Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 November 2024
	Agenda Item:	14

Report Title:	**Bi-annual Population Health and Inequalities Report**	
Author(s):	Jo Hardwick: Head of Population Health and Inequalities	
Accountable Director:	Helen Crimlisk – Medical Director, James Drury – Director of Strategy	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	13 November 2024
Key points/ recommendations from those meetings	Consider how we measure impact and success.	

Summary of key points in report

The purpose of this report is to provide a general overview of the work underway in the Trust in relation to population health, healthcare inequalities and prevention. This is a bi-annual report and covers the period May – October 2024

The aim of this work is to address population health and inequalities in a systematic and strategic way, to support Sheffield's commitment to improve healthy life expectancy and reduce health inequalities.

Data quality and completeness continue to be a challenge to working in a population health way. We are not capturing completely or accurately the personal characteristics of the people we serve, impacting on the extent to which we can address health inequalities. There is positive progress, through focused protected characteristics work, of which Rio implementation will be an enabler.

Highlights of what has been achieved during this time and next steps are detailed in appendix 1.

The main areas of development include:

- Health Inequalities Statement 2023/24 – completed first draft of report to publish.
- Health inequalities Board self-assessment – completed following Board development session in June 2024.
- Trust draft inequity action plan – formed in response to the self-assessment, Fair and Healthy Sheffield Plan and to align to Trust strategy refresh.

Appendices attached:

A. Health Inequalities Statement 2023/24
B. Health Inequalities Board Self-assessment report
C. Framework and action plan
D. Population Health and Inequalities Quarterly Update

Recommendation for the Board/Committee to consider:

Consider for Action		Approval	X	Assurance	X	Information	

This report is to provide assurance on the work underway in this area, that it continues to align to the trust

strategic objectives and meets our expectations.

Board is asked to

- Receive the Health Inequalities Statement 2023/24 and confirm this is ready to publish
- Note the Health inequalities Board self-assessment
- Note the Trust draft inequity action plan and agree to direction of travel

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	**x**	*No*	
Deliver Outstanding Care	*Yes*	**x**	*No*	
Great Place to Work	*Yes*	**x**	*No*	
Ensuring our services are inclusive	*Yes*	**x**	*No*	

Is this report relevant to compliance with any key standards?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*		*No*	**x**	
Data Security and Protection Toolkit	*Yes*		*No*	**x**	
Any other specific standard?					

Have these areas been considered? YES/NO					If yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	*Yes*	**x**	*No*		Service User experience is a core consideration for this work. Equitable access, excellent experience and optimal outcomes are key drivers. As such Service User and carer engagement will be key to achieving these. Co-production continues to be considered alongside trust Experts by Experience, throughout the development of this work. Joint working opportunities and sharing learning with the Engagement Team is ongoing and will continue to be a core part of this work.
Financial (revenue &capital)	*Yes*	**x**	*No*		Alongside the creation of the Head of Population Health and Inequalities roles, a 0.5WTE B5 was also created. This role has been put forward and approved a as a non-recurrent VIP for the 2024/25 financial year.
Organisational Development /Workforce	*Yes*	**x**	*No*		There is a hope that population health and inequalities become core thinking across all services. Increasing knowledge in this area and learning opportunities will be key. Time for this will be required.
Equality, Diversity & Inclusion	*Yes*	**x**	*No*		This works aligns closely to that of the EDI team, as such a strong working relationship has been established and there is a health inequalities standard agenda item on the Inclusion and Equality Group. Regular joint working is underway to support both the population health & Inequalities and EDI shared agenda
Legal	*Yes*		*No*	**x**	No legal implications
Environmental sustainability	*Yes*	**x**	*No*		There is much cross over between this work and that identified in our Green Plan. There are strong links to sustainable models of care and impact on patient population. Due to lack of resource in both areas, progress of this work is limited. Joint session has created for the Developing as Leaders programme considering systems leadership.

Section 1: Analysis and supporting detail

Background

1.1 The momentum has continued to gather speed, with interest increasing across the trust to understand and consider the role we all have within reducing health inequalities, including strategically focused work as well as team level support.

In June 2024, the Public Health Registrar post ended. We are keen to recruit another Public Health Registrar as the Trust does not have a Public Health Consultant within SHSC to provide supervision.

The 0.6wte band 5 post has been approved by the Trust QEIA panel to be utilised as a non-recurrent VIP for the remainder of 2024/25.

Positive developments include the appointment of an Associate Medical Director of Quality, which a specialist interest in Public Mental Health.

Close working relationships are being developed with the Trust Healthy Hospital Team Manager and Sustainability Lead where there is clear and evidenced overlap of priorities.

Several elements have influenced the focus over the last 6 months, and as such, refinement of the strategic plan that was approved at EMT in Jan 2024 was necessary to incorporate the trust, place and regional developments. All elements, detailed below, inform the revised health inequalities action plan.

- Health Inequalities Statement 2023/24
- Health inequalities Board self-assessment

Health Inequalities Statement

1.2 The Health Inequalities Statement is a legal requirement of all Trust/Foundation Trusts, and ICBs to complete on an annual basis. The statement required the reporting on several domains, cross referenced by ethnicity and deprivation. Going forward the characteristics required to report on will increase, further emphasising our need to improve our data collection and recording.

The domains related to our trust are:

- Rates of total Mental Health Act Detentions
- Rates of restrictive interventions
- NHS Talking Therapies recovery
- Proportion of adult acute inpatient settings offering smoking cessation services

Our report is in draft form currently, having been discussed by the Board in a development session on 23rd October. Amendments have been made to the Health Inequalities Statement in response to feedback from the Board development session and a final draft version is attached at Appendix A. Board is invited to approve the publication of the statement.

Health Inequalities Board Self-Assessment

1.3 NHS Providers produced a framework and associated self-assessment to support trust boards to focus on health inequalities and ensure it was part of their core business.

This was discussed and reviewed during the Board development session in June 2024 and the self-assessment subsequently completed. Based on answers given, a

set of objectives are identified through the tool, which are in the process of being turned into smart targets. See appendix C for the self-assessment objectives.

The objectives are themed into four categories and given a self-assessed maturity rating. SHSC overview is below

Building public health capacity and capability	Developing
Data, insight, evidence and evaluation	Developing
Strategic leadership and accountability	Developing
Systems partnerships	Maturing

The objectives include ensuring training and development opportunities are available to all staff, including training in Making Every Contact Count (MECC), performance outcomes and data is reported to board by relevant characteristics, reviewing comms with patients in response to health and digital literacy levels of the patient population, support to address inequalities in the workforce, establish health inequalities oversight in the governance structure and establish pathways to engage with the VCSE sector. The full list of objectives can be found in appendix B.

SHSC is undertaking some great work to address health inequalities of the population we serve, which is becoming more joined up and strategic. There is still much more that we can do, and this self-assessment provides a vehicle for that work.

Health inequalities action plan

1.4 The health inequalities statement, self-assessment and Fair and Healthy Sheffield Plan have all influenced the development and content of the health inequalities action plan. We have reviewed best practice amongst other Trusts that are seeking to make progress in this area. This has informed the way in which we have framed our action plan.

The action plan will link to the trust strategy refresh and ensure that health inequalities in embedded into everything that we do.

The high-level framework for our Plan is attached at Appendix C. Within the Appendix slide 3 sets out the workstreams of our plan and the aims of each element. Slide 4 demonstrates how the workstreams of our plan will address the opportunities identified through the Board self-assessment process. Slide 5 shows an indicative extract of the tracker that will be used to ensure delivery is monitored and supported. Progress will be reported to Board within future updates on Population Health and Inequalities.

Section 2: Risks

2.1 **Data**: Data continues to be a risk, with a lack of consistent recording of protected characteristics, unable to analyse and accurately target support and/or services.

Mitigation:

- A protected characteristics task and finish group was established in July 2024. The aim is to improve the capture and recording of protected characteristics and data related to inclusion health and vulnerable groups. Focus on shared learning and behavior change to ensure sustainable change and understanding.
- Connected with Digital and Rio development teams to ensure the system can capture the data needed to easily report on and understand our services from a population health viewpoint.

Section 3: Assurance

Benchmarking

3.1 A small Informal health inequalities support network has been created with peers from SHSC, Sheffield Children's Hospital and Sheffield Teaching Hospital, to share learning, challenges and opportunities.

The ICS level Public Health Network continues to develop, of which we are a member of. This offers an opportunity to link and learn from fellow public health colleagues within Yorkshire and Humber.

SHSC are represented at the Yorkshire and Humber DASIY network, which is a space to link and learn to colleagues in relation to health inequalities data and analytics.

SHSC are represented on the Health and Wellbeing Board, supporting the Sheffield Place based developments.

Regular attendance at health inequality related conferences and webinars to understand national direction, learn from others and build our wider network.

All the above offer support and learning, both locally and nationally to support the direction of our journey in relation to health inequalities.

Triangulation

3.2 Clinical and Social Care Strategy continues to focus on the reduction of health inequalities. The Outcome and benefits workstream are supporting the capture of success markers and encouraging these to be viewed through a health inequalities lens.

Building population health and inequalities data capture into Rio development and the data warehouse. There is an aspiration to build a population health platform, allowing teams and services to create their own population health reports to support service development and design, and to improve access, experience and outcomes. The data warehouse is already linking to national population health data sources. The Digital team are fully sighted and supportive of the aspirations ensuring this is embedded in the Rio programme where appropriate

Engagement

3.3 Work is underway engaging within SHSC and across the system.

Internal engagement:

- QI - Waiting List Collaborative. Focus on 'did not attend' and 'were not brought' and how to create a sustainable reduction of these. Specifically, Older Adults Memory Service. Represented on the Waiting list and Waiting Well collaborative faculty.
- Digital and Business Performance Team. Supporting team to understand importance of including ethnicity and deprivation (as a minimum) in analysis, and to ensure these are built into their governance reports for teams.
- Engagement Team – connections make around community development/engagement, PCREF and Equality dashboard development, to ensure our work complements each other and not duplicating. Utilise data already gathered to influence health inequalities focus.
- Equality and Diversity – Workforce Inequalities, particularly those of our female workforce. Head of Population Health and Inequalities is now co-chair of the Amazing Women Staff Network Group.

- Protected Characteristics Task and Finish Group – Co-leading to develop a supported behavioural change focussed approach to improving collection and recording of protected characteristics, inclusion health and vulnerable groups.
- Learning Disabilities – STOMP (stopping the over medication of patients with learning disabilities). Support to team to collate progress so far and to identify opportunities to progress work alongside transformation.

