Barnsley Hospital NHS Foundation Trust

Action Plan for Improving Public Health and Reducing Health Inequalities 2022/23

November 2021

Health Inequality in Barnsley

Background

People in Barnsley experience poorer health and wellbeing than people in many parts of the country. These inequalities in health are long-lasting, persistent, and driven by social, economic and environmental inequalities.

Health inequalities are not inevitable, they are preventable. They are socially determined by circumstances largely beyond an individual's control (such as global economic forces, political priorities and decisions, distribution of power and income). Addressing the unjust differences in health between our communities has always been important, however, as the disproportionate impact of the COVID-19 pandemic, and its roots in the social and economic structure of our society becomes increasingly clear, BHNFT and Barnsley place partners must respond.

Even though the drivers of inequalities are rooted in the social, economic and environmental determinants, equity also needs to be addressed within the health and care system. There are inequitable differences in access and quality of health care that we can influence. Some of the most marginalised people in our communities have poorer access to health services, and a poorer experience of services, even though they may have more complex needs and require more care. Accordingly, without addressing inequitable access and quality, health care services could widen inequalities rather than help to reduce them.

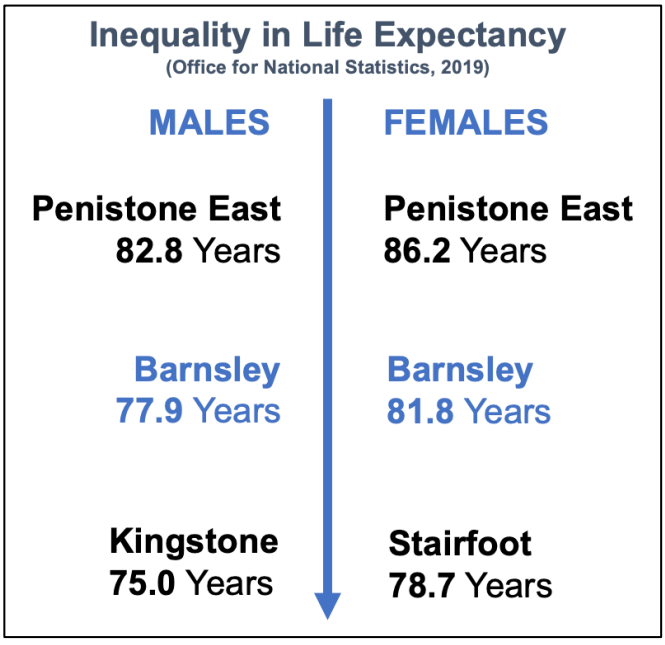
More information on how we can describe health inequalities is included in *Appendix A*.

Our Population

The population of Barnsley face stark inequalities when compared to other areas of the country. Barnsley is ranked as the 39th most deprived area in England out of 326 local authorities, and 25% of children in Barnsley are living in poverty. Two fifths of electoral wards within Barnsley are amongst the 20% most deprived in England *(PHE, 2020)*. The number of years lived in good health (Healthy Life Expectancy) for the Barnsley population is below the England and Yorkshire averages *(PHE, 2020)*.

In addition, there is a significant gap in health outcomes within the borough. For example, those in the most deprived areas (such as Kingstone and Stairfoot) spend more years living in poor health and have a shorter life expectancy than those in the least deprived areas (Penistone East and Penistone West) *(ONS, 2019).*

BHNFT analysis has identified that those from the most deprived areas of Barnsley are less likely to attend Barnsley Hospital for planned care and investigations. In addition, those from the most deprived areas make up the majority of our urgent and emergency attendances and admissions.



Action to Address Health Inequality

Our Role

The NHS constitution states that the NHS exists "to improve our health and wellbeing, support us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives." *(DoHSC, 2021)*.

Health is a fundamental human right *(WHO, 2021).* As an organisation focused on health, we must do all we can to promote and maintain good health (and prevent ill health), addressing health inequalities as we do so. Reducing inequalities in the health status of the people of Barnsley, while working to improve overall population health, will start to eliminate some of the barriers faced by disadvantaged population groups.

The NHS in England is committed to addressing health inequalities and has identified priority actions that build on the measures to implement the NHS Long Term Plan (see *Appendix B*). We intend to build on these actions to maximise the benefits BHNFT can provide to the population of Barnsley, and uphold our partnership commitment to the Barnsley Health and Wellbeing Strategy 2021–2030.

Health inequalities and their underlying causes drive unscheduled hospital activity, putting greater demand on health services. Tackling health inequalities is a key part of demand management, as unmet need presents as preventable urgent and emergency demand.

For individual patients, it is important that all staff at BHNFT understand health inequalities and the huge potential for unmet need within the health and care system. This understanding should influence investigation and management of clinical presentations to ensure need is met. For example, people from more deprived areas are not only more likely to get cancer, they're more likely to be diagnosed at a late stage for certain cancer types, and face barriers when accessing cancer or screening services. Consideration of a patient's social history and the inequalities they face has the potential to maximise individual health outcomes.

Action to Address Health Inequality

Our Plan

This action plan details the BHNFT priorities to address health inequalities over the next 18 months and complements *Horizon 1 (Recovery & Building Back Better)* of the BHNFT Strategy 2021-2026.

The initial actions our Trust will take to improve population health and promote health equity are spread across three tiers of activity. We aim to achieve the following:

A. By **establishing new services,** we will prevent the onset, progression and impacts of disease through early intervention, narrowing the inequality gap in the healthy life expectancy of the Barnsley population.

B. By **enhancing existing services,** we will reduce inequalities in access to care, and address disparities in patient's experience of care to improve patient outcomes.

C. By harnessing the Trust's role as an anchor institution to help **build a more inclusive society and economy in Barnsley**, we will help to address inequalities in the wider determinants of health. We will influence these social, economic and environmental factors to improve population health.

Health inequalities are caused by complex interaction between many different factors, and therefore will not be solved by a single organisation's action plan. However, it is important we start somewhere with the factors that we can influence. This plan describes the initial priority actions that we can take as an organisation to reduce health inequalities in Barnsley.

There are three enablers which are essential to deliver this action plan:

- Understanding of the concepts of health inequalities and population health.
- Barnsley integrated care partnership collaboration (place level working).
- Organisational leadership that promotes health equity.

The majority of activity described in this action plan will be delivered without additional resource. Existing investment and pooling resource through partnership working will enable key aspects. If specific services need additional resource to support any of these priority actions alongside current commitments, business cases will be proposed in due course.

It is important to acknowledge our partnership role in improving public health and reducing health inequalities. This action plan feeds into the *Barnsley Metropolitan Borough Council (BMBC) Public Health* plan for the next three years.

Governance

It is anticipated that action to address inequality will be embedded within existing workstreams and governance, and therefore integrated to the way of working. This is consistent with a shift in culture change that makes health inequalities part of all roles within the organisation.

