Meeting 15 January 2025

ADULT SOCIAL CARE & HEALTH SCRUTINY REVIEW PANEL

Understanding Inequalities in Health Outcomes across Stockport

Report of the Director of Public Health

Recommendations for the Panel

The review panel is asked to:

1. **Consider and review the progress of the work to date – particularly the new sections of the report developed since the last meeting**
2. **Consider and agree the format of the final report, and**
3. **Consider and agree the outlined next steps for finalising the review report.**

Introduction to this Report

The report below builds on sections already included in the report to the previous panel meeting and adds new sections with information gathered since then. This emerging draft final report also highlights areas where work is still ongoing (e.g. Discussion, Recommendations). No part of it should be quoted as final as the entire report is currently considered a draft.

Proposed Next Steps to Finalise the Report

- Share draft with more officer colleagues to enable them to add more local intelligence
- Hold meetings with sector representatives to formulate draft recommendations based on lived experience findings, evidence reviews, and their knowledge of the sector.
- Panel to receive final draft with recommendations for final comments by 20 February.
- Submit to Scrutiny Committee by 26 February, for presentation on 6 March 2025.
- Submit final report to Cabinet by 10 March, for presentation on 18 March 2025.

Contents of the draft report

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

The review aims 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 reduce the inequalities affecting these cohorts, including in health outcomes.

2. Scrutiny Review Panel Membership

Chair:	Cllr Wendy Wild
Members:	Cllrs Geoff Abell, Jake Austin, and Karl Wardlaw
Lead Officers:	Judith Strobl (07815 653975) judith.strobl@stockport.gov.uk, Heather Knowles heather.knowles@stockport.gov.uk

3. Methods used by the review

- A rapid review of evidence from the literature was undertaken to better understand the inequalities in health outcomes affecting people belonging to both cohorts. 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 from both cohorts (for people with SMI, this included the possibility for carers to complete the questionnaire too). Both tools were co-developed with vital support from voluntary sector partners to ensure the use of appropriate and positive language; the tools were circulated to partners who work with or support people from both cohorts, to share with their networks.

- To address the third objective, a questionnaire for officers from different sectors potentially relevant to the determinants of health was used; this was addressed to colleagues in the sectors relevant to education, social connections, housing, employment, transport and leisure, health and social care.
- Thematic analysis was used to analyse the narrative from the questionnaires and interviews and to develop themes.

4. Description of the cohorts

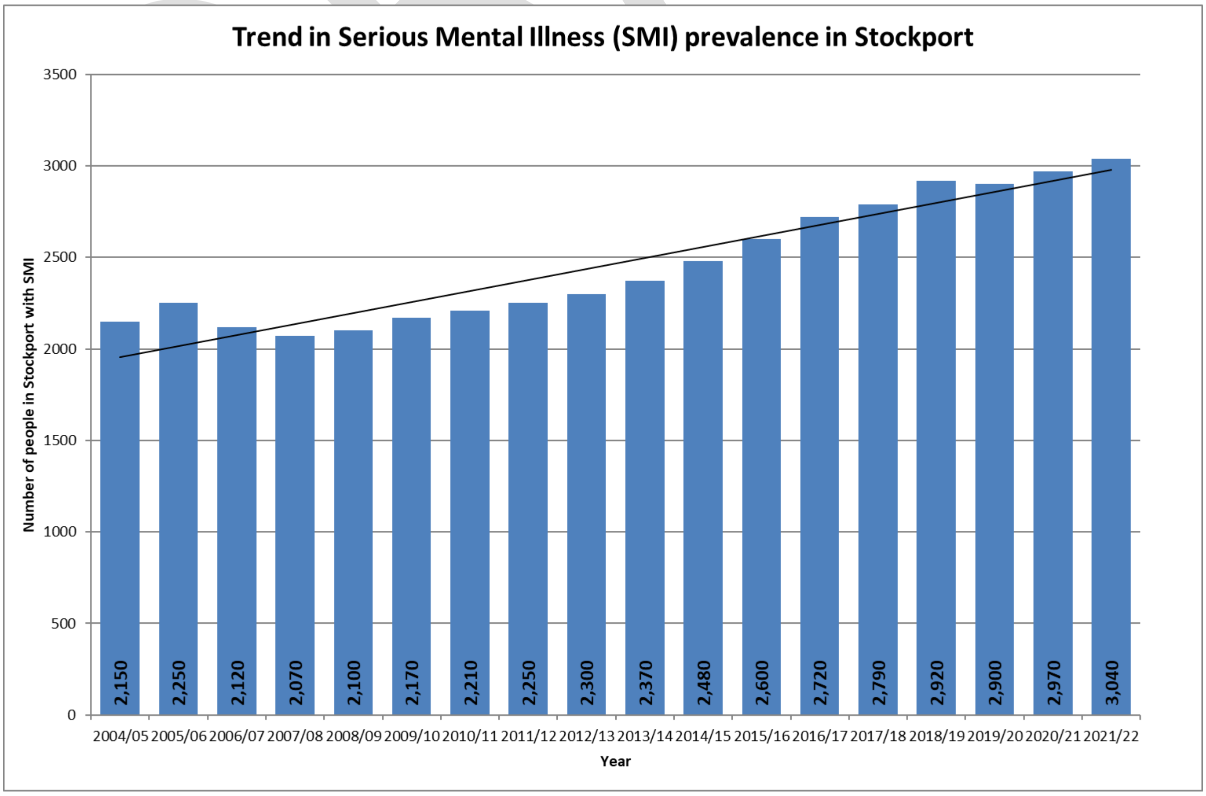
4.1 People living with severe mental illness

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 1- 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.

4.2 People from Black African, Pakistani or Bangladeshi communities

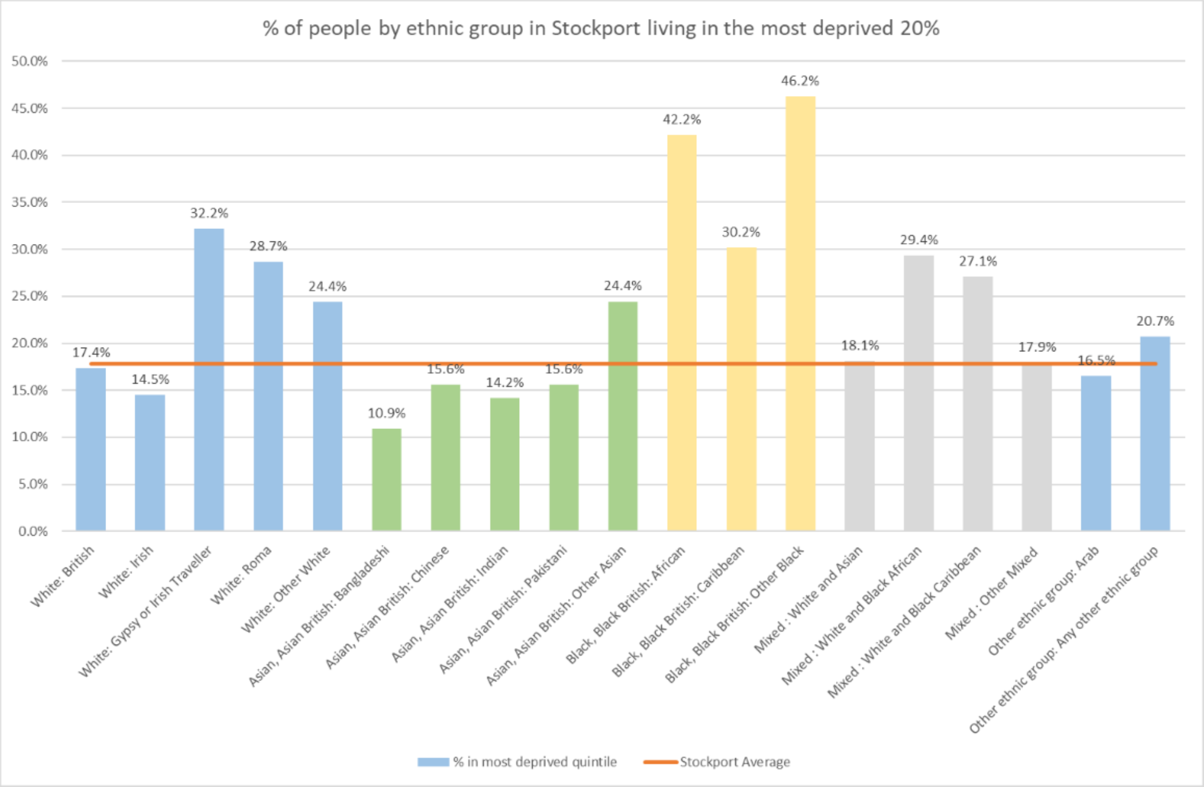
The United Kingdom is becoming more ethnically diverse. In the 2021 Census, 81.7% (48.7 million) of usual residents in England and Wales identified their ethnic group within the "White" category, a decrease from 86.0% (48.2 million) in the 2011 Census. The next most common high-level ethnic group was "Asian, Asian British or Asian Welsh" accounting for 9.3% (5.5 million) of the overall population, this ethnic group also saw the largest percentage point increase from 2011, up from 7.5% (4.2 million people). Large changes were also seen in the numbers of people identifying their ethnic group as "Black, Black British, Black Welsh, Caribbean or African: African" (2.5%, 1.5 million in 2021, up from 1.8%, 990,000) (ONS, 2022).