External engagement:

- Planned delivery of population health workshop at Yorkshire and Humber School of Psychiatry Conference on 22nd November
- South Yorkshire Health and Housing Summit. Working together with colleagues in Public Health, Local Authority Housing, SYMCA, ICB, and housing providers to improve the connection between housing and health colleagues, to improve outcomes for services users.
- Member of the health workstream of the Sheffield Refugee, Asylum Seeker and Migration Strategic Partnership Group.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

4.1 A Population health approach is defined as 'improving physical and mental health outcomes and wellbeing of a defined population, whilst reducing health inequalities', by its very nature it will ensure our service are inclusive. Effective use of resources, and delivering outstanding care are benefits of this approach. When applied similarly to workforce, it ensures this is a great place to work.

Population health, prevention and health inequalities are integral to the trust strategy refresh discussions ad a golden thread.

A health Inequalities action plan is under development in line with Board self-assessment outcomes and Fair and Healthy Sheffield Plan commitments. This will ensure that population health and inequalities are fully embedded into the work we do within the trust.

Equalities, diversity and inclusion

4.2 Health inequalities now form an element of the QEIA process. The Head of Population Health and Inequalities sits on the panel and the paperwork is being reviewed to better include health inequalities considerations.

There are strong links and frequent joint working with the EDI team to ensure there is no duplication and that our work compliments and supports, for example, Health inequalities will be included within the annual Equality and Human Rights Report.

Culture and People

4.3 There are strong links between this work and that of the People Directorate to support people to gain and retain meaningful employment, to ensure that the workforce reflects our population and to improve the wellbeing of our workforce who themselves can be experiencing health inequalities, all making this a great place to work.

The gathering momentum and enthusiasm with the workforce around population health and inequalities is fantastic. To support this, we will continue to develop and utilise an informal and supportive workforce, through the population health forum, Jarvis page and training and learning opportunities.

The vision is for this to be a golden thread throughout the organisations, and teams and services taking ownership of their role in reducing health inequalities. to achieve this the Head of Population Health and Inequalities role will continue to be an advisory role, supporting teams to develop skills and take work forward themselves.

We continue to promote SHSC as a placement for trainee Public Health Registrars The QEIA panel recommended the Band 5 0.6WTE, be proactively advertised and recruited to by April 2025, to further expand the resource. A case will be made to the vacancy control panel. Additionally, there an informal workforce is already starting to take shape in various ways:

- Close working relationships with the Healthy Hospital Team Manager and Sustainability Lead where there is clear and evidenced overlap of priorities.
- Associate Medical Director of Quality now in post, who has expertise and strong interest in Public Mental Health.
- The Business and Performance Management team are starting to include ethnicity and deprivation data within team governance reports, as standard.

Integration and system thinking

4.4 Commitment to Sheffield Place Fair and Healthy Sheffield Plan, aimed to address health inequalities through a population health approach. This plan was presented and approved by the Health and Wellbeing Board (HWB) in September.

Financial

4.5 Contributed a non-recurrent VIP saving for 2024/25 of a 0.6WTE band 5 role. The QEIA panel recommended the Band 5 0.6WTE, be proactively advertised and recruited to by April 2025, so if approved by the vacancy control panel, there will be a financial pressure when this post will be recruited to.

More broadly this work has the potential to make more efficient and effective use of our resources. By identifying people whose needs are not being met, and by intervening proactively at an earlier stage, it may be possible to prevent needs from escalating.

Compliance - Legal/Regulatory

4.6 There is now a legal requirement to publish the Trust Health Inequalities statement, reporting on four domains, cross referenced by ethnicity and deprivation. The four domains are:

- Proportion of adult acute inpatient settings offering Smoking cessations services
- Rates of total MH Act detentions
- Rates of restrictive interventions
- NHS Talking Therapies recovery

Our report is in draft form currently, having been discussed at Board on 23 October. Comments were made and minor amendments needed, which will be reviewed, and approval sought at Board on 27 November ready for publication. Going forward this will be included within the annual report.

Contribution to the Annual Equality and Human Rights report is underway, which will cross reference the information within the health inequalities statement.

Environmental sustainability

4.7 There are close links between population health, inequalities and environmental sustainability. Sessions for Developing as Leaders have been co-produced and delivered to the last two cohorts and continues to be an integral part of the programme.

Section 5: Recommendations

Trust Board is asked to:

- Receive the Health Inequalities Statement 2023/24 and confirm this is ready to publish
- Note the Health inequalities Board self-assessment

- Note the Trust draft inequity action plan and agree to direction of travel

Section 6: List of Appendices

This report contains five appendices, as detailed below:

A. Health Inequalities Statement 2023/24
B. Health Inequalities Board Self-assessment report
C. Framework and action plan
D. Population Health and Inequalities Quarterly Update

Appendix A

Sheffield Health and Social Care NHS Foundation Trust

SHSC Health Inequalities Statement

2023-24

Proud to care in Sheffield

Contents page

Tables and Graphs

Introduction

Sheffield Health and Social Care NHS Foundation Trust (SHSC) is fully committed to tackling health inequalities. Our aim is to address population health and inequalities in a systematic and strategic way, to support Sheffield's commitment to improve healthy life expectancy and reduce health inequalities.

We aim to support the needs of our communities in creative and evidence-based ways through partnership working. Systems leadership is central, and we are actively supporting the ICS health inequalities priorities. Core20PLUS5 is the framework we are working within to address and deliver improvements related to health inequalities.

This report addresses our requirement as a trust to collect, analyse and publish information in relation to health inequalities, under section 13a of the NHS Act 2006.

The report will detail the required domains in relation to mental health as follows:

- Proportion of adult acute inpatient settings offering Smoking cessations services
- Rates of total MH Act detentions
- Rates of restrictive interventions
- NHS Talking Therapies recovery
- Health Inequalities action within the Trust

Caveat: *SHSC currently record and access data from four electronic patient record (EPR) systems - Rio, Insight, SystmOne and IAPTus. Our current level of digital maturity has limited our ability to report on some of the demographic data within the required domains.*

This report has created a great learning opportunity as we continue to implement a new electronic patient record, ensuring we are able to access accurate and informative health inequalities data as we move forward. This learning will be fed into the health inequalities statement process for 2024/25.

Smoking Cessation

The QUIT Programme is a South Yorkshire ICB initiative under its prevention programme in response to the NHS Long Term Plan aims to proactively improve population health. Trust based tobacco treatment is seen as a key requirement to contribute towards this.

The QUIT Team in SHSC provides behavioural support and access to evidence-based treatments within NICE Guidelines in the Trust's tobacco treatment clinical pathways for Inpatient Services, Community Services and Staff. This includes learning from research that SHSC has contributed to, reflecting the aims of the Trust's Research, Innovation and Effectiveness Strategy.

Additionally, the QUIT Team actively promotes smoke free environments and supports staff to fulfill their duties set out in the Smoke Free Policy.

In August 2024 SHSC signed the Smokefree Pledge, committing everyone in the Trust to eight key principles to support a smokefree future through helping smokers to quit and providing smokefree environments which support quitting.

Data

100% of adult acute inpatient settings offer smoking cessations

SHSC has 4 acute inpatient wards, with capacity for 54 service users in total. All our acute inpatient wards offer smoking cessations. Due to the limitation on data reporting and absence of QUIT dashboards, we are unable to produce an overview by patient demographics.

Targeted work has taken place to ensure that all patients are screened on admission to an inpatient ward and receive a specialist assessment by a Tobacco Treatment Advisor, whilst as an inpatient or within 5 days of discharge.

Figure 1: Number of inpatients with smoking status recorded, 2023-24

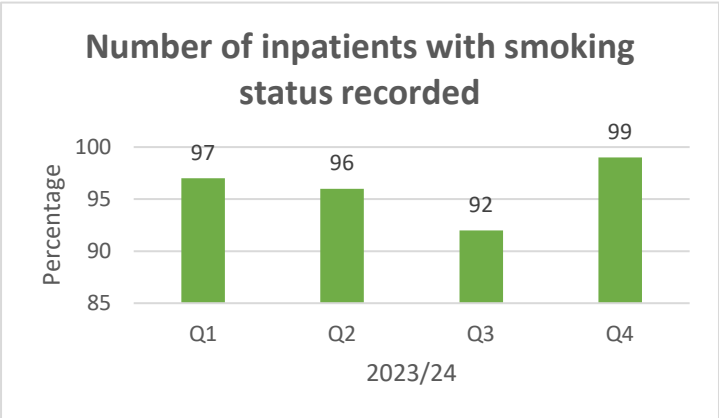
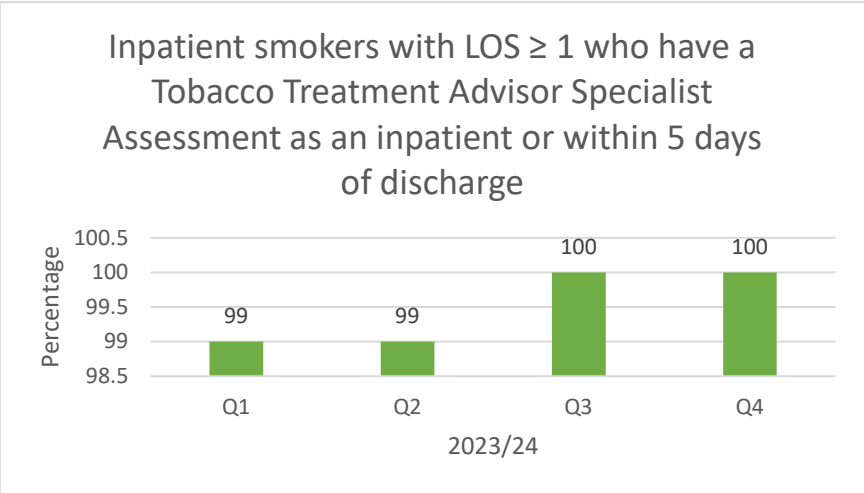


Figure 2: Percentage of inpatients smokers who have an assessment by a Tobacco Treatment Advisor as an inpatient or within 5 days of discharge



Achievements

SHSC's QUIT Team has consistently been the highest performing team out of all the other Trusts under the SY ICB QUIT Programme. This is measured by monthly returns of performance data, which was initially used to secure additional funding from Yorkshire Cancer Research.

The team achieved all funding related targets set by SY ICB in 2023-2024.

We are proud that we have contributed to the SY ICB QUIT Programme, being shortlisted for a Parliamentary Award in the Health Inequalities category. SHSC's Healthy Hospital and Community Programme Manager has been selected to represent all the mental health Trusts within the system.

The department of Health has introduced a 'Swap to Stop' scheme to encourage smokers to make the switch from tobacco to vapes (an evidence-based treatment). The Team has succeeded in a bid for vapes to the value of £6000 to provide support for community service users and staff who wish to stop smoking. This also reduces cost pressures with the budget.

Close partnership working has been developed with the Sheffield Tobacco Control Programme and we have secured the opportunity to undertake and evaluate financial incentive scheme to support staff and service users to stop smoking. This £10,000 investment can provide incentives for up to 200 people to quit.