For assurance, we propose updates on the Health Inequalities Action Plan are provided to the **Executive Team** quarterly, and to the **Quality and Governance Committee** quarterly.

All proposed timeframes in this action plan are accurate at the time of writing. However, we appreciate that increasing organisational pressures and sudden changes in national policy may cause delays to action plan progress.

Where new governance approaches are to be embedded within the organisation, these are listed against the relevant priority action.

A: Establish New Services

People's behaviour is a major determinant of how healthy they are. Public Health England's 2020–25 strategy identified smoking, poor diet, physical inactivity and high alcohol consumption as the four principal behavioural risks to people's health in England today.

Behavioural risks to health are more common in some parts of the population than in others. The distribution is patterned by measures of deprivation, income, gender and ethnicity, and risks are concentrated in the most disadvantaged groups. For example, smoking prevalence in the most deprived fifth of the England population is 28 per cent, compared to 10 per cent in the least deprived fifth.

Providing new interventions and services that aim to prevent new illness and deterioration of illness for those individuals and communities that experience poorer outcomes will reduce health inequalities. This is the core aim of the **Healthy Lives Programme**, work carried by a team of public health staff employed by BHNFT. The Healthy Lives Programme is a universal offer, but risks are concentrated in those with poorer outcomes and therefore interventions such as this will help address health inequalities.

Alongside these dedicated services it is important to consider the effect of any new service or policy within BHNFT on health inequalities. Incorporating explicit prompts regarding equity and health inequalities in the BHNFT Equalities Impact Assessment and associated training materials is the first step to ensure inclusive service design.

Progress To Date
Dedicated population health services in BHNFT QUIT: We now have an established team of tobacco control advisors to support the treatment of tobacco addiction. As a result of QUIT, BHNFT now screens over 70% of admitted patients, is finding close to the expected prevalence of smokers and is supporting a large proportion to quit. Alcohol Care Team (ACT): BHNFT has completed recruitment to the team at the end of the summer and now have an ACT sited in the emergency department and acute frontage of the hospital.

Healthy Lives Programme						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
1	**Extension of Tobacco Control (QUIT)** The BHNFT QUIT Team has been established to treat tobacco addiction in hospital inpatients. The service provides access to nicotine replacement treatments (NRT) and specialist stop smoking support during the hospital stay for all patients identified. We wish to further expand this service by reaching more inpatients and outpatients, in addition to providing a QUIT offer to all BHNFT staff who smoke.	Proportion of patients admitted who are screened for tobacco addiction. Number of patients provided with NRT and specialist stop smoking advice. Number of staff members provided with NRT and specialist stop smoking advice.	*What will be different in one year?* We will identify at least 80% of patients being admitted who have tobacco addiction and provide appropriate treatment and access to community services.	Ongoing. Quarterly reporting on team activity metrics.	The QUIT steering group which feeds into the Healthy Lives Team Business & Governance which report to the CBU3 Business & Governance meeting.	Healthy Lives Programme Manager / Consultant in Public Health, *Healthy Lives Team.*

2	**Establish the Alcohol Care Team (ACT)** Establish the Alcohol Care Team (ACT) to provide specialist interventions for alcohol-dependent patients and those presenting with acute intoxication or other alcohol-related complications, attending A&E or admitted as inpatients.	Number of patients screened throughout the hospital using AUDIT/AUDIT-C Number of referrals to the ACT. Number of patients commencing medically-assisted alcohol withdrawal (MAW). Number of referrals to community alcohol services.	*What will be different in one year?* We will identify alcohol-dependent patients, provide appropriate treatment and access to community services and reduce their need for emergency services.	Team established by December 2021. Quarterly reporting on team activity metrics.	ACT steering group which feeds into the Healthy Lives Team Business & Governance which report to the CBU3 Business & Governance meeting.	Healthy Lives Programme Manager / Consultant in Public Health, *Healthy Lives Team.*

3	**Physical inactivity and unhealthy diet** Our Healthy Lives Facilitators currently screen hospital inpatients for unhealthy diet and physical inactivity. We will enhance the brief intervention offer provided by these facilitators. We have recruited a Population Health Fellowship post that will focus on supporting the Healthy Lives Team to identify these risk factors and provide opportunities to address them. This will include: Incorporating *Moving medicine* resources - https://movingmedicine.ac.uk/ Engaging with the *Barnsley Whats Your move campaign* https://www.barnsleywhatsyourmove.co.uk/ and linking in with Local Authority Public Health colleagues. Linking in with Barnsley Premier Leisure who current provide Barnsley weight management services.	Proportion of patients admitted who are screened for these risk factors. Number of patients provided with brief interventions to prevent obesity. Plan for encouraging physical activity in hospital inpatients, with appropriate metrics developed.	*What will be different in one year?* We will identify these risk factors by screening at least 60% of patients being admitted, and provide brief intervention advice and access to community services.	Review April 2022. Quarterly reporting on team activity metrics.	Healthy Lives Team Business & Governance which report to the CBU3 Business & Governance meeting.	Healthy Lives Programme Manager / Consultant in Public Health, *Healthy Lives Team.*

4	**Collaboration & Co-ordination with Community Services** Vulnerable people that face barriers to accessing community services are more likely to attend emergency services (e.g. hospital emergency departments). Attendance and subsequent admission to secondary care provides an opportunity for access to the appropriate community services. Excellent community services exist in Barnsley, but these have faced barriers to in-reach into hospital. The Healthy Lives Programme can provide a platform to facilitate community services to work with people in need when they attend Barnsley Hospital. For example, Barnsley Recovery Steps can engage with individuals seeking support with substance misuse; the Family Early Help service can provide a link-in to services to support families. We aspire to extend these opportunities through support for Barnsley people with no fixed abode, and also extend some of the primary care offer into hospital during their stay to ensure safe and appropriate follow-up in the community.	Proportion of patients attending services that are offered additional Healthy Lives Team. Number of families provided early help interventions. Number of adults patients provided with additional Healthy Lives intervention. Number of patients referred on to community services (not including smoking and alcohol). Number of patient that referred to community services whose first contact is in the hospital	*What will be different in one year?* We will liaise with and facilitate community services to access vulnerable patients during their hospital stay and make plans for community follow-up.	Service established by April 2022. Quarterly reporting on team activity metrics.	Healthy Lives Team Business & Governance which report to the CBU3 Business & Governance G meeting.	Healthy Lives Programme Manager / Consultant in Public Health, *Healthy Lives Team.*

BHNFT Equality Impact Assessments						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
5	**Enhance the Equality Impact Assessment (EIA) Toolkit to include health inequality resources** Inclusion of Health Inequalities Resources and prompts in the Equality Impact Assessment (EIA) Toolkit and associated training materials will ensure health inequalities are considered alongside the development of any new services.	Addition of Health Inequalities prompts and questions to EIA toolkit and template.	*What will be different in one year?* Health inequalities will be considered at an early stage in the planning of organisational change, new or changing activity, or developing or changing service delivery.	Ongoing. Quarterly reporting on team activity metrics.	*People & Engagement group* to review and approve.	Head of Inclusion and Wellbeing

A. Establish New Services **in Partnership**

Working in Partnership across Barnsley Place

The clinical lead for the Healthy Lives Programme is Dr Ceryl Harwood (Consultant in Public Health), who is supported by Dr Andy Snell (Consultant in Public Health). Under the supervision of Bob Kirton, both Dr Snell and Dr Harwood represent BHNFT on partnership groups. Both Dr Harwood and Dr Snell have joint positions hosted by BHNFT and Barnsley Metropolitan Borough Council.

