Meeting: 19 November 2024

ADULT SOCIAL CARE & HEALTH SCRUTINY REVIEW PANEL

Understanding Inequalities in Health Outcomes across Stockport

Report of the Director of Public Health

Recommendations:

With reference to this paper, the review panel is asked to:

1. Consider and review the progress to date
2. Consider the findings from an evidence review relating to people living with severe mental illness (SMI) and the health inequalities they face
3. Note emerging themes from early analysis of lived experience of people with SMI
4. Consider and agree the planned next steps for the review

Scrutiny Review Panel:

Chair:	Councillor Wendy Wild
Members:	Councillor Geoff Abell, Jake Austin, and Karl Wardlaw
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Background and Objectives

Stockport Council and partners are committed to addressing health inequalities. The recent annual report by the Director of Public Health has added impetus to this, partners have received it positively and are supportive of this ambition. This Scrutiny Panel Review provides an opportunity to focus on the lived experience of two particular cohorts who may be expected to face a higher risk of comparatively poorer health outcomes. The review wants to address the following objectives:

1. Understand the inequalities in health outcomes for the agreed cohorts of people, when also affected by deprivation.
2. Understand the lived experience of people affected by deprivation and disability / ethnic minority status.
3. Ascertain whether local systems are equipped to improve the inequalities affecting these cohorts, including in health outcomes.

In the first panel meeting it was agreed that the focus of the review should be on the lived experience of two particular cohorts of residents: (1) people living with severe mental illness (SMI), and (2) people from Bangladeshi, Pakistani, and Black African communities, both also affected by deprivation.

Progress with the review so far

- A rapid review of evidence from the literature was undertaken to better understand the inequalities in health outcomes affecting people with SMI. This was done using local data, online searches for policies and guidelines and bibliographic database searches (MEDLINE, Ovid and Google Scholar) for journal articles. This corresponds to the first objective.
- To address the second objective, following a meeting with partners, it was decided an online questionnaire and a guidance document for conducting group discussions would be developed to elicit the lived experience of people living with SMI (including carers and staff). Both tools were co-developed with Pure Innovations to ensure the use of appropriate and positive language; the tools were circulated to partners who work with and support people with SMI to share with their networks (a link to view the questionnaire is here: https://forms.office.com/Pages/ResponsePage.aspx?id=nvZeoElhuk-kDN8ziBD2RN39Nvycfa9Pmte0FVRwBTBUMFpPWTRHOE5FN0xZRjhTS0hSRlUxNEpMUC4u).
  At the time of writing this report, Public Health had conducted one group discussion with nine participants, and seven people had completed the online questionnaire. Data from both allowed us to identify emerging themes which are presented in this report below. Feedback from those living with SMI will continue to be collected until the 1st of December.
- To address the third objective, we are currently testing a questionnaire for officers from different sectors potentially relevant to the determinants of health, including education, social connections, housing, employment, transport and leisure, health and social care.