Additionally, we have secured access to £8,000 worth of marketing and communications services from Diva Creative, who have delivered campaigns for Smokefree Sheffield. This is solely for the purpose of supporting the Trust to achieve its smokefree commitments.

Commitments

Creation of a regular and accessible data report, with the ability to report by ethnicity and deprivation as a minimum.

Liaise with Digital team to ensure capture of the most appropriate data in relations to smoking within the new EPR.

Establish a Trust Smoke Free implementation group, to continue the partnership approach and progress the work

Join the Smoke Free Action Coalition (SMAC), the alliance of organisations working to reduce the harm caused by tobacco.

Design and implement a smoke free quality improvement project

Mental Health Act Detentions

We are committed to ensuring care is delivered closer to home whenever possible, and that any detentions where necessary are appropriate, that the experience of the service user is as positive and as supportive as possible. Ways we are achieving this are through improved staff training and refurbishment of wards to ensure a welcoming and therapeutic environment.

Data

Rates of total Mental Health Act detentions during 2023-24

1042 detentions under the Mental Health Act

539 people were detained

During 2023-24, 539 people were detained under the Mental Health Act. This equated to 1042 separate detentions. Upon reviewing the data, it suggested that individuals were detained under multiple sections during a single stay.

Of these 1042 detentions, 55% relate to male service users, being detained 55% of the time, and detentions more prevalent within 18-34 year olds.

Figure 3: Mental Health Act detentions by sex, 2023-24

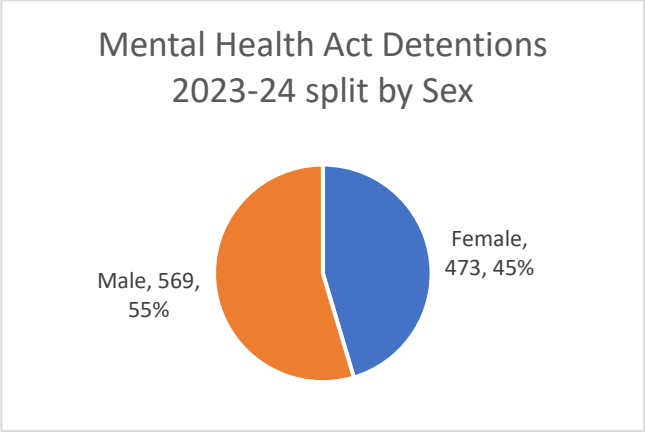
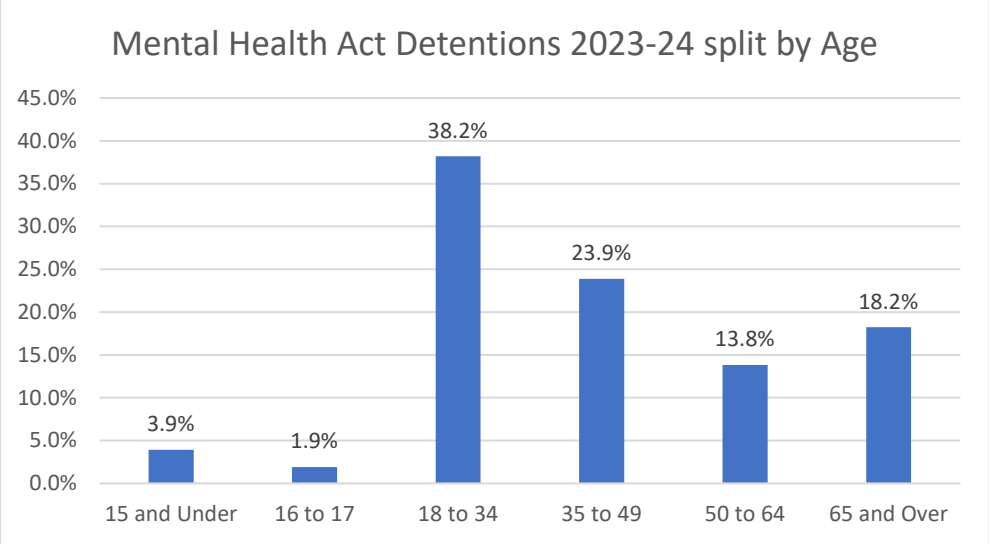
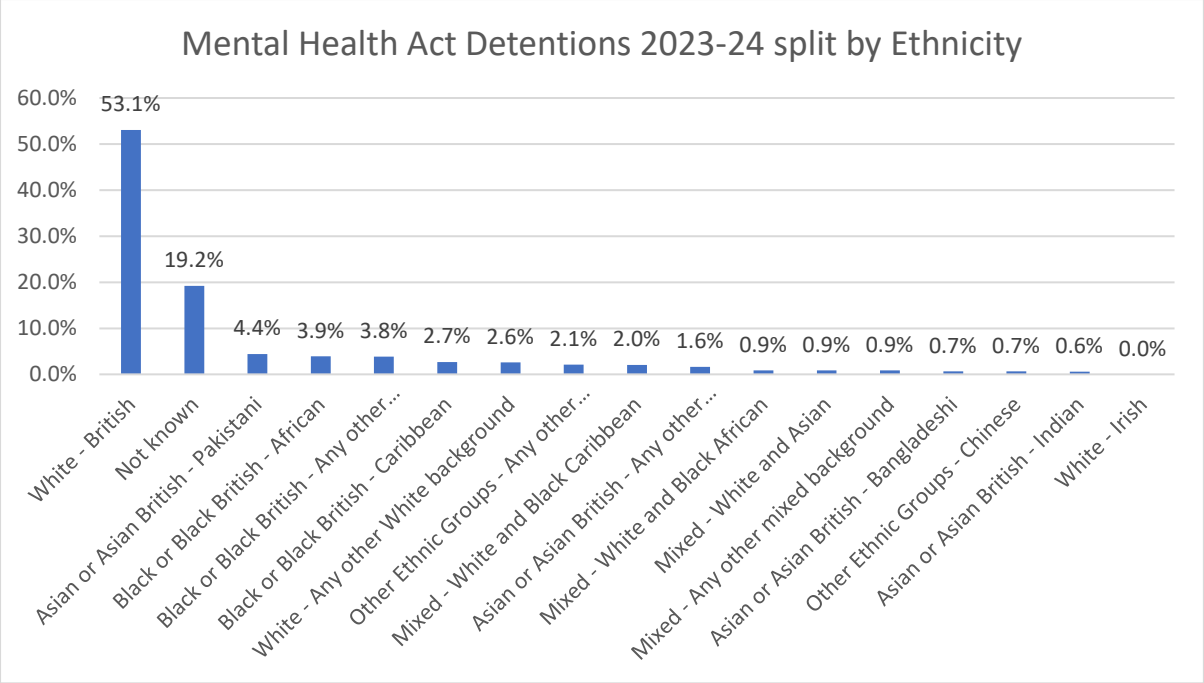


Figure 4: Mental Health Act detentions by age, 2023-24



SHSC does not admit or detail people aged under 18 to its own wards. However SHSC is contracted to complete the Mental Health Act administration for Sheffield Teaching Hospitals. The safest way to achieve this is to input the information onto the SHSC electronic patient record. This is why there are detentions recorded for people aged under 18 years old.

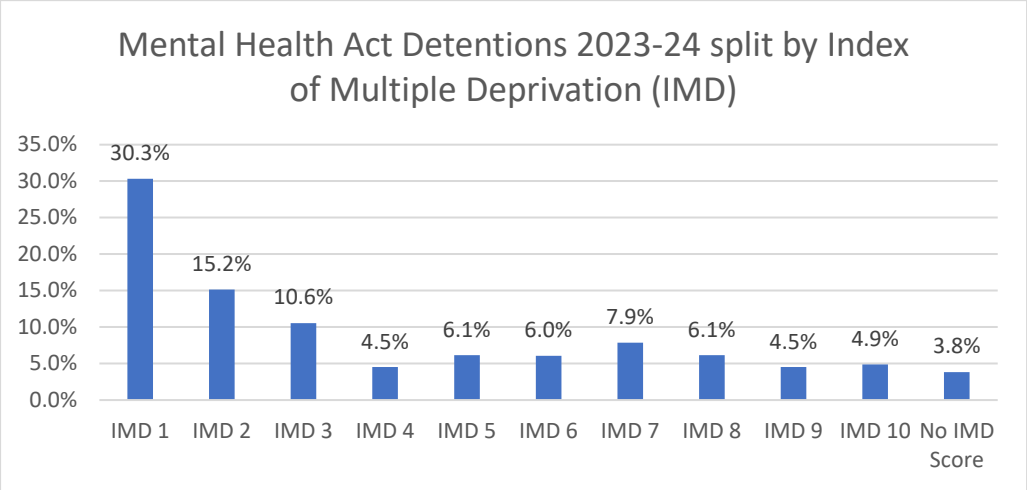
Figure 5: Mental Health Act Detentions by ethnicity, 2023-24



The above graph indicated the highest proportion of people detained under the Mental Health Act are White British. However, 19.2% of ethnicity of those detained is not known, meaning we are unable to base an accurate judgement from the data. Further work is needed to support clinical staff to improve rates of demographics recorded.

People who are detained under the Mental Health Act are more likely to be from the most deprived areas, with 30.3% from decile 1.

Figure 6: Mental Health Act Detentions by indices of multiple deprivation (IMD), 2023-34



Achievements

In March we opened the refurbished Stanage ward, a 16-bed therapeutic environment for male service users with modern, safe and comfortable features and the work to address remaining wards will take place in 2024/25.

The new Health Based Place of Safety (also known as the section 136 suite), opened to service users in January 2024. The new space provides a more modern, safe and comfortable environment for those using it. It was codesigned through engagement between experts by experience, our staff and the capital and therapeutic environments team.

The National Mental Health Act Quality Improvement programme launched in September 2023, and Forest Lodge, our low-secure inpatient unit, is one of the 15 teams actively participating in this nationwide programme

Commitments

Deep dive into episodes of care to ensure data is accurately reflecting what is happening on the wards.

Further review of data in a more detailed and explorative way to gather a much clearer understanding of the inequalities relating to Mental Health Act detentions.

Restrictive Interventions

Our Least Restrictive Practice Strategy and workplan commenced in 2021 following the appointment of a Nurse Consultant for Restrictive Practice and the alignment of the Respect team to the Quality Directorate. We commenced the programme in April 2021 with the launch of our clinical model “SafeWards”.

Our commitments as detailed in our Clinical and Social Care Strategy is to be a least restrictive, safe and positive, human rights respecting and trauma informed organisation. Co-production has been at the heart of the strategy, working alongside service users, staff, teams and partners to truly represent the needs and strengths of all the groups and individuals, diversity and characteristics.

2023/24 is the third and final year of the Least Restrictive Practice Strategy, where it will be reviewed for future developments.