BHNFT is a member of the Barnsley Tobacco Control Alliance; Barnsley Alcohol Control Alliance, Barnsley Physical Activity Partnership (chaired by Dr Snell) and the Heart Health Alliance (Chaired by Dr Harwood). These groups exist to improve the health, environmental and economic status of people living and working in the borough through co-ordinated, effective and sustained action against relevant risk factors by organisations and individuals working in partnership.

Our clinical leads provide technical public health input to these groups, in addition to the BHNFT Health Lives Programme providing service capacity for prevention of ill health and reducing inequalities in health outcomes for people living in Barnsley.

We have a key role in guiding the place-wide approach to tackle the relevant risk factors above, but also strengthen accountability of all partners (including BHNFT) to improve the health of Barnsley people.

B: Enhance Existing Services

Access to health services refers to the availability of services that are timely, appropriate, sensitive and easy to use. Inequitable access can result in particular groups receiving less care relative to their needs, or more inappropriate or sub-optimal care, than others, which often leads to poorer experiences, outcomes and health status.

Inequitable access might mean that a group faces particular barriers to getting the services that they need, such as real or anticipated discrimination or challenges around language. It can mean that information is not communicated in an easily understandable or culturally sensitive way.

We can also measure access in terms of service availability and uptake. More deprived areas tend to have lower rates of admission to elective care than less deprived areas, despite having a higher disease burden.

The first step to addressing inequality is to identify the inequalities that exist in our key services. The priority actions below describe the steps we will take to monitor any inequality that exists within our service activity, and the steps we will take to support any population groups that have unequal access to diagnostics and/or treatment.

Progress To Date
We have analysed hospital activity to identify our baseline emergency and planned care activity by age, gender, level of deprivation and ethnicity. This goes beyond the minimum ask of the NHS 2021/22 operational planning guidance, and informs the actions outlined in this Action Plan. We have shared this data with teams and where relevant developed best practice in line with national policy. Proposals for extension of services (e.g. diagnostic services to be offered at the Glassworks) incorporate an awareness of identified inequalities and aim to address them. Working in partnership with Barnsley Metropolitan Borough Council we have developed a more sophisticated method for identifying vulnerable people in Barnsley. These tools provide an opportunity for us to target those in the greatest need and narrow the inequality gap. In addition, we have continued networking locally and across the region, learning from others and joining up work on health inequalities.

Elective Recovery						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
6	**Monitor ethnicity and most deprived decile proportions in planned care waiting lists** To identify inequalities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations. Ethnicity and most deprived decile proportions will be monitored across all waiting lists for elective procedures. This will include specific analysis of: ▪ Performance against 18-week Referral to Treatment waiting time standard. ▪ Number of patients on the Referral to Treatment pathway who have been waiting for 52 weeks or more. ▪ Referral to Treatment pathway waiting list size.	Proportion of patients meeting the 18-week Referral to Treatment waiting time standard by age, gender, ethnicity and deprivation decile. Proportion of on the Referral to Treatment pathway who have been waiting for 52 weeks or more by age, gender, ethnicity and deprivation decile. Number of those on all waiting lists by age, gender, ethnicity and deprivation decile.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans.	Review April 2022.	Existing CBU governance arrangements.	Associate Directors of Operations, *CBU1, CBU2 & CBU3.* *(Supported by Consultant in Public Health).*

7	**Monitor ethnicity and most deprived decile proportions in outpatient referrals** To identify inequalities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations. Ethnicity and most deprived decile proportions will be monitored across our hospital referrals.	Number of patients referred to outpatient services analysed by age, gender, ethnicity and deprivation decile.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans.	Review April 2022.	Existing CBU governance arrangements.	Associate Directors of Operations, *CBU1, CBU2 & CBU3* *(Supported by Consultant in Public Health)*
8	**Health Inequalities Service Improvement Plan for planned care** Based on the monitoring above (Priority Action 7) we commit to developing a service improvement plan to address any identified health inequalities in planned care access, quality or outcomes. As a secondary care provider, we are responsible for one part of the care pathway and the service improvement plan will require engagement with partners. We will present any inequalities identified at Planned Care Board and work with partners to narrow the health inequality gap.	Development of a Health Inequalities Service Improvement Plan for planned care with partners.	*What will be different in one year?* Service improvement plan specific to planned care will outlined targeted actions that can be taken by BHNFT and partners to address identified inequality.	July 2022.	Existing CBU governance arrangements. Barnsley Planned Care & Outpatients Group (Integrated Board).	Associate Directors of Operations, *CBU1, CBU2 & CBU3.* *(Supported by Consultant in Public Health).* Place Programme Leads.

Emergency and Urgent Care						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
9	**Monitor ethnicity and most deprived decile proportions in emergency department usage** To identify inequalities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations. Ethnicity and most deprived decile proportions will be monitored across disease pathways, and according to acuity of initial presentation.	Proportion of ED attendances by age, gender, ethnicity and deprivation decile. Acuity of ED presentations by age, gender, ethnicity and deprivation decile.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans.	Review April 2022.	Existing CBU governance arrangements.	Associate Director of Operations, *CBU1 – Medicine.* *(Supported by Consultant in Public Health).*

10	**Health Inequalities Service Improvement Plan for emergency and urgent Care** Based on the monitoring above (Priority Action 9) we commit to developing a service improvement plan to address any identified health inequalities in emergency and urgent care access, quality or outcomes. As a secondary care provider, we are responsible for one part of the care pathway and the service improvement plan will require engagement with partners. We will present any inequalities identified at Emergency and Urgent Care Delivery Board and work with partners to narrow the health inequality gap.	Development of a Health Inequalities Service Improvement Plan for emergency and urgent care with partners.	*What will be different in one year?* Service improvement plan specific to emergency care will outline targeted actions that can be taken by BHNFT and partners to address identified inequality.	July 2022.	Existing CBU governance arrangements. Barnsley Emergency & Urgent Care Delivery Board (Integrated Board).	Associate Director of Operations, *CBU1 – Medicine* *(Supported by Consultant in Public Health).*

