Board of Directors - Public

SUMMARY REPORT	Meeting Date:	22 May 2024
	Agenda Item:	19

Report Title:	**Bi-annual Population Health Report**	
Author(s):	Jo Hardwick: Head of Population Health and Inequalities Jaimee Wylam: Public Health Registrar	
Accountable Director:	Helen Crimlisk – Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	09/05/2024
Key points/ recommendations from those meetings	Update following QAC: There is a need for further external focus to influence and make relevant changes to be included in future reporting. Jaimee Wylam was thanked formally by the committee for her contribution to this important work during her time with the Trust as her placement was shortly coming to an end.	

Summary of key points in report

The Population Health and Inequalities strategic plan has been created in line with SHSC strategic aims and priorities, with the actions themed and relationships evidenced. See appendix 3 for a driver diagram that demonstrates the flow from national and local policy to SHSC priorities through into the population health and inequalities programme of work.

Further work is planned, as current strategies are reviewed, to explicitly embed population health and inequalities. This includes the clinical and social care strategy, where reduction of health inequalities is a core outcome.

Input into strategy development at a system level is underway. Sheffield Health and Wellbeing Board strategy is in the process of being refreshed. SHSC are represented to ensure mental health priorities are adequately addressed and prioritised within the strategy. This will be reviewed and incorporated into the population health and inequalities work plan.

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.

This is an exciting opportunity 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. SHSC are unique in the region having a population health focused role.

Journey:
SHSC have had Public Health resource in the form of a Public Health registrar on placement since July 2022 working 60% whole time equivalent. This offered a unique insight to our patient population and

alternative way of viewing our services.

Further capacity has been built through the creation of a Head of Population Health and Inequalities role, which has been in post since 2nd January 2024. A strategic plan related to this role was developed and approved at EMT on 18th Jan 2024 (Appendix 2).

Highlights of what has been achieved in this time and next steps can be found in appendix 1.

The main risk associated is the loss of Public Health expertise come June 2024, due to the end of the Public Health Registrar placement, with no replacement.

Appendices attached:

1. Population Health and Inequalities Update – April 2024.
2. EMT Report – Approved 18th Jan 2024
3. Alignment to SHSC priorities driver diagram

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

This report is to provide assurance on the work underway in this area, that it aligns to the strategic plan approved at EMT on 18th Jan 2024, and meets the Trusts expectations.

No decisions or actions are required.

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*		*No*	**x**
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*		SU experience is a core consideration for this work. Equitible access, excellent experience and optimal outcomes are key drivers. As such SU and carer engagement will be key to achieving these.
Financial (revenue &capital)	*Yes*		*No*	**X**	Currently there are no financial implications of this work as we are still in the scoping and discovery stage. Going forward there may be financial considerations based on recommendations for future focus.
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 standard agenda item on the Inclusion and Equality Group.
Legal	*Yes*		*No*	**X**	No legal implications
Environmental sustainability	*Yes*	**X**	*No*		Strong links to sustainable models of care and impact on patient population.

Population Health and Inequalities Bi-annual Report

Section 1: Analysis and supporting detail

Background

1.1 SHSC have had Public Health resource in form of a Public Health registrar on placement since July 2022 . This offered a unique insight to our patient population and alternative way of viewing our services.

Capacity has been built through creation of Head of Population Health and Inequalities role, which has been in post since January 2024. A Population health approach is defined as 'improving physical and mental health outcomes and wellbeing of a defined population, whilst reducing health inequalities'.

A strategic plan was developed and approved at EMT in Jan 2024. This contains details regarding the need for this type of role and focus (Appendix 2)

Highlights of what has been achieved in this time and next steps can be found in appendix 1.

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.

Section 2: Risks

2.1 Public Health Registrar placement ends June 28th, 2024. Resource available to support this work will reduce and vital knowledge and expertise will be lost.

Mitigations: funding secured for a 0.6 Band 5 post. This will offer additional capacity to support the programme of work.

While there is potential to secure a further Public Health registrar placement in the future, there is no current Public Health registrar placement planned at SHSC. For any future placement, supervision considerations would be needed. All Public Health Registrars must have a supervisor who is a Consultant in Public Health alongside a placement supervisor. The current placement has been supported via dedicated supervision from the School of Public Health Yorkshire and Humber,

alongside placement supervision from the Medical Director and Deputy Medical Director.

Section 3: Assurance

Benchmarking

3.1 SHSC is leading the way and are unique in the region having a population health focused role.

3.2 We are part of an ICS level network which convened in April 2024. The ICS Prevention lead has re-convened a Public Health network group to bring together people working in Healthcare Public Health, Prevention, Health Inequalities and Population Health to:

- Share information about South Yorkshire wide and place priorities.
- To input into the development of SY strategies, planning and responses to consultations.
- To share examples of local best practice.
- To act as a sounding board and support network for local challenges.
- To support the development and elements of the implementation of the ICP accelerating prevention bold ambition.

Triangulation

3.3 The Population Health and Inequalities strategic plan has been created in line with SHSC strategic aims and priorities, supporting the overarching Trust Vision. See appendix 3 for a driver diagram that demonstrates the flow from national and local policy to SHSC priorities through into the population health and inequalities programme of work.

Further work is planned, as current strategies are reviewed, to explicitly embed population health and inequalities. This includes the clinical and social care strategy, where reduction of health inequalities is a core outcome.

Clinical and social Care Strategy overarching focus is to reduce health inequalities. This work is central in supporting the achievement of that. An additional workstream has been created to support the benchmarking and creation of outcomes and benefits through a health inequalities lens.

Evidence Led:
Population Health is one element of the Research and Evidence Hub; and a partner in its development.

Person-Centred:
Working with teams to create population health reports, to inform service design and delivery.

Strengths Based:
Support to identify and engage VCSE organisations

Trauma Informed:
Inclusion Health Summit identified ‘trauma informed MH care’ as a key goal for Sheffield. SHSC active members of the summit and positioned to support the development of this city-wide work.

Input into strategy development at a system level is underway. Sheffield Health and Wellbeing Board strategy is in the process of being refreshed. SHSC are represented to ensure mental health priorities are adequately addressed and prioritised within the

strategy. This will be reviewed and incorporated into the population health and inequalities work plan

Engagement

3.4 Work is underway engaging within SHSC and across the system. Currently engaged with the following teams within SHSC:

- QI - Waiting List Collaborative
- Older Adults CMHT
- Learning Disabilities,
- Gender Identity Clinic,
- Digital and Business Performance Team,
- Engagement Team – PCREF and Equality dashboard,
- Equality and Diversity – Workforce Inequalities

Workforce Inequalities - a workforce deprivation report was created, to display data relating to staff of SHSC, with a focus on health inequalities. The report provides an exploration into deprivation and attendance and is cross referenced with age, gender, pay band, ethnicity, disability and geography. The report contains a series recommendations to begin the conversation on how we respond to health inequalities faced by our workforce and will support the creation of an 'improvement plan to address health inequalities within their workforce' as recommended in the NHSE Equality, Diversity and Inclusion Plan.

