driving initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.
- **Strengthening Leadership and Accountability** – ensuring named executive leads are appointed for tackling health inequalities and improving awareness and knowledge of the workforce. This also includes optimising the NHS' impact on the broader determinants of health (such as employment and environmental sustainability) by contributing to social value through our roles as Anchor Institutions.

2.2.2. In addition to the five key areas, NHS England also developed the Core20PLUS5. The Core20PLUS5 is a framework to support the NHS to make targeted and driven improvements in health and healthcare inequalities.

2. **Core20** refers to people living in the 20% most deprived areas as defined by the Indices of Multiple Deprivation (IMD).

3. **PLUS** refers to population groups identified by local intelligence as more likely to experience poorer health outcomes. This includes people such as those with learning disabilities or autism, drug and alcohol users and people experiencing homelessness.
4. **5** refers to the five key clinical areas where evidence suggests accelerated improvement is most needed. For adults, this includes Cardiovascular Disease, which contributes to over 25% of the inequality in life expectancy we see in Shropshire, Telford & Wrekin. It also includes Cancer, Respiratory, Severe Mental Illness and Maternity.

Smoking is a leading cause of preventable mortality and a leading modifiable cause of health inequalities amongst Core20PLUS communities. Smoking cessation is therefore highlighted in the Core20PLUS5 as a key area of improvement which, if addressed, can lead to a positive impact across all 5 key clinical areas of the Core20PLUS5.

2.2.3. A high-level implementation plan was developed with system leads in Q1 2024/25 to identify key programmes of work aligned to priority objectives and which targeted improvements specifically for Core20PLUS population groups. The plan identifies 20 high-level priority objectives aligned to the Operational Planning Guidance and Core20PLUS5 and outlines key actions and deliverables for the forthcoming year with a view to monitor progress each quarter in alignment with national reporting requirements.

2.3. Health Inequalities Programme Governance

2.3.1. In September 2023, the Shropshire, Telford & Wrekin Health Inequalities and Prevention Group (previously referred to as a Board) was established to maintain oversight of the plan. The group meets bi-monthly and continues to be Chaired by Public Health, Telford & Wrekin Council, with the Head of Healthcare Inequalities from Shropshire, Telford & Wrekin ICB as Vice-Chair and membership from Healthcare Inequality Senior Responsible Officers from health sector organisations.

2.3.2. The function of the Health Inequalities and Prevention Group is both to monitor the progress of the specific programmes currently being undertaken as they relate to the core health inequalities objectives in the NHS Operating Guidance and Joint forward Plan and to ensure greater collaboration takes place across the system.

2.3.3. A robust reporting and monitoring framework was developed to provide oversight of progress made against the actions and deliverables outlined in the high-level implementation plan, relevant risks and mitigations but also key highlights of best practice and successes taking place across the system to celebrate achievements. The highlight reports for each programme can be seen in **Appendix 1**. These appendices detail the reporting templates used at the Health Inequalities and Prevention Group, enabling members to draw attention to projects reporting delays to progress or escalating issues.

2.4. Delivery Against the 2024/25 Healthcare Inequalities Implementation Plan

2.4.1. This report details the key findings of the end of year stocktake of progress against actions planned to be delivered in 2024/25. Of the 20 programmes referred to and included in the Shropshire, Telford & Wrekin Healthcare Inequalities Implementation Plan, most programmes completed between 70-80% of planned work. Only 20% (the equivalent of 4 programmes) completed all planned work and very few completed less than 60%.

2.4.2. An overview of completed deliverables for each programme has been included in the table below:

Programme		Delivery
KLOE 1: Inclusive Recovery		
1	Elective Recovery	No deliverables identified in-year
2	Waiting Well	5/5 deliverables completed = 100%
3	Urgent & Emergency Care	5/9 deliverables completed = 56%
KLOE 2: Mitigating Digital Exclusion		
4	Digital Transformation	3/6 deliverables completed = 50%
KLOE 3: Complete & Timely Datasets		
5	Collective Intelligence and Population Health Management Programme	4/5 deliverables completed = 80%
KLOE 4: Accelerating Preventative Programmes		
6	A System Approach to Smoke-free	5/7 deliverables completed = 71%
7	Weight Management	24/25 deliverables completed = 96%
8	Drug and Alcohol	5/7 deliverables completed = 71%
9	Learning Disability Annual Health Checks	7/7 deliverables completed = 100%
10	Maternity & Neonatal Services	14/19 deliverables completed = 74%
11	Severe Mental Illness (SMI) Physical Health Checks	6/6 deliverables completed = 100%
12	System Vaccinations	8/8 deliverables completed = 100%
13	Cancer Improvement	10/11 deliverables completed = 91%
14	Cardiovascular (CVD) Prevention	7/9 deliverables completed = 78%
15	Children & Young People's (CYP) Asthma	6/9 deliverables completed = 67%
16	Children & Young People's (CYP) Epilepsy	6/10 deliverables completed = 60%
17	Children & Young People's (CYP) Diabetes	3/4 deliverables completed = 75%
18	Children & Young People's (CYP) Oral Health	9/12 deliverables completed = 75%
19	Children & Young People's (CYP) Mental Health	4/6 deliverables completed = 67%
KLOE 5: Leadership & Accountability		
20	Leadership Programme	26/34 deliverables completed = 74%

2.5. Key Challenges

2.5.1. Through programme reporting and an end-of-year analysis, the following common themes relating to delays in progress across key programmes of work have been identified:

2.5.2. **Theme 1: Data availability and incompleteness**

Significant work has taken place to identify and develop essential intelligence and data tools which enable service design leads and commissioners to target interventions where they are needed most. This has led to a series of developments, such as disaggregating data within existing dashboards, developing new dashboards and working extensively with partners across the system to measure impact against reducing existing disparities in access, experience and outcomes. Whilst substantial progress has been made, there remains a number of key focus areas where the granularity of data needed to monitor measurable improvements is not available to the ICB. In addition to this, where granular data is available, there remains a substantial proportion of ethnicity data within the system recorded as 'unknown', therefore hindering the ability to utilise this data to understand current access and outcomes for population groups from minority ethnic backgrounds. This is a significant issue, as evidence tells us that people from certain ethnic backgrounds are at higher risk of some conditions, or are more likely to experience a poorer outcome after developing an illness e.g. rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes are higher among Black and South Asian groups than white groups.