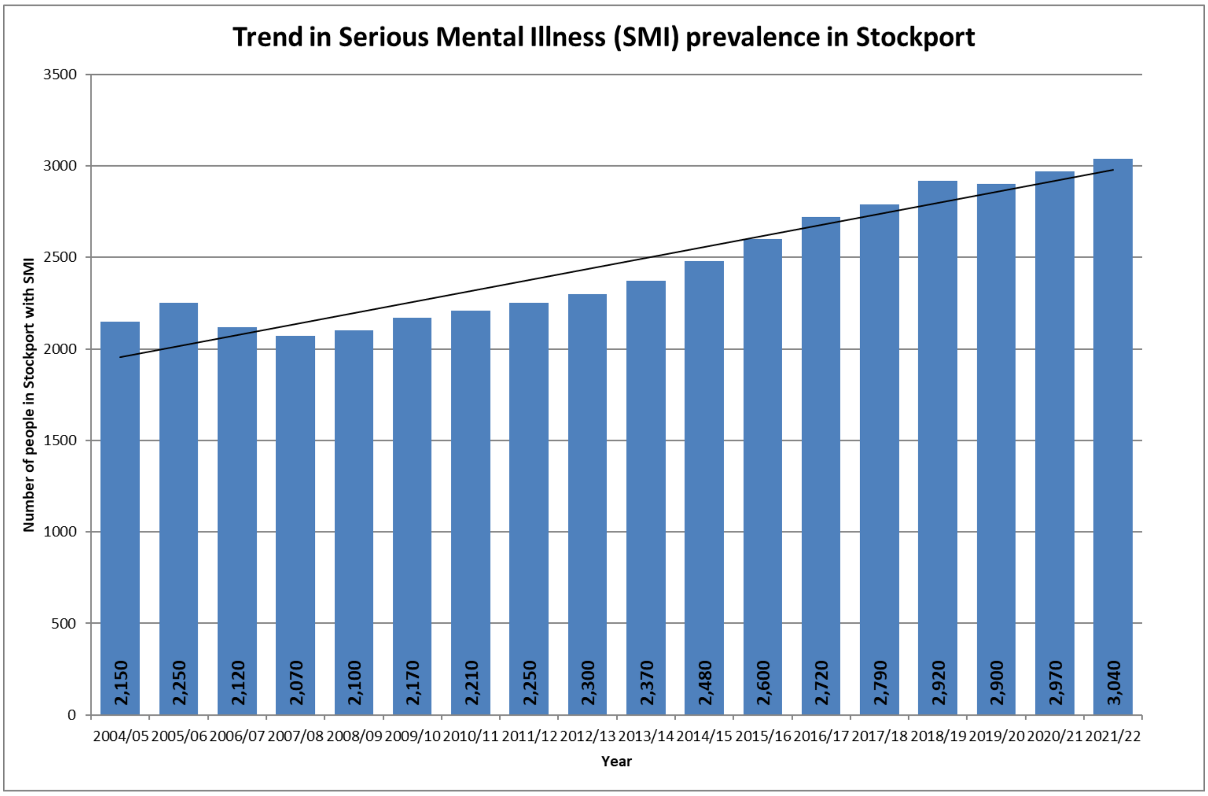
Description of the cohort

The term severe mental illness (SMI) is used to describe people with a group of conditions including (but not limited to) schizophrenia, bipolar, personality disorder, eating disorders and severe depression (Gov.uk, 2023; NHS, 2019).

Bipolar disorder affects around 2% of the population in England and schizophrenia affects around 0.7% (NHS Digital, 2014). In 2023/24, there were more than 527,000 people on GP SMI registers (NHS England, 2024b) but at local levels numbers are small – a typical GP practice will have 60-100 patients with SMI on their register (NHS, 2019).

The number of people diagnosed with SMI in Stockport is rising. Data from 2021-22 suggested there were 3,040 people registered with a Stockport GP and a diagnosis of a SMI (including people with schizophrenia, bipolar affective disorder, other psychoses and other patients on lithium therapy). This is a 41% rise since 2004/05 when reporting began.

Figure- trend in SMI prevalence in Stockport 2004-2022.



In Stockport, trends show that the rate of premature mortality under the age of 75 from all causes is 4.3 times higher for those with SMI compared to the general population. The prevalence of multi-morbidity is around double for people with SMI, compared to people without. As of October 2024, 57.5% of those eligible (1,492 people out of 2,594) had received an SMI Health Check with all 6 elements.

The rates of people with SMI in Stockport's most deprived areas is three times higher than the least deprived areas.

Due to the increasing number of people in Stockport being diagnosed with SMI and the health inequalities they face; this review aims to collate the lived experience of those living with SMI to help form recommendations to reduce inequalities.

Rapid evidence review: understanding the inequalities in health outcomes for people with severe mental illness

Challenges and risks to health experienced by people with SMI:

Physical health

People living with SMI face one of the greatest health equality gaps in England, living 15 to 20 years less than the general population (Carswell et al, 2022; Gov.uk, 2018; Gov.uk, 2023). This disparity is largely due to preventable physical illnesses (Gov.uk, 2023).

In England, people with SMI are 5 times more likely to die before the age of 75 than those who do not have SMI. Two in every three deaths of people with SMI before the age of 75 were potentially preventable (Gov.uk, 2023). The main causes of death include coronary heart disease (CHD), stroke and liver disease.

Other chronic health conditions include asthma, diabetes and chronic obstructive pulmonary disease (COPD) and people with SMI are at increased risk of developing more than one of these chronic conditions (Carswell et al, 2022; Gov.uk, 2023). In addition to chronic physical medical conditions, around a fifth (20%) of the excess mortality in people with SMI is due to suicide and accidents (Dregan et al, 2020; PHE, 2018).