Collaborating with community partners via the Cancer Alliance funded work. An Innovation Hub fund allowed partnership working between SHSC, Sheffield Flourish and SACMHA between April 2023 and April 2024 regarding cancer screening in those with mental health needs. Coproduction sessions were carried out and a resource created to raise awareness of screening. You can view digital resources created via this project here Cancer Screening | Sheffield Mental Health Guide

Sheffield Place, have secured and ringfenced their health inequalities funding, focussing on 3 priority worstreams – Inclusion Health Groups, QUIT Programme and Model Neighbourhoods. The North-East Model Neighbourhood focusses on 4 areas within Foundry PCN (top 20% most deprived) to empower and connect these communities, build VCSE offer through increased investment and devolve power to that community. SHSC are represented on delivery Group, creating strong connections to learn and use to positively influence access, experience and outcomes for this population.

Service user, carer and community engagement is a necessary step and planned going forward. This will provide the story and reality behind the data allowing a true picture of the SHSC population health needs.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

1. Effective Use of Resources
2. Deliver Outstanding Care
3. Great Place to Work
4. Ensuring our services are inclusive

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.

This work primarily focusses on **Equalities, diversity and inclusion** and **Integration and system thinking** creating alignment to the ICS approach and priorities to reducing health inequalities.

Taking the same approach to **Culture and People,** it will support people to gain and retain meaningful employment that reflects the community we serve. Focused work to improve the wellbeing of the workforce who themselves can be experiencing health inequalities will help create a great place to work.

Environmental sustainability and population health are closely linked, particularly in reference the sustainable models of care. Sessions for Developing as Leaders have been co-produced and delivered by the population health and sustainability leads, highlighting the links and connectivity.

There are increasing **Compliance - Legal/Regulatory** requirements linked to health inequalities. Every Trust are required to publish data on several domains with health inequalities focus, specifically ethnicity and deprivation. These are to be published alongside or with the Trust annual report.

There are no **financial** implications at this stage.

Section 5: List of Appendices

5.1 Population Health and Inequalities Update – April 2024. PowerPoint slide
5.2 Population Health and Inequalities EMT Report. Word document
5.3 Alignment to SHSC priorities driver diagram

Appendix 1

Population Health and Inequalities Update: April 2024

Lead: Jo Hardwick

Exec Sponsor:

NHS Sheffield Health

Overview

The first 4 months have consisted of discovery work and foundation setting. Building relationships with colleagues within SHSC, Sheffield Place and ICS. Understanding opportunities and limitations

Progress Past 3 Months

Infrastructure:
- Appointed Head of Population Health and Inequalities
- Strategic plan developed and approved at EMT
- Health Inequalities embedded into Equality and Inclusion Group

Data:
- Established a focussed workstream within the clinical and social care strategy to consider outcomes and benefits through a health inequalities lens
- Commencement of a series of population health reports:
    - SHSC population overview
    - Older Adults CMHT population
    - Learning Disabilities data report
    - SHSC workforce health inequalities

Knowledge:
- Created a comms plan, Jarvis page under development and learning library created

Partnerships:
- Built strong links with Public Health colleagues
- Member of the Community Development and Inclusion Delivery Group, overseeing the 'model neighbourhood' work
- Represented SHSC at Inclusion Health Summits
- Attend SY Health and Housing Group. Connected in HIT and HAST leads to this work
- Connected with ICS Health Inequalities Lead
- Connected with ICS Targeted Lung Health Check Programme, SHSC to be a key partner

Programmes and Projects:
- Successful completion of Cancer Alliance funded project.
- Linked to Waiting List Collaborative to support from a health inequalities perspective

Staff:
- SHSC workforce health inequalities report created to support wellbeing of staff on bands 2-5

Action Next Month

Infrastructure:
- Commence recruitment process for Band 5 post
- Review and Align place to ensure capture of ICS 5 strategic priorities for tackling health inequalities

Data:
- Finalise plan for Health Inequalities reporting statement
- Continue to develop health inequalities outcomes and benefits for CSCS. Establish baseline
- Commence conversations with Gender Identity Service regarding a population health report
- Support Digital and BPM Team to understand performance reporting and include health inequalities focus
- Complete VCSE scoping task

Knowledge:
- Delivery of Population health and health inequalities sessions within SHSC Developing as Leaders Programme
- Launch of Jarvis page, learning library and first monthly blog
- Support Board in response to NHS providers publication *'Reducing Health Inequalities: A guide for NHS Trust Board Members'*. Summary and recommendations going to EMT – 16th May

Partnerships:
- Continue to represent SHSC in Model Neighbourhood and Inclusion Health work
- Attend re-launch of SY Public Health Network

Proud to care in Sheffield

Programmes and Projects:
- Clarify role and support into Waiting List Collaborative. Identify team to begin focussed work

Appendix 2

Sheffield Health and Social Care NHS Foundation Trust

Report to Executive Management Team

Date:

Subject	Population Health and Inequalities, 12-month work plan			
Executive lead	Mike Hunter – Executive Medical Director			
Author	Jo Hardwick – Head of Population Health and Inequalities Jaimee Wylam – Public Health Registrar			
Purpose of the report	This report provides an overview, function and vision of the role of Population Health and Inequalities, alongside a long-term and short-term strategic work plan.			
Received at	**N/A**			**Approved Y/N**
Status ***(highlight/tick)***	**To note**	**For discussion**	**EMT approval**	**BoD approval**

STRATEGIC PRIORITIES IMPACTED

Recover services and improve efficiency	✓
Continuous Quality Improvement	✓
Transformation – Changing things that make a difference	✓
Partnerships – working together to make a bigger impact	✓

KEY POINTS (provide additional material as appendices)

Part A: Rationale

Vision:

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.

Background:

What is population health?

The Kings Fund define **population health** as "an approach aimed at improving the health of an entire population" and describes it being "about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities." This is fundamentally about tackling inequalities by considering the drivers of health at a population level (and not individual level) and utilising strategies to improve this.

Population health should not be confused with **population health management,** which is a data-driven approach or methodology to identify a specific population, for example most at risk, that may need to be prioritised for particular services. This allows targeted and proactive models of care to be developed.

What are Health Inequalities?

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". Inequalities in health are related to inequalities in society; where we are born, live, grow and age. These social factors are often described as the social determinants of health, which includes education, housing, employment, social connections and so on. The unequal distribution of the social determinants drives physical and mental health inequalities. Furthermore, there is a social gradient in mental health, which means that those of lower socioeconomic status are more likely to experience mental health problems. Ultimately, health inequalities is a term used to describe differences in the status of people's health, which may include differences in the care people receive and differences in opportunities people have to lead a healthy life.

Why are health inequalities important?

Health inequalities lead to premature death and avoidable morbidity and mortality. For example, in England, those living with SMI are more likely to die before the age of 75 years (premature mortality) than those without SMI. Between 2018 and 2020 there were higher levels of premature mortality in more deprived areas. It is important to understand where inequalities exist to allow us to take a targeted approach and thus prevent the widening of and reduce inequalities.

Covid-19 has amplified health inequalities which are being further exacerbated by the current cost of living crisis. These environmental factors further highlight the increased need to work proactively in this area.