In addition to issues surrounding the completeness of data, in 2024/25 Shropshire, Telford & Wrekin's main Acute Services Provider experienced issues with their data warehouse. This led to a significant portion of data being unavailable from July 2024 and reduced Business Intelligence and Data Team capacity amidst working to resolve this issue. The issue has since been resolved, with a full and complete data submission for the full year taking place in May 2025, however, this has had a significant impact on key programmes of work in-year, which required data to inform improvement. For example, limited progress has been made with regard to restoring elective waiting lists inclusively, as this work relies on understanding data which shows the demographic breakdown of current waiting lists to identify existing inequality, reasons behind long waits and then identify the appropriate interventions.

2.5.3. **Theme 2: Reduced financial budgets**

The programme of health inequality plans includes improvements/ incremental changes to existing services and a portion of enhanced services that deliver change through implementing specific targeted interventions or new innovations. There are continued challenges in relation to the limited availability of ongoing funding for new initiatives, especially those which require additional workforce resources. Many service and project leads have advised that delays to progress are a direct result of withdrawn national funding or the uncertainty that funding would continue beyond March 2025.

After similar challenges were raised in 2023/24, work has taken place 2024/25 to embed consideration for health inequalities as a key criterion in the ICB's Strategic Decision-making Framework, thereby increasing the likelihood of approved funding whereby projects or services are able to demonstrate the positive impact they will have on reducing health inequality.

As part of the refreshed ICB Strategic Commissioner Operating Model, the ICB developed a Strategic Decision-making Framework. As part of the joint commissioning and health inequalities objectives, the highest possible weighting was given to the assessment of how proposals would address or reduce healthcare inequalities. This process is a key mitigation in the promotion of health inequalities against other competing demands for resources and assists in the likelihood of projects receiving funding where they can demonstrate the evidence for impact.

Following the directive from NHS England, some elements of the previously ring-fenced System Development Fund (SDF) that had been used to support programmes addressing health inequalities has become part of the core budgetary processes.

As the Board are aware, NHS Shropshire, Telford & Wrekin, as a system, is in a significantly challenged financial position and as part of the recovery process, the system is required to demonstrate rigour with regard to resource commitments. Therefore, an additional process has been put in place to assess service value ahead of future commitment to recurrent funding of services that were funded from system development funding.

Through this process the ICB**,** in its role as strategic commissioner**,** will evaluate the impact of the existing funded services and new proposed services with a potential to de-prioritise services which are assessed as either not responding proportionately to patient need, duplicate existing services , do not offer high quality or value for money or which do not deliver against the ICB statutory responsibilities, such as reducing health inequalities. Service assessments remain ongoing into Quarter 1 2025/26, with an interim arrangement to offer continued funding to all services until decisions have been made until the end of Quarter 1.

Services that have been subject to this process include tobacco dependency, alcohol care, Continuity of Carer, Cardiovascular Disease (CVD) prevention and children and young people's asthma and epilepsy services. The process has unavoidably led to uncertainty of service continuation and challenges in progress in these areas, leading to substantial risk to the development and delivery of plans in 2025/26 which continue to support the reduction of inequalities in access, experience and outcomes from healthcare services and which relate to the delivery of the Core20PLUS ambitions**.** Risks to the delivery of health inequality strategic priorities have been raised, highlighting the potential

negative impact any decision to decommission or discontinue such services would have on our most under-served populations.

2.5.4. **Theme 3: A changing landscape and its impact on capacity**
Throughout 2024/25, there has been significant change with regard to the staffing and recruitment structures across the system. The ICB has undertaken a Management of Change which aimed to meet 30% cost reductions set out by NHS England and the ICS have also seen substantial recruitment pauses more broadly across the system. As a result, there have been a number of changes to leadership portfolios, project ownership and long lead-in recruitment times to fill newly established team structures, which continued into Quarter 4 2024/25.

Positively, the ICB Management of Change consultation and design process introduced a substantive Health Inequalities Team (4.75WTE) in recognition of the value provided by dedicated roles which would drive forward the NHS healthcare inequalities agenda and strategically support the system to meet its statutory duty of reducing inequalities in access, experience and outcomes. Two previously fixed-term roles were made permanent and three new roles were introduced, including a part-time senior Head of Healthcare Inequalities, a Healthcare Inequalities Partnership Lead and a Team Administrator.

In March 2025 however, existing pressures were further exacerbated by national announcements stating that ICBs were required to make additional cost reductions of 50% by Quarter 3 of 2025/26, leading to all live recruitment being paused. This included pausing recruitment to two full-time health inequality roles.

This changing landscape has understandably led to a significant number of delays in progress due to unplanned, reduced capacity and lead-in times for new project leads to familiarise themselves with their new portfolios as part of work handovers. This has included work to mitigate against digital exclusion, as senior digital leadership changed in-year, resulting in delays to delivery against this key area. Two additional significant changes included the adoption of Greener NHS into the ICB Health Inequality Team portfolio and the shift of NHS Long Term Plan Prevention to the Strategy and Development Team.

2.5.5. In addition to the above themes, it should be noted that there has continued to be less progress made than planned in relation to restoring elective services inclusively (KLOE 1) and mitigating against digital exclusion (KLOE 2). Both objective areas have been identified for their limited progress in previous end-of-year evaluations. These delays in progress are as a result of the key themes and challenges identified within this report. As a result, escalations have been made in-year to members of the Health Inequalities and Prevention Group to make recommendations and seek senior support in removing barriers to progress.

2.6. Key Achievements

2.6.1. Despite significant challenges, Shropshire, Telford & Wrekin has seen a wealth of progress in areas across the programme. These examples demonstrate excellent leadership across all levels of staff, the use of evidence-based information and intelligence to target improvements in population health and the application of quality improvement approaches.

