Public Board of Directors
Item number: 27
Date: 24 September 2025

Confidential/public paper:	Public
Report Title:	**Bi-annual Population Health and Inequalities Update**
Author(s)	Jo Hardwick – Head of Population Health and Inequalities
Accountable Director:	Helen Crimlisk – Interim Medical Director James Drury – Director of Strategy
Presented by:	Jo Hardwick – Head of Population Health and Inequalities
Vision and values:	This work supports the vision and values of the Trust by ensuring we offer equitable access **(we are inclusive)**, excellent experience and optimal outcomes to all those who use our services (**we keep improving)** This work supports and reflects the contents of the revised Trust strategy, specifically Strategic Aim 3 – Reduce Inequalities
Purpose:	This is a bi-annual report and covers the period 01 March 2025 – 31 August 2025. Providing an update on progress made and general overview of the work underway in relation to population health, healthcare inequalities and prevention. The report also includes the annual statement on health inequalities which is to be reviewed and approved for publication alongside the Trust annual report.
Executive summary:	This bi-annual update comes in the form of: - an extended **health inequalities statement.** The update achieves our requirement to collect, analyse and publish information in relation to health inequalities, under section 13a of the NHS Act 2006. The intention is for this to become the annual update to track and benchmark our progress in delivery of Strategic Aim 3: Reduce Inequalities. It will be structured to reflect the deliverables and measures of this strategic priority. The health inequalities statement is to be reviewed and approved by EMT, QAC and Board prior to publication alongside the annual report - **Board health inequalities self-assessment**, An annual re-assessment has taken place. The results show improvements across all four domains - **Governance process** for health inequalities The governance process for health inequalities has been reviewed to streamline and reduce volume of reports and potential duplication. Reporting will align with both health inequalities statement and annual report timelines. Please note that the information within the reducing inequalities annual report covers a period from April 2024 to March 2025 to mirror the annual report. Therefore, it will not include activity from April 2025 onwards **Appendices** 1. Reducing Inequalities Annual Report: 2024-2025 2. Health Inequalities Self-Assessment Report 3. Board Health Inequalities Self-Assessment: 2025 4. Reduce inequalities annual report summary

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*		*No*		
Deliver Outstanding Care	*Yes*	**x**	*No*		
Great Place to Work	*Yes*		*No*		
Reduce inequalities	*Yes*	**x**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
Supporting the Sheffield's commitment to improving healthy life expectancy and reducing health inequalities Support delivery of national inequalities priorities and strategic aim for inclusive services	
Board assurance framework (BAF) and corporate risk(s):	**BAF0027**: There is a risk that we do not ensure effective and timely stakeholder involvement and partnership working, which would have a negative impact on addressing population health and/ or sustainability of the organisation resulting in a failure to meet our strategic objectives. **BAF0031**: There is a risk that the Trust fails to maximise its contribution to reducing inequalities caused by a failure to adopt a population health management approach including a focus on prevention, leading to poorer outcomes and unfair differences in outcomes.
Any background papers/items previously considered:	This is the fourth bi-annual report, previous reports were heard at the following QAC meetings: • 09 May 2024 • 13 November 2024 • 09 April 2025 This is the second Health Inequalities Statement. The first being approved at Board: • 27 November 2024 This report was presented to the Executive Management Team on 4 September 2025 and Quality Assurance Committee 10 September 2025
Recommendation:	The Board of Directors are asked to: • Note the report for **assurance** and progress made • **Note** the proposed governance process • **Approve** Reducing Inequalities Annual Report for publication

Board of Directors

Bi-annual Population Health and Inequalities Update

24 September 2025

1. Purpose of the report

To provide an update on progress made and general overview of the work underway in relation to population health, healthcare inequalities and prevention, covering the period 01 March 2025 – 31 August 2025

2. Background

The importance of addressing health inequalities is firmly established within the Trust, emphasised through the strategy refresh and identifying 'reduce inequalities' as a strategic priority. This focus on inequalities is further strengthened through the move to University Trust status and development of a joint strategy with University of Sheffield which will have an inequalities focus, as well as joint work with SHU which will also emphasise joint strategic work on inequalities.

An update of work in relation to health inequalities is received by Board via QAC on a bi-annual basis as well as through the Research, Innovation, Evidence and Improvement Group (RIEI) update and ad hoc reports as requested.

The Trust is committed to playing a role as a provider and as a system partner. We adhere to our legal duties and requirements whilst also committing to recommended and best practice guidelines.

The focus of this report is three main areas:

- Reducing Inequalities Annual Report 2024/25: SHSC extended Statement of Health Inequalities
- Board health inequalities self-assessment: ensuring health inequalities is core business of all Board members.
- Governance process: To provide assurance and oversight, to reduce duplication and streamline reporting

3. Reducing Inequalities Annual Report

Every Trust has a requirement collect, analyse and publish information in relation to health inequalities, under section 13a of the NHS Act 2006 – a statement on health inequalities.

There are four domains SHSC are required to report on:

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

Data and high-level narrative have been completed and included within the 2024/25 annual report fulfilling our requirements. The document attached provides a more detailed review and analysis of this data, review and progress update of 2024/25 commitments for each domain and commitments for 2025/26.

Additionally, this report offers detail into the achievements and progress for 2024/25 in relation to wider health inequalities.

The intention is for this to become the annual update to track and benchmark our progress in delivery of strategic aim 3: Reduce Inequalities. Going forward it will be structured to reflect the deliverables and measures of this strategic priority.

See appendices 1 for the full report.

4. Board Health Inequalities Self-Assessment

NHS Providers created a self-assessment to support Trust Boards to ensure health inequalities is core business for all members. This is not a statutory or legal requirement, it is recommended and best practice. It offers structured support to the Board and organisation through bespoke objectives to build this focus and commitment. The self-assessment provides a score and maturity rating for each of the four domains, see figure below.

An internal Trust target has been set to stive for a 'maturing' rating across all four themes.

Percentage	Maturity Rating
0	Not started
1-24	Emerging
25-49	Developing
50-74	Maturing
75-100	Thriving

The initial self-assessment was completed in September 2024 following a Board development session in June 2024.The plan is to re-assess annually. This will offer a progress update and refine our action plan. The 2025 re-assessment was completed based on feedback received from Board members and where the response was not unanimous, final judgement fell to Head of Population Health and Inequalities. Results are below.

	Sept 2024	Sept 2025
Building public health capacity and capability	Developing	Maturing
Data, insight, evidence and evaluation	Developing	Developing
Strategic leadership and accountability	Developing	Maturing
Systems partnerships	Maturing	Maturing

The results show great progress and improvements across all four domains, with two moving from 'developing' to 'maturing'. There is still a great deal of work to do, and this improvement is positive and reassuring. The objectives detailed in the report will be included within the health inequalities action plan with named leads and timescales.

See appendix 2 for full report and scores.

5. Governance

To streamline reporting and oversight and to reduce volume and duplication the following governance process has been agreed.

Bi-annual reports are currently received by Board via QAC bi-annually (May and November) as well as reporting via RIEI and ad hoc reports in relation to the health inequalities statement. It is proposed that health inequalities reporting will be aligned to the annual report and health inequalities statement timescales of April and September. It would look something like this:

April – Board development session
Review and discussion of high-level data. It will offer the opportunity for all to contribute to the statement and help shape the section that will be included within the annual report. This will become the first bi-annual population health and inequalities update.

September – Board report
This will follow the same process as 2025, with the longer report produced, reviewed and approved through the agreed governance process. This will become the second bi-annual population health and inequalities update and the annual update for strategic aim 3: Reduce Inequalities.

Further conversations are needed to review alongside EDI annual reporting and see if there is opportunity to further streamline.

Going forward this update will support and contribute to the completion of the NHSE capability assessment cycle of which guidance was published on 26th August 2025. This process includes a self-assessment on 6 domains. Domain 4, access and delivery of services, links strongly to population health and inequalities. There is a requirement to complete this annually and consideration should be made as to how this can be pulled together to compliment existing work and reduce potential duplication.

6. Recommendations

The Board of Directors are asked to:

- Note the report for **assurance** and progress made
- **Note** the proposed governance process
- **Approve** Reducing Inequalities Annual Report for publication

Appendices

1. Reducing Inequalities Annual Report: 2024-2025
2. Health Inequalities Self-Assessment Report
3. Board Health Inequalities Self-Assessment: 2025
4. Reduce inequalities annual report summary

SHSC Reducing Inequalities Annual Report

2024-25

The purpose of this report is to provide an overview of the actions and achievements in relation to our commitment to reducing health inequalities.

The report will cover the following:

1. Implement our Inequalities and Population Health Plan
    a. Annual Statement on health inequalities
    b. Board health inequalities self-assessment
    c. Recording of personal data
    d. Active participation and learning
2. Local partnerships
3. PCREF Implementation

1. Implement our Inequalities and Population Health Plan

a. Annual Statement on Health Inequalities

This section 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.
It will detail the required domains in relation to mental health as follows:

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

Smoking Cessation

SHSC provides a Trust-wide tobacco dependence treatment service which is available to all service users who smoke.

All ward areas (100%) (3 acute, 1 PICU, 3 older adult, 1 step-down, 2 Forensic and 3 Rehabilitation and Recovery) **screen smoking status on admission and offer a specialist mental health smoking cessation service**. All smokers and users of nicotine are seen by the Trust Tobacco Dependence Treatment Team (QUIT Team) and offered assessment for ongoing support to stop smoking or manage temporary abstinence from smoking while on a smoke free ward.

Service users admitted to the Health-Based Place of Safety (HBOS) or Decisions Unit (DU) should be screened by ward staff, but, due to short nature of stay, are only seen by the QUIT Team if they go on to be admitted to an acute ward. All identified smokers should be offered appropriate nicotine treatment to manage their dependence.

100% of adult acute inpatient setting offer smoking cessation

Data

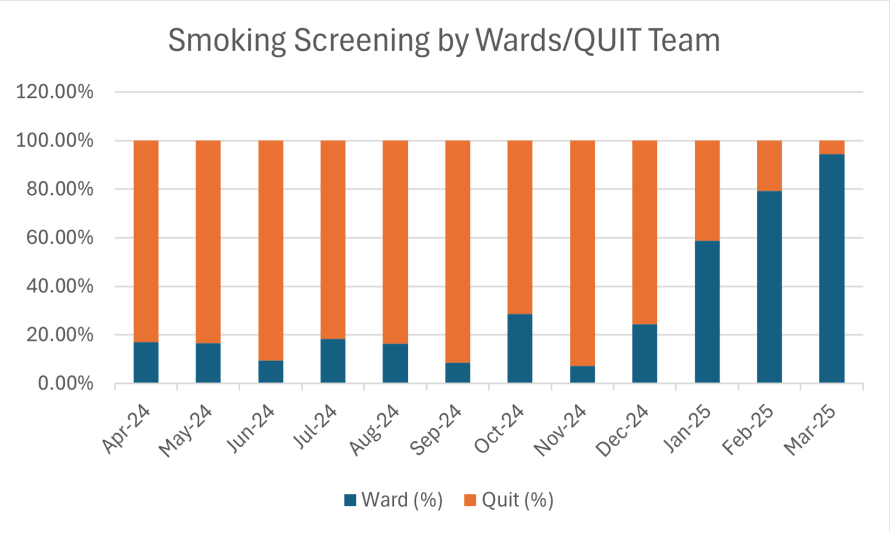
Inpatients:

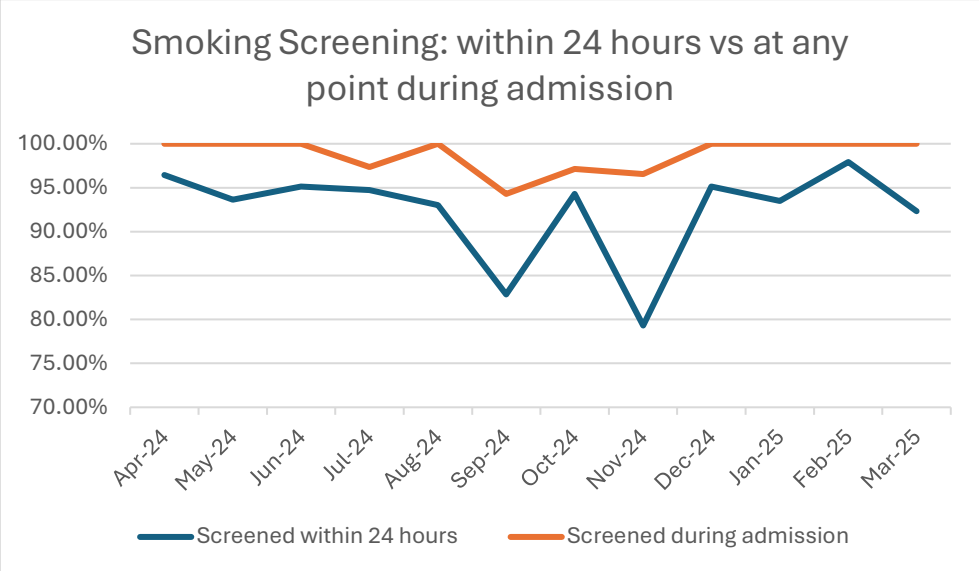
92.4% of admissions were screened within 24 hours

98.8% of admissions were screened at any point during admission

100% of identified smokers or vapers were seen by the QUIT Team

99.1% of identified smokers or vapers were offered nicotine treatment





Progress against Smoking Cessation Commitments:

Commitments (2024/25)	Progress

Create a regular and accessible data report, with the ability to report by ethnicity and deprivation as a minimum.	Partial achievement: Delay to Rio implementation has meant this was not achieved within 2023/24. The functionality is available within Rio, the report has been requested and will be developed in line with Digital team prioritisation process.
Liaise with Digital team to ensure capture of the most appropriate data in relation to smoking within the new EPR.	Partial achievement: Smoking screening forms are available and in use. Smoking data capture is to be achieved via Physical Health forms. This is awaiting development within optimisation process. Data reporting remains work in progress; Digital have set a completion date of end September 2025
Establish a Trust Smoke Free implementation group, to continue the partnership approach and progress the work	Not achieved: securing the appropriate clinical leadership has been a barrier to implementing this group. Partnered with Least Restrictive Practice team to form a subgroup and aim to increase participation and oversight of this work. Progress still a challenge. Seeking alternative approaches and creative solutions in place of a smoke free implementation group.
Join the Smoke Free Action Coalition (SMAC), the alliance of organisations working to reduce the harm caused by tobacco.	Achieved: Active membership. Also secured membership of National Smoke Free Mental Health Leads group. SHSC are well embedded as part of regional and national networks. Strong partnership with Sheffield Tobacco Control Board and therefore have links into South Yorkshire Tobacco Control Board and South Yorkshire Tobacco Control Partnership.
Design and implement a smoke free quality improvement (QI) project	Partial achievement: Two QI projects have been designed and registered with QI team (one inpatient and one community). Rio roll out has highlighted the lack of baseline data to monitor these projects. Reviewing how to progress without formal QI approach.

2025/26 Commitments:

1. Smoke Free Policy Group: Review the progress of this group. Consider ceasing and develop and alternative approach.
    a. Continue to report within restrictive practice work so this remains connected
    b. Identify possible training solutions for clinical staff
    c. Embed into respect training
    d. Utilise change and improvement group to support progress
2. Quality Improvement: Progress bespoke pieces of work with teams through a QI lens. First wave teams include: Gender Identity Clinic (GIC), Early Intervention Psychosis (EIS), Assertive Outreach Team (AOT), Specialist Community Forensic Team (SCFT), and Homeless

Assessment and Support Team (HAST). Focus includes review of screening processes and expansion of healthy hospital team remit.

3. ICB Delivery Plan: Focus for 2025/26 is increasing screening in the community.
    a. Seek to have baseline data for community teams in next health inequalities report.
    b. Begin to demonstrate outcome of improvement work
4. Optimisation of Rio: improve maturity and capability in relation to recording and data reporting
    a. Explore opportunities in relation to the NHS spine
    b. Establish robust baseline data to better implement improvement and change in the future

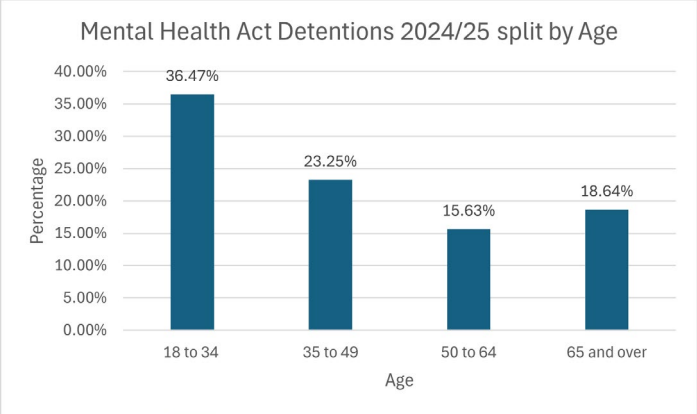
Mental Health Act Detentions

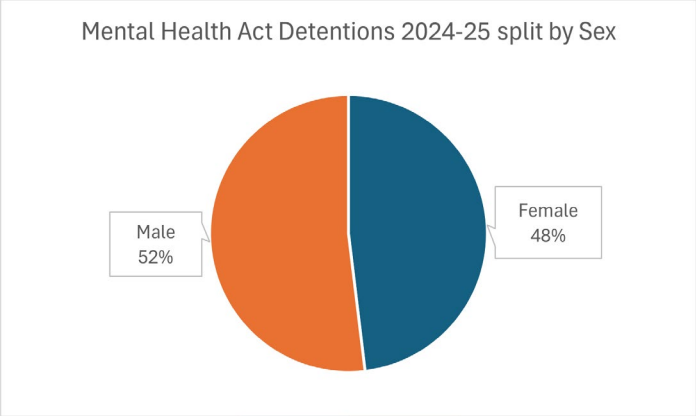
We are committed to ensuring care is delivered closer to home whenever possible, and that any detentions where necessary are appropriate, that the experience of the service user is as positive and as supportive as possible

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

Data

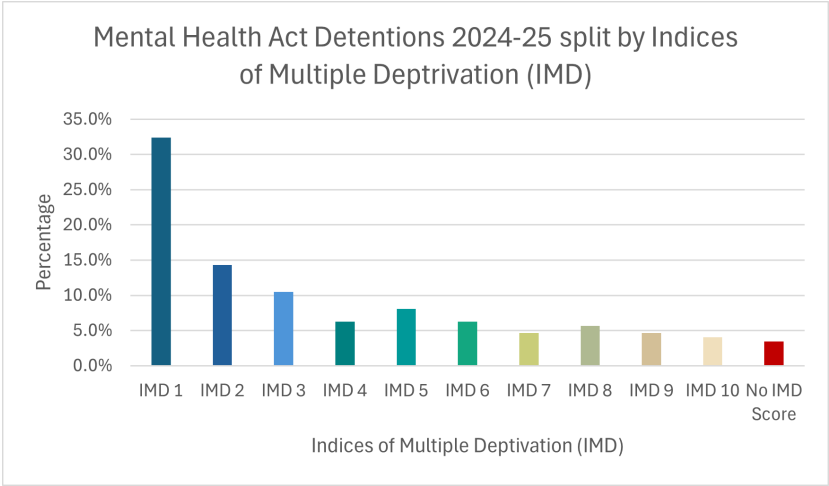
	2023/24	**2024/25**
Detentions under the Mental Health Act	1042	910
Number of people detained	538	497



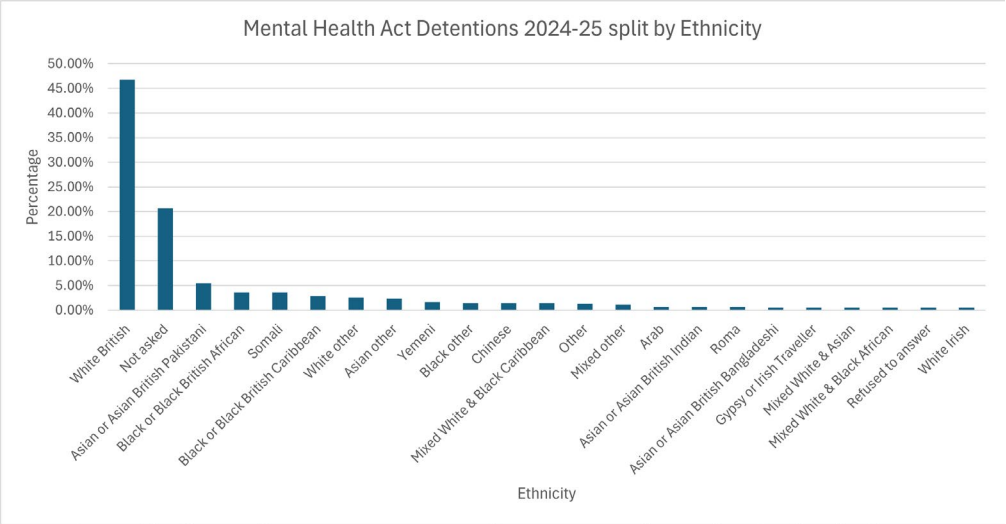


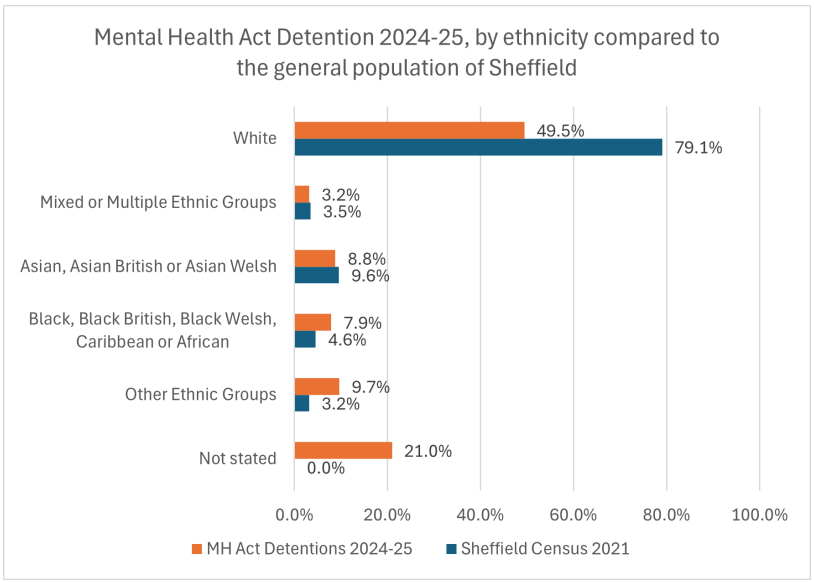
The data retrieved from the system produced only male/female categories, raising the question of where the non-binary patients are recorded on our system and reported within the data.

The highest number of service users detained under the Mental Health Act (all detentions) reside in the City's most deprived decile (IMD1), showing a steady reduction throughout the deprivation scale, with the smallest number of detentions from the least deprived areas of the city (IMD10).