The data: (see Appendix B for further info)

It is well known and documented that residents of the poorer parts of Sheffield live shorter lives and have poorer health than those in the more affluent areas. SHSC provide a service to a higher proportion of those living in poorer parts of the city. According to 2020-2021 national Mental Health Bulletin statistics, over 40% of patients in contact with NHS funded secondary mental health, learning disabilities and autism services in SHSC were from the most deprived areas of Sheffield.

Those living with severe mental illness and learning disabilities also experience shorter lives and poorer health, dying up to 20 years earlier than the general population. It is also true that groups with specific and shared characteristics, such as Black, Asian, Minority Ethnic and Refugee backgrounds, face health inequalities. In 2020-2021, Black or black British people were more likely to be admitted and spend time in hospital in SHSC than white people. 11.18% of black or black British people in contact with NHS funded mental health services spent time in hospital, compared to only 2.3% of white people.

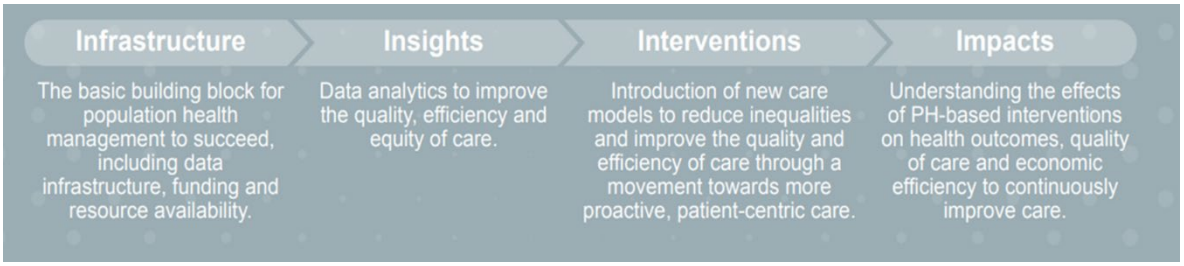
Links within SHSC:

Population health and health inequalities are relevant to several areas of SHSCs vision, aims, values and strategy. The most prominent links are with the following:

- Refocusing our services towards prevention and early intervention (Our Vision)
- Continuous improvement of our services (Our Vision)
- Effective use of resources (Our strategic aims)
- Ensure our services are inclusive (Our strategic aims)
- Knowing we make a difference (Clinical and Social Care Strategy)
- Leading the system for outstanding care (Clinical and Social Care Strategy)
- Evidence-led (Clinical and Social Care Strategy)

Principles:

The approach will follow the 4Is principle.



This role will focus primarily on Infrastructure and Insights, with clinical and other support services leading interventions and impacts.

Governance:

Population health and inequalities will report monthly into the Research, Innovation, Effectiveness and Improvement Group (RIEI), which in turn will report into the Quality Assurance Committee.

An additional bi-annual population health update will be created for both the Quality Assurance Committee and the Board. This will alternate meetings with the existing RIEI update report.

2024 timescale below:

April - RIEI
May – Quality Assurance Committee and Board
October - RIEI
November – Quality Assurance Committee and Board

Part B: Plan

Long term: (4-5 years)

5 priority areas have been identified within the strategic work plan. These are as follows:

- **Data** is collected and recorded and accurately reflects our population
- **Knowledge** of health inequalities and its importance is increased in SHSC staff
- **Partnerships** are built and maintained to inform SHSC direction and to influence system change
- Support is offered to existing **Programmes and Projects** to contribute to reducing health inequalities
- **Staff** experiencing health inequalities are supported to maintain and enjoy their work

All 5 areas have a theme of celebrating success running through them and are founded on quality and critically appraised evidence and research.

Appendix C contains a driver diagram detailing how these priorities link to SHSC Strategic aims and overall vision.

Short term: (Jan 2024 – Dec 2024)

The initial 12 months will be a period of discovery work and foundation setting, addressing elements within each of the 5 of the priorities above.

Specific pieces of work include:

Data:

- Improve data collection by working alongside PCREF Team re: recording of ethnicity project:
    - Reduction in number of patient records without an ethnicity recorded.
- Increased understanding of SHSC population and gaps in knowledge/reporting:
    - Data report detailing SHSC population, gaps and plan to address.
- Board level understanding of health inequalities of SHSC population:
    - Health Inequalities metrics embedded into board reports.
    - Compliance with NHSE Health Inequalities reporting framework
    - Regular update report to Quality Assurance Committee and Board.

Knowledge:

- Promote awareness of population health and inequalities by:
    - Embed health inequalities in Developing as Leaders course.
    - Monthly blog on Jarvis.
    - SHSC intranet page.
    - Present at Quality Improvement Forum

Partnerships:

- Build relationships and identify partnership opportunities with colleagues at Place and ICS level:
    - Identify and begin to attend relevant meetings at local and regional level.
    - Connect with ICS SRO for Health inequalities.
- Identify opportunities to expand resource to support this area of work:
    - Create an informal workforce/network.
    - Begin to create a portfolio of opportunities/initiatives available for temporary resource.
- Explore and consider opportunities related to cost-of-living crisis, work and housing

Existing Programmes/Projects:

- Clinical and Social Care Strategy
    - Support progression and achievement of objectives where appropriate
- Waiting List collaborative - understand who is on our waiting list:
    - Identify a service to test approach and response.
    - Gather, review and challenge data of patients waiting and identify data gaps.
- Cancer Alliance project:
    - Complete objectives aligned to funding requirements.
- Research and Evidence Hub
    - Established key partner in the hub.

Staff experience:

- Understand inequalities and deprivation of staff to develop targeted support:
    - Create staff data report.

Appendices:

A: Drivers for action
B: SHSC v Sheffield data presentation
C: Alignment to SHSC strategic aims driver diagram

KEY RISKS AND HOW THESE ARE BEING MITIGATED

Data:

Lack of consistent recording of protected characteristics, unable to analyse and accurately target support and/or services.

Mitigation:

- Bring together core people to influence change,
- Use data we have to identify services that are finding this more challenging.
- Understand if these are technical or behavioural barriers. Close working with Digital to understand technical challenges and possible solutions, and QI and clinical services to support behaviour change.

Workforce/resource:

One role, one person.
Huge array of potential initiatives and focus of work.
Reigning in my enthusiasm

Mitigation:

- Create and promote clear definition and remit of the role.
- Utilise Jarvis page and comms to disseminate.
- Develop an informal supportive workforce among existing SHSC staff
- Consider apprenticeship levy to upskill existing workforce.

System Pressure:

Potential increase in referrals to services where targeted work has taken place.

Mitigation:

- Collate a portfolio of gaps and initiatives and prioritise.
- Clear governance process to approve work focus where there is an imbalance of priorities.
- Utilise informal and temporary workforce to work through them as available (Leadership Fellow, Graduate Management Trainee).

Prevention effects:

Difficulty seeing the effects of prevention work, as the more upstream the intervention, the harder it is to quantify change.

Mitigation:

- Celebrate small successes.
- Regular updates to detail prevention work
- Recognise the value and strength of qualitative outcomes.

RECOMMENDATIONS

The Executive Management Team is asked to:

Approve approach detailed in report.

Support direction of travel and priorities for 12-month plan

- If you are unable to support, what would you like to change and what are the next steps?

Appendices

Appendix A: Drivers for action

There are several national, regional and local policy and strategy links relating to population health and inequalities. These are described below.