People with SMI make more use of secondary urgent and emergency care (Gov.uk, 2018) and are more likely to have poor dental health than the general population (OHI&D, 2024). Infectious diseases appear to contribute to an increased risk of death in people with SMI, with a 4- to 8-fold risk of death due to infection compared to the general population. People with SMI were also more likely to catch and have poorer health outcomes from COVID-19, including mortality from the illness (OHI&D, 2024).

Health behaviours

These diseases are partly attributable to modifiable unhealthy behaviours and adverse social context (Carswell et al, 2022; Dregan et al, 2020). For example, compared with the general population, people with SMI are at substantially higher risk of COPD and are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder (Gov.uk, 2018). They are also at higher risk of obesity and diabetes and less likely to do any moderate or vigorous physical activity (OHI&D, 2024), have less access to healthy foods and fewer opportunities to be involved in healthy activities (PHE, 2018b). The most significant modifiable factor for enhancing life expectancy for people living with schizophrenia is smoking, and for people living with bipolar disorder it is sedentary behaviour (NHS, 2024).

Addressing unhealthy behaviours and poor life circumstances have the potential to prolong life expectancy at birth by four years for people with bipolar and six years for those with schizophrenia (Dregan et al, 2020). Many deaths from these diseases could have been prevented with screening or earlier treatment (Gov.uk, 2023). Physical illnesses can be underdiagnosed and undertreated in those living with SMI, because the co-occurring psychiatric diagnosis overshadows recognition of physical health symptoms (Carswell et al, 2022; NHS, 2024). It is estimated that the life expectancy gap between people with SMI and the general population could be narrowed by approximately 24% to 28% for men and women respectively by tackling modifiable risk factors (Dregan et al, 2020).

Health and social care

Diagnostic overshadowing can happen if someone has more than one health condition at the same time which is overlooked and under-treated. For some people with a mental illness, physical ill-health is perceived to be part of the mental health condition or related medication even when their symptoms could mean there is a physical health problem (OHI&D, 2024). The increased prevalence of diseases for people with SMI is also partly attributable to suboptimal healthcare use and efficiency (prevention, treatment adherence) (Dregan et al, 2020).

Wider determinants

Mental health inequalities are often linked with wider cultural and societal systems of disadvantage which impact a person's wellbeing (NHS, 2019).

There is a positive association between premature mortality in adults with SMI and deprivation. Four times as many adults with SMI die prematurely in the most deprived areas compared to adults with SMI in the least deprived (Gov.uk, 2023).

Deprivation is impacted by a person's ability to maintain good quality work which is protective for health and can be a vital element of recovery from mental health problems. There are challenges for people with mental health problems in gaining and maintaining employment due to negative attitudes and stigma (PHE, 2018b). Nationally, only 6% of working age adults (18 – 69) with an SMI were recorded as being employed (NHS digital, 2023). They are also often over-represented in low-pay and temporary work (PHE, 2018b).

Variation in premature mortality in the population with SMI is not driven by deprivation alone and other factors such as ethnicity and access to services come into play (Gov.uk, 2023).

Intersectionality

Intersectionality is a concept used to describe the way in which different aspects of a person's identity, such as race, deprivation, or disability interact and contribute to and potentially intensify the impact on systematic social inequality. For example, high rates of psychosis among people from Black African and Caribbean groups are related to experiences of social disadvantage that include unemployment and social isolation, which represent forms of structural racism (Gilburt & Mallorie, 2024).

During 2021/22, the proportion of people admitted to acute mental health services who were not previously known to services was 17% for people from ethnic minority groups, compared with 12% for people of white British origin (Gilburt & Mallorie, 2024).

People with autism are also more likely to have SMI, although estimates vary across reviews. For example, some reviews report there to be a 5% to 21% prevalence of bipolar disorder and 4% to 67% prevalence of schizophrenia spectrum and other psychotic disorders for people with autism (Hossain et al. 2020; Meng-Chuan et al, 2019).

People with mental illness are more likely to experience homelessness due to barriers in accessing appropriate accommodation including stigma, discrimination and poverty as well as being due to limited housing supply (PHE, 2018b). Rates of psychosis are up to 15 times higher among people who are homeless compared to the general population and people with severe mental illness are also more likely to live in less safe neighbourhoods (PHE, 2018b).