Patient Vulnerability Data to Support Clinical Assessment & Prioritisation						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
11	**Establish an Information Sharing Agreement (ISA) with Barnsley Metropolitan Borough Council** Establish a data sharing agreement between Barnsley Metropolitan Borough Council (BMBC) and BHNFT will allow a more complete picture of individual's health and care needs. Through a better understanding of an individual's social and economic circumstances, those in the greatest need can be prioritised for planned care. This allows individuals in greatest needs to be seen earlier in a care pathway, therefore averting a serious deterioration in their health and the need for unplanned care. This data sharing will allow BMBC to provide information to BHNFT on the vulnerability of residents to enable us to plan and provide services, ensuring the most vulnerable receive the services they need, better utilise resources and address health inequalities.	Information Sharing Agreement approved by Trust (including Caldicott Guardian).	*What will be different in one year?* A signed information sharing agreement will be in place between both organisations.	December 2021.	Existing Information Governance arrangements at BHNFT and BMBC.	Information Governance and Clinical Applications Manager.

12	**Pilot use of Barnsley Vulnerability Index to assist clinical prioritisation for planned care waiting lists** The Barnsley Vulnerability Index is a tool that will enable clinical business units to be able to take into account additional information that indicates vulnerability to a prolonged wait for planned NHS care. This will allow prioritisation based on social and economic need in addition to clinical need to address health inequalities faced by the Barnsley population. We intend to pilot this using existing waiting lists and evaluating the effect of incorporating additional information about a patient's circumstances during the planned care pathway.	Evaluation of the effect of utilising information regarding patient vulnerability to inform clinical prioritisation.	*What will be different in one year?* The effect of using information regarding patient vulnerability to inform clinical prioritisation will be evaluated. Learning will be captured and shared.	Review April 2022.	Working with existing governance arrangement within CBUs, and exploring a need for additional governance if required.	Consultant in Public Health. Associate Directors of Operations, *CBU1, CBU2 & CBU3.*

13	**Pilot use of Barnsley Vulnerability Index to flag vulnerable patients within the Emergency Department** The Barnsley Vulnerability Index is a tool that will enable clinicians to be able to take into account additional information that indicates vulnerability, and may influence management in the emergency department. A better understanding of an individual's social circumstances and need, in addition to clinical need may influence investigation and management. We intend to pilot this approach for direct emergency care.	Evaluation of the effect of utilising information regarding patient vulnerability to inform clinical care.	*What will be different in one year?* The effect of using information regarding patient vulnerability to inform clinical prioritisation will be evaluated. Learning will be captured and shared.	September 2022.	Working with existing governance arrangement within CBU1, and exploring a need for additional governance if required.	Consultant in Public Health. Associate Director of Operations, *CBU1 – Medicine.*

Cancer Services						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
14	**Monitor ethnicity and most deprived decile proportions in usage of Cancer Services** To identify inequalities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic population groups. Ethnicity and most deprived decile proportions will be monitored across service restoration and NHS Long Term Plan metrics. For cancer services this will include the following headline metrics: ▪ Cancer referral treatment levels. ▪ Proportion of cancers diagnosed at stages 1 or 2. ▪ Urgent two-week cancer referral performance – potentially (subject to Government agreement) to be replaced by the 28-day faster diagnosis standard during 2021-22. Percentage of patients starting cancer treatment within 62 days of GP referral.	Proportion of cancer referrals by age, gender, ethnicity and deprivation decile. Proportion of cancers diagnosed at stages 1 or 2 by age, gender, ethnicity and deprivation decile. Urgent two-week cancer referral performance – potentially (subject to Government agreement) to be replaced by the 28-day faster diagnosis standard – by age, gender, ethnicity and deprivation decile. Percentage of patients starting cancer treatment within 62 days of GP referral by age, gender, ethnicity and deprivation decile.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans.	Review April 2022.	Existing governance arrangements for Cancer Services.	Lead Cancer Manager, *Cancer Services.*

15	**Health Inequalities Service Improvement Plan for Cancer Services** Based on the monitoring above (Priority Action 14) we commit to developing a service improvement plan to address any identified health inequalities in cancer care access, quality or outcomes. As a secondary care provider, we are responsible for one part of the care pathway and the service improvement plan will require engagement with partners. We will present any inequalities identified at Planned Care Board and work with partners to narrow the health inequality gap.	Development of a specific Health Inequalities Service Improvement Plan for Cancer Services.	*What will be different in one year?* Service improvement plan specific to Cancer Services will outline targeted actions that can be taken by BHNFT and partners to address identified inequality.	July 2022.	Existing governance arrangements for Cancer Services.	Lead Cancer Manager, *Cancer Services.*

Maternity Services						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
16	**Monitor ethnicity and most deprived decile proportions in usage of Maternity Services** To identify inequalities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic population groups. Ethnicity and most deprived decile proportions will be monitored across existing maternity service metrics.	Data submitted to the Maternity Services Data Set (MSDS) that contains valid postcode for mother at booking. Data submitted to MSDS that includes a valid ethnic category.	*What will be different in one year?* 95% of MSDS will have a valid postcode and 80% will have ethnicity recorded. Regular monitoring of activity through an inequality lens will inform service improvement.	Review April 2022.	Existing governance arrangements for Maternity Services.	Head of Midwifery, *CBU3 - Women's, Children's and Clinical Support Services.*

17	**Understanding the experience of Maternity service users from Black and Minority Ethnic Groups** Barnsley Maternity Voices Partnership (MVP) work alongside our midwives and with other healthcare professionals as an independent group known as National Maternity Voices. They pass on feedback gathered from local families during pregnancy and after, to influence improvements to services in the community and at hospital. Building on the existing success of gathering service user feedback and working with service users through the Barnsley MVP, we will prioritise hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation.	Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation. *(This is likely to include the MVP work programme, survey feedback, and records of activity taken as a result of service user engagement.)*	*What will be different in one year?* A greater understanding of the maternity experience of people from minority ethnic groups.	July 2022.	Existing governance arrangements for Maternity Services.	Public Health Specialist Midwife, *Maternity Services.*