NHS Long Term Plan

The NHS Long Term Plan places focus on NHS organisations strengthening their contribution to prevention and health inequalities in order to help people to stay healthy while reducing demand on the NHS. This includes actions to cut smoking in people with long term mental health problems, ensure people with learning disability and/or autism get better support, provide outreach services to people experiencing homelessness, help people with severe mental illness find and keep a job, and improve uptake of screening and early cancer diagnosis for people who currently miss out.

Core20PLUS5

Core20PLUS5 is an NHS England approach to inform action to reduce healthcare inequalities. The CORE20+5 framework focuses on population level approaches. 'Core20' refers to the most deprived 20% of the national population as defined by the Indices of Multiple Deprivation (IMD). 'PLUS' refers to locally defined population groups, and examples of such groups include people with learning disabilities, people with long term health conditions or people experiencing homelessness. '5' refers to five clinical areas of focus; maternity, SMI, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding and optimal management and lipid optimal management.

The five clinical areas of focus are relevant to SHSC. Many people accessing our services will experience SMI and we have a role to play in their physical health. People living with SMI are more likely to experience chronic respiratory disease and hypertension. In addition, those with SMI were more likely not to participate in breast, cervical and bowel screening. Analysis suggested between 2016 and 2018 adults with SMI were 2.1 times more likely to die from cancer under the age of 75 than people without SMI.

South Yorkshire Integrated Care Partnership Strategy

This regional strategy sets out a commitment to "working together to take action to address health inequalities and improve healthy life expectancy". One of the four ambitions focuses on strengthening prevention and early intervention; key components of a population health approach.

SHSC Strategic Direction 2021-2025

The SHSC Strategic Direction describes a focus on "addressing inequalities and embracing diversity both within SHSC and externally within the communities we serve, to ensure that everyone is provided with the very best opportunity to realise their potential."

SHSC Clinical and Social Care Strategy

The SHSC Clinical and Social Care Strategy "is focused on reducing health inequalities". It describes five key deliverables with the "Knowing We Make a Difference" section focused on helping "people to live well and reducing the inequalities associated with mental health problems and learning disability through early intervention, prevention and transformation of mental health care to be closer to communities and capturing impact and outcomes".

Race Equality Commission Report

In 2020 the Sheffield Race Equality Commission was established. The aim was to provide an independent strategic assessment of the nature, extent, causes and impacts of racism and race inequality within the city. Health inequalities are highlighted throughout the report, particularly in relation to the impact of COVID -19. A call to evidence within the report highlighted Health as an area of focus and how alongside Public Health the balance could be readdressed. As an NHS anchor organisation, SHSC have

a responsibility to respond to the report findings and contribute to the improvement in this area

Appendix B: SHSC v Sheffield data presentation

SHSC Population

This report sets out information about the population of people who use Sheffield Health and Social Care NHS Foundation Trust (SHSC) services. It considers this against the general population of Sheffield, using information from the Census in 2021. The purpose of this document is to provide an overview of the SHSC population, as well as offer a starting point for discussions around how we understand who is using our services, who is not and how we can use this information to tackle health inequalities.

Caveat: *This report uses the 2020-2021 Mental Health Bulletin Data tables as these are the most recent national tables available with breakdowns for ethnicity, gender and deprivation. More recent data has not been accessible via SHSC Digitial due to capacity issues within the digital team and focus on RIO. Any similar data considerations will be highlighted in the text in italics in this way.*

Contents

1. Total population of people who used SHSC services in 2020-2021

Between 1 April 2020 and 31 March 2021, **29,895 used SHSC services** [1]. The total population of Sheffield in 2021 was 556,500 [2]. This means that SHSC services were in contact with 5.4% of the Sheffield population as a whole, and 6.6% of those aged 16 and above.

Of the people who used our services **2.19% of people were admitted** at some point between 1 April 2020 and 31 March 2021 [1], meaning 97.81% people were not admitted and only used community services [1].

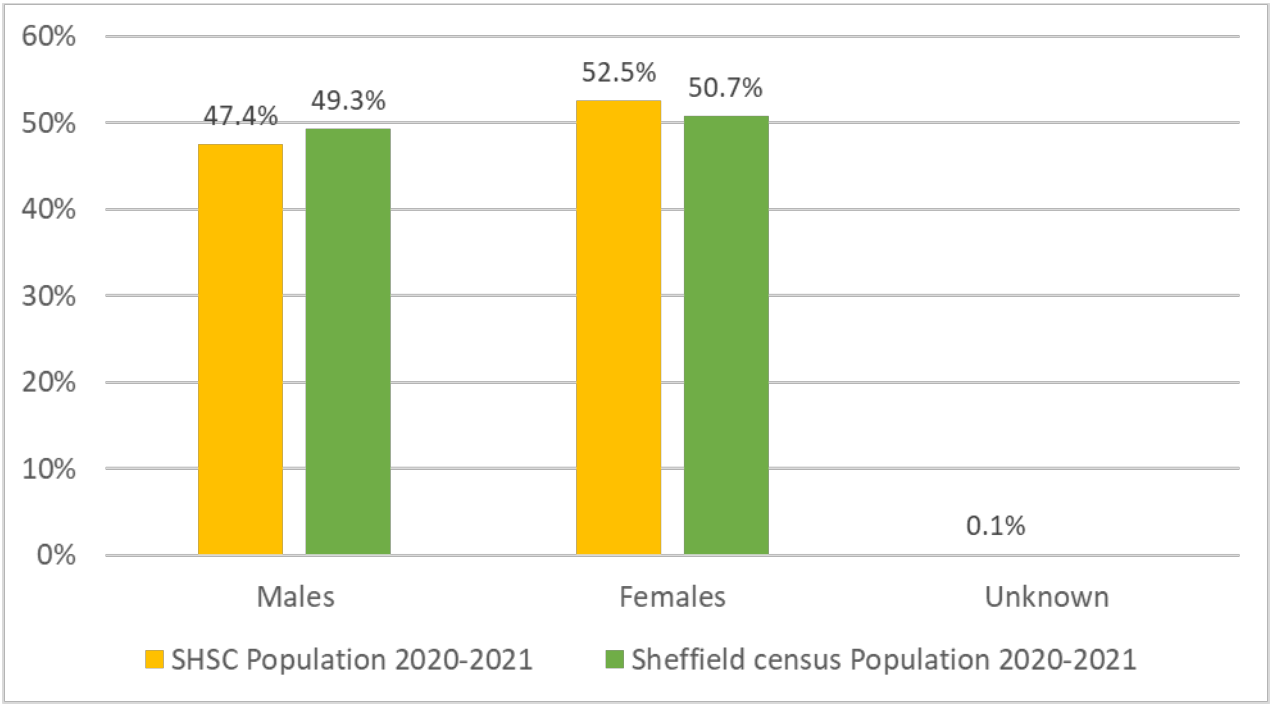
The total number of people admitted as an inpatient between 1 April 2020 and 31 March 2021 is 655 [8]. Of these, 465 were adult acute admissions and 110 were adult specialist admissions [8]. These admissions represented a total of 52,230 bed days, with an average of 79.7 bed days per person [8].