IMD 1 = Most Deprived IMD 10 = Least Deprived





When compared to the general population of Sheffield, there is a disparity of detentions towards the global majority, specifically Black, Black British/Welsh and Caribbean and African service users, and other ethnic groups.

Ethnic minorities are overrepresented nationally within Community Treatment Orders (S17). Throughout 2024-25 SHSC detained 25 services users under S17 and a further 5 service users had their S17 extended. Further work is needed to analyse this data.

Commitments (2024/25)	Progress
Deep dive into episodes of care to ensure data is accurately reflecting what is happening on the wards.	Delayed: this will be progressed now we have migrated to Rio, enabling us to review and track this data more effectively.
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.	Delayed: this will be progressed now we have migrated to Rio, enabling us to review and track this data more effectively.

2025/26 commitments:

Commitments from 2024/25 will be rolled forward

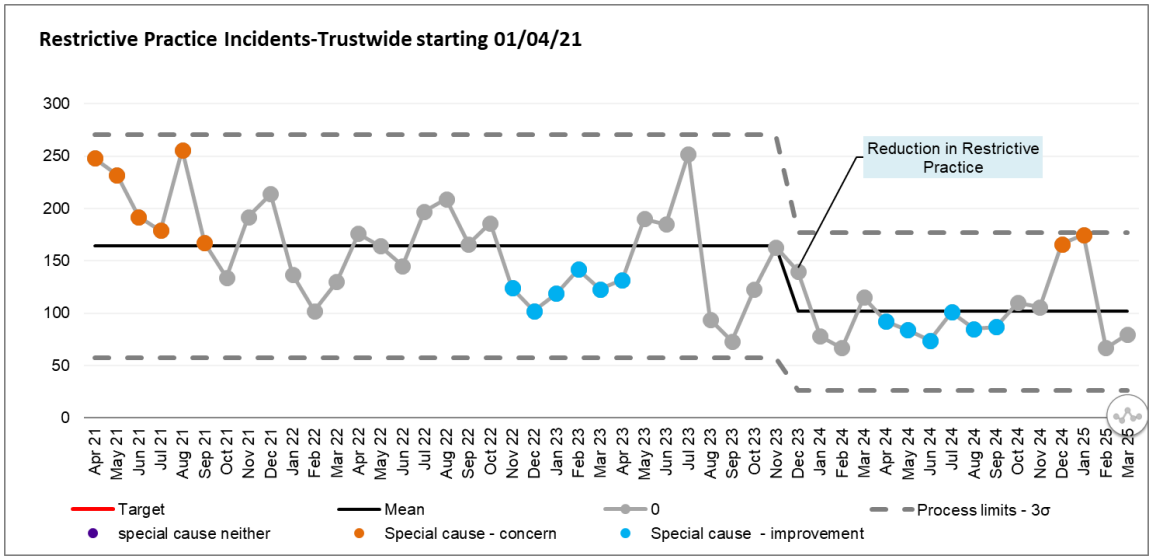
1. Deep dive into episodes of care to ensure data is accurately reflecting what is happening on the wards.
2. Further review of data in a more detailed and explorative way to gather a much clearer understanding of the inequalities relating to Mental Health Act detentions.
3. Further analysis of S17 data.
4. Head of Population Health and Inequalities and Head of Mental Health Legislation to meet monthly and review data
5. Review process for translation of detention evidence to support those where English is not their first spoken or written language, to be able to actively and fully engage in their detention review process.

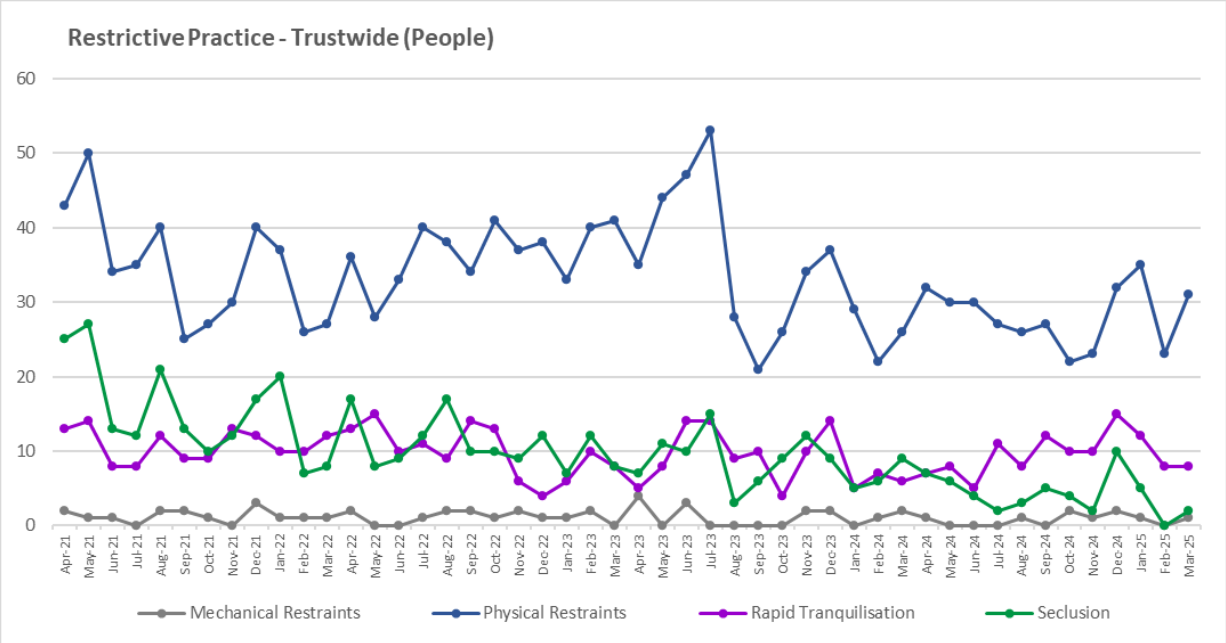
Restrictive Interventions

Throughout 2024/25 there has been an increased focus on addressing and reducing seclusion and restrictive practice. The work to implement and embed PCREF has contributed to the increased awareness of disproportionate rates of restrictive practice and the relationship this has with inequalities.

Data

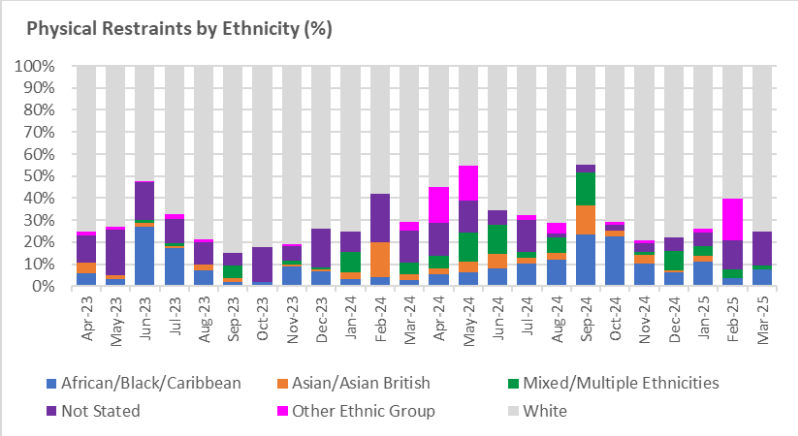
	2023/24	2024/25
Seclusion	95 people received 156 incidents of seclusion (9.6% of people admitted)	50 people received 65 incidents of seclusion (5.1% of people admitted)
Physical Restraint	320 people experienced 1144 incidents of physical restraint (25.8% of people admitted)	338 people experienced 893 incidents of physical restraint (33.9% of people admitted)
Rapid Tranquilisation	100 people received 194 incidents of rapid tranquilisation (10.4% of people admitted)	114 people received 260 incidents of rapid tranquilisation (11.4% of people admitted)

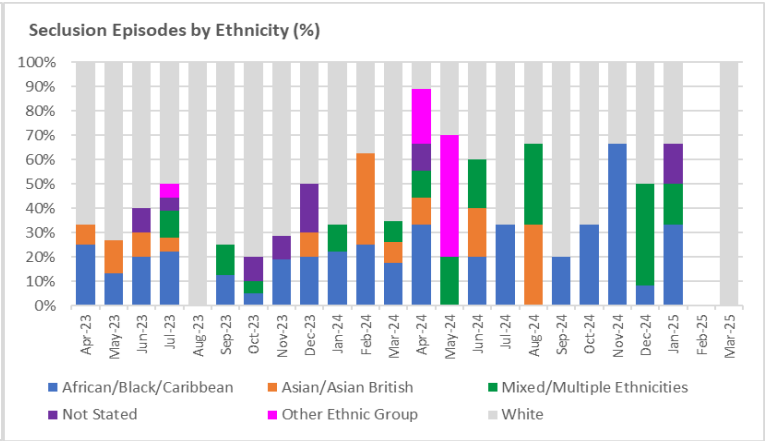


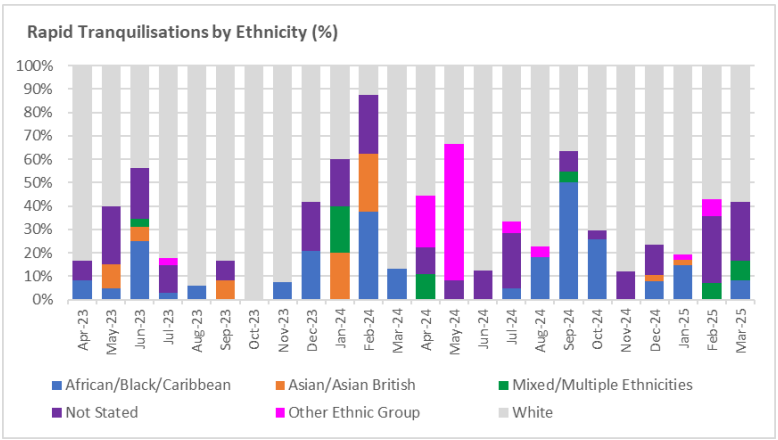


Number of restraints and seclusion episodes for Black British/African/Caribbean people	
2023/24	**2024/25**
23.4% of Black British/African/Caribbean people admitted in 2023/24 were physically restrained, compared to 28% in 2022/2023	28.2% of Black British/African/Caribbean people admitted in 2024/25 were physically restrained, compared to 23.4% in 2023/2024

13.5% of Black British/African/Caribbean people admitted in 2023/24 were recipient of seclusion compared to 22.5% in 2022/2023	12.8% of Black British/African/Caribbean people admitted in were recipient of seclusion compared to 13.5% in 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 the output from physical restraint incident reports found that only 7 of the 338 people restrained had a full post code recorded. Of the seven people, 2 reside in IMD1. Work is underway with Rio team to review and address interoperability and connections to Ulysses, as well as ongoing work to improve the quality of data reporting.

Commitments (2024/25)	**Progress**
Deliver advanced Human Rights training within Respect Level 3 – compliance 80%	From September 2022 to August 2024, approximately 500 staff members participated in 3+ hours of face-to-face training on the operation of the Human Rights Act, initially through an elective course and later via the mandatory RESPECT Level 3 update course.