2.6.2. We have strengthened our governance arrangements, building on the clear strategic oversight arrangements in place at system-level to replicate focused governance arrangements across our Provider Trusts.

2.6.3. Good governance and escalatory processes have led to positive steps being taken forward in relation to areas of limited progress, such as restoring elective services inclusively (KLOE 1) and mitigating against digital exclusion (KLOE 2). In Quarter 4 2024/25, recommendations were agreed to ensure health inequality is core to newly established Elective Reform Steering Groups and that quarterly reviews of waiting list data (children and young people and adults) are undertaken and collectively discussed within the System Planned Care Delivery Group to better understand trends in inequality and actions required to address them.

2.6.4. Work has also been facilitated by the STW ICB Health Inequalities Team to accelerate progress in digital inclusion. In Quarter 4 2024/25, a series of workshops were held with system partners (including Local Authority, Healthcare Trusts, Primary Care and the Voluntary and Community Sector) to understand and identify priority action to improve digital inclusion within the NHS. This was with the aim of co-developing a 2-year Plan for Mitigating Against Digital Exclusion, for delivery between July 2025 and March 2027, which specifically takes into account how the system will ensure mitigations are in place to reduce the risk of excluding communities who are not digitally enabled amidst the increasing shift to digitally-provided services. This plan is in the final stages of engagement with system partners and will be driven forward by a newly established Digital Inclusion Steering Group from 2025/26 onwards.

2.6.5. Shropshire, Telford & Wrekin has continued to grow a passionate network of Core20PLUS Ambassadors. These Ambassadors actively promote a culture where staff understand health inequality, the barriers which make it harder for under-represented communities to access healthcare services and the actions healthcare professionals can take to remove them. An additional 23 healthcare staff successfully applied to the NHS England Core20PLUS Ambassador Programme this year, accumulating to 38 Ambassadors in total representing change within the ICB, Primary Care and Trust settings and across a range of specialisms and departments such as clinical, strategy, medicines, operational and data analytics. They have been pioneering new projects based on evidence and the experiences of our local communities to improve access for under-represented groups.

2.6.6. The healthcare inequalities team have continued to build on our health inequalities resource and intelligence, having developed a shared space on our local system intranet to share best practice, signpost to essential resources and spotlight the excellent work taking place across the system to reduce inequalities in access, experience and outcomes.

2.6.7. Business Intelligence Teams have worked collaboratively with Public Health and Health Inequality Leads to co-develop the first phase of the Shropshire, Telford & Wrekin Population Health and Health Inequalities Dashboard. The dashboard intends to support and enable analysis of inequalities in service planning and delivery, using key, nationally set metrics as identified in the Statement on Information on Health Inequalities, as well as locally agreed measures. The dashboard further aims to provide an overview of trends in improvement and demonstrate progress against reducing gap variance between demographic groups over time. The dashboard entered into User Access Testing (UAT) in January 2025, with further planned development due to take place in May 2025 prior to being made accessible to service commissioning and re-design leads.

2.6.8. Midlands Partnership University Foundation Trust (MPUFT) have worked collaboratively with system partners to strengthen the offer of support for people experiencing poorer mental health and people with Severe Mental Illness (SMI). This has included developing health and wellbeing offers, such as access to free football and tennis activities and the adaptation of case-worker led outreach models of care, offering dual diagnosis support for both physical and mental health to people experiencing, or at risk of homelessness.

2.6.9. The system have seen significant improvements in the number of children and young people with access to diabetic technologies. A recent Getting it Right First Time (GIRFT) Review highlighted that Shropshire, Telford & Wrekin has one of the highest proportions of children and young people on Hybrid Closed Loops. Quality improvement work led by Paediatric Teams at Shrewsbury and Telford Hospital NHS Trust (SaTH) has led to more than 200 children starting insulin pump therapy, a reduction in waits from 18 months to 6 months and access for children in the lowest deciles of deprivation increasing by 40%.

2.6.10. Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) have undertaken a comprehensive DNA Audits at Trust and Service level, which identified a theme in children and young people who were not brought to their appointments (CYP WNB). A series of actions were introduced in an attempt to reduce CYP WNBs moving forward. This has included proactively contacting patients to discuss their appointment and documenting reasons for missed appointments. As a result, the Trust has seen positive improvements in the rates of CYP WNB, which have reduced from over 10% to under 5% in 14 months.

2.6.11. General Practice, in partnership with Midlands Partnership University Foundation Trust (MPUFT), have successfully exceeded this year's target of 75% of annual health checks to be completed for people with a registered learning disability, achieving 85.6% by the end of March 2025.

2.6.12. Shropshire Community Health NHS Trust have continued to build upon evidence-based approaches to improve vaccination uptake amongst at-risk population groups. This has included working in partnership with Public Health and Voluntary, Community and Social Enterprise (VCSE) organisations to develop joined-up approaches for offering vaccinations to people with learning disabilities and/or autism, people experiencing homelessness and socially isolation populations such as people who are in contact with the justice system, refugees and Gypsy, Roma, Traveller communities.

2.6.13. Shropshire, Telford & Wrekin Integrated Care System (ICS) became formally recognised as a Sustainability Exemplar Site, having successfully sustained the Shropshire, Telford & Wrekin Cancer Champions project (part of the NHS England Core20PLUS5 Connector Programme). The project has demonstrated excellent partnerships with our broader partners and communities, resulting in successfully training over 400 people from diverse and under-represented backgrounds in spotting the signs of early cancer symptoms and raising awareness of local screening. Last year, we saw big increases in the uptake of cancer screening and that trend has continued into 2024/25. For breast and bowel screening, we were 5% higher than the national and regional average.

2.6.14. Collaborative working with partners from Local Authority the Voluntary and Community Sector has led to over 260 pop-ups events taking place this year to offer outreach blood pressure checks and lifestyle conversations in targeted areas. These events were held across 98 locations, including faith and community venues. 52 champions have been trained and approximately 1 in 4 people checked have been from a Black, Asian or Ethnic Community. The project has identified over 13% of people who had a blood pressure check to have undetected hypertension.