Data

Restrictive interventions, 2023-24

95 people received 156 incidents of seclusion (9.6% of people admitted)

320 people experienced 1144 incidents of physical restraint (25.8% of people admitted)

100 people received 194 incidents of rapid tranquilisation (10.4% of people admitted)

A service-to-Trust level dashboard was developed and implemented, with progressive improvements seen in the recording and analytics of various types of restrictive practice and the different communities we care for. Year three sees us with advanced data, scrutiny, being inquisitive and learning the stories behind the data. The post incident review work has provided us with real life accounts from our patients and staff, helping us think about what else we might need to consider.

It is reflected that while there have been fluctuations in the number of incidents, the trendline shows the work being done to improve the care we provide is showing success and decreasing the amount of restrictive practice used in our services. As we continue to improve the care we provide, we expect the data will also reflect our continual improvement in 2024-25.

Figure 7: Trust wide restrictive practice incidents, 2020 -2024

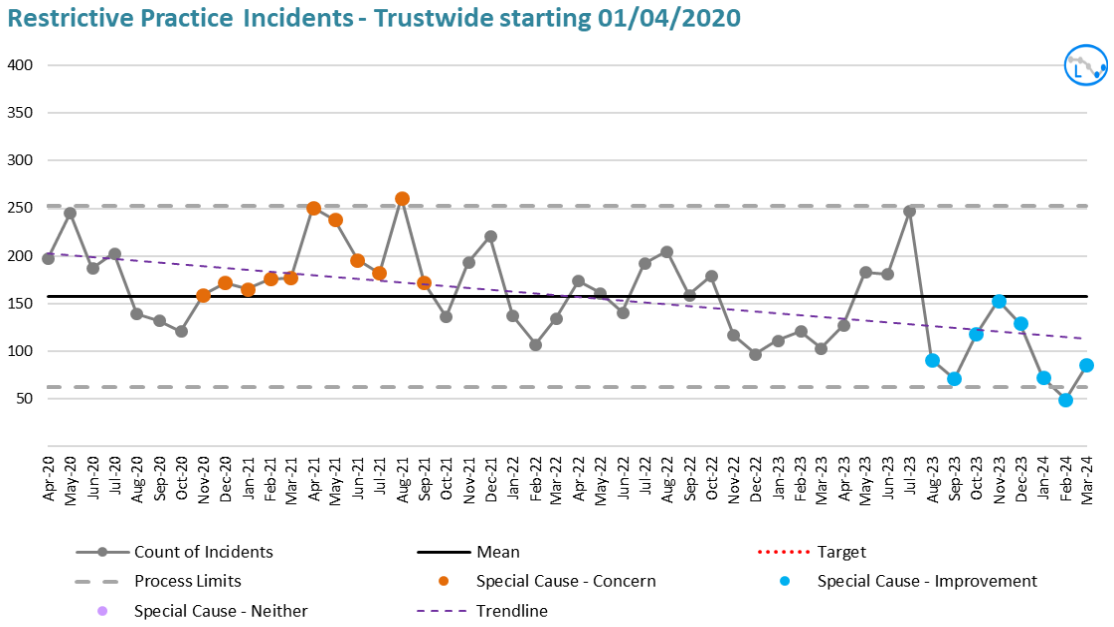
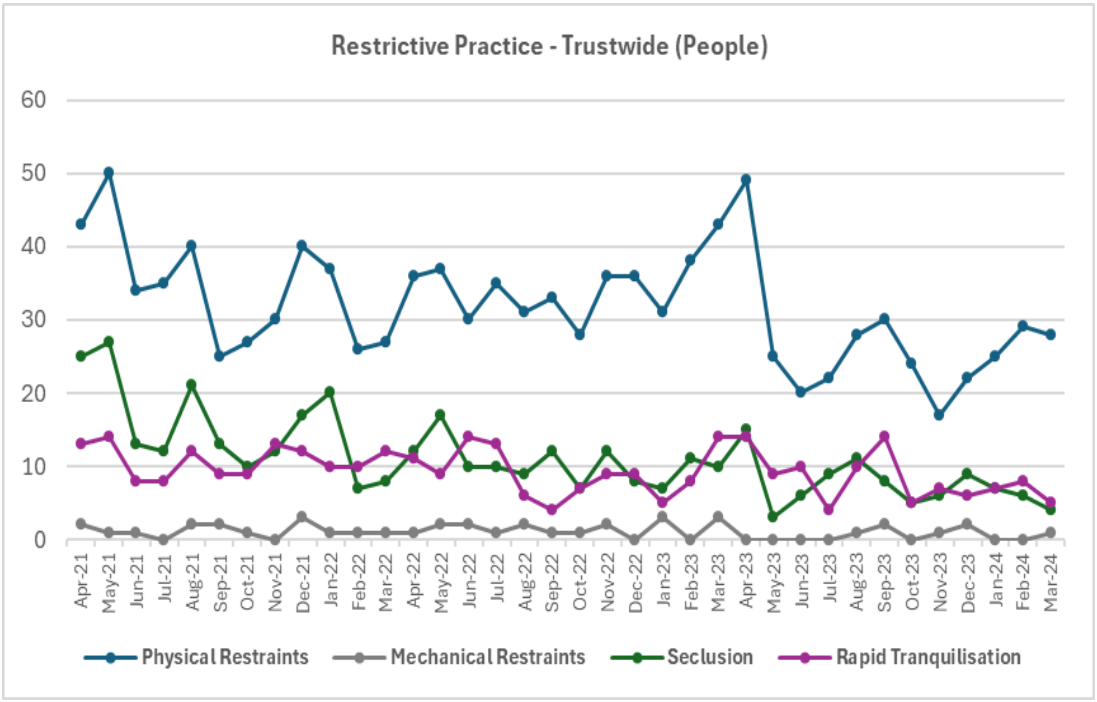


Figure 8: Trust wide restrictive practices by patient, April 2021 – March 2024



While the overall number of restrictive interventions has fluctuated since April 2021, improvements can be seen this year in the number of restraints and seclusion episodes for Black British/ African/ Caribbean people.

Number of restraints and seclusion episodes for Black British/African/Caribbean people have seen improvements

23.4% of Black British/African/Caribbean people admitted in 2023/24 were physically restrained, compared to 28% in 2022/2023. The rate of physical restraint for all people admitted was 25.8%, indicating that Black British/ African/ Caribbean people were less likely to be physically restrained than the overall in-patient population.

13.5% of Black British/African/Caribbean people admitted in 2023/24 were recipient of seclusion compared to 22.5% in 2022/2023. The rate of use of seclusion for all people admitted was 9.6%, indicating that Black British/ African/ Caribbean people were more likely to be subject to seclusion that the overall in-patient population.

The below graphs show the overview of physical restraints, seclusion and rapid tranquilisation by ethnicity.

Figures 9: Physical restraints ethnicity, Apr 2022 – Mar 2024

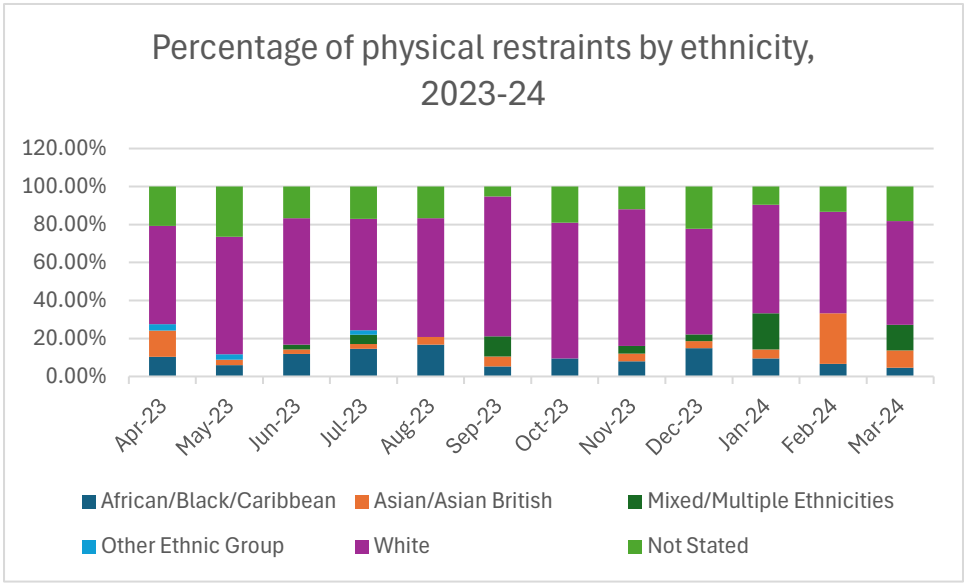


Figure 10: Seclusion incidents by ethnicity, Apr 2022 – Mar 2024

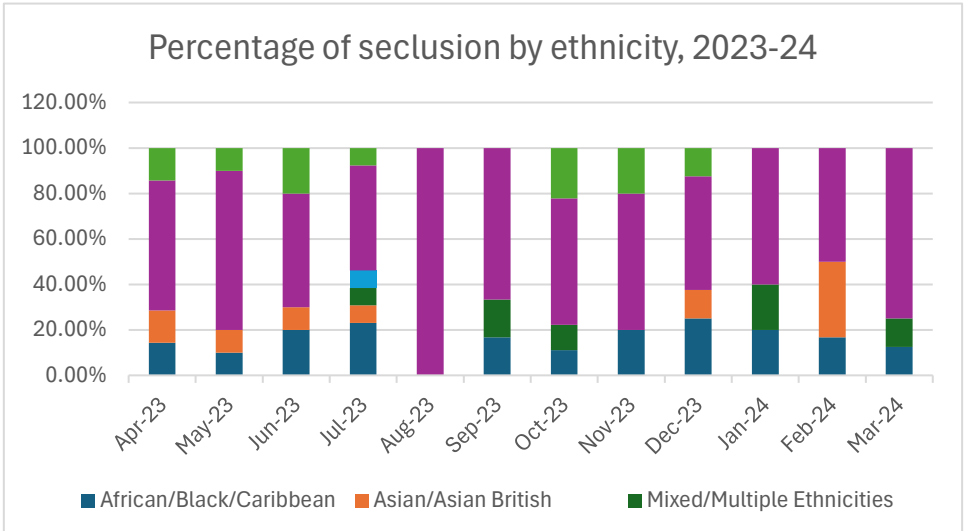
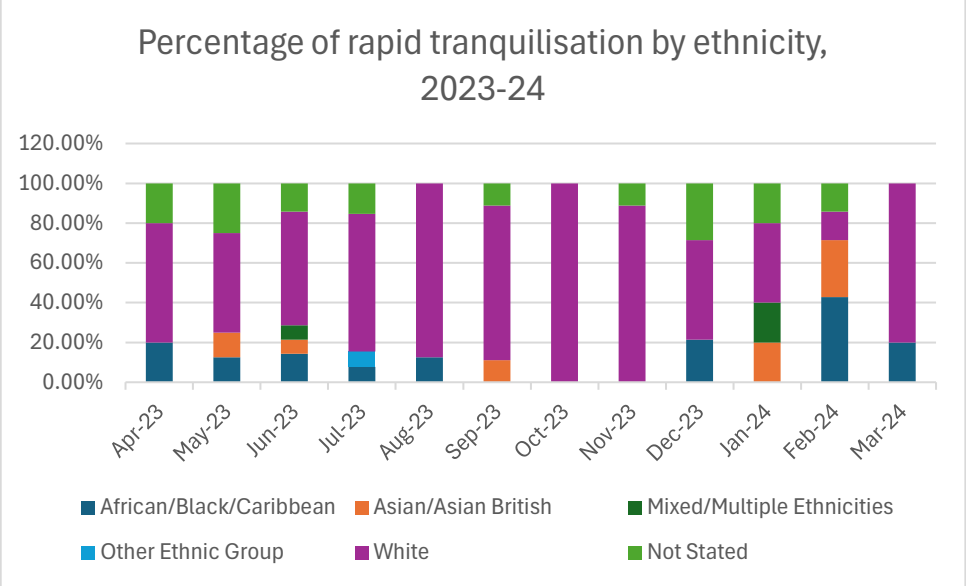


Figure 11: Rapid tranquilisation by ethnicity, 2023-24



With regards to reporting by deprivation, while we now include postcode data in the reports extracted from our Risk Management System (Ulysses) we do not have confidence in the accuracy of the data.