	Since August 2024, training is delivered through RESPECT level 1 and Human Rights Practice leads (38 since December 2024). Current compliance Respect Level 1 training: 73.3% (1131 out of 1544 staff) From Sept 2025 a new cycle of training will commence that will no longer include Human Rights training
Reduce the use of seclusion and prolonged seclusion for those people from a black and Afro Caribbean ethnicity	Whilst we have seen marginal improvement under this commitment (reduction of 0.7% compared to the previous year) – further work is needed and will continue to remain a commitment for SHSC.
Introduce and evaluate cultural advocacy	Race Equity Officer works with our Respect team supporting people involved in restrictive practice from ethnically diverse background. Evaluations of this work is reported on a quarterly basis into LRPOG
Ensure (100%) post-incident reviews for staff and service users following seclusion or prolonged restraint	Target achieved for 2024/25 was 50-60% Our risk management system has been updated to flag what support is available when certain types of incidents are reported. This will follow with a clear directive for staff to complete to indicate the support that has been offered and taken. Post incident review is included in training, this training is currently being reviewed by SHSC Race Equity Officer. This work will continue into 2025/26 with an aim of improving the percentage of post-incident reviews.
Implement training and resources on psychological restraint	As part of Respect training, staff went through a half days training on psychological restraint, there are provided access to online resources through the Restraint Reduction Network created with SHSC Human Rights Officer.

2025/26 commitments:

The following areas will continue to be a focus.

1. Health-Based Place of Safety - support the development of practice and operating procedures for new build specific to restrictive practice
2. Reduce the use of physical restraints, seclusion and prolonged seclusion for those people from a black and Afro Caribbean ethnicity

3. Utilise PCREF Stakeholder Delivery Group including community leaders from racialised communities to focus on inequalities data within restrictive practice.
4. Continue to ensure post-incident reviews for staff and service users following seclusion or prolonged restraint are completed, with the aim of increasing percentage achieved.
5. Continue to improve data literacy and practices in recording of information. This is currently a focus for the organisation and being progressed through several initiatives, including protected Characteristics work to improve data quality, digital Literacy to support the workforce and PCREF objective to ensure data is included in clinical records.
6. Ensure improvements are made to enable deprivation data reporting, through both system and quality of reporting

NHS Sheffield Talking Therapies

The Sheffield Talking Therapies Central and Equalities Team was established in April 2022 and has developed to become a fully established team in the service, operating in the same way as core teams but focussing on delivering clinics and having presence in the voluntary and community sector. The strategy was first created in 2021/22 and is reviewed annually, focussing on improving access, experience and outcomes for all.

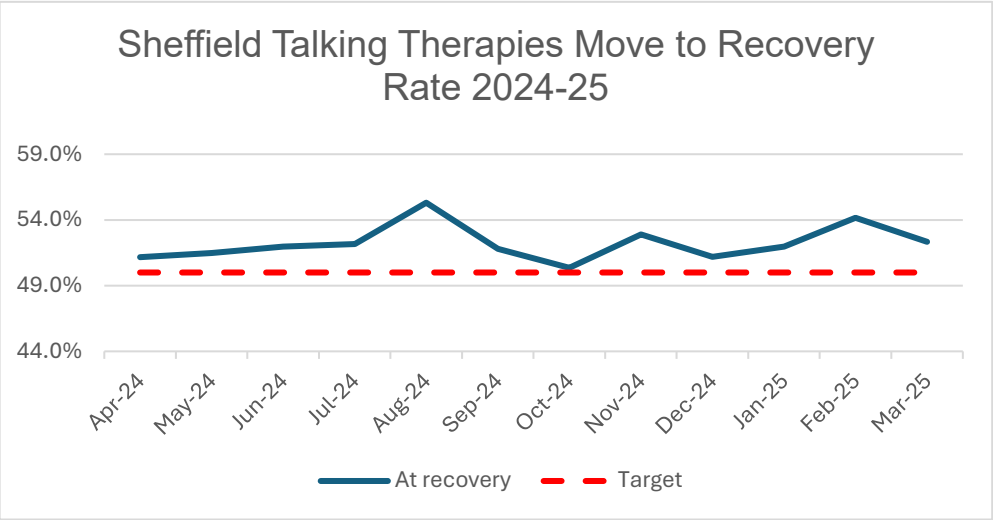
Data

NHS Sheffield Talking Therapies has exceeded the 50% target recovery rate every month in 2024-25

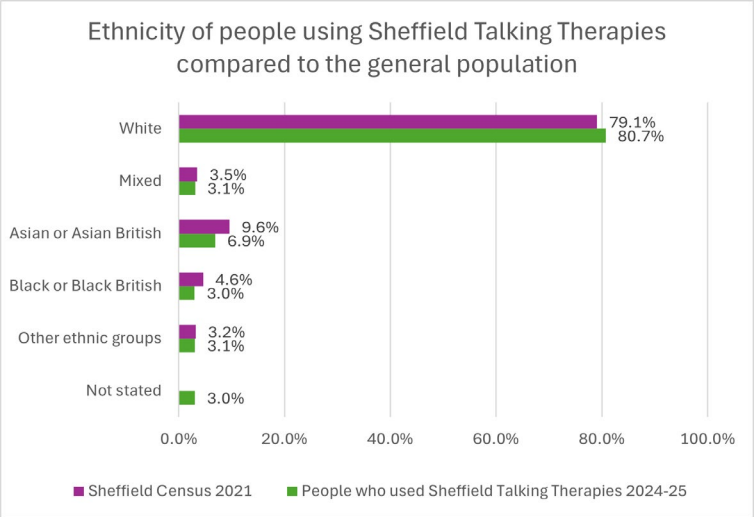
Over the 12-month period, a total of 6,476 people received treatment from Sheffield Talking Therapies. Of those an average of 52.2% moved to recovery. The service has exceeded the recovery rate target every month throughout 2024-25.

Sheffield Talking Therapies service have created several focussed working groups service wide to address the disparities of access and experience within their service as identified through analysed data. Additionally, the Central and Equalities Team working closely with statutory and Voluntary, Community and Social Enterprise (VCSE) partners to ensure greater connection and opportunities for improvement.

The rate of service users with an ethnicity recorded has improved. The service has now got 2.8% of records where an ethnicity is not stated/recorded, an improvement from 4.1%.

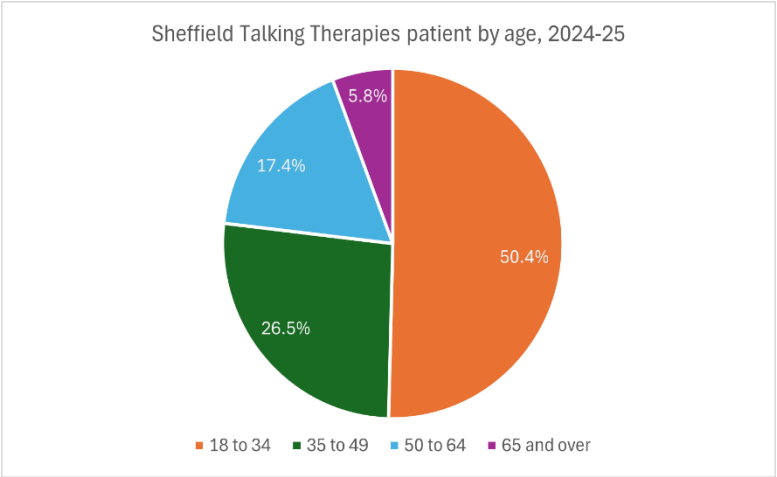


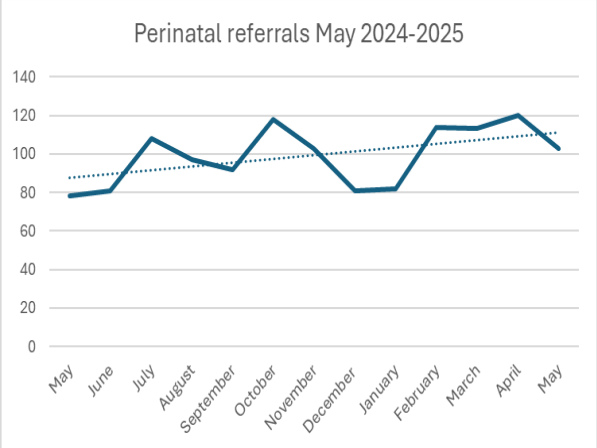
Sheffield Talking Therapies service has achieved a recovery rate of over the target 50% every month



When compared to the general population of Sheffield people accessing STT shows a under representation for those from Mixed and Black/Black British ethnicity, and over representation of white people. This is a known gap to the service who are working to address, see commitments below for detail.

Age of service users continues to be primarily 18–34 year-olds, at 50.04% of service users. Those ages 65 and over make up on 5.8% of the Talking Therapies population.





Sheffield Talking Therapies has a focus on perinatal, and work undertaken has shown an increase in referrals to the services from women who are pregnant or 1 year post birth. Going forward this data will be reviewed in more detail to better understand inequalities and intersectionality.

Commitments (2024/25)	**Progress**
Increase access and outcomes for people from ethnically and culturally diverse communities (ECDC), older adults and students	Implementation of NHS Talking Therapies Positive Practice Guides.

	Bi-monthly working group has been established for all populations highlighted within national strategies All staff encouraged to join the working groups, learning is disseminated through governance and team meetings
Improve recovery rates for non-white British patients in line with white British	Implementation of NHS Talking Therapies Positive Practice Guides. Bi-monthly working group established and leading on this work The service has not seen the recovery rates increase for this cohort of patients. A large amount of work has been done to understand and improve this, Including a service wide Cultural Awareness staff CPD event in June 2024, cofacilitated with VCSE organisation. This supported staff to feel more equipped to work with the person in front of them and to ask questions and be curious about culture.
Establish clinics in voluntary sector across the city.	All working groups engage with the community and voluntary and community sector organisations to build relationships and support work to improve access, experience and outcomes.

2025/26 commitments

1. Access, experience and outcomes – focus on patients and referrers, continue to develop work within population working groups. This may include
   - Service User forum – to gather feedback from specific communities e.g. older adults, perinatal, ECDC patients.
   - Regular outreach within ECDC communities and specifically VCSE organisations – comms campaigns including stalls in libraries/Grand Mosque etc
   - Review data to ensure we can report by deprivation.

2. Website development – to ensure that the website is accessible and represents the diverse Sheffield community
   - Review referral form based on feedback from our communities
   - Mission statement for service

3. Project work
   - Fortnightly project review meetings
   - ECDC students – presence during freshers' week, outreach sessions on campus
   - Connect with other services in relation to Equalities work

- Connect to working groups – review feedback and feed into team governance meetings for service wide updates
- Follow on actions from cultural awareness sessions - ECDC questionnaire for staff, identifying training needs or challenges.
- Monthly service newsletter – to continue with an effective feedback loop

b. Trust Board Health Inequalities Self-Assessment

A self-assessment has been developed by NHS providers to ensure that health inequalities is a core focus of the work of the Board. A series of 25 questions assess the maturity level of the Board and offers a bespoke series of objectives to support improvements. In June 2024, the Trust **Board of Directors** held a health inequalities development session, which included reviewing the self-assessment themes. September 2024 the self-assessment was completed.

SHSC scores for 2024 are below:

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

The objectives from the self-assessment will form part of the health inequalities action plan. The Trust will complete a re-assessment annually to review progress and focus objectives.

c. Recording of personal data

A focused and targeted programme of work to improve the collection and recording of **protected characteristics** for service users accessing care within SHSC commenced in December 2024. An approach was developed focusing on behaviour science model COM-B (capability, opportunity, motivation and behaviour), with supportive performance management, leading to sustained long term change.