2.6.15. Shropshire, Telford & Wrekin were one of the first systems to be visited by the Regional NHS England Health Inequalities Team as part of a new approach to understanding system progress against statutory duties to reduce inequalities in access, experience and outcomes. Feedback from the visit, held in January 2025, was extremely positive, noting particularly the vast range of colleagues who attended the day to share and discuss their work and the enthusiasm felt by all to make a difference to under-served and under-represented communities in STW.

2.7. Progress Against Health Inequality Outcome Metrics

2.7.1. On 28th November 2023, NHS England released a Statement on Information on Health Inequalities. The statement sets out a description of the powers available to relevant NHS bodies, including the Integrated Care Board (ICB) to collect, analyse and publish information on health inequalities under Section 13SA of the National Health Service Act 2006.

2.7.2. The purpose of exercising these powers is to:

- Understand healthcare needs, including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes, including by collecting, analysing and publishing information on health inequalities set out in the Statement and relevant domains.
- Publish information on health inequalities within or alongside annual reports in an accessible format.
- Use data to inform action, including as outlined in the Statement.

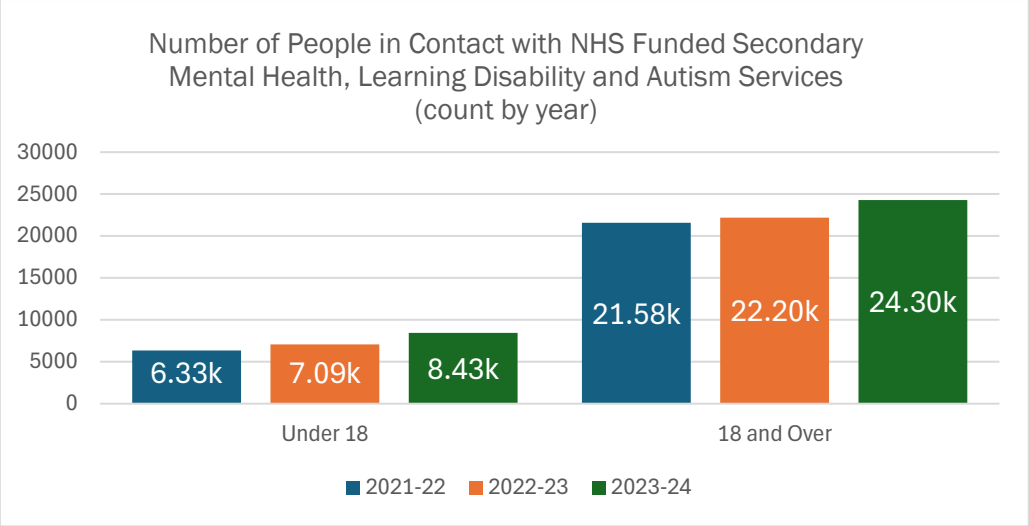
2.7.3. The domains of indicators included within the statement align to the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.

2.7.4. It should be noted that throughout 2024/25, local capability to access data has been limited due to local issues with the Acute Trust's data warehouse The report does provide a limited a set number of metrics with further analysis undertaken by the NHS STW ICB Health Inequalities Team to understand progress and improvement against key health inequality metrics available.

2.7.5. Shropshire, Telford & Wrekin's full response to the statement will be published, in line with NHS England's requirements, on the Health Inequalities Page of the ICB's website by the end of June 2025, at which time additional data will be available to publish a full report against all key metrics outlined in the statement, including a small set of additionally agreed local metrics.

2.7.6. In addition to issues relating to data availability for the 2024/25 year, further caveats much be regarded relating to the completeness and quality of ethnicity data and high rates of data recording ethnicity as 'missing', 'not known' or 'not stated'. As a result, the full extent of inequality between ethnic group is not fully known.

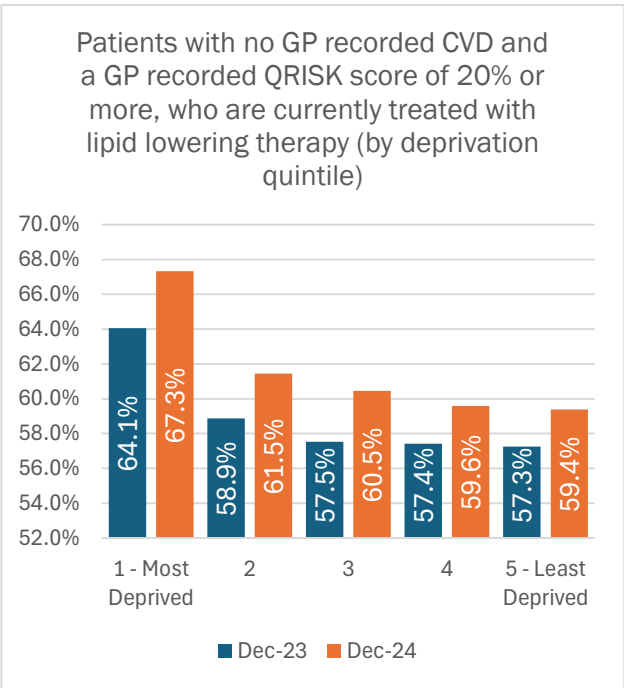
2.7.7. The data available has shown positive increases in the number of children and young people able to access support for mental health and wellbeing since the previous year as per nationally set access rates.

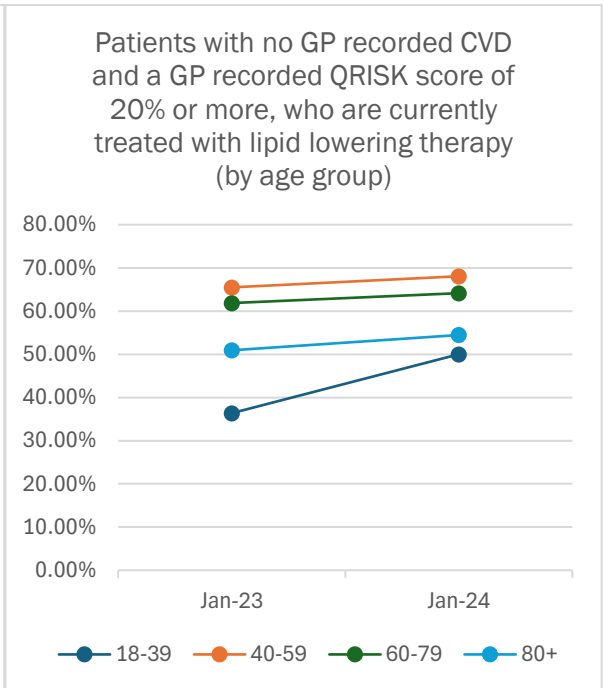


Source : NHS England : Mental Health Bulletin, 2023/24 Annual Report

2.7.8. It should be noted however that this data is not currently available split by deprivation or ethnicity and therefore no assessment can be made as to the potential inequalities which may exist between children and young people from deprived or minority ethnic backgrounds.