Stockport has seen similar trends with the number of people identifying themselves as being from a Black, Asian or other minority ethnic group having increased by 65% between 2011 and 2021 to 37,240 people. People who describe themselves as Asian / Asian British Pakistani are the largest ethnic minority group in Stockport (3.7% of the population), followed by other White (2.5%) and Asian / Asian British Indian (2.5%).

People from certain ethnic minorities (such as Indian and Chinese people) have continued to succeed in education and at work or have seen improvements in other areas of life. However, some ethnic minority groups are falling behind. Black African, Bangladeshi and Pakistani people are most likely to live in poverty nationally, and - given the damaging effects of poverty on education, work and health - families can become locked in disadvantage (EHRC, 2019; Francis-Devine, 2024).

The links between ethnicity and deprivation in Stockport are less clear. National data shows Pakistani groups most likely to live in deprived areas (Robertson et al., 2021). In Stockport, this is not the case, but we can see that Black / Black British populations are more likely to live in areas of higher deprivation than average. People of ethnic minority in Stockport also have a lower employment rate (72.2% by the end of 2022) compared to those with white ethnicity (79%).

Figure 2- Percentage of people by ethnic group in Stockport living in the most deprived 20%.



There are some indications that certain ethnic minority populations in Stockport have different experiences of preventive offers: some are less likely to access cancer screening and the uptake of certain vaccines for certain populations is lower than those in the White British population. People from ethnic minority communities in Stockport are also more likely to develop long term conditions than people from White British communities, such as diabetes where the rates are highest in the Asian / Asian British Bangladeshi and Asian / Asian British Pakistani groups.

Due to Stockport’s communities becoming increasingly diverse and the health inequalities some of these communities’ face, this review aims to collate the lived experience of people of Bangladeshi, Pakistani and Black African ethnicity to help form recommendations to reduce inequalities.

5. Findings of the rapid evidence reviews

A rapid evidence review was undertaken to explore what is known already about health inequalities experienced by people from both cohorts, as well as to identify relevant policy and guidance already intended to address these inequalities. The findings are presented in this section.

5.1 Inequalities in health outcomes for people with SMI

5.1.1 Challenges and risks to health experienced by people with SMI

5.1.1.1 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 get COVID-19 and have poorer health outcomes from their infection, including mortality from the illness (OHI&D, 2024).

5.1.1.2 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).

5.1.1.3 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).

5.1.1.4 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).

5.1.1.5 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).

5.1.2 Relevant policies and guidelines to reduce inequalities for 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 formed a major part of NHS Long Term Plan (NHS, 2019b). Priorities included:

- Physical health checks – by 2023/24, the NHS was to ensure that at least 390,000 people living with SMI had their physical health needs met.
- New and integrated models of primary and community mental health care would support adults with SMI. This involved 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 was to be made 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 would widen, diversify, and become more accessible.

Work to address inequalities in health outcomes for people with SMI is part of Core20PLUS5, NHS England's 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.

A key 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.

5.2 Inequalities in health outcomes for people from Bangladeshi, Pakistani or Black African communities

5.2.1 Challenges and risks to health experienced by people this cohort

5.2.1.1 Physical health and mental health

The most recent data from the Office for National Statistics (ONS, 2023b) shows that overall mortality is lower in ethnic minority groups compared to the White British group. This is due to them having lower mortality from certain major diseases such as cancer, chronic obstructive pulmonary disease (COPD) and dementia. However, mortality from several largely preventable conditions including some cardiovascular diseases (CVD) and diabetes, is higher among ethnic minority groups and mortality patterns differ by condition and ethnicity.

For example, Bangladeshi and Pakistani groups have the highest rates of diabetes, chronic kidney disease, coronary heart disease, hypertension, stroke, myocardial infarction (heart attack), asthma and pneumonia out of all ethnic groups nationally (NHS Digital, 2022; ONS, 2023b). In contrast, Black groups have a lower risk of heart disease compared to the general population, but a higher incidence of, and mortality from, hypertension and stroke, and have strokes at a younger age (Marmot et al., 2024; Robertson et al., 2021).

While cancer incidence registration is generally lower among ethnic minority groups compared with the White ethnic group, there is a higher level of registering prostate cancer in the Black ethnic group (Marmot et al., 2024). Black and Asian ethnic groups also had more than double the prevalence of pre-diabetes (22%) compared with White, Mixed and Other ethnic groups (10%) (ONS, 2024).

Long-term conditions are those expected to last 12 months or more and include physical and mental health issues. People from ethnic minority groups are more likely than White British people to experience long-term illnesses and poor health (Williams et al., 2022). Life limiting long-term conditions reduce a person’s ability to do daily activities. Pakistani, Bangladeshi, and Black Caribbean men are most likely to have life limiting long-term conditions, while Chinese and Black African men are least likely. Pakistani and Bangladeshi women are most likely, and Chinese women are least likely to have limiting conditions (NHS Digital, 2022).

The Covid-19 pandemic had a disproportionate impact on most ethnic minority communities. They experienced higher infection and mortality rates than the White population, in large part due to differences in location, occupation, deprivation, living arrangements and health conditions such as cardiovascular disease and diabetes (Raleigh, 2023; Robertson et al., 2021).

Data from the ONS (2022) shows that Black African men and women reported better emotional wellbeing than other ethnic groups. However, people from ethnic minority groups are less likely to access mental health support than White groups due to stigma, cultural beliefs, and fear of racism (Bansal et al., 2022; Memon et al., 2016). There are high rates of psychosis among Black African and Caribbean groups

(Gilburt & Mallorie, 2024), and in the year to March 2023, Black people were 3.5 times more likely than White people to be detained under the Mental Health Act (Gov.uk, 2024). Black men also have the highest rates of drug use and dependency in the UK, and suicide rates are higher among young Black men and middle-aged Black and South Asian women compared to their White British counterparts (McDaid & Kousoulis, 2020).

5.2.1.2 Health behaviours

Ethnic minority communities face a higher prevalence of some preventable conditions like CVD and diabetes, which are linked to modifiable risk factors. Low levels of health literacy, exacerbated by language barriers, can lead to unhealthy behaviours and poorer uptake of preventive services (Raleigh, 2023).

Black African, Black Caribbean and Pakistani women are more likely than other groups to be obese, but for men, rates do not vary significantly across ethnicities (other than Chinese who are less likely to be overweight or obese) (NHS Digital, 2022). However, men from Pakistani backgrounds are more likely to be inactive, whereas among women, no group stood out as having particularly high or low proportions who were inactive (NHS Digital, 2022). The percentage of adults in the Black, Asian, Chinese, and mixed ethnic groups who ate five pieces of fruit and vegetables a day was also lower than the national average (Gov.uk, 2024b).

People from Indian, Pakistani, Chinese and Black African backgrounds are less likely to smoke than people from White British backgrounds. Pakistani and Bangladeshi people are also less likely to drink alcohol than those from other ethnicities (NHS Digital, 2022).

5.2.1.3 Health and social care

A survey completed by the Care Quality Commission (CQC) showed that people from ethnic minority groups face inequalities in terms of delays or cancellations of hospital treatment and fewer patients from ethnic minority groups reported that expected care and support was available when they needed it after leaving A&E (68%) compared to White patients (72%). This reduces further for those with a long-term condition where 61% of White patients were satisfied with care and support and even fewer patients from ethnic minority groups (53%) (CQC, 2023).

While maternity services have improved and maternal mortality occurs in fewer than 1 in 10,000 pregnancies (NHS, 2019b), Black women are still almost three times more likely to die from pregnancy and childbearing-related complications than White women, and women from Asian ethnic backgrounds are almost twice as likely to die (Felker et al., 2024). Women from the poorest backgrounds and ethnic minority groups are at higher risk of their baby dying in the womb or soon after birth (NHS, 2019b).

In comparison with White British people, those from minority ethnic groups (with the exception of Chinese people) experience worse outcomes from accessing psychological therapies although this has narrowed in recent years. They generally wait longer for assessment and are less likely to receive a course of treatment following this (NCCMH, 2023)

5.2.1.4 *Wider determinants/deprivation*

Unpicking the causes of ethnic inequalities in health is difficult. Available evidence suggests a complex interplay of many factors including deprivation, environment and health-related behaviours (Raleigh, 2023). Some groups are characterized by high levels of average qualifications, income and wealth, while others are persistently disadvantaged, have increased levels of poverty and unemployment. Most ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health (Raleigh, 2023; Robertson et al., 2021).

Education and job success influence differences in living standards (Mirza & Warwick, 2024). In education, Bangladeshi, Pakistani and Black Africans pupils had a 10-percentage point attainment gap behind White British pupils at GCSE level in 2004, but in recent years have almost entirely closed or even overturned this (Gov.uk, 2024c; Mirza & Warwick, 2024).

Socio-economic background explains most of the differences in educational achievement between second-generation minorities and the majority population. (Mirza & Warwick, 2024). For example, children on free school meals, often an indicator of socio-economic disadvantage, tend to have lower academic achievement. Children in Bangladeshi and Pakistani households are the most likely to live in low income and material deprivation out of all ethnic groups. They were 2.8 and 2.4 times as likely, respectively, to live in low-income households, compared with children living in White British households, with 47% of children living in Pakistani households, and 41% of children living in Bangladeshi households with a low income (ONS, 2020).