2. Gender

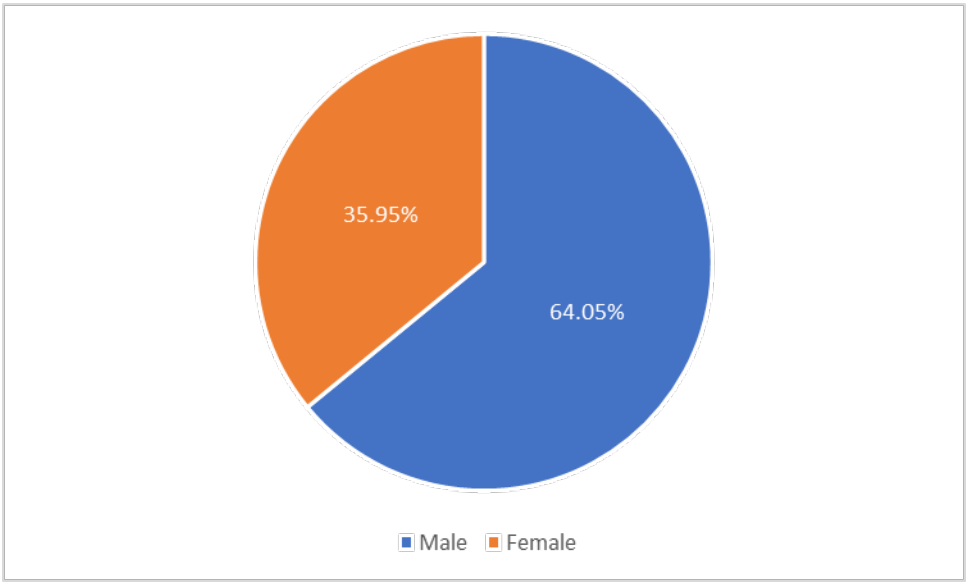
Of those who used SHSC Services between 1 April 2020 and 31 March 2021, 47.4% were male and 52.5% were female [3] (Graph 1). Male service users had a higher number of bed days of admission than female service users (Graph 2).

Caveat: *There is no category to consider transgender and non-binary people.*

Graph 1: Sheffield Population compared to the population of people who used SHSC services in 2020-2021 by gender [2,3]



Graph 2: Bed days by gender [8]



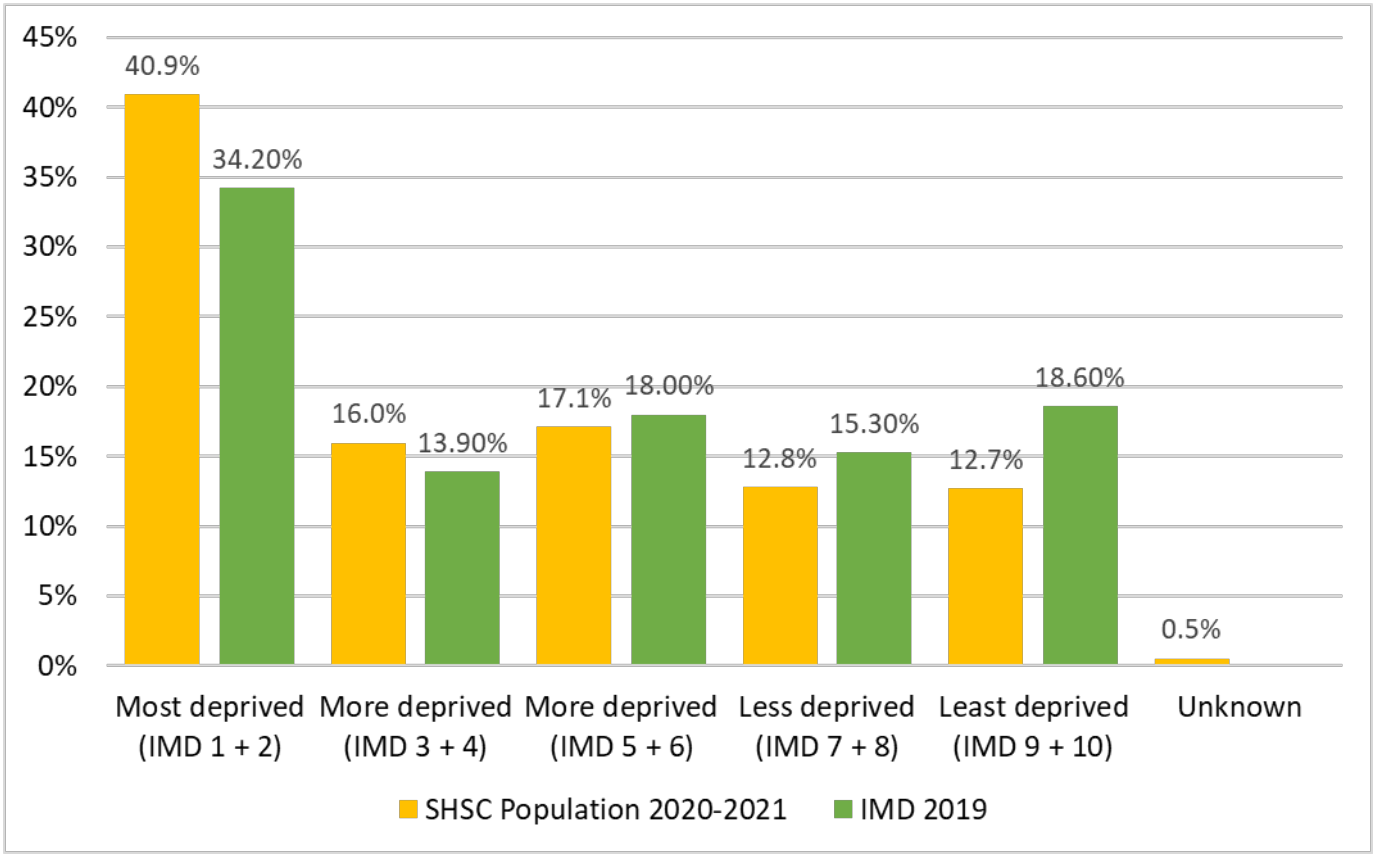
3. Indices of Multiple Deprivation (IMD)

IMD is an official measure of deprivation in England. IMD ranks small areas, known as Lower Super Output Areas (LSOA), from most deprived (1) to least deprived (32844). These are then placed into deciles to consider relative deprivation. IMD uses a variety of domains of deprivation including income, employment, education, skills and training, health, disability, crime, barriers to housing and services and living environment.