People in contact with the criminal justice system are more likely to experience mental ill-health than people in the general population. This is compounded by coexisting social disadvantage including substance misuse, poor physical health, homelessness, offending behaviour, unemployment, persistent poverty and debt (PHE, 2018b).

Relevant policies and guidelines to support people living with SMI

There are multiple policies and guidelines to help improve the health and wellbeing of people with SMI and reduce inequalities, and this section presents the main sources.

Investing in services for people with SMI forms a major part of NHS Long Term Plan (NHS, 2019b). Priorities include:

- Physical health checks – by 2023/24, the NHS will ensure that at least 390,000 people living with SMI have their physical health needs met.
- New and integrated models of primary and community mental health care will support adults with SMI. This involves reorganising core community mental health teams to move towards place-based, multi-disciplinary services across health and social care.
- Smoking cessation - a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of mental health and learning disability services.
- Social Prescribing - the range of support available to people will widen, diversify, and become more accessible.

Work to address inequalities in health outcomes for people with SMI is part of Core20PLUS5, NHS England’s flagship approach for tackling health inequalities: ensuring annual health checks for 60% of those living with SMI (NHS, 2024).

The NHS mental health implementation plan (2019) also sets out targets on the number of people with SMI having the physical health check and accessing the Individual Placement and Support services.

Public Health England (2018b) set out actions that local areas can take to reduce health inequalities, improve physical health and life chances of people living with mental illness. These include:

- Understanding the mental health needs of the local population.
- Addressing social factors and improving the conditions in which people live and work.
- Addressing loneliness, social isolation, building a sense of belonging and participation in a local area and creating good social networks and social support.
- Use community-centred approaches to engage marginalised groups and vulnerable individuals.
- Early detection and intervention for physical health risks by completing annual health checks.

More recently, the NHS (2024c) has developed 10 key actions to tackle the physical health inequalities faced by people living with SMI. This includes co-production and lived experience, providing care that advances equality, delivering the annual health check, outreach and health promotion, make every contact count, don’t just screen-intervene, support for family/carers, joined up care, personalised care and workforce/leadership.

NICE guidance for people with bipolar (NICE, 2014), psychosis and schizophrenia (NICE, 2014b) focus on the wider determinants of health as well as recommending psychological and pharmaceutical interventions, completing the annual health check and having a case register in primary care. This includes offering assistance with education, financial difficulties, employment programmes and carer-focused education and support programmes as part of a family intervention. Guidance also recommends the use of peer support groups.

The most frequently cited intervention to improve health outcomes for people with SMI is the annual health check (with a target of 60% of those eligible having been completed by the end of 2024). Peer support via social prescribing to address feelings of loneliness and build support networks were recommended along with providing advice and support for social factors such as debt management and employment. Psychological and pharmaceutical interventions are part of NICE (2014 & 2014b) guidance and providing education and support for those who care for people with SMI is also cited in several policies.

The final report of this review will collate information on the current status of local implementation of the current key guidance.

Emerging themes from lived experience of people living with SMI

This section is an early analysis of the data obtained from group discussion participants and online questionnaire respondents to elicit the lived experience of people living with SMI (including carers and staff).

Social connections

Friends and family

Several participants feel well supported by loyal family, friends and partners. One participant said their parent was really understanding and would speak to the GP for them when they were unwell. It is also reported to be helpful when family/friends understand the social care system as they can help people to access support.

However, many people feel judged by family and friends and that only others who have had similar experiences to them really understand what they are going through. Some people reflected that when their mental health deteriorates, they aren’t able to keep up with other things such as housework and this can make them feel under pressure when seeing friends or family.

Activities and groups

Several participants enjoy attending different social groups to meet people, make friends, socialise, connect and talk with others. Generic mental health or social groups can be anxiety provoking and triggering with no common ground to start from, or they end up becoming ‘venting’ sessions. Groups focused on an activity such as an exercise class, helping maintain an allotment or learning to knit, are perceived as more helpful. Attending groups also helped get people out of the house and structure their days. Other people found they were able to meet new friends at the gym and by attending church.