18	**Prioritising women from BAME backgrounds into Continuity of Care teams** Review of monthly electronic patient record data to identify GP practices with black and minority ethnic (BAME) women. Clear identification of these women will aid future planning of continuity teams. We will ensure that women identified to be from a BAME background are allocated to Continuity teams.	The proportion of women from BAME background allocated to a continuity team.	*What will be different in one year?* More women from black and ethnic minority backgrounds allocated to Continuity of Care teams with a target of at least 60%.	Review April 2022.	Existing governance arrangements for Maternity Services.	Matron for Community Midwifery and Antenatal Day Services, *Maternity Services.*
19	**Prioritising women living in the bottom 10% most deprived areas into Continuity of Care teams** Review of monthly electronic patient record data to identify GP practices with women from the bottom 10% most deprived areas. Clear identification of these women will aid future planning of continuity teams. We will ensure that women identified to be from the bottom 10% most deprived areas are allocated to Continuity teams.	The proportion of women from bottom 10% most deprived areas allocated to a continuity team.	*What will be different in one year?* More women from the most deprived areas of Barnsley allocated to Continuity of Care teams with a target of at least 60%.	Review April 2022.	Existing governance arrangements for Maternity Services.	Matron for Community Midwifery and Antenatal Day Services, *Maternity Services.*

Ensuring Digital Inclusion						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
20	**Offer face-to-face care to patients who cannot use remote services** Throughout the pandemic BHNFT has offered face-to-face care to patients who cannot use remote services through informal discussion with clinicians. We will continue this approach to mitigate against digital exclusion.	Proportion of face-to-face appointments provided.	*What will be different in one year?* Those who will benefit from face-to-face care will receive it.	Ongoing.	Existing governance arrangements for Outpatient Services.	Head of Outpatients, *Outpatient Services*.

21	**Monitor ethnicity and most deprived decile proportions in usage of remote services** We will identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups. In particular we will assess for inequalities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic population groups.	Proportion of face-to-face consultations, broken down by relevant protected characteristic and health inclusion groups. Proportion of telephone consultations, broken down by relevant protected characteristic and health inclusion groups. Proportion of video consultations, broken down by relevant protected characteristic and health inclusion groups.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans.	Review April 2022.	Existing governance arrangements for Outpatient Services.	Head of Outpatients, *Outpatient Services.*

Outpatient Services						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
22	**Policy for the management of missed outpatient appointments for adult patients** We will establish a system to enable the identification of patients' vulnerabilities such as dementia, learning disabilities, patients unable to attend appointments on their own and patients living in care homes. This policy will enable an offer of support to facilitate patient attendance, ensuring effective communication and sharing appropriate information between health and social care professionals.	Reduction in the numbers of missed outpatient appointments ('did not attends'). Identify reasons why vulnerable adults do not attend outpatient appointments.	*What will be different in one year?* Additional follow-up for patients that are identified as vulnerable to help address any barriers to appointment attendance.	December 2021.	Existing governance arrangements for Outpatient Services.	Head of Outpatients, *Outpatient Services*.

23	**Evaluate the effect of outpatient transformation initiatives on health inequalities** Outpatients transformation requirements laid out in the 2021/22 Operational Planning Guidance requires providers to take steps to avoid outpatient attendances of "low clinical value" and redeploy capacity where it is needed, alongside increased mobilisation of Advice & Guidance and Patient Initiated Follow-Up services. It is important to consider the effect of these transformation initiatives on health inequalities. We will monitor the effect of these initiatives on health inclusion groups, and those with protected characteristics.	Proportion of outpatient referrals and attendances by age, gender, ethnicity and deprivation decile. Proportion of missed outpatient appointments ('did not attends') by age, gender, ethnicity and deprivation decile. Comparisons between those on PIFU pathways and those not on PIFU Pathways by age, gender, ethnicity and deprivation decile.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans.	Review April 2022.	Existing governance arrangements for Outpatient Services.	Head of Outpatients, *Outpatient Services.*

24	**Health Inequalities Service Improvement Plan for Outpatient Services** Based on the monitoring above (Priority Actions 21 and 23) we commit to developing a service improvement plan to address any identified health inequalities in access to Outpatient Services. As a secondary care provider, we are responsible for one part of the care pathway and the service improvement plan will require engagement with partners. We will present any inequalities identified at Planned Care Board and work with partners to narrow the health inequality gap.	Development of a specific Health Inequalities Service Improvement Plan for Outpatient Services.	*What will be different in one year?* Service improvement plan specific to Outpatient Services will outline targeted actions that can be taken by BHNFT and partners to address identified inequality.	July 2022.	Existing governance arrangements for Outpatient Services.	Head of Outpatients, *Outpatient Services.*

Patient Experience						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
25	**Evaluate the Friends and Family Test (FFT) feedback through a health inequality lens** The Friends and Family Test (FFT) provides service user feedback on the care and treatment received at BHNFT. We will specifically look for patterns in the feedback related to in health inclusion groups, and those with protected characteristics. Where possible, the anonymised feedback will be grouped by ethnicity.	Quarterly reporting on patient experience feedback that identifies any inequalities faced by patients.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans and engagement work.	Review April 2022.	Existing patient experience governance arrangements.	Head of Quality and Clinical Governance.

26	**Analysis of patient complaints through a health inequality lens** There is an opportunity for us to evaluate complaints by collecting data on the complainants demographics and personal circumstances. We will specifically look for patterns in the feedback related to those in health inclusion groups, and those with protected characteristics. Where possible, the anonymised feedback will be grouped by ethnicity and Index of Multiple Deprivation (IMD).	Quarterly reporting on complaints grouped by themes and population groups (e.g. ethnicity) that identifies any inequalities faced by patients. Incorporate this evaluation into the quarterly Learning from Experience (LFE) reports.	*What will be different in one year?* Regular monitoring of activity through an inequality lens will inform service improvement plans and engagement work.	Review April 2022.	Existing patient experience governance arrangements.	Head of Quality and Clinical Governance.
27	**Engage with relevant population groups in response to any specific inequality issues** Through wider partnership working, engaging with relevant population groups in response to any specific issues identified through patient experience feedback (e.g. FFT). For example, building on existing links with groups such as Barnsley Carers or the Children and young people's empowerment project (Chilypep), we have the opportunity to respond to issues, improve our services and reduce inequalities.	Evidence of partnership working, engaging with relevant population groups in response to any specific issues identified.	*What will be different in one year?* We will engage with specific population groups identified through analysis of activity and experience data.	Review April 2022.	Existing patient experience governance arrangements.	Head of Quality and Clinical Governance.

Communications						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
28	**Continue to provide accessibility and language options to view BHNFT website content** Website accessibility software will be incorporated into the BHNFT website. This creates a more inclusive experience online by providing accessibility and language options to enable users to customise the website in a way that works for them. This provides translation into over 100 different languages and dialects and provides an option for the content to be provided as audio.	Inclusion of *ReciteMe* website accessibility software on the BHNFT website.	*What will be different in one year?* More patients and members of the public will be able to access our online resources.	Ongoing.	Existing governance processes for marketing and communications.	Head of Communications, *Marketing and Communication.*

B. Enhance Existing Services **in Partnership**

Working in Partnership across Barnsley Place

Through existing integrated transformation boards that make up the Barnsley Integrated Care Partnership, we continue to champion the importance of addressing health inequalities. For example, through Planned Care & Outpatients Group, Care Closer to Home Board and the Urgent & Emergency Care Delivery Board. Through each of these groups we have provided examples of BHNFT public health work and action taken to enhance existing services.