There are significant differences in access to and outcomes of higher education. White British people are less likely to have a degree than those from ethnic minorities, but they are more likely to receive a first or 2:1 than ethnic minority students and only small numbers of Asian and Black students secure a place at Britain’s top universities (EHRC, 2019).

However, first generation immigrants tend to have higher average qualifications than the UK-born population, but immigrants typically find themselves in lower-paying jobs, at least in the first few years following migration (Dustmann et al., 2024), and have higher rates of unemployment (ONS, 2023).

According to the 2021 census data, unemployment rates in England and Wales were highest among people who identified as African, Caribbean, White and Black African, and White and Black Caribbean (ONS, 2023). Pakistani and Bangladeshi people also have high unemployment rates, though these have decreased in recent years. They are more likely to be in low-paid and insecure jobs (EHRC, 2019), especially those not born in the UK (Mirza & Warwick, 2024). These groups tend to have larger families, and many women report being unemployed due to caring responsibilities

(ONS, 2023). Pakistani and Bangladeshi people also have the lowest median incomes nationally, while White, Chinese, and Indian people have the highest (Francis-Devine, 2024).

Poor-quality housing is related to poor physical and mental health; this inevitably affects a whole household (PHE, 2021). People who identify as Bangladeshi are more likely to live in overcrowded housing, with 39% of people in this living situation compared to 8% of the overall population of England and Wales (ONS, 2023). Around 17% of the population in England and Wales live in social rented housing. The Council are required to prioritise the allocation of social housing to those in greatest need. Nationally, this type of housing is more commonly occupied by people who identify as Black, Black British, Black Welsh, Caribbean or African (ONS, 2023).

Inequalities faced by people from ethnic minorities are reinforced by entrenched structural and institutional racism, and interpersonal experiences of racism and racial discrimination (Nazroo, 2024). This can be seen in different systems and services such as employment, housing and the criminal justice system, which in turn can have a negative impact on physical and mental health (EHRC, 2019; McDaid & Kousoulis, 2020; Raleigh, 2023; Robertson et al., 2021).

5.2.2 Relevant policies and guidelines to reduce inequalities for people from ethnic minority backgrounds

There are multiple policies and national guidelines to tackle ethnic health inequalities. Existing legislation seeking to directly address ethnic inequalities has generally done so by either promoting greater representation and/or by taking steps to outlaw or address discrimination (Mirza & Warwick, 2024).

The NHS Long-Term Plan (2019b) focused on reducing health inequalities for all groups, including ethnic minorities. It aimed to reduce variations in care across the NHS. Some of the areas of the plan with a specific focus on ethnic minority groups include using the bowel cancer screening test, which has increased participation by 7% among ethnic minorities. Women from ethnic minority backgrounds would receive better maternity care to reduce the risk of losing their baby before 24 weeks. The Diabetes Prevention Programme would also be expanded to offer targeted support and weight management services for ethnic minorities.

The Long-Term Plan (2019b) also emphasized the NHS’s commitment to fostering a culture of respect, equality, and diversity within its workforce. It focused on developing cultural change, a diverse workforce including ethnic diversity in leadership roles and implementing the Workforce Race Equality Standard (WRES) to ensure employees from minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Another plan aimed at the NHS workforce is the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan which aims to reduce prejudice and discrimination.

It seeks to create a more inclusive and supportive environment for all staff, which should improve patient care (NHS England, 2023b).

Building on the proposals in the Long-Term Plan, the Health and Care Act 2022 aims to establish a legislative framework that supports collaboration to integrate services for patients. This includes targeted changes to public health, social care and the oversight of quality and safety. By putting the emphasis on integrating care, the Act should lead to improvements in population health and patient experience to reduce inequalities (DH&SC, 2022; TKF, 2022).

The *Core20PLUS5* model is NHS England's approach for tackling health inequalities. One of the five clinical areas of focus which require improvement is maternity services. This includes ensuring continuity of care for women from ethnic minority communities and from the most deprived groups. People of ethnic minority are also one of the targeted population groups in which access to healthcare needs to improve (NHS, 2024).

The *Patient and Carer Race Equality Framework* (PCREF) provides guidelines to improve mental health equality. It helps mental health services enhance access, experiences, and outcomes for diverse ethnic communities by using their feedback. NHS mental health providers must have a PCREF by the end of the 2024/25 financial year to meet the needs of different ethnic backgrounds (NHS England, 2023c).

The *Inclusive Britain* strategy is the UK government's response to the Commission on Race and Ethnic Disparities. It is a major effort to address racial and ethnic disparities in the UK. The strategy aims to reduce inequalities, promote unity, and build a fairer society through a detailed plan and effective actions. More than 70 actions are outlined which are grouped under three main themes:

- Trust and Fairness: Focusing on building trust in institutions and ensuring fairness in treatment.
- Opportunity and Agency: Creating opportunities for all individuals and empowering them to take control of their lives.
- Inclusion: Fostering a sense of belonging and inclusion within society.

Addressing variations in access to services are highlighted frequently as being a significant way to reduce health inequalities for people from ethnic minority backgrounds. This is recommended in several areas of the health and social care system but especially in maternity, diabetes and mental health services. Several strategies and plans cite the importance of equality in the workforce for people from ethnic minority communities which in turn would help foster a better understanding of need to reduce prejudice and discrimination towards patients.

6. Lived experience findings

6.1 Lived experience of people living with SMI

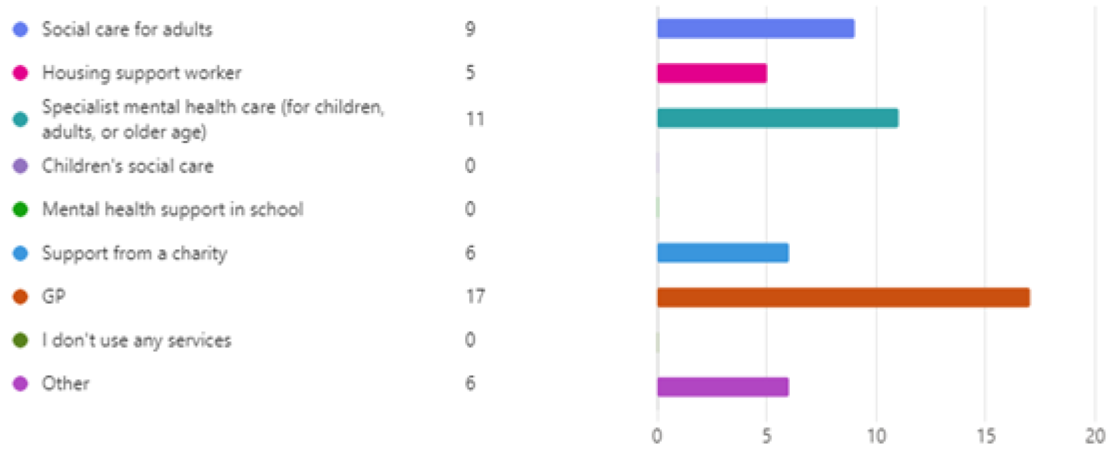
This section contains the analysis of data obtained from a group discussion with 9 participants and 24 online questionnaire respondents to elicit the lived experience of people with SMI (including carers and staff). The latter group included 12 people with SMI and 12 people who cared for and worked with people with SMI.

We were able to obtain some demographic and additional information from those who completed the online questionnaire, but we were not able to get this information during the group discussion due to time constraints.

The majority of people (22) who shared their lived experience were aged between 18-64, two were 65 and over and no one under the age of 18 took part.

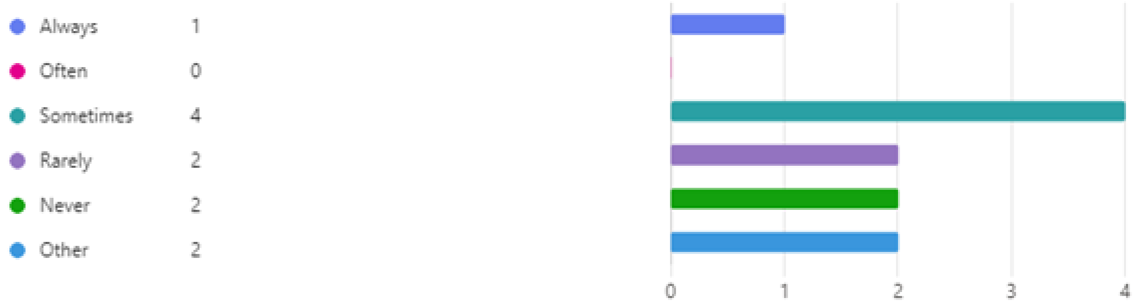
Most participants (13) were receiving benefits, and nine in paid work. Two people were retired and five people selected ‘other’. Some people may have been in paid work and receiving benefits simultaneously.

In terms of what services people access, most access their GP (17) and over a third of people use specialist mental health services for support (12). A third of people use adult social care (9) and less people use other services such as charities (6) and housing support workers (5).