One participant noted that sometimes people are interested in going to groups but do not have the motivation or confidence to attend. It is reported to be beneficial when a family member or support worker is able to attend new groups with the participant if they are feeling nervous about going for the first time.

Voluntary and community organisations

Different voluntary and community organisations such as Pure Innovations and SPARC were highlighted by several participants as being very supportive.

Many participants noted that community support is not well publicised in the community and via health services. People didn't know they could self-refer to some groups meaning they waited longer to be able to access this support.

> *"If you are not internet savvy then you can't find half the information about the support you can access and what you / your family are entitled to."*

Education – early childhood, school, college

Relationship with staff and pupils

Several participants report having had strong relationships with teachers who were compassionate while they were in education. However, many found the opposite with teachers and fellow pupils showing a lack of understating of mental illness. Some people had support from friends while in education, but others felt picked on due to their illness and being singled out by teachers who weren't able to adequately prevent bullying.

Practical support

One to one support in education is reported to be helpful along with being given extra time to complete exams.

Extended periods of time off due to enduring mental illness meant that some people missed a full education. Some educational settings were reported to be understanding when people needed time off whereas others gave too much homework to catch up on when people returned to school causing them to feel stressed and unable to keep up.

> *"When you can't keep up in school, you get left behind, feel isolated and stupid".*

Some participants didn't feel there was any practical or emotional support when they became unwell. This led to feelings of isolation and fear as they had no-one to turn to.

Routines and structure

School helped give a sense of structure which was helpful. On the other hand, university was reported to be harder as there is less routine making balancing personal life, studying and work overwhelming.

Special Educational Needs and Disabilities (SEND)

Several participants feel that schools have become better at recognising and supporting pupils with mental health difficulties and disabilities (such as people with dyslexia, autism, attention deficit and hyperactivity disorder (ADHD)) and that SEND services have improved over time. However, there were still reports of unsatisfactory experiences including poor access to SEND placements and children with additional needs having to be in mainstream schools which are not the most appropriate environments to support them. Concerns were also raised regarding the education health and care plan (EHCP) process which takes too long to complete meaning there is not enough time to ensure adequate provision in schools.

Limited support for people who are neurodivergent or have learning difficulties was raised as a concern for some participants which made it hard for some children to form relationships with others.

Housing

Affordable housing

Having a safe, warm and affordable place to stay was highlighted by many people as being essential to overall wellbeing.

Some participants reflected how they feel lucky not to have any concerns with their housing, they feel happy and secure in their homes as they own them.

Most participants feel there is not enough social and affordable housing. The prices of rent in the private sector are increasing and becoming unmanageable. This causes concerns about getting into debt, people being evicted or having to live in areas that are less desirable (such as being further away from support networks) to be able to afford somewhere to live.

Some participants have been able to negotiate how they pay their rent but not everyone has had such positive experiences. Some people feel the housing department are not interested in whether or not someone can afford the rent and do not take personal circumstances (such as caring for someone) into consideration.

Good quality home and adequate maintenance

Those who own their homes acknowledged that this was not much of an issue for them as they are able to do necessary work and decorating as and when this is needed.

Several participants report poor quality housing in both private and social rental properties. They have had issues with landlords doing repairs which can take a long time or do not happen at all. There can be issues with sound proofing and inadequate facilities such as there being no lift in a block of flats which is difficult to manage with a physical disability. One participant reported it has been challenging to get adequate adaptations made to properties and requests for this to be done have been met with hostility by the housing department.

Social housing systems

The points and priority system to obtain social housing is reported to be complicated and people feel “passed around” by the housing system. It can be hard to move as people can be deemed as “adequately housed” by the Council but the property might be making them feel isolated as it is not near their support network.

Temporary accommodation

Many participants feel people are in temporary accommodation for too long. This accommodation is often inappropriate such as not having a kitchen in which to cook or the property being too small. Some participants noted that people with mental illness may struggle when in temporary accommodation as they are sharing with others and the residents are transient.

Work / employment

The role of managers

Several participants report having a supportive and understanding manager has been critical to them being able to stay in work. This includes ensuring people leave on time, helping them maintain a work-life balance and not being intrusive about people’s mental health or offering unsolicited advice.

Not everyone has had such positive experiences with managers who have shown no understanding of the effects mental health difficulties have on someone. This is also experienced by people who are working and care for someone at home with a mental health difficulty which can make working intolerable and force people to give up their careers.