The majority of partnership action to tackle health inequality across Barnsley occurs in the Health Inequalities Action Group (HIAG), a group comprised of Barnsley health and social care service providers. The HIAG is chaired by Dr Andy Snell (BHNFT Consultant in Public & Global Health), and reports directly to the Barnsley Integrated Care Delivery Group (ICDG).

The greatest impact that BHNFT has had on enhancing existing services delivered by partner organisations has been through the development of the three-tier framework (see Appendix C). This framework forms the basis of this Health Inequalities Action Plan and through BHNFT's leadership, is being adopted by other health providers in Barnsley (for example, SWYPFT and primary care colleagues).

Some of the areas we want to improve most as part of this action plan and the wider work depends on working in partnership, and so this aspect is crucial. However, there is a lot BHNFT can enhance through its own approach and services, and so it is important that the trust progresses this action plan whatever the pace and progress of our partners.

C: Build a More Inclusive Society and Economy in Barnsley

The majority of what makes us healthy and what makes our lives fulfilling is determined outside services provided by the NHS (*Health Foundation, 2018*).

The term “anchor institution” is often used to describe organisations such as Barnsley Hospital. An anchor institution is one that is not going anywhere. It is tied to a particular place by its core business, physical assets and local relationships. By their very nature, anchor institutions are in a prime position to address the social determinants of health as influential partners in local strategy, large employers, purchasers of services and goods, holders of physical assets and community partners.

The BHNFT strategy commits to ‘**embracing our role as an anchor institution**…using our influence to improve employment opportunities for local people, add social value by sourcing local supply chains, adopt stretching environmental policies and design and deliver services to reach and benefit disadvantaged communities to reduce health inequalities and improve population health.’

In doing so, we aim to increase our positive effects and reduce our negative ones. Our goal is to support, enable and promote:

- An inclusive economy
- The health of our planet
- A fair and just society for all (including future generations)

Progress To Date
The BHNFT Strategy 2021-2026 commits to embracing our role as an anchor and formal adoption of 6Ps as well as key workstreams in the first horizon on employment, procurement, environment, design of services and as a partner in Barnsley to reduce health inequalities. We have established an “anchor” charter which has been written into the BHNFT Strategy 2021-2026. There is a full interactive version now developed for use. We are using demonstrator projects to put the anchor principles and practices into action and working closely with the Quality Improvement (QI)I team to include staff-led QI projects that connect with the hospital’s six P principles and therefore the Anchor approach through initiatives such as *Give it a Go Week* and building environmental sustainability and equity into our understanding of quality. We have provided tools and training on providing sustainable healthcare.

Progress To Date (continued)
Lead staff for each of the domains of the charter have been identified and they have generated some high-level recommendations for ‘good work’ and ‘environmental sustainability’ and initial ideas for procurement, services for social value and land and assets. Draft metrics are in development for each of the domains of the charter and a proposal to establish a network of domain leads has been developed.

BHNFT as an Anchor Institution						
Priority Actions		**Metrics**	**Impact**	**Timeframe**	**Governance**	**Action Owner**
29	**Establish the "Anchor" Charter within BHNFT Strategy Implementation** The key practices of an anchor institution have been widely described through work conducted by organisations such as the Health Foundation, the Joseph Rowntree Foundation and the Centre for Local Economic Strategies. We wish to adopt these practices and have developed an anchor charter to embed the principles within the BHNFT strategy. The charter describes the way BHNFT can contribute to a more inclusive society & economy across **eight domains**: 1. Our goals & values and how we use them 2. How we deliver services 3. Our role as an employer 4. How we work in partnership 5. How we buy and procure goods & services 6. Environmental sustainability 7. Our land and assets 8. Power and ownership	BHNFT's adoption of an anchor charter. Integration of the anchor charter in BHNFT Strategy and its implementation. Establish a network group of domain leads established and Terms of Reference agreed. The network will coordinate domain leads to develop metrics to measure progress in each domain of the anchor charter.	*What will be different in one year?* The BHNFT five-year strategy implementation will adopt the anchor domains. We will have a network group of anchor domain leads that are delivering work within each anchor domain.	Group of domain leads established by December 2021. Ongoing work – continuous.	Existing BHNFT Strategy implementation governance through the programme management office (PMO). Anchor network domain leads meeting.	Consultant in Public Health.

30	**Anchor Demonstrator Project: Pilot of reusable personal protective equipment (PPE)** Use of reusable PPE within BHNFT is a helpful demonstrator of an approach that covers multiple areas of good practice in the anchor charter. It covers procurement, provides the potential to stimulate the local economy (reusable PPE produced in Barnsley), has a connection to sustainability and staff wellbeing. We intend to pilot the procurement, and use of reusable PPE within BHNFT, demonstrating how it can be used effectively to protect staff and adhere to infection prevention and control guidance.	One-month pilot of reusable PPE within BHNFT. Logistics and oversight groups established. Evaluation and report. Plan for future phases.	*What will be different in one year?* The impact of the reusable personal protective equipment pilot will be evaluated. Learning will be captured and shared including a case for scaling up.	April 2022.	Anchor network domain leads meeting. Existing governance structures in procurement.	Consultant in Public Health.

31	**Develop Anchor demonstrator projects for all domains of the Anchor Charter** We will develop and commence other demonstrator projects across each of the domains. Demonstrator projects can be linked to other aspects of this plan. For example, if BHNFT signed up to the Barnsley Local Authority Declaration on Healthy Weight, and engaged with the *Barnsley Food Plan* this would help strengthen our work under tier one to reduce harm from physical inactivity and unhealthy diets.	At least one demonstrator project led by each domain lead has commenced.	*What will be different in one year?* Each domain of the anchor charter will have at least one demonstrator project in progress.	Review July 2022.	Anchor network domain leads meeting.	Anchor Domain Network group. Consultant in Public Health.

32	**Identify current position in relation to Anchor Charter to inform future project planning** We will review our current position as an organisation against the Anchor Charter, identifying areas for development. This baseline understanding will be used to identify future projects that can be embedded within BHNFT, and adopted by domain leads.	Baseline maturity matrix completed for each domain against the draft Anchor Charter. *Horizon 2* projects identified and agreed by the network group of domain leads.	*What will be different in one year?* The organisation will have mapped progress against the anchor charter, and identified areas of focus for future years.	Review July 2022.	Anchor network domain leads meeting.	Anchor Domain Network group. Consultant in Public Health.
33	**Communications plan for the BHNFT Strategy 2021-2026 highlighting anchor practices** We will develop our communications so that all colleagues and partners can understand our work and how they can contribute. This will most likely take the form of "Our Barnsley Story" which will use real people's stories to make the 6 Ps (Best for Patients & the Public, Best for People, Best for Performance, Best Partner, Best for Place and Best for Planet) tangible.	Communications plan implemented for the BHNFT Strategy 2021-2026 highlighting anchor practices.	*What will be different in one year?* Communications will make the ideas anchor institution concepts more tangible by linking examples of anchor work to real Barnsley people.	Review July 2022.	Existing governance processes for marketing and communications.	Director of Communications and Marketing.