Most people (10) feel they are not asked for feedback or to share their opinions regarding the services they or their loved ones use. However, 5 people said they are asked for feedback and 5 said other which could mean they are sometimes asked. 3 weren’t sure and 5 people did not answer the question.

Only 1 person felt their feedback was always considered by services when it was collected. Of the other 11 people who responded, 4 felt feedback was sometimes taken into account, 3 felt never, 2 felt rarely and 2 selected other.



6.1.1 Social connections

6.1.1.1 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.

6.1.1.2 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.

6.1.1.3 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."*

6.1.2 Education – early childhood, school, college

6.1.2.1 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.

6.1.2.2 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.

6.1.2.3 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.

6.1.2.4 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.

6.1.3 Housing

6.1.3.1 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.

6.1.3.2 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.

6.1.3.3 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.

6.1.3.4 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.

6.1.4 Work / employment

6.1.4.1 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.

6.1.4.2 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.

6.1.4.3 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.

6.1.4.4 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.

6.1.4.5 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.

6.1.5 Access to food and other necessary things

6.1.5.1 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.

6.1.5.2 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.

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

6.1.6 Being out and about – transport, leisure facilities

6.1.6.1 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.

6.1.6.2 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.

6.1.6.3 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.

6.1.6.4 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.

6.1.7 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, including in primary care.

6.1.7.1 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.

6.1.7.2 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.

6.1.7.3 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 let down by the service.

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

6.1.7.4 Experience in hospital

Many people express having had a good experience of physical health care at Stepping Hill Hospital 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 Hospital are making improvements.

6.1.7.5 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 could show more professional curiosity. 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."*

6.1.7.6 Waiting lists and finances

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

6.1.8 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."*

6.1.9 Changes people would like to see

People with lived experience of SMI were asked '*What changes or improvements could make things better for you?*' Their responses to this question are recorded in this section and are reported largely verbatim. Although it is recognised that these responses may not necessarily convert into recommendations, they will feed into the discussions with officers / sector colleagues about potential recommendations

6.1.9.1 Social connections

People generally feel that support in all areas has improved the older they have become. This may be due to others having a better understanding of mental health difficulties these days. However, many people think there needs to be better signposting to community groups by professionals so they can share experiences and build new social connections.

One suggestion was that online groups for people living with the same condition could be beneficial as people might want to share coping strategies and problem solve. Although not all participants agree that this would be beneficial as they find it hard to interact online. Peer support spaces which are culturally appropriate would also be beneficial.

6.1.9.2 Education – early childhood, school, college

Increased training in schools for all staff members and pupils to help everyone better understand different mental health difficulties was highlighted by multiple participants as a good initiative to improve experiences. This training should be culturally appropriate, and trauma informed allowing children and young people to develop the vocabulary to talk about their feelings. Training should also be extended to include information about neurodivergence and learning difficulties. This in turn, should develop more caring attitudes in both staff and fellow pupils.

Improved communication and joined up working across different departments would improve pupil experiences. Communication could also be improved between staff and pupils to help build trusting relationships and reduce anxiety. This could be done by have a *"friendly face"* and have more warm and open conversations such as asking, *"how are you today?"*

- More support staff so pupils can have one to one help and be able to keep up with the rest of the class.
- Support plans should be developed between staff and pupils so staff know what to do and what might help if a pupil is having a bad day (in terms of their mental health).
- More accommodating settings for exams with less disruptions such as a space where people don't walk out when they have finished.
- Offer more provision for pupils with SEND and provide parents with information on how schools support pupils with SEND.
- More support from teachers to encourage pupils to keep engaging in the subjects that most interest them to create feelings of achievement.
- Education for pupils and families on risk factors for mental illness e.g. cannabis use and psychosis.
- More support during early childhood.

6.1.9.3 Housing

- Simplify the system to obtain social housing.

- Simplify the system to be able to contact Stockport Homes when tenants have questions or concerns.
- There should be a limit on the length of time a landlord can leave a tenant without a repair being done.
- Rental caps should be in place for private tenants.
- There should be more halfway houses, therapeutic communities and affordable housing on discharge from hospital.
- More housing schemes available for people with mental health challenges and disabilities.
- More good quality supported housing or short-term housing for people leaving hospital.
- Provide personalised assessments according to individualised needs.
- More safe housing and better protection from the police in terms of safeguarding vulnerable adults.

6.1.9.4 Work / employment

Many participants think managers need to be understanding of people with mental health difficulties. Small check ins with people help such as managers giving time to ask how people are really feeling that day. Managers may need more training to gain knowledge and understanding on mental health difficulties and should speak with the people they line manage to make plans on how best to support them in work. Managers might also benefit from having better conflict management skills to defuse situations and help people stay in work rather than feeling pushed out due to conflict between staff.

- Work colleagues should also be understanding and patient.
- Personalised support should be developed for people with SMI and their managers.
- It would help to have mentors in various fields to give advice to those looking to get jobs in certain areas.
- One to one support to help people with SMI to find and stay in work.
- More support should be offered to people with SMI who feel able to work to access employment.
- Training that is user friendly and not intimidating to undertake.
- Advice and support on applying for relevant benefits.
- Support to travel to and from work.
- Buddy scheme to ease people into a new job.
- More recognition for people who volunteer.

6.1.9.5 Access to food and other necessary things

- Prepared shopping lists and cooking classes to help develop skills on cooking low cost, healthy meals.
- Help to order online and set up a list of nutritious repeat orders.
- Increased benefits.
- Provide food vouchers for those on low incomes.

- Have more cheap shops to support people on benefits.

6.1.9.6 Being out and about – transport, leisure facilities

- Simplify payment systems for public transport.
- Have a travel buddy scheme for those who can’t travel alone.
- Free bus passes for carers.
- Make it easier to have a discount with taxis and use the car scheme.
- Better street lighting so people feel more confident going out in the dark.
- Easier access to free gym and swimming passes for people with health problems.
- Life leisure facilities are well used but could do with updating.

6.1.9.7 Health and care services

People living with SMI describe rich experiences with the health and care system, including support they receive from VCFSEs and primary as well as secondary care, as individuals as well as carers. This review cannot do this experience full justice, but here are the main themes expressed by the respondents:

- There needs to be more funding in mental health services. This includes more financial support for the VCSFE services who support people with mental health difficulties.
- Increase staffing levels in mental health services.
- Give more training to A&E/GP staff on mental health and support available in the community to signpost people to. Signposting and advice given needs to be delivered in a way that is simple and easier for people to understand.
- Better communication between services and within teams to be able to work together effectively and conduct more face-to-face meetings.
- Offer appointments remotely through MS Teams or Zoom as well as face to face and telephone to make them accessible to all.
- Campaigns to inform people about mental health difficulties on TV as some people can’t read or write or use a smart phone but most people have a TV. These campaigns could be similar to safety campaigns and give details or who to contact for advice. These could be on local TV channels across Greater Manchester and could include designated programming for people with SMI to aid understanding and signposting.
- Named professionals should forward plan appointments with patients to ensure consistency in care and being flexible to meet patients at times/places that are convenient for them.
- Support workers could offer more telephone check-ins with people to see how they are. This may reduce some of the face-to-face contacts support workers undertake freeing them up to offer supportive calls to more people.
- Wherever possible, continuity of care should be provided to prevent people having to repeat themselves.
- Carers have commented that they have had to give up careers, but still have to work part-time as carers allowance is not sufficient, and a minimum wage

for carers is needed. Also the vital support from VCFSEs for families affected by SMI.

> *'I would not have survived my caring responsibilities without Mind Carers.'*

- Some professionals still lack a reasonable understanding of mental health conditions and people still feel stigmatised, ignored, or feel their needs are not well understood or addressed.

6.2 Lived experience of people from Bangladeshi, Pakistani or Black African Communities

This section contains the analysis of data obtained on lived experience of people from ethnic minority communities.

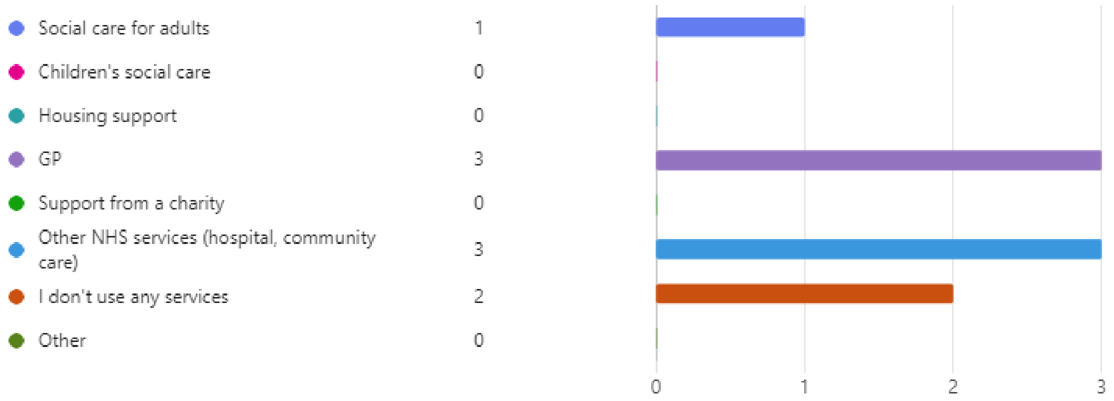
At the time of writing this report, 5 people had completed the online questionnaire. In order to increase the amount of lived experience we could analyse; we collected information from a group discussion with 12 participants conducted by SREP and the inclusion team in the Council in July 2023. This provided lived experience of accessing healthcare services but not the wider determinants of health. Feedback was also collected from two interviews held by the inclusion team regarding the Council's antipoverty work between October and December 2024. Although collected for a different purpose, some of the information was directly relevant and is therefore used as additional information to enrich this report. A focus group with professionals who work with people from ethnic minority backgrounds will take place after this report has been submitted so themes from this discussion will form part of the final report.