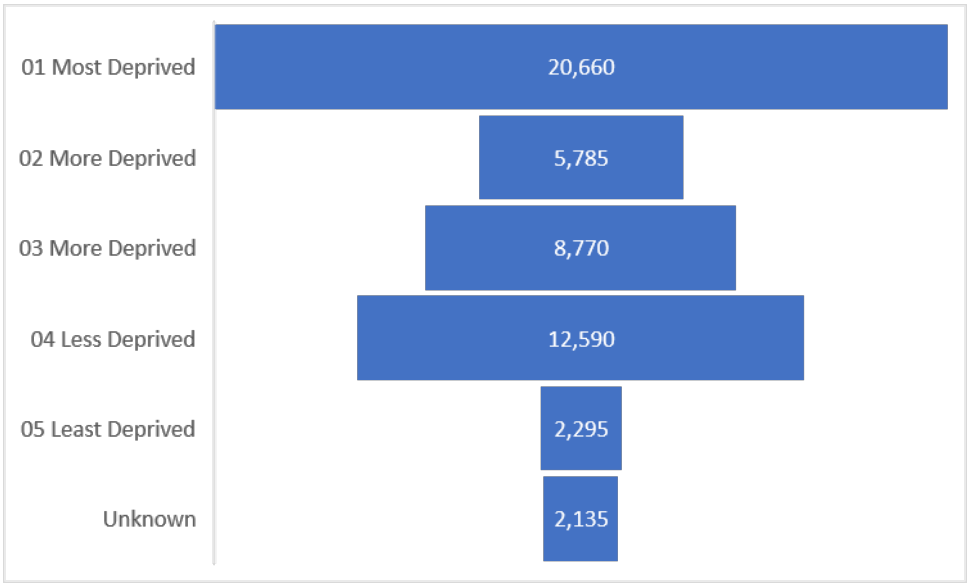
People who use SHSC services are also more likely to be from the most deprived areas (Graph 3). Those who spent the most time in hospital (bed days) were more likely to be from the most deprived areas (Graph 4).

Caveat: *The national data tables use the heading "more deprived" to describe two data points, therefore the IMD deciles are displayed also on Graph 3.*

Graph 3: People who use SHSC services by deprivation compared to the general population of Sheffield using Indices of Multiple Deprivation (IMD) [4.5]



Graph 4: Bed days by Indices of Multiple Deprivation [8]