Partnership Working				
Priority Actions		**Metrics**	**Timeframe**	**Action Owner**
34	**Barnsley Inclusive Economy Board Leadership** The Barnsley Inclusive Economy Board is the strategic partnership board driving the Inclusive Economy strategy with representatives from private sector businesses and public, voluntary and community organisations. BHNFT and partners have maintained focus on shaping the long-term socio-economic wellbeing of the borough beyond the pandemic. The vision is established by Barnsley 2030 – a partnership commitment to: improving health; inclusive growth; strengthening lifelong learning; and maximising environmental sustainability. The anchor charter developed within BHNFT is being considered for use by the Barnsley Inclusive Economy Board to enable improvements in population & planetary health and to reduce inequalities.	Establish BHNFT Consultant in Public Health as Chair of the Barnsley Inclusive Economy Strategy sub-group. Provide leadership on an inclusive economy strategy for Barnsley. BHNFT Membership on Inclusive Economy Board. BHNFT Membership of Barnsley 2030 Board.	Continuous.	Consultant in Public Health.

35	**Barnsley Health Inequalities Action Group Leadership** The Health Inequalities Action Group (HIAG) was formed to work on behalf of the Barnsley Integrated Care Delivery Group (ICDG) ICDG to develop a programme for tackling inequalities with an understanding that this runs as a golden thread through our partnership work. It is a partnership group where we co-ordinate, connect and fill in any gaps to make sure that we make demonstrable progress on Health Inequalities. BHNFT has led the way in the development of a three-tier framework for categorising action to address health inequalities (see *Appendix C*). This framework has been approved by the Integrated Care Partnership Group (ICPG) is now being adopted by partners.	Establish BHNFT Consultant in Public Health as Co-Chair of the Health Inequalities Action Group. Provide leadership on development of the three-tier framework for addressing health inequalities across Barnsley.	Continuous.	Consultant in Public Health.

C. Build a More Inclusive Society and Economy **in Partnership**

Working in Partnership across Barnsley Place

Like the majority of aspects of this action plan, building a more inclusive society and economy in Barnsley will only be successful if done in partnership. That is why BHNFT has ensured that BHNFT senior leadership is included on the membership of the *Barnsley 2030* Board and the Barnsley Inclusive Economy Board.

Dr Andy Snell (Consultant in Public & Global Health) chairs the Inclusive Economy Strategy / Anchor Institutions subgroup of the Barnsley Inclusive Economy Board to ensure we broaden our accountability beyond the work we do as a trust but also share learning with partners, and help to shape the Barnsley-wide approach.

Enablers

In order to progress this action plan, there are three key enablers.

Understanding of the concepts of health inequalities and population health

This means that everybody that works within the organisation needs to understand what is meant by population health, health inequalities and social determinants. This includes a better understanding of the local Barnsley population and their needs.

This can be achieved by initially raising the profile and expanding the remit of the Healthy Lives Team. In addition, education and training of staff on health inequalities can be incorporated into existing staff education programmes, quality improvement training and induction of new staff.

Barnsley Integrated Care Partnership (ICP) collaboration

We cannot address health inequalities in Barnsley alone; place and system collaboration is important. As an organisation we are currently taking a lead in the absence of a developed Barnsley place plan. We intend to work with partners on specific projects identified in this plan.

We are aligning work to other local, regional and national programmes.
Key examples of this work include:

- Working at place with Barnsley partners (e.g. delivering Barnsley 2030)
- Establishing the ICDG Health Inequalities Action Group.
- Local collaborations (e.g. Tobacco control alliance, Heart Health Alliance).
- South Yorkshire collaborations (e.g. South Yorkshire Cancer Alliance).

Organisational leadership that promotes health equity

We have a named executive board-level lead for tackling health inequalities, however it is important that senior leadership engage with promoting health equity. Training is being made available to senior leaders through the NHS Health Equity Partnership Programme, and all should be encouraged to take part.

Action on health inequalities has been incorporated into the BHNFT Strategy 2021-2026. Next year when the BHNFT Quality Strategy is reviewed, leaders should consider the inclusion of “Equity” in the BHNFT Domains of Quality.

The Trust has already made steps to address inequalities and develop this action plan. We have an important role in sharing good practice and learning from others. Collaborations between partner organisations and NHS organisations from across the region provide opportunity to better serve our local population and narrow the gap in health inequalities.

Appendix A

What are Health Inequalities? (taken from *The Kings Fund*)

Inequalities of what?

Health inequalities are ultimately about differences in the status of people's health. But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status. Health inequalities can therefore involve differences in:

- health status, for example, life expectancy and prevalence of health conditions
- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.

Inequalities between who?

Differences in health status and the things that determine it can be experienced by people grouped by a range of factors. In England, health inequalities are often analysed and addressed by policy across four factors:

- socio-economic factors, for example, income
- geography, for example, region or whether urban or rural
- specific characteristics including those protected in law, such as sex, ethnicity or disability
- socially excluded groups, for example, people experiencing homelessness.

People experience different combinations of these factors, which has implications for the health inequalities that they are likely to experience. There are also interactions between the factors. For example, groups with particular protected characteristics can experience health inequalities over and above the general and pervasive relationship between socio-economic status and health.

Appendix B

National NHS Requirements

The requirements of the NHS 2021/22 operational planning guidance related to addressing health inequalities are summarised below. The BHNFT Health Inequalities Action Plan incorporates the national requirements and goes a step further to narrow the health inequalities gap for our patient population.

The following content is taken from the 2021/22 priorities and operational planning guidance: October 2021 to March 2022 (published 30 September 2021)

> "We will also continue the focus on the five priority areas for tackling health inequalities and redouble our efforts to see sustained progress across the areas detailed in the NHS Long Term Plan, including early cancer diagnosis, hypertension detection, respiratory disease, annual health checks for people with severe mental illness, continuity of maternity carer, and improvements in the care of children and young people. To support this, we are improving the quality and presentation of health inequalities data and will shortly set out further details of our approach. We are also asking that all NHS Board performance reports include reporting by deprivation and ethnicity."

The "five priority areas for tackling health inequalities" are described in the 2021/22 priorities and operational planning guidance: Implementation guidance (published 25 March 2021) and are copied below.