Exploring this data has shown there are a number of reports where this information is coming back with Nil or No Fixed Abode and in a number of instances, the address of the service user has been changed on the EPR to that of the inpatient unit they are residing on and so unable to analyse data by deprivation accurately. Work is needed in improving data literacy and for practices in recording of information to be improved.

Achievements

The overall key success across the strategy and quality objectives are:

- Reduction in seclusion provision and taking the steps to “work without seclusion” on all our acute inpatient wards.
- Commissioning and receipt of resources with the Restraint Reduction Network to highlight the impact of psychological restraint and the embedding into our restraint reduction training (RESPECT)
- Development of RESPECT training to include human rights and psychological restraint with Expert by Experience involvement. Consistent and sustained positive feedback and indication of benefits from evaluation.

- Partnership working with Flourish, SACMHA, Sheffield voices, Advocacy and Disability Sheffield with a focus on post incident support and follow up for both staff and service users
- Mental Health Act Reform project
- Sustained Restrictive practice oversight and operational groups with focused in reach support to individual teams or professional groups such as preceptee nurses and new Doctors
- System of review and support to teams and individuals via the daily incident huddle
- Continued safe wards project and monthly forum.
- Audit schedule and quality improvement projects
- Development of standard operating procedures. Using learning, to support practice and policy implementation and local training sessions to support this
- Review and update of all relevant policies (Use of force and Seclusion) with planned review of the remaining later into 2024. Relevant guidance documents have also been updated or developed to support practice at team level such as "caring for the pregnant service user"

The most significant success during 2023/24 has been the enhancement of ward environments, provision of de-escalations spaces and plans for the removal of seclusion from our last acute ward, introducing the Broset tool to risk assess the risk of violence and establishing an Urgent PICU Pathway to support this work. Reduction in use of seclusion in a sustained way and use of restraint. Greater understanding of other forms of restrictive practice with improved reporting, such as search.

There has been a reduction in restrictive practices, most notably seclusion and restraint and we continue to improve the quality of data we record around restrictive practices to further our understanding and develop meaningful action plans to address issues or areas of concern.

Equity Lead (SACMHA) to commence inpatient liaison work with acute wards to reduce use of restrictions supporting post incident reviews for service users and staff post seclusion and prolonged restraint. 100% of reviews completed.

2023 HSJ Patient safety award winners

- Mental Health Safety Improvement Award
- Patient Safety Team of the Year

Commitments

2023/24 focussed on bringing together all the progress, learning and outstanding actions from 2021/22 and 2022/23 and ensuring that we had a clear plan established. Much of the work done already needs to be embedded into business as usual across clinical services but also within the governance framework.

This is a continual journey, beyond the length of the formal restrictive practice strategy and workplan, we will continue to focus on this work and strive to achieve improvements. The strategy is currently being reviewed to inform a work plan going forward.

The following areas will continue to be a focus.

- Deliver advanced Human Rights training within RESPECT Level 3 – compliance 80%
- Reduce the use of seclusion and prolonged seclusion for those people from a black and Afro Caribbean ethnicity
- Introduce and evaluate cultural advocacy
- Ensure (100%) post-incident reviews for staff and service users following seclusion or prolonged restraint
- Implement training and resources on psychological restraint

NHS Talking Therapies recovery

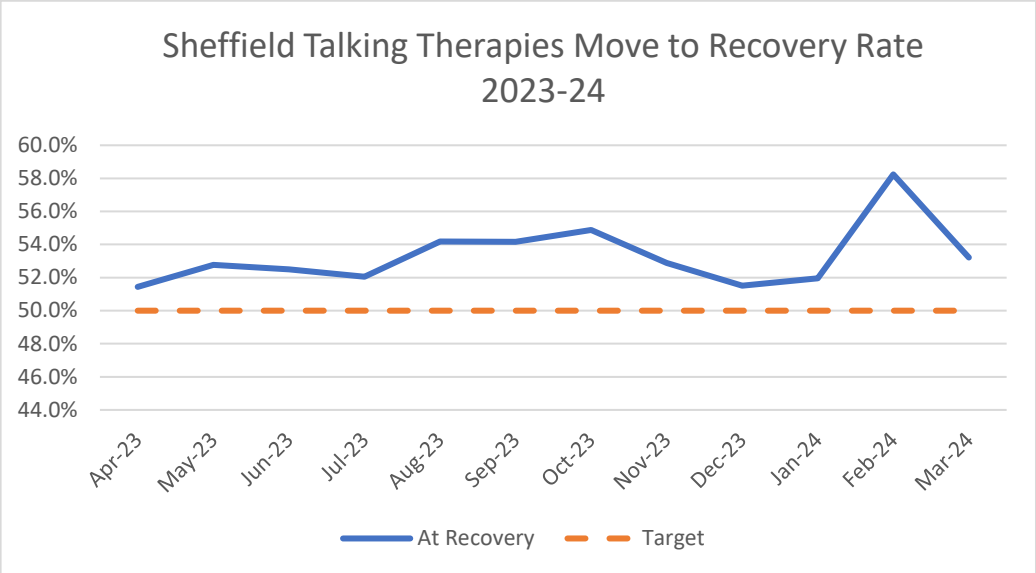
Sheffield Talking Therapies recognised the need to address inequalities in access and outcomes for their service users. As a result, in April 2022 the service established an Equality Team to focus on the strategic equality related work.

Data

NHS Sheffield Talking Therapies has exceeded the 50% target recovery rate every month in 2023-24

Over the 12-month period, a total of 6206 people received treatment from Sheffield Talking Therapies. Of those an average of 53.3% moved to recovery. The service has exceeded the recovery rate target every month throughout 2023-24.

Figure 12: Recovery rate for Sheffield Talking Therapies over 2023-24, month by month



The gender split of patients is outweighed 66.3% female to 32.8% male, and just 0.6% non-binary.

Despite the disproportionate number of men accessing Talking Therapy services, once accessing the service they are more likely to recover. Further work into understand why men are not accessing talking therapies would be of value.

Figure 13: Sheffield Talking Therapies patients by gender, 2023-24

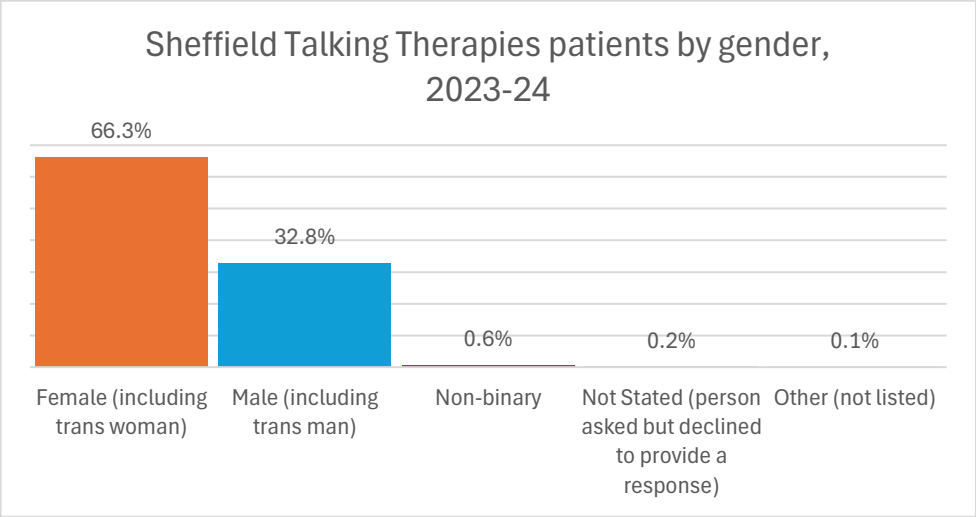


Table1: Gender of Talking Therapies patients and recovery rate, 2023-24

Gender	Total	At recovery	Not at recovery
	100.0%	**53.3%**	**46.7%**
Female (including trans woman)	66.3%	52.3%	47.7%
Male (including trans man)	32.8%	55.5%	44.5%
Non-binary	0.6%	50%	50%
Not Stated (person asked but declined to provide a response)	0.2%	50%	50%
Other (not listed)	0.1%	100%	0.0%

Over half of people accessing Sheffield Talking Therapies are between the ages of 18-34, closely followed by people aged 35-49 years at 25.4%