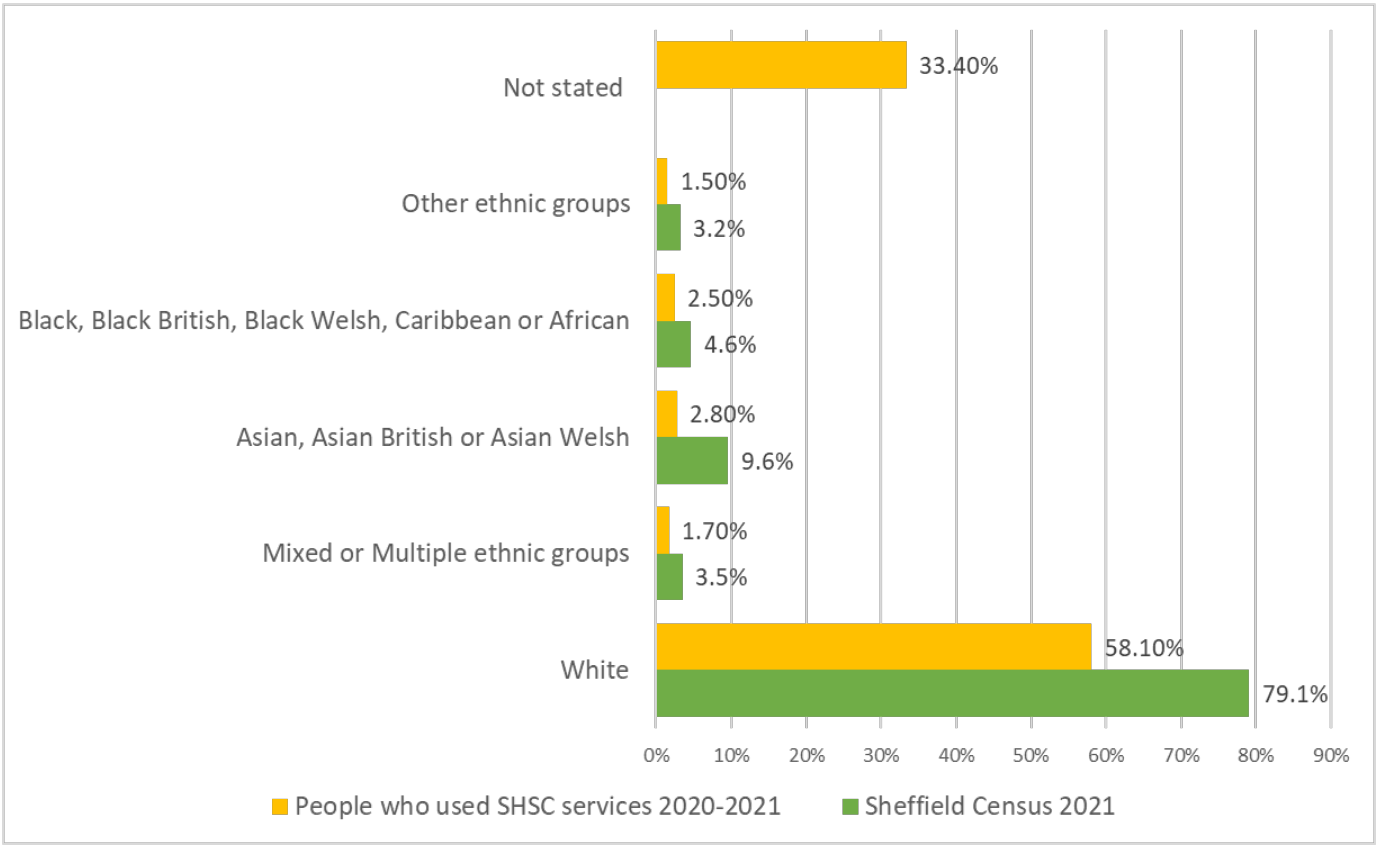


4. Ethnicity

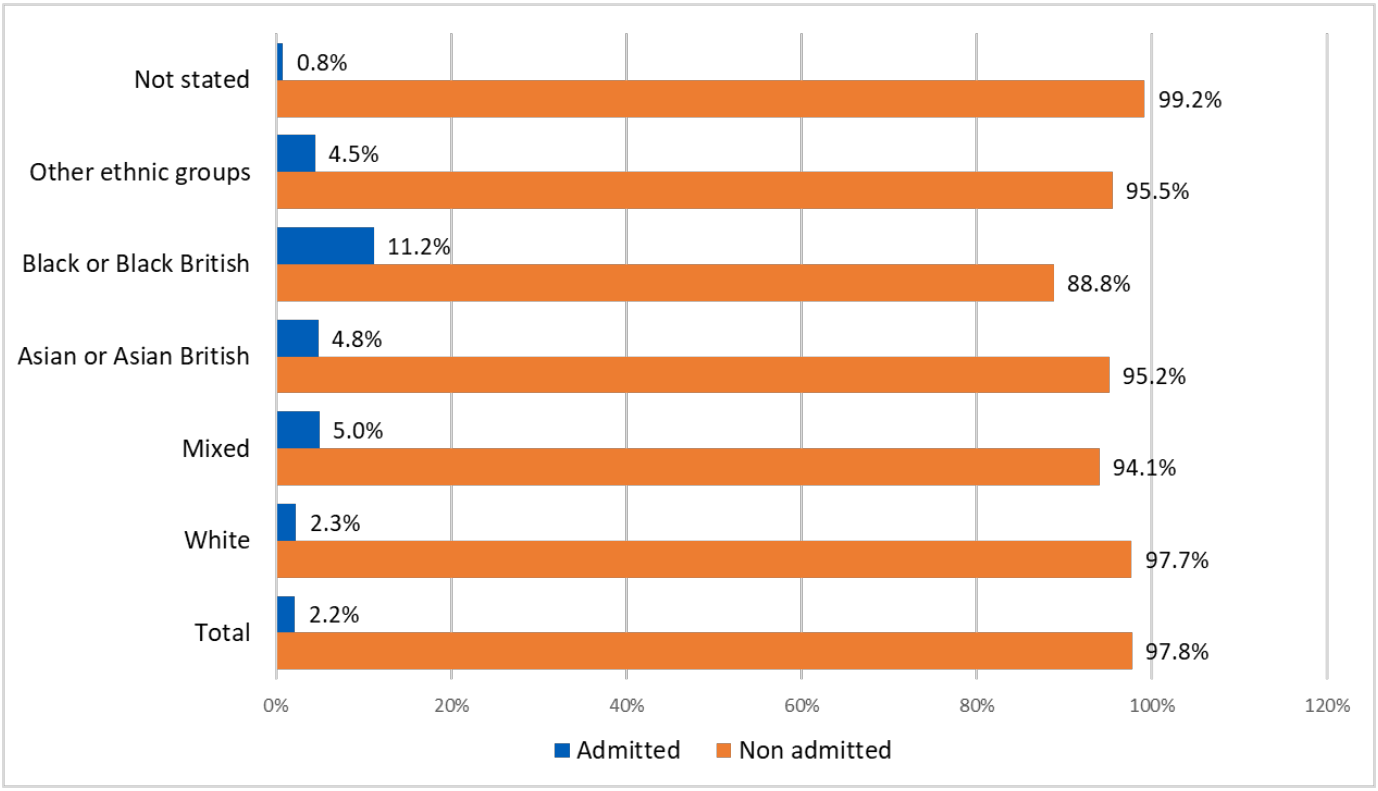
Sheffield is a diverse city which is home to people from a variety of ethnically diverse backgrounds. There are significant gaps in data recording of ethnicity which makes drawing conclusions from the data challenging. However, we do know that those who belong to an ethnic group other than “White” are more likely to be admitted than those who are “White” (Graph 6). For example, of Black or Black British people using SHSC services 11.8% were admitted at some point between 1 April 2020 and 31 March 2021, compared to just 2.2% of White people [6].

Caveat: *There are significant gaps in data recording of ethnicity which makes drawing conclusions from the data challenging.*

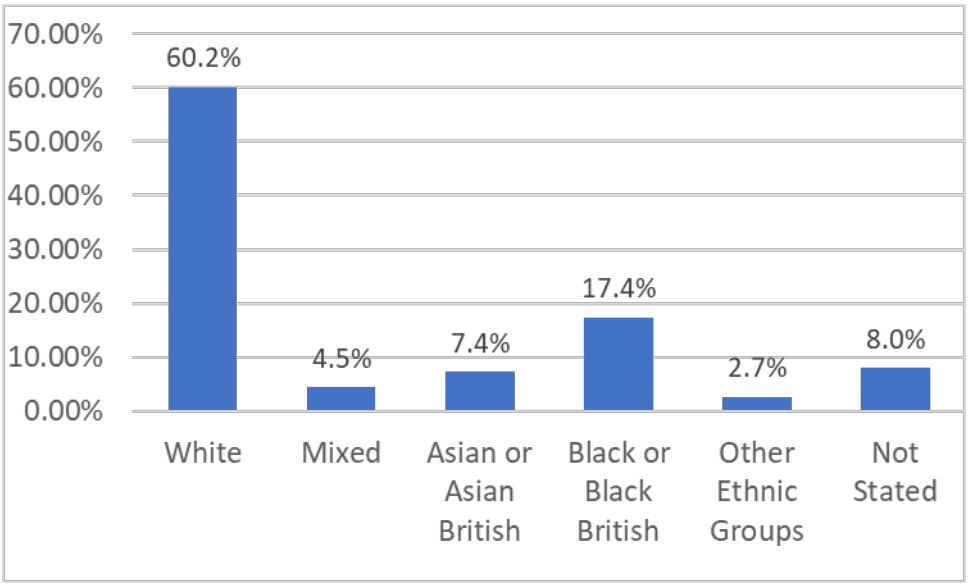
Graph 5: Ethnicity of people using SHSC services compared to the general population of Sheffield [6,7]



Graph 6: Percentage of people in contact with SHSC services between 1 April 2020 and 31 March 2021 - ethnicity and admission [6]



Graph 7: Bed days by ethnicity between 1 April 2020 and 31 March 2021 [9]