> "COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan.
>
> To help achieve this, NHS England and NHS Improvement issued guidance as part of its 'phase 3' response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities. Systems are now asked to focus on **five priority areas** in the first half of 2021/22, distilled from the eight actions.
>
> The effective use of data is central to tackling health inequalities including delineation of our waiting list and performance data by deprivation and ethnicity as set out in section 3.2.
>
> **Priority 1: Restore NHS services inclusively**
>
> At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.
>
> **Priority 2: Mitigate against digital exclusion**
>
> Systems are asked to ensure that:
> - providers offer face-to-face care to patients who cannot use remote services

- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

Priority 3: Ensure datasets are complete and timely

Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021.

Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:
• Ongoing management of long-term conditions
• Annual health checks for people with a learning disability
• Annual health checks for people with serious mental illness
• In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.

Priority 5: Strengthen leadership and accountability

Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme.”

Appendix C

Integrated Care Delivery Group (ICDG) Three Tier Framework

The role of Barnsley Integrated Care Partnership (BICP) in tackling health inequalities…. An emerging framework

How we develop our service offer?

- Engaging with people and communities who are experiencing poorer health outcomes to co-create future models of care
- New interventions and services that aim to prevent new illness and deterioration of illness for those individuals and communities that experience poorer outcomes
- Increasing relative investment in areas that have been historically underfunded – prevention/primary care/mental health services

How we deliver our existing core services?

- Engaging with people from communities that experience poorer health outcomes to understand their collective experience of health and care
- Taking account of health inequalities in prioritising people for treatment
- Systematically tackling barriers that people experience when accessing/engaging with health and care services

Helping to drive a more inclusive, society and economy in Barnsley

- Contribution to Barnsley 2030 aspirations as anchor institutions
- Improving sustainability of services – social, economic and environmental
- Creating diverse and inclusive workforce and leadership that represents our changing communities in Barnsley
- Providing excellent employment and career opportunities for local communities experiencing inequalities
- Influencing wider socio-economic policy to improve living environments and opportunities for local communities

Healthy Barnsley

Learning Barnsley

Growing Barnsley

Sustainable Barnsley

Gradual shift in our focus and investment as a system to support the needs of all, starting with the most vulnerable; improving health and wellbeing across the whole life-course; and developing a parity across physical, mental, social, environmental and economic health.

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Barnsley Hospital NHS Foundation Trust
Action Plan for Improving Public Health and Reducing Health Inequalities 2022/2023 Summary (November 2021)

	Priority Action to Address Health Inequalities	Time Frame	Action Owner
A: Establish New Services			
Healthy Lives Team			
1	Extension of Tobacco Control (QUIT)	Ongoing	Healthy Lives Programme
2	Establish the Alcohol Care Team (ACT)	December 2021	Healthy Lives Programme
3	Physical inactivity and unhealthy diet	April 2022	Healthy Lives Programme
4	Collaboration & Co-ordination with Community Services	April 2022	Healthy Lives Programme
Equality Impact Assessments			
5	Enhance the Equality Impact Assessment (EIA) Toolkit to include health inequality resources	December 2021	Inclusion & Wellbeing
B: Enhance Existing Services			
Elective Recovery			
6	Monitor ethnicity and most deprived decile proportions in planned care waiting lists	April 2022	ADOs (CBUs 1,2 & 3)
7	Monitor ethnicity and most deprived decile proportions in outpatient referrals	April 2022	ADOs (CBUs 1,2 & 3)
8	Health Inequalities Service Improvement Plan for planned care	July 2022	ADOs (CBUs 1,2 & 3)
Emergency & Urgent Care			
9	Monitor ethnicity and most deprived decile proportions in emergency department usage	April 2022	ADO (CBU1)
10	Health Inequalities Service Improvement Plan for emergency and urgent Care	July 2022	ADO (CBU1)
Patient Vulnerability Data to Support Clinical Assessment & Prioritisation			
11	Establish an Information Sharing Agreement (ISA) with Barnsley Metropolitan Borough Council	December 2021	Information Governance
12	Pilot use of Barnsley Vulnerability Index to assist clinical prioritisation for planned care waiting lists	April 2022	Public Health
13	Pilot use of Barnsley Vulnerability Index to flag vulnerable patients within the Emergency Department	Sept 2022	Public Health
Cancer Services			
14	Monitor ethnicity and most deprived decile proportions in usage of Cancer Services	April 2022	Cancer Services
15	Health Inequalities Service Improvement Plan for Cancer Services	July 2022	Cancer Services
Maternity Services			
16	Monitor ethnicity and most deprived decile proportions in usage of Maternity Services	April 2022	Maternity Services
17	Understanding the experience of Maternity service users from Black and Minority Ethnic Groups	July 2022	Maternity Services
18	Prioritising women from BAME backgrounds into Continuity of Care teams	April 2022	Maternity Services
19	Prioritising women living in the bottom 10% most deprived areas into Continuity of Care teams	April 2022	Maternity Services
Ensuring Digital Inclusion			
20	Offer face-to-face care to patients who cannot use remote services	Ongoing	Outpatient Services
21	Monitor ethnicity and most deprived decile proportions in usage of remote services	April 2022	Outpatient Services

Priority Action to Address Health Inequalities		Time Frame	Action Owner
Outpatient Services			
22	Policy for the management of missed outpatient appointments for adult patients	December 2021	Outpatient Services
23	Evaluate the effect of outpatient transformation initiatives on health inequalities	April 2022	Outpatient Services
24	Health Inequalities Service Improvement Plan for Outpatient Services	July 2022	Outpatient Services
Patient Experience			
25	Evaluate the Friends and Family Test (FFT) feedback through a health inequality lens	April 2022	Quality & Clinical Gov
26	Analysis of patient complaints through a health inequality lens	April 2022	Quality & Clinical Gov
27	Engage with relevant population groups in response to any specific inequality issues	April 2022	Quality & Clinical Gov
Communications			
28	Continue to provide accessibility and language options to view BHNFT website content	Ongoing	Communications
C: Build a More Inclusive Society and Economy in Barnsley			
BHNFT as an Anchor Institution			
29	Embed an “Anchor” Charter within BHNFT Strategy	December 2021	Public Health
30	Anchor Demonstrator Project: Pilot of reusable personal protective equipment (PPE)	April 2022	Public Health
31	Develop Anchor demonstrator projects for all domains of the Anchor Charter	July 2022	Public Health
32	Identify current position in relation to Anchor Charter to inform future project planning	July 2022	Public Health
33	Communications plan for the BHNFT Strategy 2021-2026 highlighting anchor practices	July 2022	Communications
Partnership Working			
34	Barnsley Inclusive Economy Board Leadership	Continuous	Public Health
35	Barnsley Health Inequalities Action Group Leadership	Continuous	Public Health