Figure 14: Sheffield Talking Therapies patients by age, 2023-24

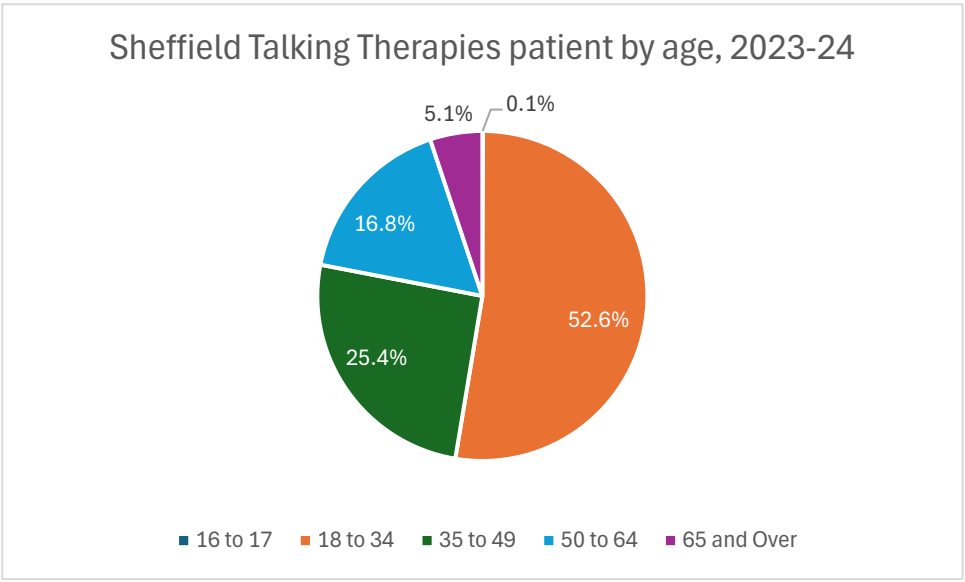
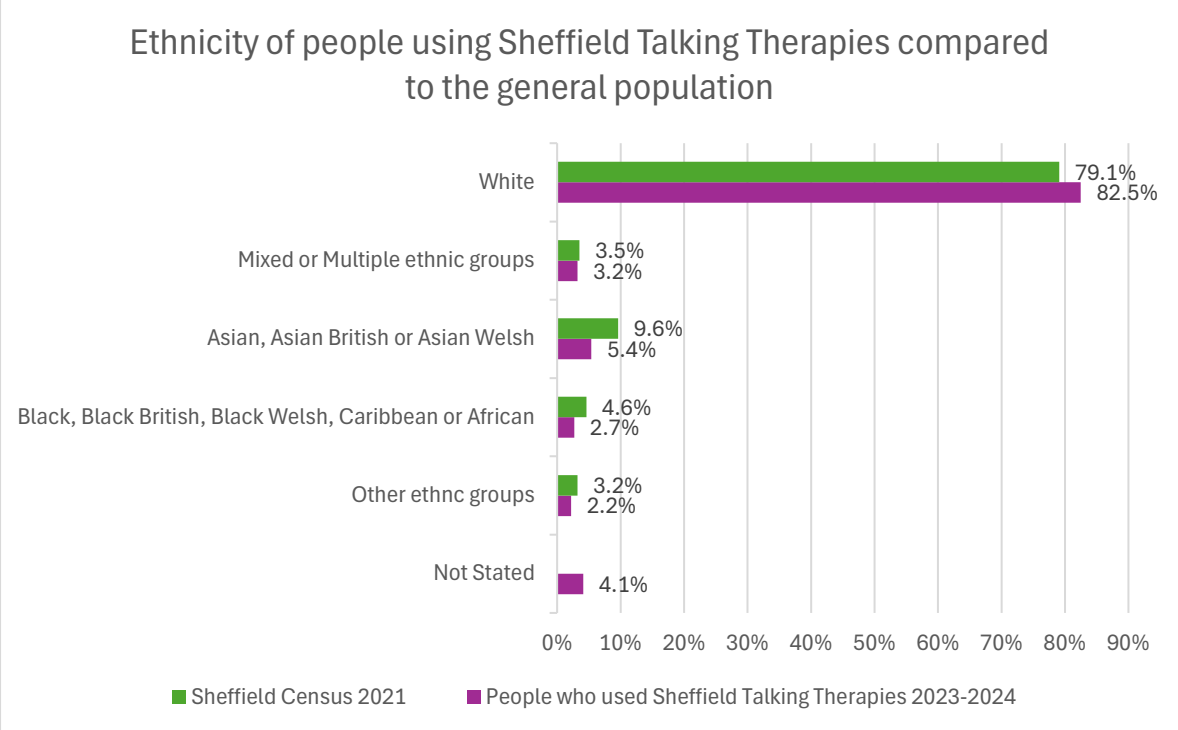


Table 2: Age of Talking Therapy patients and recovery rate, 2023-24

Age	Total	At recovery	Not at recovery
	100.0%	**53.3%**	**46.7%**
15 and under	0.0%	0.0%	0.0%
16 to 17	0.1%	0.0%	0.0%
18 to 34	52.6%	50.8%	49.2%
35 to 49	25.4%	53.1%	46.9%
50 to 64	16.8%	56%	44%
65 and over	5.1%	74.5%	25.5%

Sheffield Talking Therapies, has a high rate of ethnicity recorded, with only 4.1% not stated. The proportion of White British, Irish, any other background accessing Sheffield Talking therapies for 2023-24 equates to 82.5% of the patient population, this is higher than the Sheffield population according to the 2021 census.

Figure 15: Ethnicity of people using Sheffield Talking Therapies compared to the general population



The likelihood of recovery varies across ethnic groups. The table below show us that

- White British patients are more likely to recover
- Asian or Asian British (any other Asian background, Bangladeshi, Indian or Pakistani) patients are more likely to not recover
- Patients from other ethnic groups are also more likely to not recover

- Patients where ethnicity is not known or not stated, have a higher likelihood of not recovering

Table 3: Talking Therapies patients by ethnicity, 2023-24

Ethnicity	Total	At recovery	Not at recovery
	100.0%	**53.3%**	**46.7%**
Asian or Asian British - Any other Asian background	1.7%	29.4%	70.6%
Asian or Asian British - Bangladeshi	0.4%	50.0%	50.0%
Asian or Asian British - Indian	1.1%	45.5%	54.5%
Asian or Asian British - Pakistani	2.2%	36.4%	59.1%
Black or Black British - African	1.4%	50.0%	50.0%
Black or Black British - Any other Black background	0.2%	50.0%	50.0%
Black or Black British - Caribbean	1.1%	54.5%	45.5%
Mixed - Any other mixed background	0.9%	55.6%	44.4%
Mixed - White and Asian	1.0%	50.00%	50.0%
Mixed - White and Black African	0.2%	50.00%	50.0%
Mixed - White and Black Caribbean	1.1%	36.36%	63.6%
Not known or not stated	4.1%	41.46%	58.5%
Other Ethnic Groups - Any other ethnic group	1.5%	33.33%	66.7%
Other Ethnic Groups - Chinese	0.7%	71.43%	42.9%
White - Any other White background	4.3%	46.51%	53.5%
White - British	77.5%	56.00%	43.9%
White - Irish	0.7%	57.14%	42.9%

Due to data challenges and migration issues, we are unable to obtain deprivation data for Talking Therapies patients.

Achievements

Sheffield Talking Therapies service set up an equality team in April 2022 to focus on strategic equality work. The team is made up of Psychological Wellbeing Practitioners (PWPs), counselling and CBT staff as all other core teams, with an addition of a team leader and two senior roles to focus of this work.

Sheffield Talking Therapies are an agile and responsive team:

During the COVID-19 pandemic, the service teamed up with BBC Radio Sheffield to record a 10 part series called ‘mindset’. Mindset provided an introduction to the support offered and a taster of some of the practical techniques, like mindfulness that we use on our courses.

An incredible response and mobilisation of a bespoke support offer to ice hockey supporters, following the death of a Nottingham Panthers player during their game in Sheffield last year. A 20 strong, dedicated team from Sheffield Talking Therapies attended the first game back after the incident hosting a wellbeing lounge to offer

support and advice about trauma and wellbeing. Additionally, an online session was set up, attended by more than 600 people, which is now available on a dedicated webpage.

Commitments

Sheffield Talking Therapies will continue to review and analyse the data through a health inequalities lens. The core areas of focus are below:

- increase access and outcomes for people from ethnically and culturally diverse communities (ECDC), older adults and students
- Improve recovery rates for non-white British patients in line with white British
- Establish clinics in voluntary sector across the city.

We will strive to establish a robust process to record and extract deprivation data as a minimum.

Health Inequalities Action

In addition to the information detailed above there are a number of areas in which we are progressing work and focus in relation to health inequalities.

Strategy

Between July 2022 and June 2024 SHSC hosted a Public Health Registrar on placement, working 60% whole time equivalent. This offered a unique insight to our patient population and alternative way of viewing our services. Due to the success of this placement, in January 2024 further capacity was built as the trust appointed a **Head of Population Health and Inequalities.** This role is unique within the region's mental health services and evidences the commitment to addressing health inequalities. The aim of this work is to address population health and inequalities in a systematic and strategic way, and to support Sheffield's commitment to improve healthy life expectancy and reduce health inequalities.

A population health and inequalities strategic plan was created in line with SHSC strategic aims and priorities, supporting overarching Trust vision. Further work is planned, as current strategies are reviewed and refreshed, to explicitly embed population health and inequalities. Alongside developing a health inequalities **action plan and framework** to ensure health inequalities are embedded into everything that we do and form a golden thread throughout the organisation. Core20PLUS5 is the framework we are using to embed this work.

This includes the **Clinical and social Care Strategy** where reduction of health inequalities is a core outcome. The strategy in in year 3 of 5 and has four pillars each with its own focused workstream - person centred, evidence led, trauma informed, and strengths based. An additional workstream has been created to support the benchmarking and creation of outcomes and benefits through a health inequalities lens

We have developed and established a **Research and Evidence Hub.** The goal of the research and evidence hub is to make it easier for you to access evidence, information and knowledge services to support your continuous improvement, improve health outcomes and reduce inequalities.

During 2023-24, we produced a series of population health reports, including a **workforce deprivation report.** This offered a unique understand our workforce from a health inequalities perspective. It has allowed us to design targeted work programmes to support our workforce to enjoy and maintain meaningful work.

July 2023 saw the launch of our **Waiting Less and Waiting Well** quality improvement collaborative. This collaborative has brought together nine teams across the trust to learn together and drive forward change and improvement focussing on waiting lists and waiting well.

We have led the ICS **STOMP** (Stopping over medication of people with a learning disability and autistic people) quality improvement project, supported by Health Foundation with the aim of reducing the unnecessary use of medication in people with a learning disability which we know is a contributory factor in their reduced life expectancy. Clinical Audits are underway which will inform the next stages of this work.

In 2023 we joined a new **Digital Health Hub** aimed at working with service users, patients, doctors, health professionals, industry, academics and the public in developing equitable digital innovations. The hub launched in November 2003 at the Advanced Wellbeing Research Centre which will tackle healthcare inequalities and transform how patients are treated in South Yorkshire. We are really pleased to be working alongside other health partners, community groups, industry and both Universities in Sheffield on this work.

Operations

SHSC became an early adopter of the **patient and carer race equity framework** (PCREF) during 2022. During this time, we have

- appointed a Race Equity Lead and a Community Network Lead
- created a three-tier involvement pathway and high-level implementation plan
- developed a race equality dashboard
- produce a series of videos for staff and community members
- developed a range of cultural awareness and human rights training
- hosted a series of ‘let’s talk about race’ events
- progressed work in regard to feedback mechanisms

We recognise that the accurate capture and recording of **protected characteristics** within the Trust is poor. This importance of this has been reinforced throughout the organisation over the last 12-18 months, linking closely with the PCREF work programme to focus on increasing the recording of ethnicity.