A pilot of the approach began with a small number of teams. A collective steering group was formed to allow the sharing of learning across all teams and services. Shared challenges were identified and collaboratively resolved. Support was offered to better understand the importance of this work, to be clear on the expectations. Teams were engaged individually to further explore team specific barriers and opportunities. Bespoke approaches and team level targets were created to make the task manageable and realistic as well a target work and improve efficiency. A data pack was created for each team to highlight data gaps in a clear and simple way. Thes data reports were co-produced with services to ensure they met their needs and supported these conversations and reporting

The approach is showing marked improvement and high levels of engagement. Plans are underway to roll out and embed the approach and learning Trust wide.

d. Active participation and learning

In June 2024, a **population health forum** was established, open to all staff to learn together and share best practice. Since its inception, it has been well attended by colleagues across the Trust.

This is a space for anyone interested in population health, and how this approach can have positive impact on patient access, experience and outcomes, and reduce health inequalities. It aims to be an informal forum for connection, to share ideas, and discuss challenges and opportunities, and where possible invite guest speakers. So far sessions have covered:

1. The basics: understand what we mean when we talk about population health and inequalities.
2. Smoking is the new smoking: smoking is the leading cause of premature death, disease and disability in our communities. The impact of smoking is both amplified by all the markers of deprivation and leads to deprivation, so we cannot effectively tackle health inequalities without addressing smoking.
3. Intersectionality: understanding the importance on intersectionality. Intertwined and overlapping factors that can result in unique combinations of discrimination or privilege.

In August 2024, SHSC signed a pledge committing everyone to eight key principles to support a smokefree future. The **NHS Smokefree Pledge** is designed to be a clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smokefree environments which support quitting. In signing the NHS Smokefree Pledge, organisations commit to reduce the harm caused by tobacco through implementing comprehensive smokefree policies. Additionally, the Trust **Smoke Free Policy** was refreshed and approved in March 2025

A working group focussing on **Women's health inequalities** commenced in January 2025. This was in partnership with Sheffield Hospitals Charity (SHC) and Sheffield Teaching Hospital, to support SHC health inequalities programme of work. The group have been working together to use research and evidence to identify opportunities for improvement.

In March 2025 a **Health Inequalities Action Group** was established. This was in response to the success of the population health forum and desire for people to see action and improvements as well as access to learning opportunities.

Alongside this a staff intranet page has been created with links to presentations and reports, recording of forums and online learning. This space includes a **Learning Library**, a bank of resources, ranging from long reads to short videos, helpfully categorised to maximise the time.

SHSC have a strong staff network with six active **staff network groups**; Amazing Women, Ethnically Diverse, Rainbow Forum, Disability, Lived Experience and Carers. These group are well attended and considered a safe space for staff to share and learn. Several of the groups promote and mark awareness days as well as working towards accreditations.

Quality Improvement **Waiting List and Waiting List Collaborative** continues to progress. Reducing waiting lists and supporting service users to "wait well" whilst on waiting lists is the key area of focus. All teams involved are supported by a QI coach to utilise various tools and to plan and implement their change ideas. The Collaborative is a two-year programme set to run until July 2025

A **population health report** was created for Liaison Psychiatry service as evidence for their service re-accreditation. The report has helped to highlight gaps in service data and knowledge and offered a series of recommendations.

Additional learning opportunities for staff and wider health care colleagues include, SHSC Developing a Leaders programme that runs sessions on Equality, Diversity and inclusion, health inequalities and population health. Sourcing guest speakers from the local health system. Intersectionality at the South Yorkshire School of Psychiatry Conference, and health inequalities focus at the Research Departments 'Drop In On Research and Evidence' sessions.

An **integrated change framework** has been developed throughout 2023/24. A series of workshops helped to review, refine and develop the integrated change offer across the Trust. This framework will enable effective planning and governance of change and improvements, through an enabling and permissive framework, and support a culture of continuous improvement where everyone can make improvements and drive change.

Our **Quality and Equality Impact Assessment** panel now includes both sustainability and health inequality leads. The process and associated paperwork and are being reviewed to ensure these areas are fully integrated and core to the decision-making processes.

The **sustainability strategy** has recently been refreshed which identifies the connection with, and impact on health inequalities, particularly sustainable models of care

2. Local partnerships

Sheffield City Council has recently published a **'Fair and Healthy Sheffield Plan'.** In September 2024 this was adopted by the Sheffield Health and Wellbeing Board and taken back to partner organisations to commit to action within the plan. This is a 10-year plan to improve the health and wellbeing of Sheffield residents. SHSC were involved in the development of the plan and are committed to supporting its success. A series of annual commitments have been identified to acknowledge the Trusts role in supporting the success of this plan and will be incorporated into our revised Trust strategy and health inequalities action plan.

SHSC launched a **Home First initiative** in September 2024**,** Focused work to improve patient flow to ensure people are admitted to hospital when needed, discharged when ready, and are not sent out of area for care. To support this, we have engaged with the NHS England Getting it Right First Time team and an external supplier, both have a proven track record in supporting mental health trusts to improve patient flow. We have set ourselves a challenging trajectory to reduce the use of out of area beds by November and acute, community, crisis and rehab and specialist teams are aligned behind this to support its achievement.

SHSC are a referral partner of the National Energy Action (NEA) 'Warm Homes Healthy Futures' Programme. A nationally coordinated network of locally delivered services that will tackle **fuel poverty** and improve health for tens of thousands of people across Great Britain. The programme will enable effective partnership working between health, energy and housing in various local areas.

SHSC are an active member of the **North-East Neighbourhood Programme Board** 'This is Us'. Focussing on four north-east neighbourhoods of Sheffield, that face inequality and deprivation, resulting in poor life expectancy, health, educational attainment, and skill levels, as well as disempowered and disconnected communities. Disconnection and loneliness negatively impact

health. By funding prevention and building community capacity in these areas, the aim is to connect and empower communities and, in turn, improve people's health.

3. PCREF Implementation

Patient and Carer Equity Framework under development within the Trust. PCREF is NHS England's first ever anti-racism and accountability framework to tackle and eliminate the unacceptable racial inequalities in access, experience and outcomes faced by racialised and ethnically and culturally diverse communities and to significantly improve their trust and confidence in mental health services.

Our PCREF programme is focused on the three core components also known as three priorities. These are listed below with progress made during 2024/25:

Part 1: Leadership and Governance

- SHSC have an Executive PCREF Lead at Trust Board level accountable for delivery & oversight of PCREF; the Executive Director of Nursing, Quality and profession is the nominated executive lead
- Local evaluation of PCREF has been completed led by University of Sheffield
- Creation of health inequalities dashboard which includes measures which we have a statutory obligation to provide; including use of restrictive practice by ethnicity, safety incidents and near misses for people from racialised communities and complaints broken down by ethnicity
- Partnered with NHSE's 'Advancing Mental Health Equalities Taskforce' as a PCREF early implementor site
- Continued to grow the scope and impact of the 'Being There' project. Through collaboration with Pakistan Muslim Centre (PMC) the 'Being There' project focuses on providing informal cultural advocacy recognising the diverse needs of our service users and the need for independent involvement to gain experience feedback from all service users.
- We are part of the Culture of Care Programme from NHS England's Quality Transformation Programme aiming to improve the culture of care in our inpatient mental health wards. Cultural advocacy workers are involved in this work and anti-racism is a key component.
- Introduction of the Head of population health inequalities role which has had huge contribution and impact on work regarding data recording and a clear plan to address our recording of data in relation to ethnicity.

Part 2: Organisational Competencies

- SHSC is the first Trust in the UK to have made embedding human rights into day-to-day practice a core strategic priority. In practice, this means that human rights go beyond legal compliance, serving as a catalyst for cultural change within the Trust and its principal ethical practice framework
- Human rights have become a well-established and influential part of the Trust's discourse. The integration of human rights into the RESPECT training has been particularly significant in SHSC - by August 2025, approximately 1,500 staff members will have completed between 90 minutes and 3 hours of training across all groups and professions.
- The 'Human Rights and Practice Leads' training is a comprehensive three-day course that is conducted twice a year for approximately 20 staff members whose role is to lead on human rights. All members of the PCREF team have successfully completed this essential training.

- Across the year several cultural awareness training sessions (circa 10 sessions) have been delivered to teams by the cultural advocacy workers with further sessions planned.
- Organisationally we continue to develop links with VCSE. An engagement officer employed by the trust continues to work into Aspiring Communities Together (ACT) to focus on supporting members of the community to access care for the Yemeni community and addressing barriers to care.
- Funding has been received by Sheffield Charities and two Somali peer support workers are now working into SHSC to support understanding, development, training and access to care.
- We have invested in external contracts with a focus on co-learning and co-producing how we develop staff and services. This includes the continuation of the 'being there' project with PMC and work with SACMHA.
- An Equality officer from SACMHA works within the restrictive practice team ensuring training, development and awareness on the impact of restrictive practice to service users from a racialised background is understood by staff.
- Locally there continues to be a focus on the reciprocal mentoring programme and the Inclusion, Diversity and Equality Group
- Forest Close inpatient rehabilitation unit for adults have their own catering budget to support service users to cook their own halal meals.
- Over the last 6 months, 174 service users were supported by the cultural advocacy link workers and over 40 family members were liaised with. Of note is the impact of working with family and supporting with feedback to the MDT, specific examples of this were received from the PMC report highlighting the need for cultural advocacy for family members.
    - achieving a consistent reduction in the use of seclusion and physical restraint across inpatient services (number of incidents and use of seclusion)
    - Further rollout of the RESPECT training programme.
    - Embedding of Safewards interventions to improve inpatient safety.

Part 3: Patient and Carer Feedback Mechanisms

- PMC Qualitative and Qualitative feedback on patient experience which continues to increase. The feedback is given in themes which highlights areas which are required for improvement then acted on; this includes access to religious materials and culturally appropriate meals.
- Implementation of first star of Triangle of Care and work on the second star. The triangle of care ensures the voices of carers including those marginalised by race are included and inform service improvement
- Engagement officer input to wards and to community service to gather qualitative feedback
- Growth of lived experience colleagues in a range of opportunities and fixed roles across the organisation
- Safe 2 Share work recommenced with a new project lead in November 2024, capturing live feedback on wards.
- Feedback shared with Lived Experience and Coproduction Assurance Group
- Provided relevant data to national bodies according to our statutory responsibilities
- Coproduction and extensive engagement taken place with community organisations through community mental health transformation, trust strategy refresh and Feedback February

In Summary

SHSC continue to strive to achieve equitable access, excellent experience and optimal outcomes for everyone who is in receipt of our services now or in the future.

The last 12 months have formed solid foundations to build from and the progress we have made is notable. Consideration needs to be given to the long-term approach to addressing health inequalities in line with the strategy refresh and related impact on resources required to achieve meaningful change.