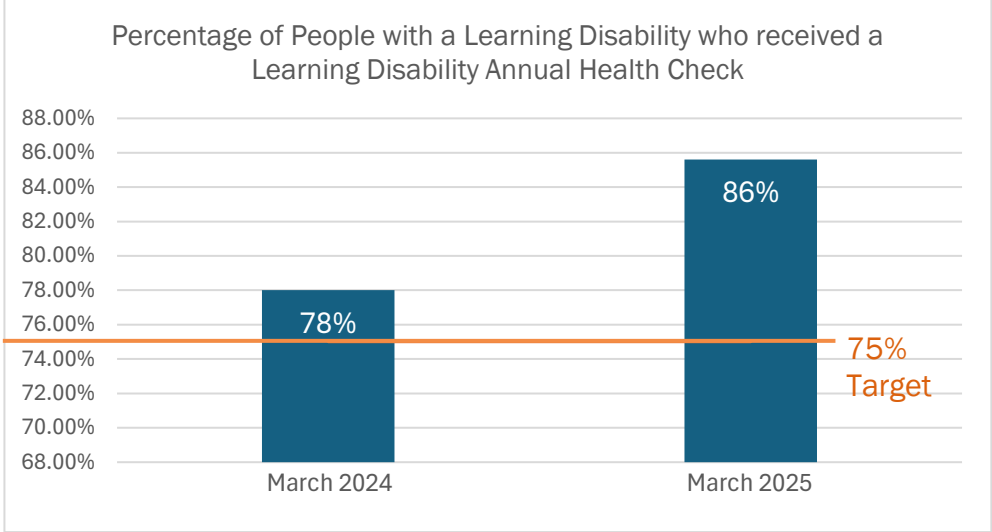
2.7.9. There has continued to be higher rates of people aged 18+, with no recorded Cardiovascular Disease, a QRISK score of 20% or more and who live in our most deprived geographical areas, being provided with lipid lowering therapy (67% compared to 64% last year). This year's figures indicate large substantial reductions in the gap in treatment between younger people (aged 18-39), which was previously 36%, up to 50% in 2024/25, compared to people aged 40+ (treatment rates between 54-68%).





Data Source: https://www.cvdprevent.nhs.uk/

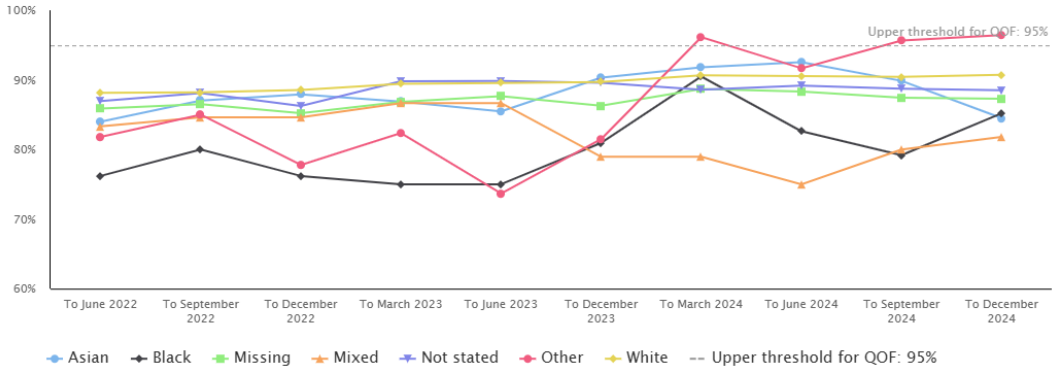
2.7.10. At the end of March 2025, 85.6% of people aged 14+, with a registered learning disability, had received a Learning Disability Annual Health Check (LDAHC). This is a 7.6% increase on the previous year (78% in March 2024) and exceeds the national target of 75%.



Data source: NHS England Learning Disabilities Health Check Scheme

2.7.11. There has been a substantial increase in the number of people recorded with 'other ethnicity', aged 18+ with GP recorded Atrial Fibrillation and a record of CHA2DS2-VASc score of 2 or more being treated with anticoagulation drug therapy (81 – 96% between December 2023 and December 2024).

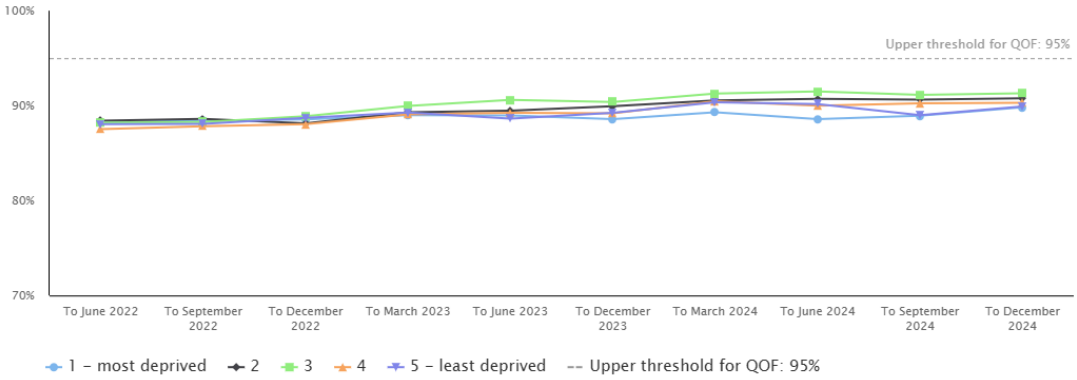
Number of people recorded aged 18+ with GP recorded Atrial Fibrillation and a record of CHA2DS2-VASc score of 2 or more being treated with anticoagulation drug therapy (by ethnicity)



Data Source: https://www.cvdprevent.nhs.uk/

2.7.12. Whilst variation has been seen in-year for people from other ethnic backgrounds (including mixed and black ethnicities), end of year figures show restored treatment levels with little variation when compared with 12 months prior. There also continues to be little variation in treatment for atrial fibrillation between people from the most deprived and least deprived areas.