We were able to obtain some demographic and additional information from those who completed the online questionnaire, but we were not able to get this information from the group discussions and interviews.

Of the five people who responded to the online questionnaire, four were Pakistani and one was Black African. The two people from the anti-poverty interviews were Black Africa as were all 12 of the participants in the group discussion with SREP. This means the experiences of Bangladeshi people have not been obtained at this stage.

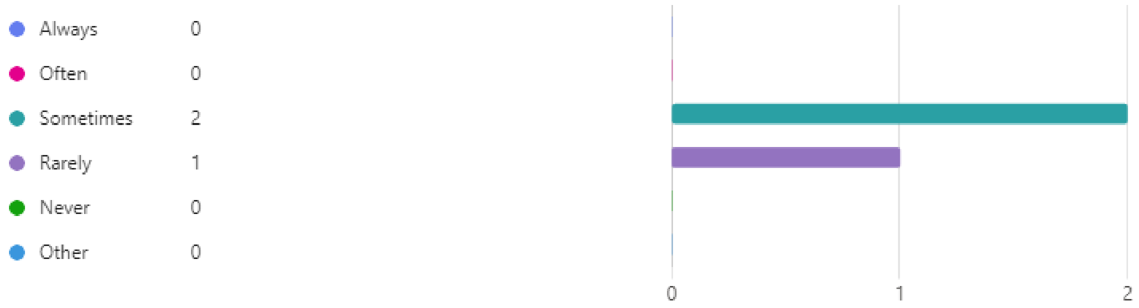
All 5 respondents were aged 18-64. Three of them were in paid work and two selected "other".

Three people use the GP and other NHS services, one person uses adult social care and two don't use any services. It is likely that the same three people use both the GP, other NHS services and adult social care.



Most people feel the services they use ask for feedback but one person felt they were not asked and another did not answer.

No one felt this feedback was taken into account on a regular basis but two thought it was on occasion, one person felt this rarely happened and the other person did not respond to this question.



6.2.1 Social connections

6.2.1.1 Family and friends

Most participants referred to family as being a good source of support and social connection. Friends are also important and are made in different ways such as through family members, in work or on social media and apps.

One participant (who is waiting for their visa and right to remain in the UK) reflects how they have made friends since moving to Stockport but finds it hard to see people moving on with their lives and feels *“my life is not like theirs”.*

The COVID-19 pandemic unfortunately still has an impact on people and how they socialise in face to face interactions due to social anxiety.

6.2.1.2 Shared experiences and connections

Genuine, open conversations, shared activities, and environments where people feel welcomed and valued are seen as essential in connecting with others. Forced interactions, judgment and lack of mutual respect, however, hinder the chances of making these genuine connections.

The local area plays a vital role in allowing people to socialise:

> *“We love to go for family walks in our local parks. We are lucky enough to have nearby beautiful, and huge parks. I like meeting my friends in local cafes and coffee shops”.*

The redevelopment of leisure activities and transport services in Stockport are also reported to help connect people socially.

On the other hand, lack of inclusivity such as social gatherings in pubs, is seen as a barrier for people being able to connect as they are not able to meet where they want to.

6.2.2 Education – early childhood, school, college

6.2.2.1 Extracurricular activities

Increasing pupil involvement in group activities, such as sports, is said to be something that can help people engage more with school and help build connections there.

6.2.2.2 Support from staff and the education system

Meeting educators informally to discuss children’s wellbeing as well as academic progress is seen to be supportive.

What doesn’t work is rigid systems, or environments that discourage questions and creativity.

Rigid systems also include people who are waiting for their visas and right to remain can’t access the courses they require:

> *“I would like to study photography, business and design but I can only study English or Maths at college. My dream is to design my own clothes brand, but I need training”.*

6.2.2.3 Religion

Some religious communities prefer single sex educational institutions for children with more flexibility around offering their prayers.

6.2.3 Housing

6.2.3.1 The cost of council tax

Council tax rates cause mixed feelings as people feel they are generally high but that they appreciate the services this provides.

6.2.3.2 New developments and affordable housing

The new developments in Stockport are said to be exciting as people look forward to seeing how they turn out, but it is unclear whether this will be genuinely affordable.

6.2.3.3 Maintenance

Clear communication with landlords who are responsive and attend to maintenance issues as they arise are important whereas the opposite causes difficult living situations.

6.2.4 Work/employment

6.2.4.1 Understanding and accommodating employers

Having an empathetic manager and being able to manage a work/life balance are reported by several participants as being beneficial for people being able to stay in and thrive in work. This includes having flexible uniform policies and breaks to accommodate different religious beliefs and flexible working so people can work from home when necessary.

One participant also noted the importance of effective communication and access to resources in order to perform tasks efficiently in work as important factors in creating a good working environment.

Micromanagement or unclear expectations of staff are reported to be things that make working life harder for people as this creates unnecessary stress.

6.2.4.2 Access to jobs

While one participant felt there are a growing number of jobs in the borough and there is an increase of business retail parks, two people report having difficult experiences in getting work.

One participant reflects how they would like to work but the list of jobs they are allowed to do is really restricted due to waiting for a visa and right to remain in the UK. Another works for an agency but the available jobs are decreasing, and they are finding it hard to get appropriate, permanent work. They feel there is increasing competition for roles and companies are cutting back on costs by employing fewer people.

6.2.5 Access to food and other necessary things

Generally, people report having good access to necessities in Stockport. This includes having shops nearby and efficient delivery services. Being able to afford the necessities is essential either by working, being supported to access all available benefits, food banks and discounts.

The increased cost of living is still a concern as some essential items remain expensive and unaffordable to some which, for example, meant that one participant wasn't able to send presents home this year.

6.2.6 Being out and about – transport, leisure facilities

Most participants feel public transport is good in the borough with an effective service that is a reasonable cost; especially for those who can access subsidised travel. Although not everyone feels this way as some parts of Stockport are deemed to have limited transport options and people who have to attend hospital appointments can't always afford the fare.

One participant reflected how costly it is to buy more environmentally friendly vehicles without schemes from the Government to support people make the switch.

6.2.7 Health and care services

A few people expressed they valued the health service in Stockport but do not have to use this often.

6.2.7.1 Language barriers

Many participants report having to spend a long time in hospital just waiting for an interpreter to become available. Some feel there is reluctance from staff to call language-line and to get the right translator when there is no one available for a face-to-face appointment. Several people think there is limited supporting information available for ethnic communities as most information leaflets are printed in English. This creates a language barrier, difficulty in explaining issues and understanding treatment options leading to feelings of disempowerment.

6.2.7.2 Communication

The process in hospital and at discharge is not always communicated effectively with patients.

> *"You are just shifted around a hospital, but it is scary when this is not your country, and you don't know what's happening".*

Communication between hospitals is also reported to be poor and if you are not tech-aided, it is difficult to make appointments.

Communication in maternity services in Stockport was highlighted as a concern as one woman said she was accused of being aggressive not leaving the hospital when asked. It transpired she was about to deliver her baby and did not receive adequate care.

6.2.7.3 Culturally appropriate

It was mentioned that health campaigns in Manchester are more culturally appropriate than in Stockport and questions were raised about how culturally appropriate mental health services are locally.

Culturally, families are really important for ethnic minority communities and people feel safer having a family member at health appointments. However, people will not speak about certain issues in front of their family such as mental health, domestic abuse, female genital mutilation (FGM) or speak freely about gynaecological issues. The elderly and women are subservient in some cultures which leads to them feeling as though they can’t question treatment and their family members make decisions on their behalf.

6.2.7.4 Attitudes of health care professionals

There were accounts from some people that agency staff from ethnic minority backgrounds are not treated fairly compared to permanent staff. There are reports of bullying from the permanent staff towards those from the agency who weren’t sure where to go [for help] and would often be left with the undesirable jobs to do on the wards.

Some people highlighted a general lack of compassion from staff in understanding their patients. They felt that staff didn’t care about them, they didn’t feel supported or listened to. Some people also felt that staff would only talk to people who could speak English or spoke with a British accent.

6.2.7.5 Availability of staff and services

Most participants shared concerns about waiting lists being very long and some reported feeling they had been forgotten about. Others feel that unless they were extremely unwell or in crisis, there is no help. It was highlighted that this may be due to services needing more investment to improve the quality and accessibility of healthcare.

Several people report difficulties getting a GP appointment then find the practice wants to do as much as possible over the phone or by sending images. This raised concerns about how GPs would recognise underlying concerns such as people experiencing abuse. Registering with and getting appointments with NHS dentists was also highlighted as an issue.

The lack of available, permanent staff in hospital meant that some participants believe the most difficult care is given to agency staff leading to inconsistency in care for patients.