In June 2023 the Sheffield Primary and Community Health Service launched a **serious mental illness health inequalities tool** at a national Community Mental Health Team transformation celebration event in London. The tool has been shared with NHS teams and services across the country. The aim is for general practices to be more aware of patients with the greatest barriers to accessing healthcare and act to break down these barriers particularly physical health checks for people with SMI, one of the Core20PLUS5 priorities.

The work of our **Homeless Assessment and Support Team (HAST)** was in the spotlight in February 2024 with a visit from the Chief Executive of NHS England. This service works with some of the most vulnerable people in our communities to support people to access healthcare and support services including accommodation.

HAST is a superb example of the positive impact SHSC has on the lives of people in Sheffield and how we work in partnership with voluntary and community organisations to support people most vulnerable to health inequalities.

In Summary

SHSC will continue to focus and drive forward change and improvements to address health inequalities. We are focussed on access, experience and outcomes, and our role as an anchor organisation.

There are significant gaps in our data which limits our ability to draw conclusions; we commit to improving our data recording.

The Trust will strive to establish a robust process to record and extract health inequalities data in order to take a population health management approach to service design and delivery.

We have achieved so much already but have so much more to address. We are under no illusion that this will be easy or straight forward, but we are committed to playing our role in improving the lives and healthcare experience of the people of Sheffield.

Health Inequalities Self Assessment Tool

Use the following link to regenerate the tool with your answers: https://health-inequality-tool.net/reload/Qw4wUzBBp

Scoring

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	3	38%	Developing
2 - Data, insight, evidence and evaluation	4	29%	Developing
3 - Strategic leadership & accountability	7	39%	Developing
4 - System partnerships	6	60%	Maturing

Recommended Objectives

1 - Building public health capacity & capability	Developing
5.1	People: Ensure all staff have training and development opportunities in health inequalities, with priority for induction programmes and leadership and development programmes. Training should be refreshed, as relevant
5.2	People: Ensure all frontline staff have training and development opportunities in 'Making Every Contact Count'. Training should be refreshed, as relevant
9.5	Data, digital and information: Build in-house capacity and capability for public health analytical work, including investment in digital, data and technology teams
10.2	Clinical, quality and research: Apply a health inequalities

	framework across quality improvement and research work, to ensure that systems and programmes do not exacerbate or perpetuate inequalities

2 - Data, insight, evidence and evaluation	**Developing**
3.9	Chief executive: Set an expectation on board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivation
3.12	Chief executive: Identify a trust lead for digital inclusion and provide supporting governance
8.8	Operations/delivery: Work with the communications lead to review trust communications with patients (such as leaflets and letters) in response to the health literacy and digital literacy levels of your patient population. Refresh and update communications accordingly
9.2	Data, digital and information: Datasets (including patient experience, patient safety, operational and clinical measures) to be broken down as a minimum by ethnicity, deprivation, age and sex. Where available, data on other protected characteristics and inclusion health groups could be considered
9.4	Data, digital and information: Set local metrics to monitor progress over time and ensure these are available in a timely manner to monitor services and support timely decision-making to ensure equity
10.3	Clinical, quality and research: Maximise research assets and expertise to develop programmes of work which have the potential to reduce health inequalities
10.4	Clinical, quality and research: Include reference to health inequalities within all pillars of clinical governance (eg patient safety, audit), including learning for individual cases and overarching themes relating to health inequalities

3 - Strategic leadership & accountability	Developing
1.1	Chair: Assure themselves that there is adequate strategic intent, relevant oversight (including clear governance approach and senior accountability) for addressing health inequalities
2.1	NEDs: NED membership and representation on relevant groups or committees within the trust governance structure with oversight for health inequalities work
3.1	Chief executive: Establish health inequality oversight within the trust governance structure
4.1	Executive lead for health inequalities: Provide strategic oversight of organisational health inequalities work and encourage other board members to embed an equity lens to their work programmes
4.4	Executive lead for health inequalities: Lead development of a trust level strategy or delivery plan for health inequalities, working with the Strategy Director, which sets out a workplan and measures of success
4.6	Executive lead for health inequalities: Provide oversight of external reporting on the trust’s health inequalities work
4.9	Executive lead for health inequalities: Embed the use of tools such as the health equity assessment tool across your organisation when making decisions about service delivery
5.10	People: Consult with staff to provide appropriate support initiatives to address inequalities in the workforce. This could include offering access to employee wellbeing assistance, financial support services or food banks for staff
7.3	Finance: Ensure opportunities are identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits
8.7	Operations/delivery: Ensure that services prioritise equity of access, experience and outcomes for the most deprived 20% of the population, inclusion health groups, those with protected

	characteristics (and other relevant 'PLUS' groups) as per 'Core20PLUS5'
8.9	Operations/delivery: Integrate equality impact assessment tools across clinical delivery

4 - System partnerships — Maturing

4.8	Executive lead for health inequalities: Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems
4.11	Executive lead for health inequalities: Work collaboratively with executive board members leading on the organisation’s anchor institutions work, to ensure alignment with the health inequalities agenda
4.12	Executive lead for health inequalities: Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations
8.6	Operations/delivery: Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms

Your Answers

1 - Building public health capacity & capability

1	Has your board received training and/or development on health inequalities?	Yes
2	Does your trust deliver regular training to all staff groups on health inequalities?	No
3	Has your trust delivered any quality improvement work or change programmes related to health inequalities?	Partial
4	Does your trust employ public health specialist staff and is the wider workforce encouraged to develop public health expertise?	No

2 - Data, insight, evidence and evaluation

1	Is your trust's data on patient ethnicity accurate and comprehensive?	No
2	Does your trust board routinely receive performance data broken down by ethnicity and deprivation?	Partial
3	Does your trust use existing population health data (e.g. population demographics and index of multiple deprivation) in your analysis of trust-level data?	No
4	Has your trust taken part in any research related to health inequalities?	Yes
5	Has your trust carried out engagement with communities to inform work on health inequalities?	Partial
6	Has your trust reviewed any care pathways to consider the extent to which they enable equitable access, experience, and outcomes?	No

7	Has your trust reviewed the accessibility of your services in relation to the digital and health literacy rates of your local population?	No

3 - Strategic leadership & accountability

1	Does your trust have commitments to reducing health inequalities within its strategy documents?	Partial
2	Does your trust have a named board-level Executive Lead for health inequalities?	Yes
3	Does your board have health inequalities objectives set in your annual review process?	Partial
4	Is your Executive lead for health inequalities providing strategic leadership and embedding an equity lens into cross-organisational work?	Partial
5	Is there a clear governance structure for the trust's health inequalities work within your trust, including a group or committee that provides oversight?	No
6	Does your trust/board use a health inequalities impact assessment tool in your business case process?	Partial
7	In allocating trust resources, are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits?	No
8	Does your trust have a programme of work aimed at reducing health inequalities experienced by staff members?	Partial
9	Does your trust use and implement NHS England's 'Core20PLUS5' framework to guide the organisation's approach to reducing health inequalities?	No

4 - System partnerships

1	Is your trust represented on appropriate Integrated Care System group(s) to contribute to population health decision making in your region?	Yes
2	Is your trust contributing to anchor institution working?	Partial
3	Does your trust have programmes in place to improve access to employment to underrepresented groups in your organisation?	No
4	Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities?	Yes
5	Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives?	Partial

Appendix C

NHS
Sheffield Health and Social Care
NHS Foundation Trust

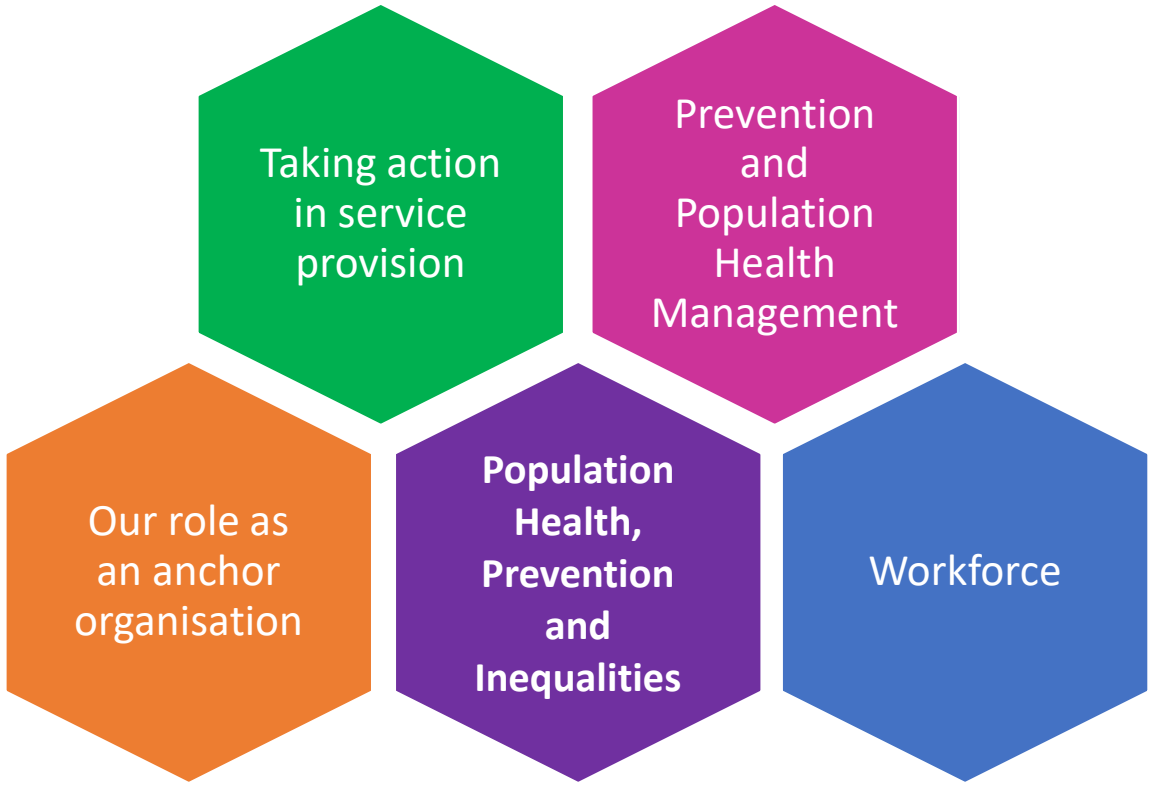
Population Health and Inequalities Action Plan