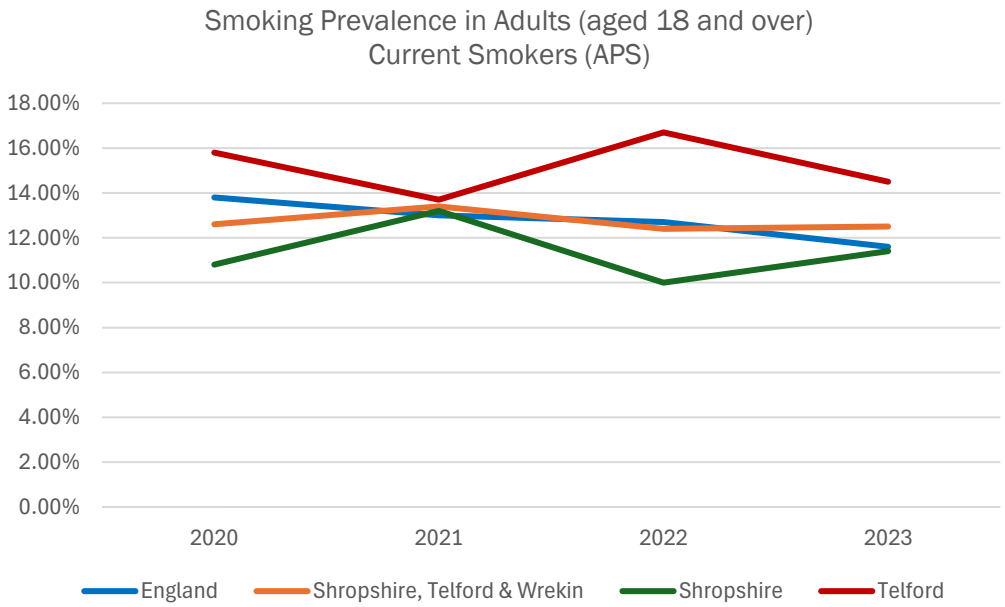
Number of people recorded aged 18+ with GP recorded Atrial Fibrillation and a record of CHA2DS2-VASc score of 2 or more being treated with anticoagulation drug therapy (by deprivation quintile)



Data Source: https://www.cvdprevent.nhs.uk/

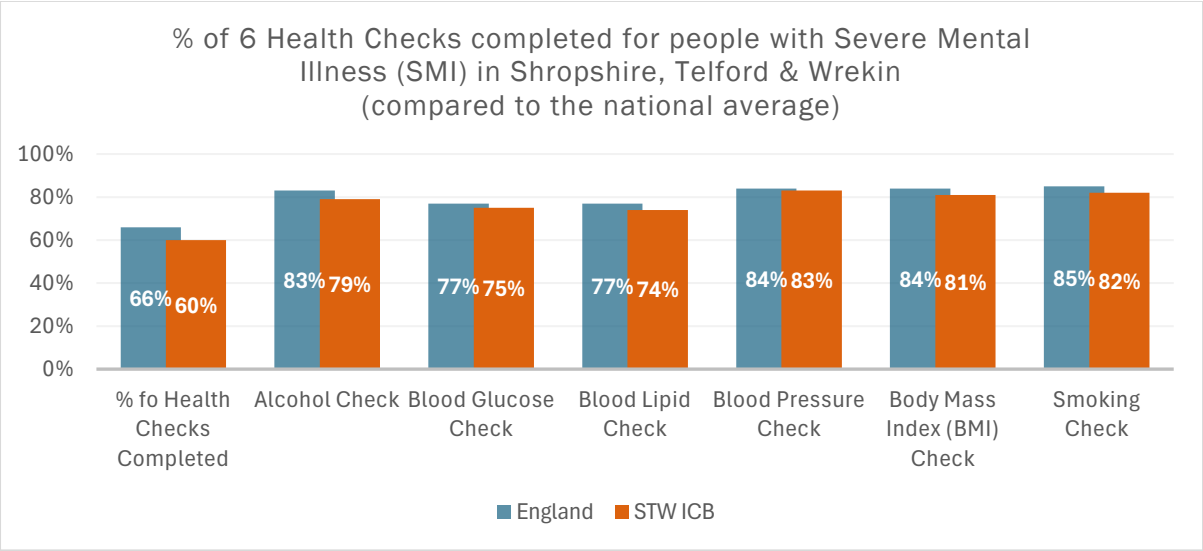
2.7.13. Data from the Office for Health Improvement and Disparities estimates that 12.5% of the Shropshire, Telford & Wrekin population (age 18+) are smokers, a higher rate than the national average of 11.6%. Trendline analysis indicates that the ICB has seen little movement in its estimated smoking prevalence, which was recorded as 12.6% in 2020, 13.4% in 2021 and 12.4% in 2022.

2.7.14. At a Local Authority level, smoking prevalence in Shropshire appears to have increased slightly since 2022, from 10 to 11.4%. Prevalence in Telford & Wrekin has reduced by 2.2% (16.7 – 14.5%).