6.2.8 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?

All participants who completed the questionnaire felt that poverty can amplify the challenges faced by individuals from ethnic minority backgrounds by creating overlapping systems of disadvantage. It may limit access to quality education, healthcare, and housing, further entrenching systemic inequalities. Discrimination in employment can exacerbate financial struggles, and poverty may increase exposure to unsafe environments or food insecurity.

People may find poverty embarrassing and shameful to talk about or seek help. Additionally, cultural or linguistic barriers can make accessing support services more difficult, and stereotypes about ethnic minorities may lead to bias in how assistance is distributed.

Addressing poverty in ethnic minority communities requires targeted support that considers both socioeconomic and cultural factors to break cycles of disadvantage.

6.2.9 Changes people would like to see

People from ethnic minority communities were asked '*What changes or improvements could make things better for you?*' Their responses to this question are recorded in this section and are reported largely verbatim. Although it is recognised that these responses may not necessarily convert into recommendations, they will feed into the discussions with officers / sector colleagues about potential recommendations

6.2.9.1 Social connections

- More affordable local restaurants and cafes would encourage people to socialise more.
- Things could be better with more opportunities for meaningful connections, and a focus on inclusivity and understanding.
- There should be more social and physical activities especially for women and more affordable day tours for elders who cannot drive.
- Focus on building connections for people with neurodivergent conditions and how to adapt communication accordingly to match individual's needs.

6.2.9.2 Education – early childhood, school, college

- To support pupils to manage academic anxieties.
- More mentoring programs.
- Sex education (on certain topics e.g. sexuality and transgender) should be optional. Parents should have right to choose if they want their children to have lessons/lectures/books on these topics.
- Increase the opportunities to join extracurricular activities.
- Increase the use of engaging teaching methods, clear guidance, constructive feedback, and access to resources like study materials or mentorship.

6.2.9.3 Housing

- More affordable housing options.
- More resources for navigating housing challenges.
- Having documentation in a multi languages and being able to access in different ways would make the system easier to navigate.

6.2.9.4 Work/employment

- More flexibility from employers to offer hybrid roles and home working.
- Further accessibility to work would help, particularly tram links and improved train services.
- More opportunities for professional growth and a supportive team environment.

6.2.9.5 Access to food and other necessary things

- More Afro-Caribbean food/store options in Stockport.

6.2.9.6 Being out and about – transport, leisure facilities

- Keep the cost of travelling on public transport down.
- More inclusive infrastructure and increased public transport options such as the tram coming to Stockport.

6.2.9.7 Health and care services

- Staff should be more proactive in booking interpreters for planned and emergency appointments, whether this is face-to-face or via the telephone.
- Information leaflets and text messages about appointments should be provided in multiple languages.
- People need privacy when being asked more personal questions about their mental health, domestic abuse, FGM or any gynaecology issues. Family attending with the person need to be asked to leave the room to give privacy. This may also help people make decisions about their care without being influenced by family.
- In-person appointments need to be encouraged at the GP to help identify concerns such as domestic abuse.
- There needs to be more targeted campaigns such as prostate cancer awareness for Black men.
- There should be a skill mix of staff across departments in terms of what languages they can speak.
- The process of complaints/challenging practice should be clearer.
- There should be more culturally appropriate food in hospitals and have pictures of foods on menus to help describe what is available to people where English is not their first language.

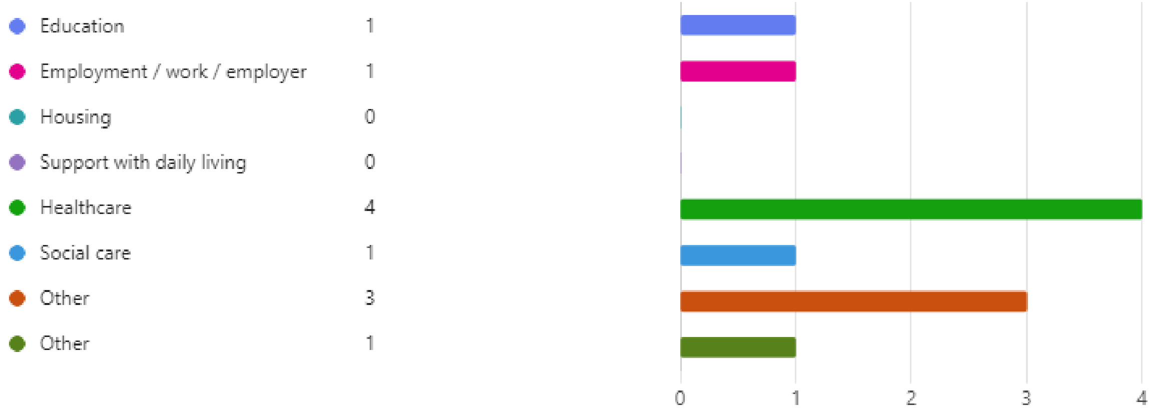
7. What did sector representatives say?

To gather information on what different sectors in Stockport are already doing to support people from both cohorts, and to reduce risks of health inequalities they face, we used a questionnaire which was distributed to a number of sector representatives. The questionnaire asked a range of questions about both cohorts: whether respondents were aware of any barriers these cohorts may face, what the organisation already does to take account of challenges or opportunities experienced by people from both cohorts, information about how the work of the organisation/sector impacts on the experience or outcomes of either of the two cohorts, what would help the organisation/sector to better support the cohorts, and any further plans to seek to either learn from people’s experience, or to address their challenges or barriers.

Meetings with sector representatives to develop the recommendations will follow, and these may also elicit further material to be added to this section.

Ten organisations from different sectors had responded to the online questionnaire at the time of writing this report.

Most of the service providers who responded were from the healthcare sector (4). There was one response from employment services, education, social care and transport services.



The majority of those who responded (6) worked in commissioning, strategic role or organisation and 4 were from client facing provider organisations.

All respondents were aware of the challenges faced by people from ethnic minority communities and people with SMI and were able to share information on how these challenges are currently and could be overcome in the future. There was more of a mixed picture in terms of the information organisations have on the impact their organisation has on the experience or outcomes of either of the two cohorts. 5 said they had this information, 2 did not and 3 were not sure.

7.1 Perceived challenges for people with SMI and people from ethnic minority communities in accessing or benefitting from an organisation/sector

7.1.1 Understanding, attitudes and availability of staff

Most organisations feel a lack of understanding and stigma about SMI could create a barrier to people accessing their services.

Stigma associated with mental health conditions and employers' reluctance to employ people who declare conditions are clear barriers to accessing work along with employers not making reasonable adjustments for people with SMI if needed. Line management could be seen as a challenge if people don’t feel understood and if colleagues don’t have adequate training to be able to understand the needs of those with SMI in their team.

One service noted there can be a lack of understanding of the role that family and carers play in the care of people with SMI which has a negative impact.

Shortages of staff was highlighted by one service as it can sometimes be challenging to support the mental health needs of patients who are admitted with a physical health conditions.

Some organisations highlighted the attitudes of staff as being a barrier as they may be seen to be treating people differently depending on their ethnicity. People from ethnic minority communities may have experienced racial trauma and have developed a mistrust of services due to institutional racism. Staff may have a lack of awareness of the impact of intersectionality on different ethnic groups.

7.1.2 Complexity of systems

Navigating certain systems can be difficult for both service users and carers, because of the complexity and number of different services offered which do not always work in an integrated manner. People with SMI may struggle to access services delivered in very structured ways, with rigid inclusion and exclusion criteria. It might also be difficult for them to attend meetings or have discussions with providers about their child (in school) and they might find it harder to engage in training/online packages for parents.

7.1.3 Anxiety and confidence attending appointments

Several organisations feel that people with SMI can find it difficult to attend appointments due to anxiety around leaving the house and having to navigate transport systems. They might be isolated and not able to get out without support from others.

Peoples' mental health can also impact on their ability to engage with services leading to them not attending appointment and being discharged.

7.1.4 Physical environment

Certain environments might not be seen as appropriate or meet the needs of some faiths, cultures or religious beliefs, such as swimming pools.

Some ethic minority groups can struggle to access employment, and many are highly skilled or qualified in their home nations but can't seem to get into jobs at an equivalent level in the UK.

7.1.5 Availability of data

Data was reported to not be readily available in relation to SMIs and ethnicity by several services. Therefore, there is not a complete picture of the extent of the challenges faced by these cohorts. For some, lack of data means they are dependent on wider evidence from outside sources. Where data is available, it is not analysed or utilised in a systematic way to address health inequalities. One service feels if they were to use the data they have at this stage, they would need to do so with caution given the limitations of an incomplete data set.

Another service finds that most consultations undertaken have a very low response rate from ethnic minority groups which limits local knowledge and makes organisations dependent on wider and national evidence.

> *“More work needs to be done to understand what the challenges are for individuals locally by looking at the data and working closely with, and listening to, our community”.*

7.1.6 Language barriers

Language barriers was highlighted as a major challenge for people from ethnic minority communities when accessing services. This may be due to a lack of routine provision of interpreters as staff have reported it being difficult to secure an interpreter for certain languages. This can lead to cancelled appointments through no fault of the attendee.

There is also reported to be a lack of provision in terms of written information in different languages. This includes information leaflets and a digital offer which is not fully comprehensive and not all languages are available.