Supportive team

Working in a team of supportive colleagues and having the opportunity to bond with colleagues through work events and team meetings is seen as something that helps people stay in and enjoy work.

Flexible working

Flexible working means that people take leave when they are having a bad episode or period with their mental health and can have work patterns that enable them to sleep well which improves mental health.

Coping in work

Some participants highlighted support to work through challenging tasks meant they didn’t feel overwhelmed in work and making sure they had regular breaks to rest and eat were all important. Workplace inclusion and support was also highlighted as being beneficial to mental health in work.

Being out of work and finding work

A few people mentioned having a Pure Innovations job coach was helpful and that Stockport has a good array of work opportunities if people have support in accessing these.

There are restrictions on work for people receiving Employment and Support Allowance (ESA) making it difficult for some people to return to work.

Access to food and other necessary things

Some participants reflect that they are lucky as they are able to live within their means as they earn above benefit levels.

Getting to the shops

Social care is reported to have been helpful for some participants as physically getting to the shops to buy food and getting it home was a big issue until they started to receive practical support.

For those who cannot drive, getting to the shops can be very difficult meaning some have to rely on family and friends to take them shopping.

The shops can also be overwhelming and contribute to sensory overload, making trips there challenging or resulting in people avoiding the shops all together.

Cost of living

Most participants feel the high cost of living makes things difficult, pushing people into poverty and reducing the amount of necessities they can buy.

Some participants note that we have good access to food banks in Stockport, but people should not have to rely on them. This is down to issues with benefits not keeping up with inflation and the increasing cost of living.

Low-cost supermarkets don’t offer delivery forcing some people to shop in more expensive retailers. The cheaper and walkable supermarkets might not have what people need to meet their dietary requirements which considerably limits what they can eat.

Being out and about – transport, leisure facilities

Service provision

Many participants feel the bus and train services are good and become a lifeline when they are not able to drive. Buses are also seen as easy to access in terms of the destinations and timings of the service and the facilities at the stations are good.

Cost of transport

Free and discounted public transport were highlighted by most people as something that really helps them to get out and about. Although, some without a discount or free pass find public transport too expensive. Some participants highlighted the discounted taxis they can obtain through Pure Innovations as helpful along with the blue badge for parking.

Access

When you can't get on public transport, you become cut off from your support network and the things you need. For some, this is due to public transport being overstimulating and difficult to wait for in the winter as the cold causes their pain to flare up.

The buses are reported to be quite easy to access for those with mobility issues but when waiting for buses and trains, it can be hard to read signs at the stations as there is a lot of information and the writing can be small.

Support to travel

For some, it is hard to travel when they can't use public transport on their own due to anxiety. A travel companion is therefore helpful to be able to get out. Some people are not able to get out unless someone else takes them, making them reliant on others and removing some of their independence.

"When I was driving, I went out a lot and did well…It's important to remain independent. Especially if you don't have family or friends nearby."

Several participants mentioned car schemes which are good when they are available, but these do not help when people need to attend a hospital appointment.

Health and care services

Most participants feel health and care staff have a better understanding of mental health now than several years ago and that the system is improving. However, they feel there is still a long way to go.

Continuity of care and named professional

Several participants mentioned having a named professional such as a mental health worker, housing officer, homeless support worker, speech and language therapist (SALT) and social worker provides consistency and continuity of care. This means people always know who to contact but it can be difficult to get hold of them at times.

Many participants report seeing a different GP or mental health professional every time is difficult as there is no consistency, people must repeat themselves and doctors don't link issues together.

Experience at the GP

Many participants have good experiences with their GPs but they can be a barrier to accessing mental health services if people don't think the GP is understanding. Reception staff are also seen as a barrier if they don't think people's concerns as "important enough" to be given a GP appointment and are often seen as "unkind, rude and abrupt".

Many participants didn't think their GPs signposted them to support in the community fast enough, possibly because they didn't know the services were available.

All GP practices have a different system to book appointments which can be confusing and the online booking system PATCHES is complicated.

Experience of community and specialist care

Some people have had good experiences of specialist and community services such as having excellent psychiatrists who listen to their concerns. Community mental health teams (CMHT) and peer support are reported to have been beneficial.