We still have much to do and are in the best position to move forward toward 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/

Scoring

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	5	63%	Maturing
2 - Data, insight, evidence and evaluation	5	36%	Developing
3 - Strategic leadership & accountability	9	50%	Maturing
4 - System partnerships	7	70%	Maturing

Recommended Objectives

1 - Building public health capacity & capability	Maturing
2.3	NEDs: All NEDs to seek opportunities for personal development on health inequalities
3.3	Chief executive: Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these
3.8	Chief executive: Ensure that board members, senior leaders (Band 9 and Very Senior Managers) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
4.10	Executive lead for health inequalities: Ensure there are systems

	in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities of interest for health inequalities
5.6	People: Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles
5.7	People: Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant
10.6	Clinical, quality and research: Build in-house capacity and capability for health inequalities research work

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 — Maturing

4.2	Executive lead for health inequalities: Ensure integrated working with HR and equality, diversity and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality
6.2	Strategy: Embed an equity lens across all organisational priorities, strategic documents and annual planning processes
7.2	Finance: Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives

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?	Partial
3	Has your trust delivered any quality improvement work or change programmes related to health inequalities?	Yes
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?	No
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?	Partial
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?	Partial

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?	Yes
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?	Partial
6	Does your trust/board use a health inequalities impact assessment tool in your business case process?	No
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?	Partial

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?	Partial
4	Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities?	Partial
5	Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives?	Yes

Sheffield Health and Social Care NHS Foundation Trust

Reducing health inequalities: a guide for NHS trust board members

26 March 2024

NHS Providers

SHSC Trust Board Self-Assessment

2024-2025 Progress Overview

Progress

Improvement seen across all four domains.
Clear shift from 'developing' to 'maturing'

Proud to care in Sheffield

NHS Sheffield Health and Social Care NHS Foundation Trust

Theme	Sep-24	% Score	Sep-25	% Score
1. Building public health capacity & capability	Developing	38%	Maturing	63%
2. Data, insight, evidence & evaluation	Developing	29%	Developing	36%
3. Strategic leadership & accountability	Developing	39%	Maturing	50%
4. System partnerships	Maturing	60%	Maturing	70%

Percentage	Maturity Rating
0	Not started
1-24	Emerging
25-49	Developing
50-74	Maturing
75-100	Thriving

2025 Themes

Strong foundations built with a clear commitment and vision for this work. Next steps require this work embedding, enhancing and formalising

Maturing

Building public health capacity and capability

Health inequalities focused training and QI work being delivered across the trust

Inconsistency of training/development to board and staff

Lack of public health specialist staff employed by the Trust

Developing

Data, insight, evidence and evaluation

Good progress being made in relation to data collection and reporting

Improvements needed in reporting of performance data by ethnicity and deprivation and analysis and application of this data

Maturing

Strategic Leadership & accountability

Strong commitment to reducing health inequalities and role in the system

Enhancing and formalising this commitment through setting board objectives, business planning process and investment in identified opportunities to prevent and mitigate healthcare inequalities

Maturing

System partnerships

Representation at system level and collaboration with system partners to contribute ot population health decision making

Clarify and establish role as anchor organisation

Build and formalise programme of work to improve access to employment for under-represented groups

Further consideration of pathway redesign with system partners

2026 Recommended Objectives

Maturing

1. Building public health capacity and capability

1. NEDs: All NEDs to seek opportunities for personal development on health inequalities
2. CE: Ensure all staff at all levels of the organization are aware of the vision and strategy for tackling HI and understand their role in delivering this
3. CE: Ensure that Board members, senior leaders (B9 & VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
4. Exec lead for HI: Ensure there are systems in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities od interest for health inequalities
5. People: Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles
6. People; Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed as relevant
7. Clinical, quality & research: Buil in-house capacity and capability for health inequalities research work

Developing

2. Data, insight, evidence and evaluation

1. CE: Set an expectation on board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where applicable), such as ethnicity and deprivation
2. CE: Identify a Trust lead for digital inclusion and provide supporting governance
3. Ops/Delivery: Work with the comms leas to review Trust comms with patients (such as leaflets/letters) in response to the health literacy levels of your patient population. Refresh and update communications accordingly
4. Data, digital & Information: Datasets (incl patient experience, patient s[illegible], operational & clinical measures) to be broken down as a min[illegible]n by ethnicity, deprivation, age and sex. Where available, data on other protected characteristics and inclusion health groups could be considered
5. Data, digital & 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
6. Clinical, quality & research: Maximise research assets and expertise to develop programmes of work which have the potential to reduce health inequalities
7. Clinical, quality & research: Include reference to health inequalities within all pillars of clinical governance including learning for individual cases and overarching themes relating to heath inequalities

2026 Recommended Objectives

Maturing

3. Strategic Leadership & accountability

1. Exec lead for HI: Ensure integrated working with HR and Equality, diversity and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality
2. Strategy: Embed an equity lens across all organizational priorities, strategic documents and annual planning processes
3. Finance: Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives

Maturing

4. System partnerships

1. Exec lead for HI: Work collaboratively with senior leaders and health equity 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
2. Exec lead for HI: Work collaboratively with executive board members leading on the organisations anchor institution work, to ensure alignment with the health inequalities agenda
3. Exec lead for HI: Work with systems partners to ensure the Trust has pathways to engage communities and local voluntary, community and social enterprise (VCSE) sector organisations
4. Ops/Delivery: Enable services to embed co-production principles to inform work on health inequalities. Co-production could include staff, public and patient reference groups, engagement events, or similar mechanisms.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Reducing Inequalities at SHSC

Annual Report 2024-2025

Proud to care in Sheffield

Executive summary

Sheffield Health and Social Care NHS Foundation Trust (SHSC) continues to advance its commitment to reducing health inequalities across services, communities, and systems. The 2024–25 annual report outlines key progress, persistent challenges, and strategic priorities that shape our equity-focused agenda.

This year, SHSC embedded its **Inequalities and Population Health Plan** across operational and governance structures, supported by the **Patient and Carer Race Equality Framework (PCREF)**, Board-level self-assessment, and a renewed focus on culturally safe care. Notable achievements include universal access to smoking cessation services in inpatient settings, improved data recording of protected characteristics, and strengthened staff engagement through forums and networks.
However, disparities remain—particularly in **Mental Health Act detentions**, **restrictive interventions**, and **access to talking therapies** among ethnically diverse and socioeconomically disadvantaged populations. These gaps underscore the need for deeper data maturity, inclusive service design, and sustained community partnerships.
SHSC has also expanded its collaboration with city-wide initiatives such as the **Fair and Healthy Sheffield Plan**, **ICB North East Neighbourhood programme** and **Sheffield Hospitals Charity** health inequalities grant making priority, aligning local efforts with national equity goals.

As we look ahead to 2025–26, SHSC is committed to embedding equity into every decision, every service, and every relationship—with a clear focus on transparency, lived experience, and measurable impact.

Strategic framework

NHS
Sheffield Health and Social Care
NHS Foundation Trust

We will become an exemplar in addressing health inequalities and working in partnership on the wider determinants of health

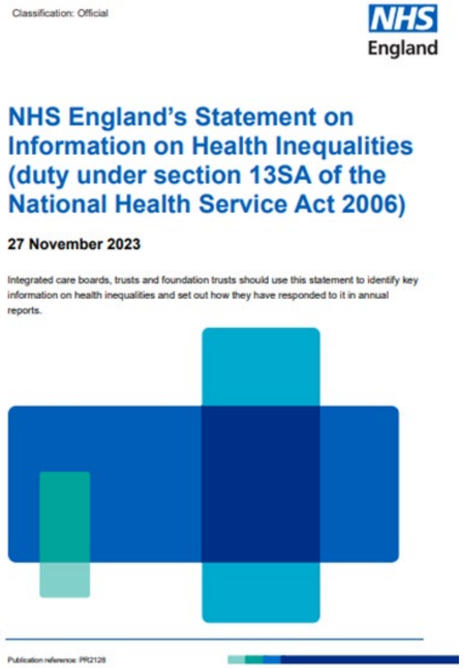
The purpose of this report is to provide an overview of the actions and achievements in relation to our commitment to reducing health inequalities.

1. Implementation of the Inequalities and Population Health Plan
    i. Annual statement on health Inequalities
    ii. Trust Board Health inequalities self-assessment
    iii. Recording of personal data
    iv. Active participation and learning

2. Local Partnerships

3. PCREF Implementation

Sheffield Health & Wellbeing Board



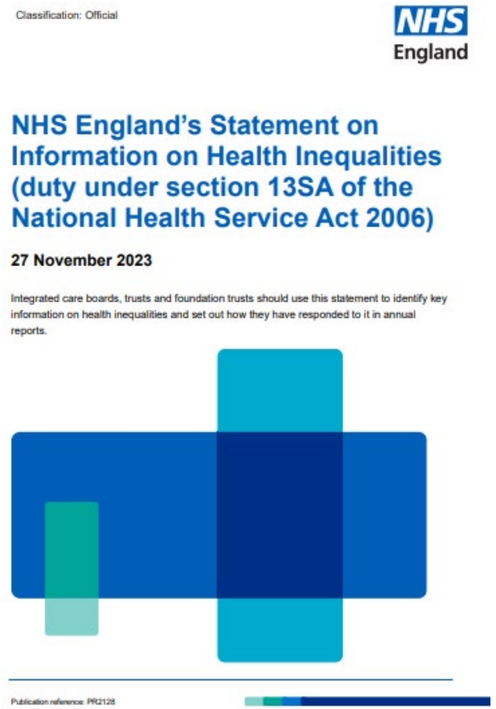
Statement of health inequalities

Sheffield Health and Social Care NHS Foundation Trust

Section 13a of the NHS Act 2006 requires the Trust to collect, analyse and publish information in relation to health inequalities.

Required domains in relation to mental health, are to be reported by ethnicity and deprivation as a minimum:

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


Classification: Official

NHS England

NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)

27 November 2023

Integrated care boards, trusts and foundation trusts should use this statement to identify key information on health inequalities and set out how they have responded to it in annual reports.

Publication reference: PR2128

Caveat: *up until March 2025 SHSC recorded and accessed data from four electronic patient record (EPR) systems - Rio, Insight, SystmOne and IAPTus. As a symptom of our digital immaturity, we have been unable to access and report on some of the demographic data within the required domains. As of March 2025, SHSC completed the migration of Insight services to Rio, and retired the use of Insight. Please note figures have been suppressed to prevent disclosure of information about individuals.*

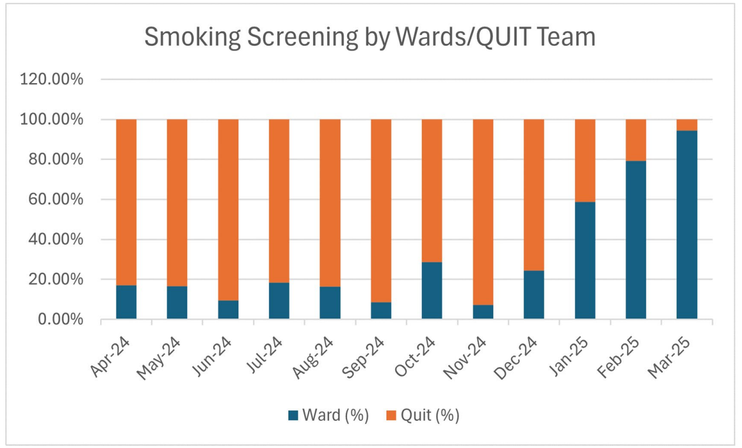
Proud to care in Sheffield

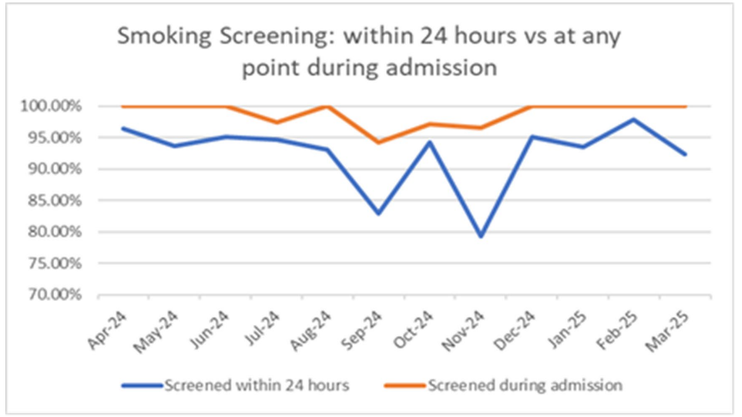
Smoking Cessation

100% of adult acute inpatient settings offer smoking cessation

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Commitment Area	Status	Key Notes	Next Steps
Data Reporting by Ethnicity & Deprivation	Partially Achieved	Rio delays impacted 2023/24 delivery. Report requested.	Develop report via Digital prioritisation process.
Smoking Data Capture in New EPR	Partially Achieved	Forms available; full capture pending optimisation.	Complete optimisation and embed in Physical Health forms.
Smoke-Free Implementation Group	Not Achieved	Leadership barrier; subgroup formed with Least Restrictive Practice team.	Explore creative alternatives and increase engagement.
Join Smoke Free Action Coalition (SMAC)	Achieved	Active member of SMAC and national networks.	Maintain partnerships and leverage national insights.
Smoke-Free Quality Improvement (QI) Projects	Partially Achieved	Two projects registered; baseline data gaps due to Rio rollout.	Progress QI work with targeted teams and refine monitoring approach.