7.1.7 Culturally appropriate

There is reported to be a lack of cultural understanding in some organisations and culturally appropriate services are not always offered. This can lead to misunderstandings between staff and people using services. Children from ethnic minority groups are excluded more frequently which poses questions about the inclusive nature of the provision but also often brings tension in the relationships between school and the family. Unfortunately, it might not always be possible to cater for the needs of individual requests from people when they access a service.

People from ethnic minority communities may also find the lack of diversity in the workforce of the service they are accessing a barrier.

7.2 How organisations/sectors take account of challenges or opportunities faced by people with SMI and people from ethnic minority communities

7.2.1 Lived experience

Working with people who are from ethnic minority communities and people who have lived experience of SMI was highlighted as a way to account for challenges and opportunities. This includes service users and carers to understand how to meet their needs, to understand their experiences of care and where and how improvements can be made.

Consultations are held with various stakeholder groups to understand how schemes, policies and plans may impact different groups of people. Stakeholder groups are open to a range of different users and help inform decision making. Operational boards are used to help provide seamless care for people moving between acute and mental health services. These boards also have a patient representative who provides crucial information and lived experience.

However, obtaining lived experience is not always easy. One service noted that behaviour change work to encourage active travel has a limited impact on people with SMI and people from ethnic minority groups (amongst others) due to an inability to undertake focused activities with them around how the service can better meet their needs.

7.2.2 Impact assessments and equity duty

Equality impact assessments are completed when services are looking at making changes and developing different types of activity. Some services report these impact assessments are also informed by lived experience. Organisations consider how their policies and programmes affect people in terms of Equality Duty. Greater Manchester is also reported to be focusing on equality in schools through the Think Equal work and the Race Equality Group.

7.2.3 Increase understanding

Two services mentioned increasing staff understanding was an important way they take account of the challenges faced by people with SMI and improve their experiences. Reducing the need for people with SMI to explain themselves each time they attend an organisation was also said to be a way of improving experience.

> *"[The mental health passport] is a card that patients, who have a mental health illness, can share with staff on presentation that includes relevant information, including their diagnosis, so that the appropriate support can be offered."*

7.2.4 Use of data, national evidence and guidance

Local data is obtained by some organisations and utilised to help understand impact and reach of services. For those who do not collect detailed local data on mental health, national evidence, best practice and guidance is used.

The Patient and Carer Race Equality Framework, a national anti-racist framework to address racial inequalities in accessing mental health services, is being implemented in relevant organisations.

7.2.5 Collaboration

One organisation reported utilising the knowledge and skills of multiple roles to meet the needs of people such as care co-ordinators and social prescribers.

7.2.6 Language barriers and cultural appropriateness

Wherever possible, organisations report utilising translation services and seek to offer culturally sensitive care.

One organisation reports undertaking a quality improvement project to support patients who require translation services, to address the challenges identified:

> *"This includes improving the pathway for using interpreters, improving access to written communications in different languages and a business case to support staff with verbal communications. There have also been projects in maternity including creating an information pack in different languages to support families to make decisions around pregnancy and focusing on the maternity needs of asylum seekers in the Stockport area".*

Imagery that reflects all potential user groups is used when promoting activities and campaigns to support inclusivity.

7.3 What would help your organisation/sector to better support people with SMI and people from ethnic minority communities?

7.3.1 Training and assessments

Several services highlighted training for staff to increase understanding and improve support for people with SMI. Expanding and embedding existing learning programmes for staff around mental health would ensure the workforce are educated on how to support patients with a mental health illness.

One organisation also suggested that having dual qualitied staff (e.g. holding both mental health and adult nurse qualifications) could support patients but sharing knowledge with colleagues.

Services agreed that there should be mandated cultural competence training for staff in different sectors.

Whole school self-evaluation programmes around race and poverty proofing should be completed by schools so they can formulate meaningful action plans about practice change.

7.3.2 Collaboration

Collaborating with other services that support people who may have mental health difficulties such as drugs and alcohol services, care co-ordinators and social prescribers was seen as something that would better support people with SMI. Sharing information between services to increase knowledge of initiatives and support options for people would aid in signposting people with SMI to additional support in the wider determinants of health. It was also acknowledged that working collaboratively with other agencies would better support people from different ethnic backgrounds.

One suggestion was that SMI could be an element of Social Value in all new contracts.

7.3.3 Lived experience

Obtaining lived experience and working with the community to understand and address the needs of people from minority ethnic groups and people with SMI was reported by several organisations as a way to better support them. This could be utilised to build on behavioural change work to encourage active travel which currently has limited impact on these groups. There should also be better representation from people from these backgrounds on partnership boards so they can provide feedback based on their experiences.

7.3.4 Translation

Improving access to interpreting services and having access to a wide variety of languages was highted several times as being a way to improve support for people of ethnic minority.

This could include the use of digital communication tools to support staff to have conversations with people when an interpreter is not available. It could also include reviewing the policies and guidance for the use of interpreters and ensuring that it is readily available to the staff to follow and reviewing the systems used to identify when someone needs an interpreter.

7.3.5 Funding and resources

Multiple organisations felt that additional funding and resources would be beneficial. This would enable them to have more targeted consultations and intensive outreach activities. It would also mean more staff members could be employed, and incentives could be given where necessary.

7.3.6 Data

Comprehensive high quality ethnicity data and the resource and expertise to utilise this data is required in order to address health inequalities. This will enable services to gain greater insights into demographic information regarding their communities.

7.4 Does your organisation have plans to learn from the experience of people from these cohorts or to address the challenges/barriers they encounter?

7.4.1 Lived experience and working with the community

To understand the reasons for health inequalities, and better support people from ethnic minority groups and people with SMI, all organisations highlighted plans to continue to work closely with these communities to understand their needs. This includes seeking their input in setting agendas and in co-producing services.

Many organisations have partnership meetings, groups and boards with people with lived experience across most cohorts including those with SMI and from ethnic minority backgrounds. One organisation also highlighted the group set up to look at the experience of staff from ethnic minority groups and address challenges and barriers within the workforce.

Organisations report having teams and inclusion leads who focus on increasing impact upon those traditionally under-served and may be experience systemic barriers to participation in physical activity. Others report programmes that have been set up to consider lived experience although some focus more on protected characteristics such as ethnic minority and not necessarily those with SMI.

7.4.2 Impact assessments

All services will continue to undertake equality impact assessments to understand where strengths and weaknesses lie and determine next steps.

7.4.3 Data and use of national evidence and guidance

To better support people, many organisations recognise the need to improve the quality of ethnicity and mental health data and explore how to use this information to systematically identify and address inequalities. Different plans were highlighted across these organisations on how the planned to do this

One organisation also highlighted novel opportunities as research develops which may help improve their ability to understand and address barriers.

7.4.4 Strategic leadership and accountability

Some services referred to the need for strategic leadership to drive change as success depends upon engagement in programmes and initiatives.

7.4.5 Staff awareness and development

Equality, diversity and inclusion training should continue to be completed by all staff who should access guidance on cultural awareness and competence as necessary. This work should improve staff awareness of racial issues, how this impacts people, to encourage a more inclusive workforce and to improve how people work with the public where there are cultural and ethnic differences between our workforce and the residents we are supporting.

8. Discussion

To be added and include main observations, implications, limitations

9. Recommendations

To be developed with sector representatives

Appendix: Questionnaires to both cohorts, and sector representatives

Improving health inequalities for people belonging to ethnic minority communities

Purpose of the questions: The Stockport Adult Social Care and Health Scrutiny Committee is reviewing the experiences of ethnic minority groups, especially Bangladeshi, Pakistani, and Black African communities across various aspects of their lives. Health inequalities can sometimes affect these groups in particular ways. We want to better understand the unique challenges and opportunities these groups face to improve services and reduce health inequalities.

These experiences will help form recommendations that will be shared with different services in Stockport to guide them in addressing any barriers experienced by people from ethnic minority backgrounds.

Your experiences matter: We invite you to share your experiences and help shape our recommendations, your input is invaluable. If you are of Bangladeshi, Pakistani or Black African ethnicity and live or work in Stockport, this questionnaire is for you. We also welcome feedback from people of different ethnic minority backgrounds.

Questions: The questions in this review address various life experiences and related services that can influence health and wellbeing. You can choose which questions to answer and skip any that don't apply, or those you don't wish to answer.

If you require an interpreter to complete the questionnaire, please contact Heather (heather.knowles@stockport.gov.uk) and Judith (judith.strobl@stockport.gov.uk) to let them know what language you speak and how many people need help with translation. We may be able to organise an interpreter to help you complete the questionnaire or organise a group discussion.

Data: Your privacy is our priority. By completing this questionnaire, you give consent for your data to be used in the report. Everything you share will be kept confidential and no one will be identified in the report, so you can feel free to be honest in your responses.

Time: The questionnaire will take about 15 minutes to complete. We understand that your time is valuable, and we truly appreciate your sharing your experiences. Your insights are crucial in helping us make a positive difference. Thank you for your time and contribution.

1. **Social connections**

(This could include friends, family or activities you attend).

Thinking about connecting with others socially, what support works for you, what doesn't, and what might make things better or easier?

2. **Education (early childhood, school and college)**

(This could include experiences [as a parent or child] with teachers, peers or specific support in educational settings.)