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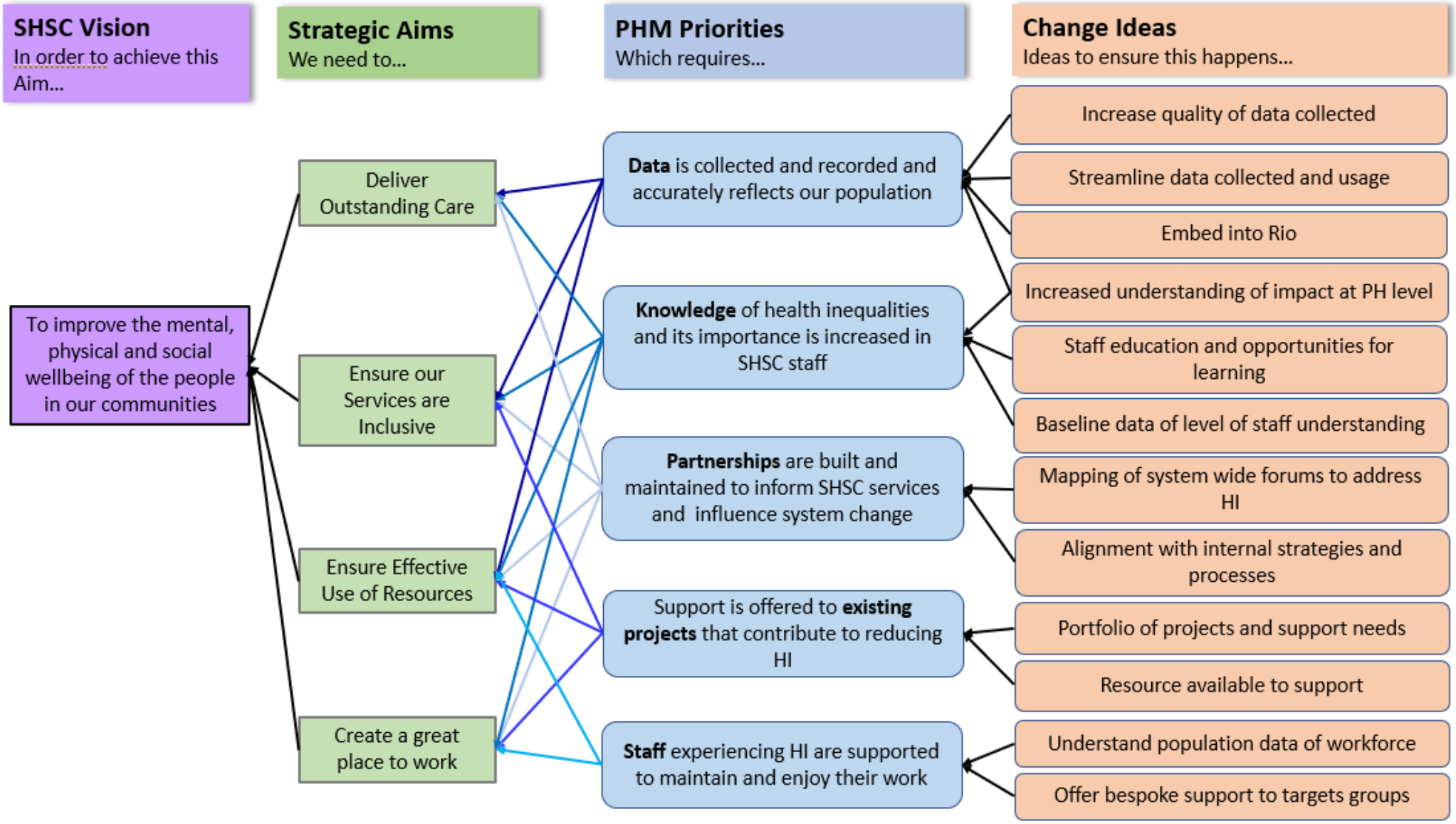
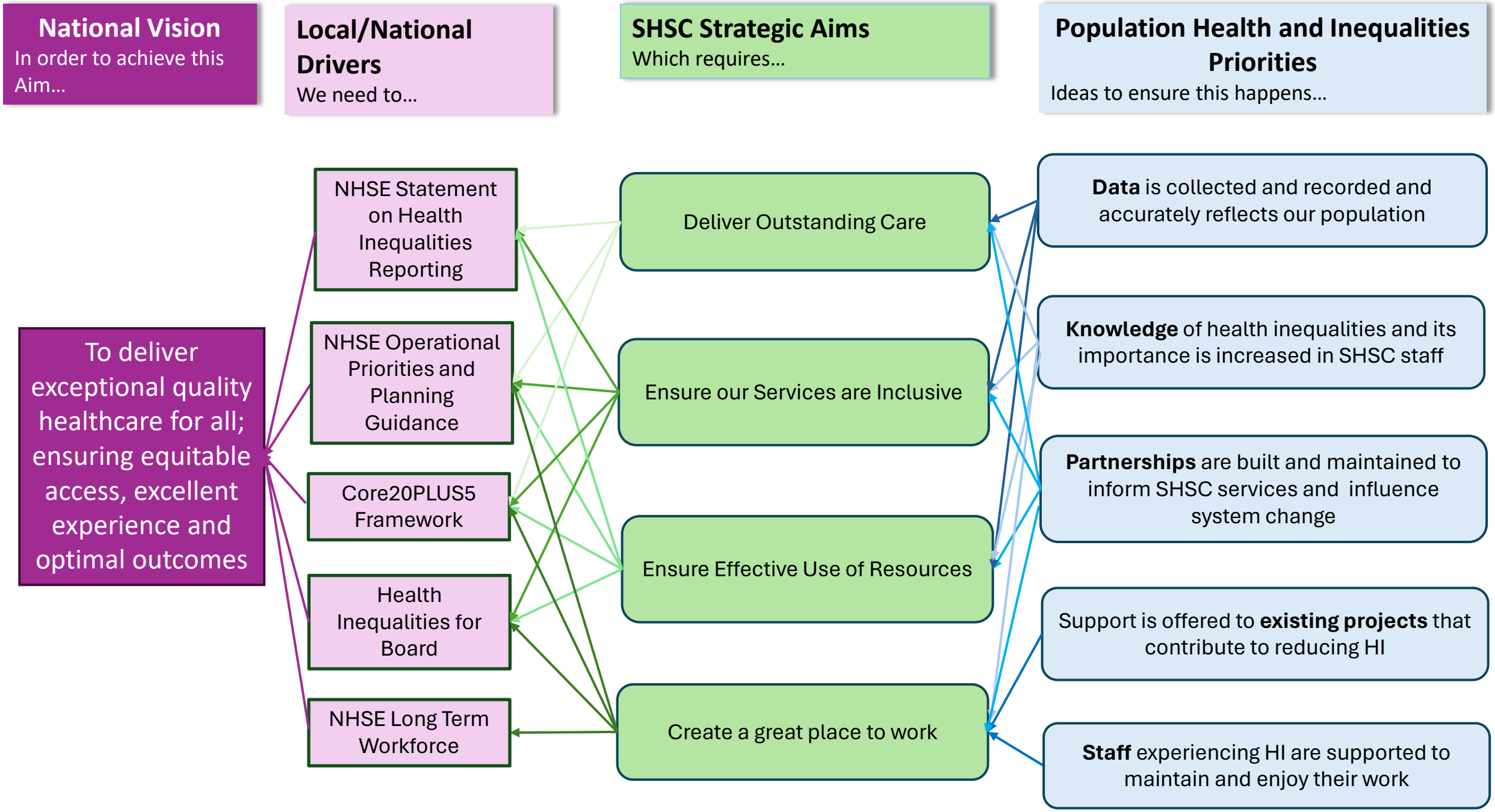
6. Mental Health Bulletin: 2020-21 Provider Outpatients Reference Tables. Table 2: Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services by provider, highest level of care and ethnicity, 2020-21. Accessed online 9 October 2023. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2020-21-annual-report
7. Sheffield Census How life has changed in Sheffield: Census 2021 (ons.gov.uk)
8. Mental Health Bulletin: 2020-21 Provider Inpatients Reference Tables. Table 5: Number of people admitted as an inpatient with NHS funded secondary mental health, learning disabilities and autism services by provider, highest level of care and bed type, 2020-21. Table 6: Number of in-year bed days in the reporting period by provider, 2020-21. https://files.digital.nhs.uk/DE/D02E6E/MHB-2021-Reference%20Tables-Provider-Inpatients-V2.xlsx
9. Mental Health Bulletin: 2020-21 Provider Inpatients Reference Tables. Table 8: Number of in-year bed days in the reporting period by provider and ethnic group, 2020-21 https://files.digital.nhs.uk/DE/D02E6E/MHB-2021-Reference%20Tables-Provider-Inpatients-V2.xlsx

Appendix 3: Alignment to SHSC priorities driver diagram




National Vision
In order to achieve this Aim…
Local/National Drivers
We need to…
SHSC Strategic Aims
Which requires…
Population Health and Inequalities Priorities
Ideas to ensure this happens…
To deliver exceptional quality healthcare for all; ensuring equitable access, excellent experience and optimal outcomes
NHSE Statement on Health Inequalities Reporting
NHSE Operational Priorities and Planning Guidance
Core20PLUS5 Framework
Health Inequalities for Board
NHSE Long Term Workforce
Deliver Outstanding Care
Ensure our Services are Inclusive
Ensure Effective Use of Resources
Create a great place to work
Data is collected and recorded and accurately reflects our population
Knowledge of health inequalities and its importance is increased in SHSC staff
Partnerships are built and maintained to inform SHSC services and influence system change
Support is offered to existing projects that contribute to reducing HI
Staff experiencing HI are supported to maintain and enjoy their work