Data Source: https://fingertips.phe.org.uk/

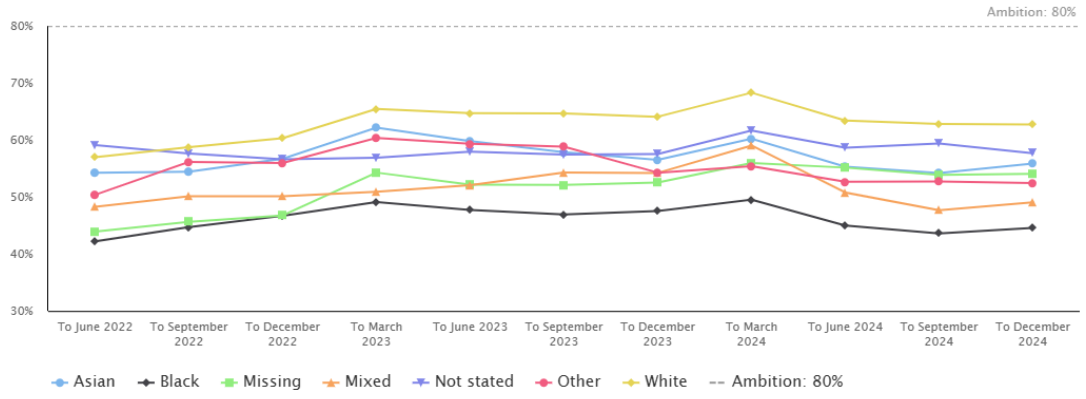
2.7.15. The percentage of people with Severe Mental Illness who received an Annual Health Check (AHC) in 2024/25 has reduced when compared to the previous year. In 2024/25, 60% of health checks were undertaken, achieving the national target. However, this is a 7% reduction compared to 2023/24, whereby 67% of health checks were completed. This trend can be seen across individual checks completed (for example, blood pressure checks, smoking status, Body Mass Index (BMI) checks) whereby data demonstrates 8-16% less checks were undertaken compared to the previous year.



Data Source: NHS Digital Physical Health Checks for People with Severe Mental Illness

2.7.16. Previously identified disparities in the treatment of hypertension (high blood pressure) for people from a black ethnic background have slightly worsened. In December 2023, 47.5% of people black ethnicity were treated to target for their hypertension, compared to 64% of people with white ethnicity (a 16.5% gap). In December 2024, 44.5% of people with black ethnicity were treated to target compared to 62% of people with white ethnicity (an 18% gap).

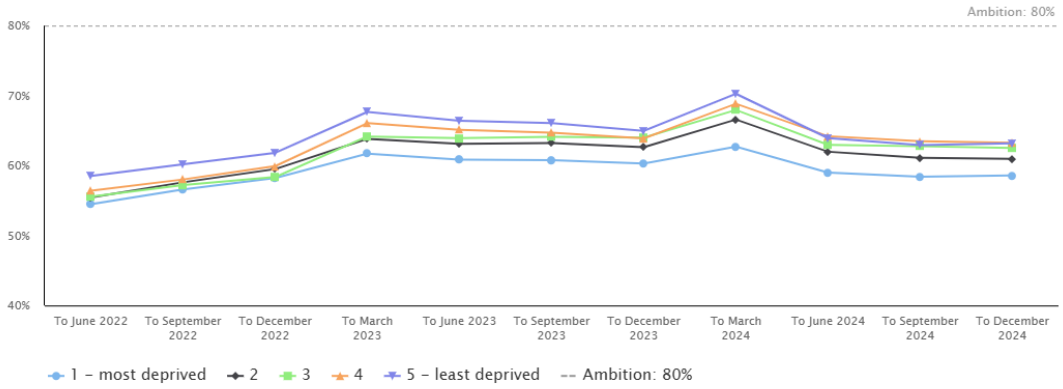
Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months (by ethnicity)



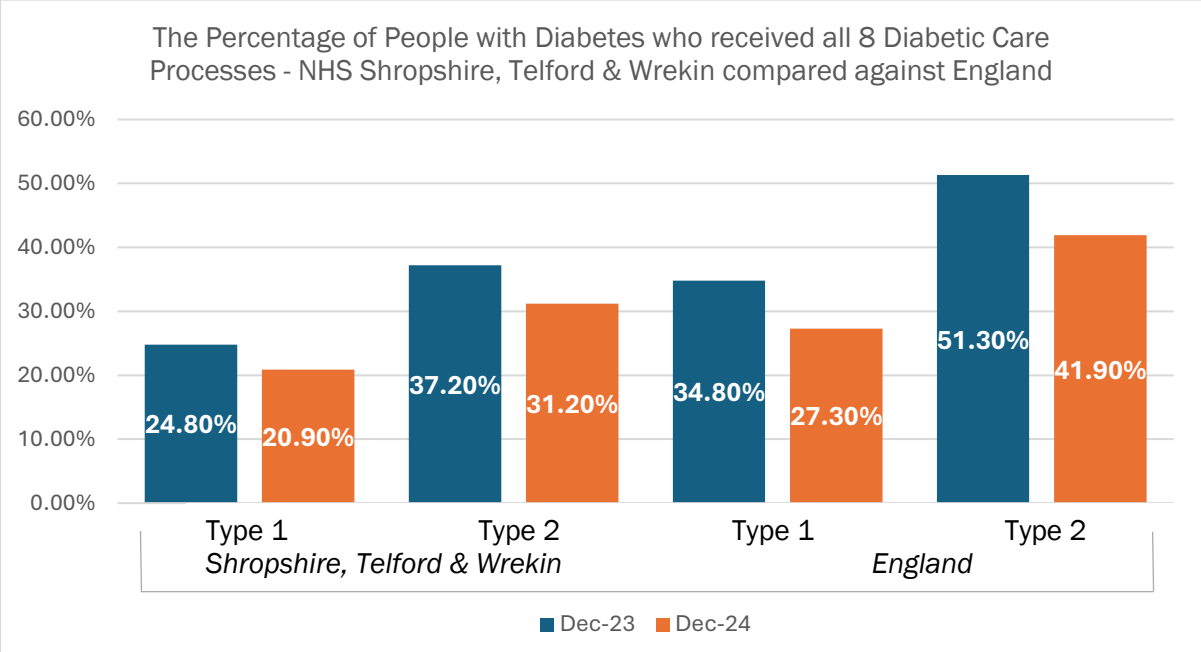
Data Source: https://www.cvdprevent.nhs.uk/

2.7.17. No significant changes have been seen in relation to gaps in treatment between people living in the most deprived areas and people living in the least deprived areas.