Thinking about experiences with education, what support works for you, what doesn't, and what might make things better or easier?

3. **Housing**

(This could include social or private rentals, the condition of your property or the cost).

Thinking about housing, what support works for you, what doesn't, and what might make things better or easier?

4. **Work/employment**

(This could include experiences of being currently or previously in work, or if you would like to work.)

Thinking about being at work, or about not working, what support works for you, what doesn't, and what might make things better or easier?

5. **Access to essentials**

(This could include access to food, medicines and other essential items).

Thinking about accessing food and other things you need, what support works for you, what doesn't, and what might make things better or easier?

6. **Being out and about**

(This could include access to transport or using different leisure facilities).

Thinking about getting out and about, what support works for you, what doesn't, and what might make things better or easier?

7. **Health and care services**

a. Which health or care services do you use, if any? (please tick any that apply)

- Social care for adults
- Children's social care
- Housing support
- GP
- Support from a charity
- Other NHS services (hospital, community care)
- I don’t use any services

b. Consider the services you use: What works well for your experience, what needs improvement, and how could these services make your experience better or easier? *(Please specify which service(s) you’re referring to as clearly as possible).*

c. Do any of the services you use sometimes seek your feedback, opinions, or contributions?

- Yes
- No
- Not sure

d. If you answered “yes” to question c), do you feel your feedback and views are taken into account?

- Always
- Often
- Sometimes
- Rarely
- Never

8. What impact do you think poverty (defined as lacking basic financial resources) has, or could have on people's experience of being from an ethnic minority background?

(Consider how this may affect where and how someone lives, what someone can buy, or what support someone has or needs)

9. What is your financial situation? Please select all that apply.

- I receive benefits
- I’m in paid work
- I’m retired

10. How would you describe your ethnicity?

- Bangladeshi
- Pakistani
- Black African

11. What is your age group?

- Under 18
- 18-64
- 65 and over

12. Do you have any final comments you would like to share? Your thoughts and feedback will be making a difference.

Your experience with mental health in different areas of life

Introduction: The Stockport Adult Social Care and Health Scrutiny Committee is conducting a panel review to explore the opportunities and challenges experienced by individuals with severe mental health conditions across various aspects of their lives. The committee aims to provide positive recommendations to address these challenges, and the resulting action plan will be made publicly available.

Your Experiences Matter: We invite you to share your experiences to help shape our recommendations. If you or someone you care for has been diagnosed with a severe mental health condition (such as schizophrenia, bipolar disorder, psychosis, personality disorder, or major depression), your input is invaluable. If you identify as being diagnosed with such conditions, this questionnaire is for you.

Background: Living with severe mental health conditions can be incredibly challenging, but also showcases remarkable strength and resilience. Our goal is to help various services in Stockport, not just health services, learn from these experiences and contribute to an action plan to better support those facing mental health challenges.

Questions: The questions in this review cover different aspects of life that can impact health and wellbeing. You can choose which questions to answer and skip any that don't apply, or those you don't wish to answer.

Topics in this review include:

- Social connections
- Education (early childhood, school, college)
- Housing
- Work/employment
- Access to essentials (e.g., food, medicines, clothes)
- Getting around (transport, leisure facilities)
- Health and Care Services

Data: By completing this questionnaire, you give consent for your data to be used in the review. But you don't need to identify yourself, and no one will be identifiable in any reports produced. So please feel free to be open and honest.

Time: The questionnaire will take about 15 minutes to complete. We understand that your time is valuable, and we truly appreciate your willingness to share your experiences. Your insights are crucial in helping us make a positive difference. Thank you for your time and contribution.

Please note: This form cannot be used to request support. If you need mental health support locally, you can find options on the Healthy Stockport website https://www.healthystockport.co.uk/topic/mental-health-and-wellbeing, or via your usual support services.

1. **Social connections**

(This could include friends, family or activities you attend).

Thinking about connecting with others socially, what support works for you, what doesn't, and what might make things better or easier?

2. **Education (early childhood, school and college)**

(This could include experiences [as a parent or child] with teachers, peers or specific support in educational settings.)

Thinking about experiences with education, what support works for you, what doesn't, and what might make things better or easier?

3. **Housing**

(This could include social or private rentals, the condition of your property or the cost).

Thinking about housing, what support works for you, what doesn't, and what might make things better or easier?

4. **Work/employment**

(This could include experiences of being currently or previously in work, or if you would like to work.)

Thinking about being at work, or about not working, what support works for you, what doesn't, and what might make things better or easier?

5. **Access to essentials**

(This could include access to food, medicines and other essential items).

Thinking about accessing food and other things you need, what support works for you, what doesn't, and what might make things better or easier?

6. **Being out and about**

(This could include access to transport or using different leisure facilities).

Thinking about getting out and about, what support works for you, what doesn't, and what might make things better or easier?

7. **Health and care services**

a. Which health or care services do you (or the person you care for) currently use? (please tick any that apply)

- Social care for adults
- Children's social care
- Specialist mental health care (for children, adults, or older age)
- Mental health support in school
- Housing support
- GP
- Support from a charity
- I don’t use any services

b. Consider the services you use: What works well for your experience, what needs improvement, and how could these services make your experience better or easier? *(Please specify which service(s) you’re referring to as clearly as possible).*

c. Do any of the services you use sometimes seek your feedback, opinions, or contributions?

- Yes
- No
- Not sure

d. If you answered “yes” to question c), do you feel your feedback and views are taken into account?

- Always
- Often
- Sometimes
- Rarely
- Never

8. 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?

(Consider how this may affect where and how someone lives, what someone can buy, or what support someone has or needs)

9. What is your financial situation? Please select all that apply.

- I receive benefits
- I’m in paid work
- I’m retired

10. Which best describes you?

- Someone with personal experience of mental health challenges
- A carer or supporter of someone living with mental health challenges
- A professional working with people who have mental health challenges

11. What is your age group?

- Under 18
- 18-64
- 65 and over

12. Do you have any final comments you would like to share? Your thoughts and feedback will be making a difference.

Questionnaire for sector representatives:

Addressing health inequalities in Stockport

People in Stockport experience stark health inequalities, including in life expectancy. Inequalities often affect people with protected characteristics more, particularly if they also experience poverty. A panel review of health inequalities by the Stockport Council Adult Social Care and Health Scrutiny Committee aims to identify barriers and facilitators for two particular cohorts of residents: those living with a severe mental illness and people belonging to particular ethnic groups (Black African, Pakistani, Bangladeshi), when also affected by deprivation. (Severe mental illnesses are generally understood as conditions such as schizophrenia, bipolar disorder, psychosis, personality disorder, or major depression.)

One of the objectives of the review is to ascertain whether local organisations and services - in various sectors - are equipped to improve the inequalities affecting these cohorts. The review seeks to develop recommendations relevant to a broad range of sectors, to help reduce health inequalities. A resulting action plan will be publicly available.

This review is therefore relevant far beyond the health and care sector, as health inequalities arise through many factors in people's lives, including education, employment, social circumstances, wealth, housing etc.

We would appreciate your thoughts on the questions below, as they apply to your organisation/sector. The questions should only take a few minutes of your time, and you may wish to submit additional evidence by e-mail to Judith or Heather (see e-mail addresses below). When answering questions about 'people', please consider service users, their family/carers, as well as staff (if you are an employer).

For any questions or issues with completing the form, please feel free to contact judith.strobl@stockport.gov.uk or heather.knowles@stockport.gov.uk.

THANK YOU

1. Which sector do you work in?
    - Education
    - Employment/work/employer
    - Housing
    - Support with daily living
    - Healthcare
    - Social care
    - Other (please specify)

2. Would you describe your role primarily as working in:

- a client-facing provider organisation (including health or social care, education, employment support, housing support, social support etc.)
- a commissioning / strategic role or organization
- an employing organisation (business)

3. Are you aware of any challenges or barriers people with severe mental illness might face in accessing or benefitting from your organisation's/sector's work?
    - Yes
    - No
    - Don't know

4. If yes, please describe the challenges or barriers

5. Are you aware of any challenges or barriers people of Black African, Pakistani or Bangladeshi backgrounds might face in accessing or benefitting from your organisation's or sector's work?
    - Yes
    - No
    - Don't know

6. If yes, what are the challenges or barriers?

7. What, if anything, does your organisation already do to take account of challenges or opportunities experienced by people with severe mental illness?

8. What, if anything, does your organisation already do to take account of challenges or opportunities experienced by people from Black African, Bangladeshi, Pakistani background?

9. Do you have information about how the work of your organisation/sector impacts on the experience or outcomes of either of the two cohorts?
    - Yes
    - No
    - Not sure

10. What would help your organisation/sector to better support those from Black African, Bangladeshi, Pakistani background, particularly if they were also affected by deprivation?

11. What would help your organisation/sector to better support those living with severe mental illness, particularly if they were also affected by deprivation?

12. Does your organisation have any further plans to seek to either learn from the experience of people with severe mental illness, or from minority ethnic backgrounds, or to address their challenges or barriers?

    - Yes
    - No
    - Not sure

13. If yes, what are your plans? (feel free to e-mail any documents - addresses at the end of the form)

14. Please feel free to share any final thoughts or comments you wish to make:

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