100% of identified smokers or vapers were seen by the QUIT team

98.8% Of admissions were screened at any point during admission

92.4% of admissions were screened within 24 hours

99.1% of identified smokers or vapers were offered nicotine replacement treatment

Mental Health Act Detentions

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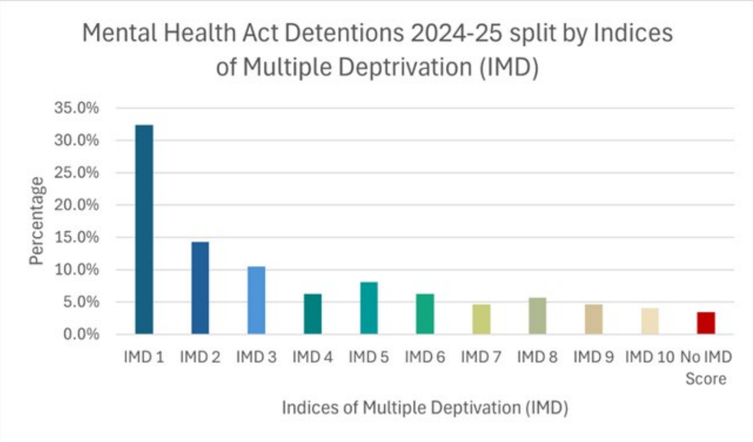
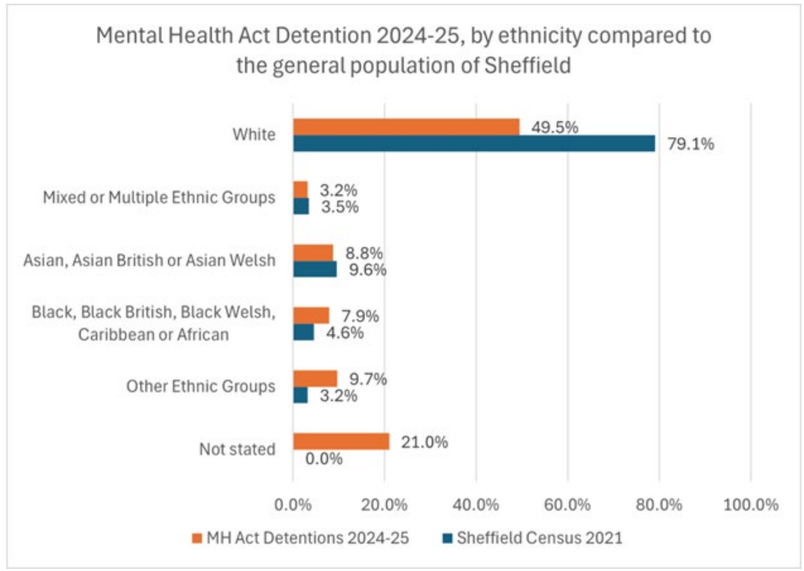
	2023/24	2024/25
Detentions under the Mental Health Act	1042	910
Number of people detained	538	497



The **majority of detentions** under the Mental Health Act occur among service users living in the **most deprived areas** of the city (IMD1).

There is a **gradual decrease** in detention numbers across the deprivation scale.

The **fewest detentions** are recorded in the **least deprived areas** (IMD10).



Compared to Sheffield's general population, **disproportionately high detention rates** are observed among **global majority ethnic groups**.

This includes **Black, Black British/Welsh, Caribbean, African**, and other minoritised communities.

🟦 Milestone	📌 Description
🔁 **Roll Forward 2024/25 Commitments**	Continue work on unresolved priorities from the previous year.
🔍 **Deep Dive into Episodes of Care**	Ensure ward-level data accurately reflects real experiences.
📊 **Review Detention Data in Detail**	Explore inequalities in Mental Health Act detentions more thoroughly.
📈 **Further Analysis of Section 17 Data**	Examine S17 leave data to identify patterns and disparities.
🗓️ **Monthly Leadership Data Reviews**	Head of Population Health & Head of Mental Health Legislation meet monthly to assess progress.
🌐 **Improve Translation Processes**	Enhance support for individuals whose first language isn't English during detention reviews.

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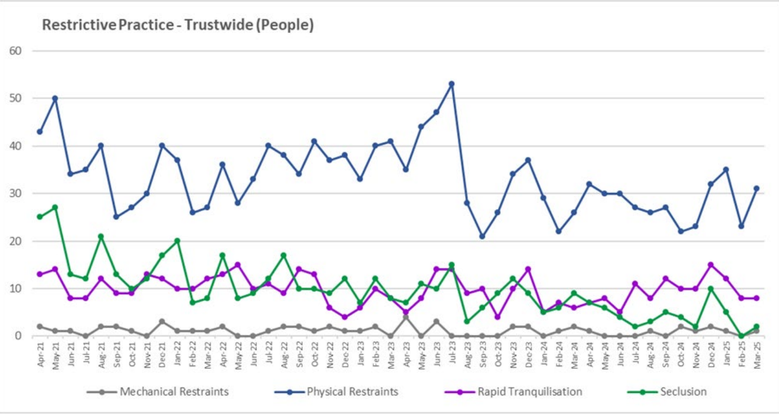
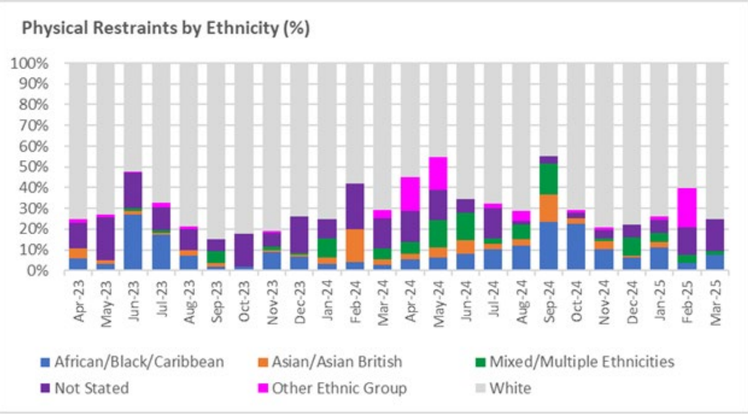
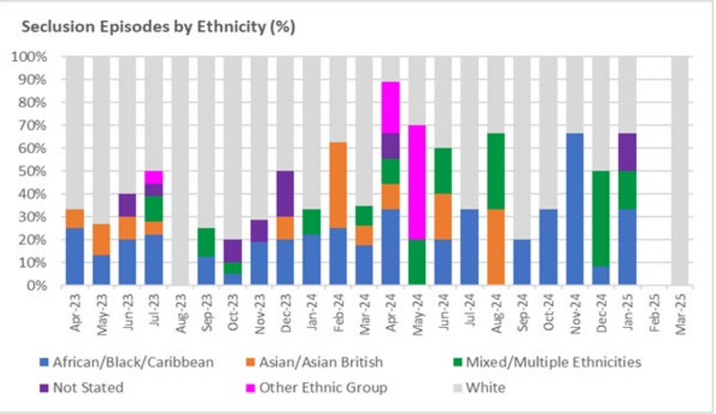
Ethnic minorities are overrepresented nationally within Community Treatment Orders (S17). Throughout 2024-25 SHSC detained 25 services users under S17 and a further 5 service users had their S17 extended. Further work is needed to analyse this data

Restrictive Interventions

	2023/24	2024/25
Seclusion	95 people received 156 incidents of seclusion (9.6% of people admitted)	50 people received 65 incidents of seclusion (5.1% of people admitted)
Physical Restraint	320 people experienced 1144 incidents of physical restraint (25.8% of people admitted)	338 people experienced 893 incidents of physical restraint (33.9% of people admitted)
Rapid Tranquilisation	100 people received 194 incidents of rapid tranquilisation (10.4% of people admitted)	114 people received 260 incidents of rapid tranquilisation (11.4% of people admitted)





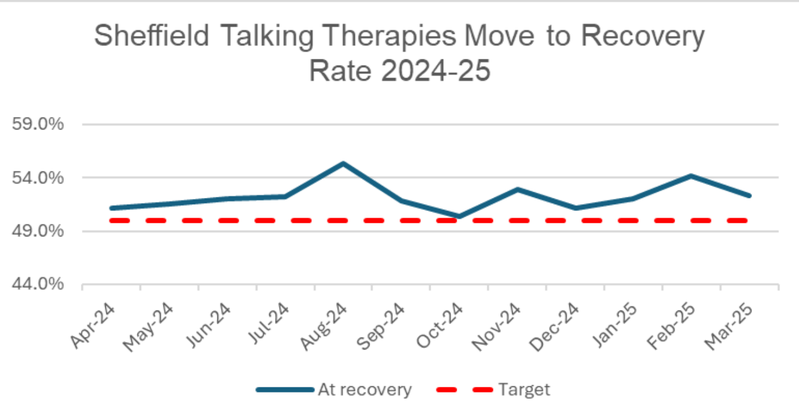


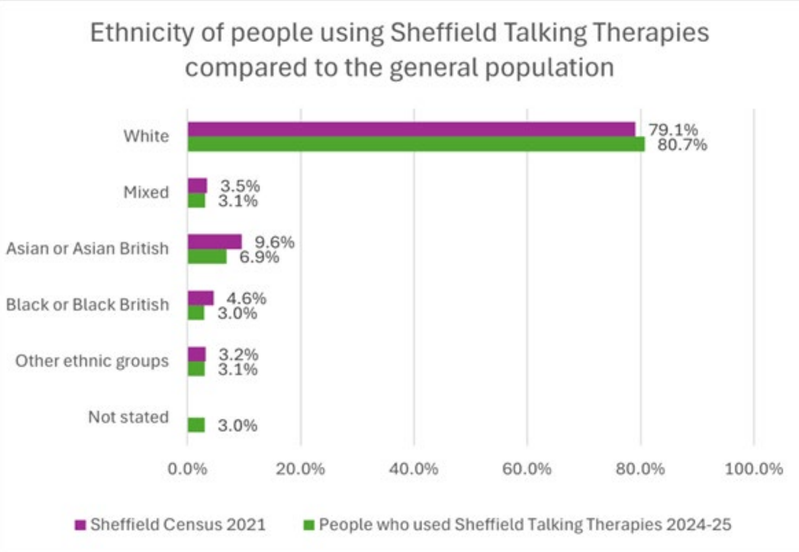
Number of restraints and seclusion episodes for Black British/African/Caribbean people	
2023/24	**2024/25**
23.4% of Black British/African/Caribbean people admitted in 2023/24 were physically restrained, compared to 28% in 2022/2023	28.2% of Black British/African/Caribbean people admitted in 2024/25 were physically restrained, compared to 23.4% in 2023/2024
13.5% of Black British/African/Caribbean people admitted in 2023/24 were recipient of seclusion compared to 22.5% in 2022/2023	12.8% of Black British/African/Caribbean people admitted in were recipient of seclusion compared to 13.5% in 2023/24

Postcode data is now included in Ulysses reports, but accuracy remains unreliable. Of 338 restraint incidents reviewed, only 7 had full postcodes—2 of which were in IMD1. SHSC is working with the Rio team to improve system interoperability and enhance data quality.