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months (by deprivation quintile)



2.7.18. Compared to the previous 12 months, the percentage of people with type 2 diabetes receiving all 8 care processes has decreased by 5% (from 37% in December 2023 to 31% in December 2024). Shropshire, Telford & Wrekin has also recorded a significantly smaller proportion of both Type 1 (20.9%) and Type 2/other (31.2%) diabetic patients receiving all 8 care processes when compared with England averaged (27.3%, 41.9%).



Data Source: National Diabetes Audit Dashboard

2.8. Priorities in 2025/26

2.8.1. As national priorities for how the NHS should tackle inequalities in access, experience and outcomes remain recurrent into 2025/26, Shropshire, Telford & Wrekin commit to continuing to build on progress made in line with delivery against the Key Lines of Enquiry and Core20PLUS5 approach.

2.8.2. This is in addition to continuing to act in line with our locally agreed building block principles for driving forward targeted health inequality improvement.

Developing our **collective intelligence** as a baseline for current inequalities	Understanding our **communities' experiences**	Building on our **Collaborative Partnerships**	**Addressing Wider Determinants** through our anchor institution and by becoming a Greener NHS
Refining governance for assurance and ownership of delivery	Creating **a culture and movement for change** through ambassadorship	Adopting **key local metrics** to support national indicators	Advocating for **quality improvement approaches** and the adoption of best practice
Delivery of National Healthcare Improvement Programme objectives			

2.8.3. There is an explicit reference in 2025/26 Operational Planning Guidance to urgent priorities relating to elective reform, supporting reduced waiting times for mental health patients in A&Es and support children and young people's mental health. As such, discussions have taken place with system leads for these areas to ensure that targeted improvement initiatives have been planned for 2025/26, with a specific focus on health inequality and supporting Core20PLUS communities.

2.8.4. Acknowledging the requirement in national guidance for systems to continue progress against all Core20PLUS objectives, the 2025/26 Healthcare Inequalities Implementation Plan will be refreshed in Quarter 1 (by end of June 2025) to ensure all key objectives have targeted improvement initiatives attached. Work will take place with system leads to ensure that plans are Specific, Measurable, Actionable, Realistic and Timely (SMART), acknowledging the financial and capacity challenges experienced throughout 2024/25 and the acknowledged risk of ongoing challenges leading into 2025/26.

2.8.5. A summary overview of the actions committed to by the ICB as part of 2025/26 plans can be found in **Appendix 2.** This document identifies key areas highlighted throughout this report as high priorities based on both the learning from the 2024/25 year and analysis undertaken to understand impact against key outcomes.

2.9. Conclusion

2.9.1. Healthcare inequality oversight and governance arrangements have successfully led to firm recommendations and corrective action whereby a lack of progress has been identified. Where required, the ICB Health Inequalities Team have deployed to convene system partners and co-develop plans which will drive forward change e.g. Elective and Digital workstreams. This has led to clear, robust action and accountability in delivery plans for 2025/26.

2.9.2. There is increasing understanding and awareness amongst workforce on what health and healthcare inequalities are, and how to address them.

2.9.3. Successful examples of progress are bedded in quality improvement methodology and learning from lived experience.

2.9.4. Despite this, there does remain a clear need for continued involvement of health inequality leadership to maintain momentum, provide support and offer critical expertise to ensure health inequalities are sufficiently understood and considered as part of healthcare decision-making.

2.9.5. Analysis of latest available data demonstrates positive improvement in key areas, such as access to children's mental health services and provision of annual health checks for people with a learning disability. However, data also demonstrates limited progress in improving outcomes and reducing inequalities in very key clinical priority areas, such as Cardiovascular Disease (hypertension treatment) and Diabetes (completion of the 8 care processes). This is of significant concern, as Cardiovascular Disease contributes towards over 25% of the inequality in life expectancy seen between people living in the most deprived compared to those living in the least deprived areas of Shropshire, Telford & Wrekin. Additionally, discussions in relation to plan setting for 2025/26 suggest there are opportunities to strengthen plans and focus more on reducing existing inequalities in access and treatment.

2.9.6. Key challenges relating to financial pressures and reducing staff capacity to lead on strategic improvement are consistent with previous years and prioritising equity amidst financial and performance pressures continues to be a key issue, with many staff still viewing the requirement to tackle inequality as an optional addition to already very busy task lists.

2.9.7. It is essential that health equity is championed as a fundamental responsibility of all staff and a 'golden thread' to all service design and commissioning with the acknowledgement that by addressing inequality in service provision, we will reduce demand on services, free up resource and assist in contributing towards addressing the system's current financial challenges simultaneously to fairly and consistently improving the health of our population.

2.9.8. There are risks moving into 2025/26 in light of recent national announcements for further reductions in costs and the consistent challenges relating to insufficient capacity to deliver against national requirements.

2.10. Recommendations

1.6.7. Note the contents of the report and the progress made to date.

1.6.8. Continue to support and champion progress against healthcare inequalities key priorities within your respective organisations to improve the experience and health outcomes of Core20PLUS populations.

1.6.9. Specifically promote and encourage urgent action to realise improvements in the completion and accuracy of coded demographic data, such as ethnicity and housing status, to enable successful population health management.

1.6.10. Support concerted efforts to address inequality in hypertension treatment and recover treatment levels to the national target of 80%, acknowledging that blood pressure is one of the leading risk factors in poorer outcomes from Cardiovascular Disease. Cardiovascular Disease contributes to over 25% of the inequality in life expectancy seen between people living in the most deprived areas compared to those living in the least deprived areas of Shropshire, Telford & Wrekin.

1.6.11. Provide top-down, senior support to promote health inequalities as a golden thread to existing service design, commissioning, transformation and delivery and not thought of as an optional, additional task, mitigating the risk of de-prioritisation amongst competing financial and performance pressures.

1.6.12. As a system, endorse the mandatory embedding of quality improvement approaches, supporting staff to attend quality improvement training and embed quality improvement principles within project management and service improvement.