Draft 31 October 2024

Proud to care in Sheffield

Framework

Sheffield Health and Social Care NHS Foundation Trust



Proud to care in Sheffield

Sheffield Health and Social Care NHS Foundation Trust

Aim: To address population health and inequalities in a systematic and strategic way, to support Sheffield's commitment to improve healthy life expectancy and reduce health inequalities

Taking action in service provision

- Use data and evidence to improve awareness of our population, their needs and adjust services to meet those needs.
- Use data and evidence to inform proactive models of care
- Support and empower teams to actively identify and address health inequalities at a service level

Prevention and population health management approach

- Collect and record data that accurately reflects our population
- Use data and evidence to inform proactive models of care
- Report to Board the performance and outcomes measures broken down by relevant characteristics

Our role as an anchor institution

- Increase sustainability and reduce the environmental impact of our work
- Work closely with system partners to identify opportunities and accelerate our collective impact
- Establish our position and contribution in relation to wider determinants of health
- Local and sustainable procurement approaches
- Accessible and quality employment opportunities

Workforce health inequalities

- Support staff experiencing health inequalities to maintain and enjoy their work
- Ensure all staff have training and development opportunities in health inequalities and MECC
- Increase representation of people from deprived areas within SHSC workforce

Proud to care in Sheffield

SHSC Board
Health Inequalities Objectives

Building public health capacity and capability

- Develop training and development opportunities in health inequalities
- Training and development opportunities for all front-line staff in MECC
- Build in house capacity and capability for public health analytical work
- Apply a health inequalities framework across QI and research to ensure HI is not exacerbated

Data, insight, evidence and evaluation

- Performance and outcomes data to be reported to board by relevant characteristics
- Identify a trust lead for digital inclusion and provide supporting governance
- Review trust comms with patients in response to health literacy and digital literacy levels of our patient population
- Datasets to be broken down by ethnicity, deprivation, age and sex as a minimum.
- Set local metrics to monitor progress over time to support decision making
- Maximise research assets and expertise to develop programmes of work which have potential to reduce health inequalities
- Include health inequalities within all pillars of clinical governance

Strategic leadership and accountability

- Adequate strategic intent and relevant oversight for addressing health inequalities
- NED membership & representation within governance structure with oversight for health inequalities work
- Establish health inequalities oversight in governance structure
- Strategic oversight of orgs health inequalities work and encourage an equity lens to all work programmes
- Trust level strategy or delivery plan for health inequalities
- External reporting on Trust health inequalities work
- Embed use of tools across SHSC when making decisions about service delivery
- Support to address inequalities in the workforce
- Identify investment opportunities for prevention and mitigation of healthcare inequalities
- Access, experience and outcomes prioritisation as per core20PLUS5
- Integrate equity impact assessment tools across clinical delivery

System partnership

- Collaborative working across ICS to share learning and scalability of strategic work across the system
- Exec board collaboration on Anchor institution work to ensure alignment with health inequalities agenda
- Establish pathways to engage with VCSE sector organisations
- Embed co-production principles to inform work on health inequalities

Tackling action in service provision
Prevention and population health
Our role as an anchor institution
Workforce health inequalities

Sample Tracker

NHS
Sheffield Health and Social Care

	Theme		Source	Statement	SHSC	Recommended Objective	Action	L
1	Building Public Health capacity and capability	5.1	Self-assessment	People	People	Ensure all staff have training and development opportunities in health inequalities, with priority for induction programmes and leadership and development programmes. Training should be refreshed as relevant	5.1a. Develop basic health inequalities training for induction	
1	Building Public Health capacity and capability	5.2	Self-assessment	People	People	Ensure all front line staff have training and development opportunities in 'Making Every Contact Count'. Training shold be refreshed as relevant.	5.2a. Develop MECC training	
1	Building Public Health capacity and capability	9.5	Self-assessment	Data, digital and information	Digital	Build in-house capacity and capability for public health analytical work including investment in digital , data and technology teams	9.5a. Educate and upskill BPM to encorporate this into service governance meetings 9.5b. Encorporate into IPQR and DIPR	
1	Building Public Health capacity and capability	10.2	Self-assessment	Clinical, quality and research		Apply a health inequalities framework across quality improvement and research work, to ensure that systems and programmes do not exacerbate or perpetuate inequalities	10.2a. Develop health inequalities framework 10.2b. Encorporate intoQI and research	
2	Data, insight, evidence and evaluation	3.9	Self-assessment	Chief Executive		Set an expectation on board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivaton	3.9a. Review governance paperwork to ensure a health inequalities element is included (link to 9.5b)	
2	Data, insight, evidence and evaluation	3.12	Self-assessment	Chief Executive		Identify a trust lead for digital inclusion and privide supporting governance		
2	Data, insight, evidence and evaluation	8.8	Self-assessment	Operations/delivery	Operations and Transformation	Work with the communications lead to review trust communications with patients (such as leaflets and letters) in response to the health literacy ad digital literacy levels of your patient population. Refresh and update communications accordingly		
2	Data, insight, evidence and evaluation	9.2	Self-assessment	Data, digital and information	Digital	Datasets (including patient experience, safety, operational and clinical measure) to be broken down as a minimum by ethnicity, deprivation, age and sex. Where available, data on other protected characteristis and inclusion health groups could be considered	Actions 9.5a and 9.5b	
2	Data, insight, evidence and evaluation	9.4	Self-assessment	Data, digital and information	Digital	Set local metrics to monitor progress over time and ensure these are available in a timely manner to monitor services and support timely decision making to ensure equality	9.4a. Establish metrics to monitor progress 9.4b. Link with Rio development team to ensure metrics are encorporated 9.4c.	
							10.2a. Revise evidence base in relation to health inequalities, create a	

Proud to care in Sheffield

Appendix D

Population Health and Inequalities Update: April - June 2024 (Q2)

Lead: Jo Hardwick

Exec Sponsor: Helen Crimlisk

NHS Sheffield Health

Overview

Months 4 - 6 have continued the discovery phase and have begun to create and deliver knowledge sessions, engagement and capture interest of SHSC workforce

Progress Past 3 Months

Infrastructure:
- Successful session at BOD development session to achieve requirements of NHS providers publication *'Reducing Health Inequalities: A guide for NHS Trust Board Members'*.
- Commence development of Population health Framework
- Spotlight on Population health within medical directorate bi-annual performance review

Data:
- Positive meeting with Digital colleagues to review inclusion and capture of health inequalities data on Rio
- Inclusion of/link to external data into data warehouse to support population health focus
- Continue to review CSCS outcomes and benefits, agreed to discuss with Digital to establish a plan to capture data
- Attend South Yorkshire DAISY Network – HI data forum

Knowledge:
- Delivery of health Inequalities session on SHSC Developing as Leaders programme Day 5 (DAL)
- Delivery of Population health and Sustainability (Adaptive Leadership) session on DAL Day 6 (DAL)
- Launch of Population Health Jarvis Page
- Launch of first Population Health Forum, attended by 40+ people
- Create Core20Plus5 knowledge video – uploaded onto Jarvis
- Attend The Kings Fund 'Tackling Health Inequalities' Conference', 'Impact of Inequalities and Poverty on health' conference and HSJ Health Inequalities Forum

Partnerships:
- Member of the relaunched South Yorkshire Public Health Network
- Engage with Sheffield Hospitals Charities and liaise with SHSC strategy team to influence long term funding plan
- Developing partnership with Nation Energy Action to consider fuel poverty support to service users.

Programmes and Projects:
- Continue to support Waiting Well Collaborative
- Continue to support the Living Well Programme

Staff:
- Support People Directorate and EDI to create a plan and execute actions from Workforce Deprivation report

Action Next Month

Infrastructure:
- Continue to develop Population Health Framework
- Complete Health Inequalities for Board, self-assessment

Data:
- Test run of health inequalities data for HI reporting statement, alongside annual review, commence narrative of report
- Complete VCSE scoping task
- Commence conversations with Gender Identity Service regarding a population health report

Knowledge:
- Development and launch of Learning library
- Create additional video learning sessions
- Develop and launch first blog
- Plan second Population Health Forum

Partnerships:
- Meet and engage with community groups

Programmes and Projects:
- Engage with teams of Waiting Well collaborative that wish to focus on DNA rates

Staff:
- Attend Women's Health Inequalities Webinar
- Continue to support People Directorate and EDI to create a plan and execute actions from Workforce Deprivation report

Proud to care in Sheffield

Population Health and Inequalities Update: July – September 2024 (Q3)

Lead: Jo Hardwick

Exec Sponsor: Helen Crimlisk

Overview

Months 7 – 9 created space to formulate areas of focus and bespoke pieces of work

Progress Past 3 Months

Infrastructure:
- Completion of Hi for Board Self-Assessment
- Continue to develop Population Health Framework and action plan
- Support development of Integrated change framework
- Represented within documentation and on the QEIA panel

Data:
- Attend and present population health overview at BA and BPM team meeting
- Review and theme VCSE contracts to support sustainable contracting

Knowledge:
- Second population Health forum – spotlight on smoking and tobacco dependency attended by 25+ people
- Launch of Learning Library
- Delivery of Quality Improvement Forum attended by 60+ people
- Community Health & Wellbeing Apprenticeship session, to consider upskilling workforce
- Supporting SHSC Manager Collaboration Event
- Create Sheffield Core20PLUS5 graphic

Partnerships:
- Warm Homes, Healthy Futures partnership with National Energy Action to offer energy advice to service users
- Engage with PCREF team
- Networking with colleagues from Walsall to share learning and ideas
- Attend South Yorkshire Housing and Health Summit and contribute the development of a regional plan

Programmes and Projects:
- Support Memory Clinic, with interest in health inequalities work and DNAs as part of waiting well collaborative
- Established and co-leading Protected Characteristics working group
- Support Learning Disabilities STOMP programme, South Yorkshire

Staff:
- Identify a work programme focussing on Women's health inequalities, learning from national webinar.
- Explore opportunity for NIHR funding for Workforce Health
- Co-chair of Amazing Women's Staff Network Group

Action Next Period

Infrastructure:
- Finalise Population Health action plan
- Continue to support development of Integrated change framework

Data:
- Finalise VCSE contract work and socialise findings
- Complete Hi Statement report
- Progress health inequalities data capture on Rio

Knowledge:
- Create video learning sessions
- Plan third population health forum
- Detail commitments to Fair and Healthy Sheffield Plan
- Deliver population health workshop to Yorkshire and Humber School of Psychiatry conference

Partnerships:
- Meet and engage with community groups
- Continue to identify teams to engage with Warm Homes, Healthy Futures programme
- Continue to work with engagement team to capture community insight

Programmes and Projects:
- Continue to engage with Waiting Well collaborative
- Identify teams for phase one of the protected characteristics work
- Closer links with SHSC LD team to review progress & identify next steps

Staff:
- Continue to support People Directorate and EDI to create a plan and execute actions from Workforce Deprivation report
- Plan and deliver December Amazing Women's Staff Network Group