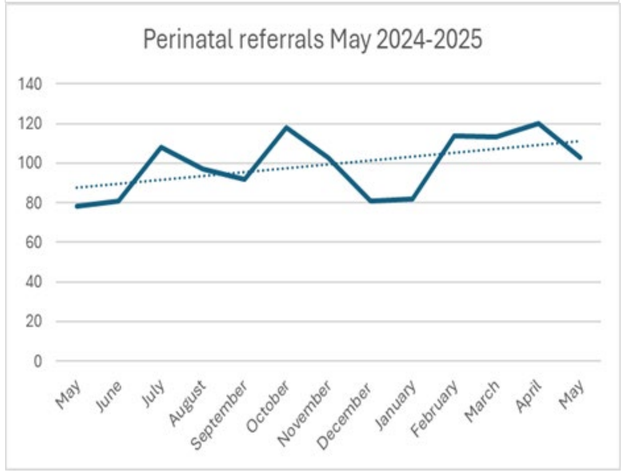
Talking Therapies Recovery Rates

NHS Sheffield Talking Therapies has exceeded the 50% target recovery rate every month in 2024-25





Referrals from pregnant and postnatal women have increased. Future analysis will explore inequalities and intersectionality within this group.



Mixed and Black/Black British groups are underrepresented in Sheffield Talking Therapies, while white service users are overrepresented. The service acknowledges this gap and is actively working to address it.

2025/25 Commitments

🟦 **Access & Experience** 👥
- Service user forums for targeted feedback
- Outreach in ECDC and VCSE communities
- Improve data reporting by deprivation

🟩 **Website & Referrals** 🌐
- Enhance website accessibility and representation
- Redesign referral forms based on community input
- Publish a clear mission statement for the service

🟥 **Project Delivery** 📦
- Fortnightly project review meetings
- ECDC student outreach
- Strengthen collaboration with equality-focused services

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Trust Board Health Inequalities Self-assessment

Sheffield Health and Social Care NHS Foundation Trust

Theme	Sep-24	% Score	Sep-25	% Score
1. Building public health capacity & capability	Developing	38%	Maturing	63%
2. Data, insight, evidence & evaluation	Developing	29%	Developing	36%
3. Strategic leadership & accountability	Developing	39%	Maturing	50%
4. System partnerships	Maturing	60%	Maturing	70%

Percentage	Maturity Rating
0	Not started
1-24	Emerging
25-49	Developing
50-74	Maturing
75-100	Thriving

Improvement can be seen across all four domains, with a clear shift from 'developing' to 'maturing'

Systems partnerships is close to achieving 'thriving' status

2025 Themes

Strong foundations have been built with a clear commitment and vision.
Next steps require this work embedding, enhancing and formalising

Maturing

Building public health capacity and capability

Health inequalities focused training and QI work being delivered across the trust

Inconsistency of training/development to board and staff

Lack of public health specialist staff employed by the Trust

Developing

Data, insight, evidence and evaluation

Good progress being made in relation to data collection and reporting

Improvements needed in reporting of performance data by ethnicity and deprivation and analysis and application of this data

Maturing

Strategic Leadership & accountability

Strong commitment to reducing health inequalities and role in the system

Enhancing and formalising this commitment through setting board objectives, business planning process and investment in identified opportunities to prevent and mitigate healthcare inequalities

Maturing

System partnerships

Representation at system level and collaboration with system partners to contribute ot population health decision making

Clarify and establish role as anchor organisation

Build and formalise programme of work to improve access to employment for under-represented groups

Further consideration of pathway redesign with system partners

Data recording and Quality

Protected Characteristics

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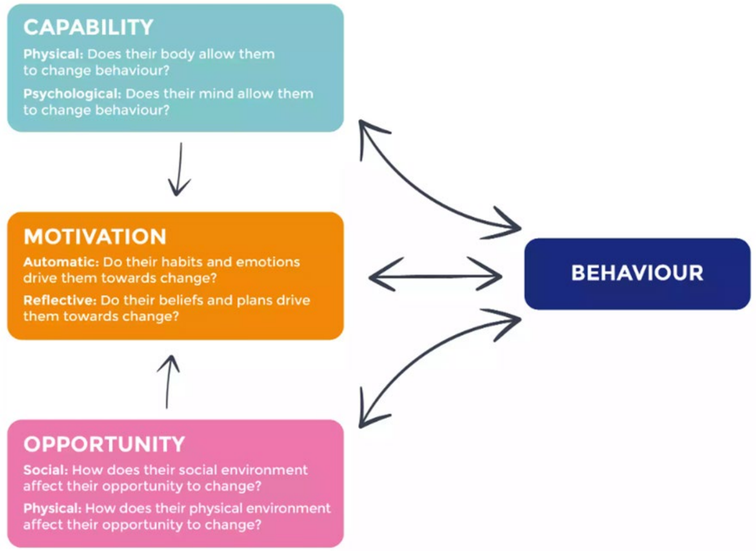
- Launched in **December 2024** to improve how protected characteristics are recorded for service users.
- Based on the **COM-B behavioural model** (Capability, Opportunity, Motivation, Behaviour) to drive sustainable change.
- **Pilot phase** involved a small number of teams and a steering group to share learning and resolve challenges.
- Teams received **tailored support** to understand expectations, identify barriers, and set realistic targets.
- **Bespoke data packs** were co-produced to highlight gaps and support team-level conversations.
- The approach has led to **high engagement** and **marked improvement** in data quality.
- Plans are in place to **roll out and embed** the model across the Trust.

A focused and targeted programme of work to improve the collection and recording of **protected characteristics** for service users accessing care within SHSC.

Having better conversations to ensure true person-centred care, influencing service design and delivery



Active participation & learning

Staff engagement has been key to 2024-25 progress and development. Establishing solid foundations of knowledge and interest of which to build from

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Population Health Forum established, open to all staff to learn together and share best practice

NHSE **Smoke Free Pledge** signed in August 2024. Trust **Smoke Free Policy** refreshed and approved in March 2025

Women's Health Inequalities working group established in collaboration with Sheffield Hospital Charity and Sheffield Teaching Hospital

March 2025 the Health **Inequalities Action Group** was established

Staff intranet page created, including a **Learning Library** containing a bank of resources

Six active **Staff Network Groups**

Quality Improvement **Waiting List and Waiting Well Collaborative** continues to progress

Population Health Report created as evidence for Liaison Psychiatry service reaccreditation

Health Inequalities central to several **additional learning opportunities,** including Developing as Leaders programme

Integrated Change Framework developed

Quality and Equality Impact Assessment process includes sustainability and health inequalities focus

Refresh of **Trust Sustainability Strategy**

Local Partnerships

SHSC were involved in the development of the **Sheffield Fair and Healthy Plan** and are committed to supporting its success. A series of annual commitments have been identified to acknowledge the Trusts role in supporting the success of this plan and will be incorporated into our revised Trust strategy and health inequalities action plan

SHSC launched a **Home First initiative** in September 2024**,** Focused work to improve patient flow to ensure people are admitted to hospital when needed, discharged when ready, and are not sent out of area for care. To support this, we have engaged with the NHS England Getting it Right First Time team and an external supplier. Setting a challenging trajectory to reduce the use of out of area beds by November.

SHSC are a referral partner of the National Energy Action (NEA) 'Warm Homes Healthy Futures' Programme. A nationally coordinated network of locally delivered services that will tackle **fuel poverty** and improve health for tens of thousands of people across Great Britain. The programme will enable effective partnership working between health, energy and housing in various local areas.

SHSC are an active member of the **North-East Neighbourhood Programme Board** 'This is Us'. Focussing on four north-east neighbourhoods of Sheffield, that face inequality and deprivation, resulting in poor life expectancy, health, educational attainment, and skill levels, as well as disempowered and disconnected communities. By funding prevention and building community capacity in these areas, the aim is to connect and empower communities and, in turn, improve people's health.

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SHSC are clear on their role as a system partners and committed to working in collaboration. 2024-25 has seen several partnerships establish and flourish

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PCREF Implementation

PCREF is NHS England's first ever anti-racism and accountability framework to tackle and eliminate the unacceptable racial inequalities in access, experience and outcomes faced by racialised and ethnically and culturally diverse communities and to significantly improve their trust and confidence in mental health services.
SHSC were an early adopter of this framework
Our PCREF programme is focused on three core priorities.

1. Leadership and Governance

- Executive PCREF Lead at Trust Board level
- University of Sheffield led evaluation
- Creation of health inequalities dashboard
- Partnered with NHSE's 'Advancing Mental Health Equalities Taskforce'
- Continued to grow the scope and impact of the 'Being There' project, providing cultural advocacy
- We are part of the Culture of Care Programme from NHS England's Quality Transformation Programme
- Introduction of the Head of population health inequalities role

2. Organisational competencies

- SHSC is the first Trust in the UK to have made embedding human rights into day-to-day practice a core strategic priority
- Human rights have become a well-established and influential part of the Trust's discourse, particularly within RESPECT training
- PCREF team completed comprehensive 3 day 'Human Rights and Practice Leads' training
- Cultural awareness training sessions (circa 10 sessions) have been delivered to teams by the cultural advocacy workers
- Continue to develop links with VCSE, including employment of engagement officer within VCSE
- Funding secured from Sheffield Hospital Charity, to recruit two Somali Peer Support Workers
- Investment in external contracts with a focus on co-learning and co-producing to develop staff and services
- Equality officer from SACMHA works within the restrictive practice team
- Equality officer from SACMHA works within the restrictive practice team
- Local focus on reciprocal mentoring programme
- 174 service users were supported by the cultural advocacy link workers and over 40 family members were liaised with.

3. Patient and Carer Feedback Mechanisms

- PMC Qualitative and Qualitative feedback on patient experience which continues to increase
- Implementation of first star of Triangle of Care and work on the second star
- Engagement officer input to wards and to community service to gather qualitative feedback
- Growth of lived experience colleagues in a range of opportunities and fixed roles across the organisation
- Safe 2 Share work recommenced with a new project lead in November 2024,
- Feedback shared with Lived Experience and Coproduction Assurance Group
- Provided relevant data to national bodies according to our statutory responsibilities
- Coproduction and extensive engagement taken place with community organisations through community mental health transformation, trust strategy refresh and Feedback February

Summary

Sheffield Health and Social Care NHS Foundation Trust

- **2024/25 Achievements**: Strong foundations established across key initiatives.
- **Ongoing Priorities**: Continued emphasis on equity, improved data quality, and deeper community partnerships.
- **Future Direction**: Strategic refresh and better resource alignment to drive meaningful, sustainable change.

2024/25 laid strong foundations. Our next phase must be bolder—embedding equity into every service, every decision, and every partnership

As we reflect on this year's progress, we must also acknowledge the work ahead. Reducing inequalities is not a single initiative—it's a mindset, a commitment, and a responsibility we all share. The data shows where we've made strides, and where we must go further. With renewed focus, deeper partnerships, and the courage to challenge our own systems, SHSC is poised to lead with equity at its core.

Thank you for your continued support and leadership in this vital journey

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