> *"CMHT peer support was life changing as they actually did interventions with me. As well as the specialist trauma clinic I go to, they actually understand my trauma diagnosis and I'm finally getting better."*

Several participants feel they have benefitted from the community support they have received form third sector organisations such as Mind, Signpost, SPARC and Pure Innovations.

Hostels having long opening hours so people can receive support in the evenings after work and at weekends is really useful, but staff are able to enter peoples flats when they feel necessary which can cause residents to feel anxious.

Speech and Language Therapists (SALT) provide support to families, so their children's communication and language development improves. However, there needs to be better access to SALT and previous support has not always been adequate leaving parents feeling alone and unsupported.

Some participants find their social worker has been helpful whereas others have struggled trying to navigate the system and feel mistreated by the service.

High staff turnover in all areas of health and care is reported to be an issue by several participants.

Experience in hospital

Many people express having had a good experience of physical health care at Stepping Hill but that there is a big difference in the care received between physical and mental health.

The state of some of the hospital buildings is reported to be poor although Stepping Hill are making improvements.

Crisis care

Many participants feel crisis care is inadequate and they, or someone they know, have been turned away from hospital when in crisis.

Staff can miss signs of crisis due to the risk assessment being a "tick box exercise" and not really looking at their patients. They are also reported to be too slow to assess people in crisis, leaving them to wait for long periods. There is no safe space for people in crisis to go to with hospital being too loud and it was felt staff were not adequately trained in neurodivergence or trauma.

> *"The stress of navigating all of these systems, constantly being reassessed and reliving it all is traumatic."*

Waiting lists and finances

Most participants feel waiting lists to see mental health professionals are too long and mental health services are under-funded.

What impact do you think poverty (defined as lacking basic financial resources) has, or could have on people's experience of living with mental health challenges?

Most participants feel poverty has a huge impact on a person’s mental and physical health. Worrying about finances causes a huge amount of stress, reduces their tolerance levels and increases people’s risk of relapse. Poverty doesn’t allow people breathing space to recover from their illness as they are constantly worried about their finances and how they will cope. People’s physical health is also affected by poverty as they can’t afford to eat as healthily, attend the gym and have less access to green space for exercise. It also makes it harder to get to health appointments if transport affordability is an issue.

Often, a first episode of psychosis occurs at a critical time for educational attainment. This can lead to reduced access to work and people becoming stuck in poverty. There is also a vicious circle as mental health patients are put on medications which make them less motivated or able to work which in turn puts even more pressure on them having no money, becoming more depressed and having low self-esteem.

Poverty effects a person's living conditions, increasing their risk of becoming homeless. Energy prices are reported to have an impact as it is hard to heat homes and living in cold environments can cause physical pain for some people.

Poverty restricts people and they have to make hard decisions about what to buy. They can become socially immobile and isolated if they can’t afford to go out and visit friends and family.

> *“I make sure my bills [are paid] and dogs are fed, I don't have much spare to do anything else, this obviously makes me feel more isolated and too much time to think about my past trauma.”*

Plan going forward

The review will begin to focus on the second cohort (people of Bangladeshi, Pakistani and Black African ethnicities, also affected by deprivation), taking a similar approach to the first. The next steps are as follows:

a) A rapid review of evidence of inequalities in health outcomes affecting this cohort
b) A questionnaire and guidance document to obtain lived experience. The tools will be co-designed with people from the relevant ethnicities, to ensure the language is appropriate and the information is circulated to the right networks.

To ascertain whether local systems are equipped to improve the inequalities affecting both cohorts, including in health outcomes, the questionnaire for officers representing different sectors will be finalised and distributed to cover these sectors:

education, employment/work, housing, support with daily living, healthcare, and social care. The questionnaire will elicit:

- Approaches in place to identify potential challenges faced by the cohorts
- Any challenges identified
- Approaches for addressing these challenges
- Ways for gathering feedback from the cohorts, and how well these are perceived to be working
- What sector representatives would find useful to better support the cohorts
- Plans for further engagement with either cohort

Both the questionnaires for service providers and people from ethnic minority backgrounds will have a deadline of the end of December to allow time for the majority of the analysis to take place before the next review panel meeting in January.

The final report, along with recommendations, will be presented on 6 March 2025. If it is agreed that this report will go Cabinet, it will be sent on 18 March 2025.

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