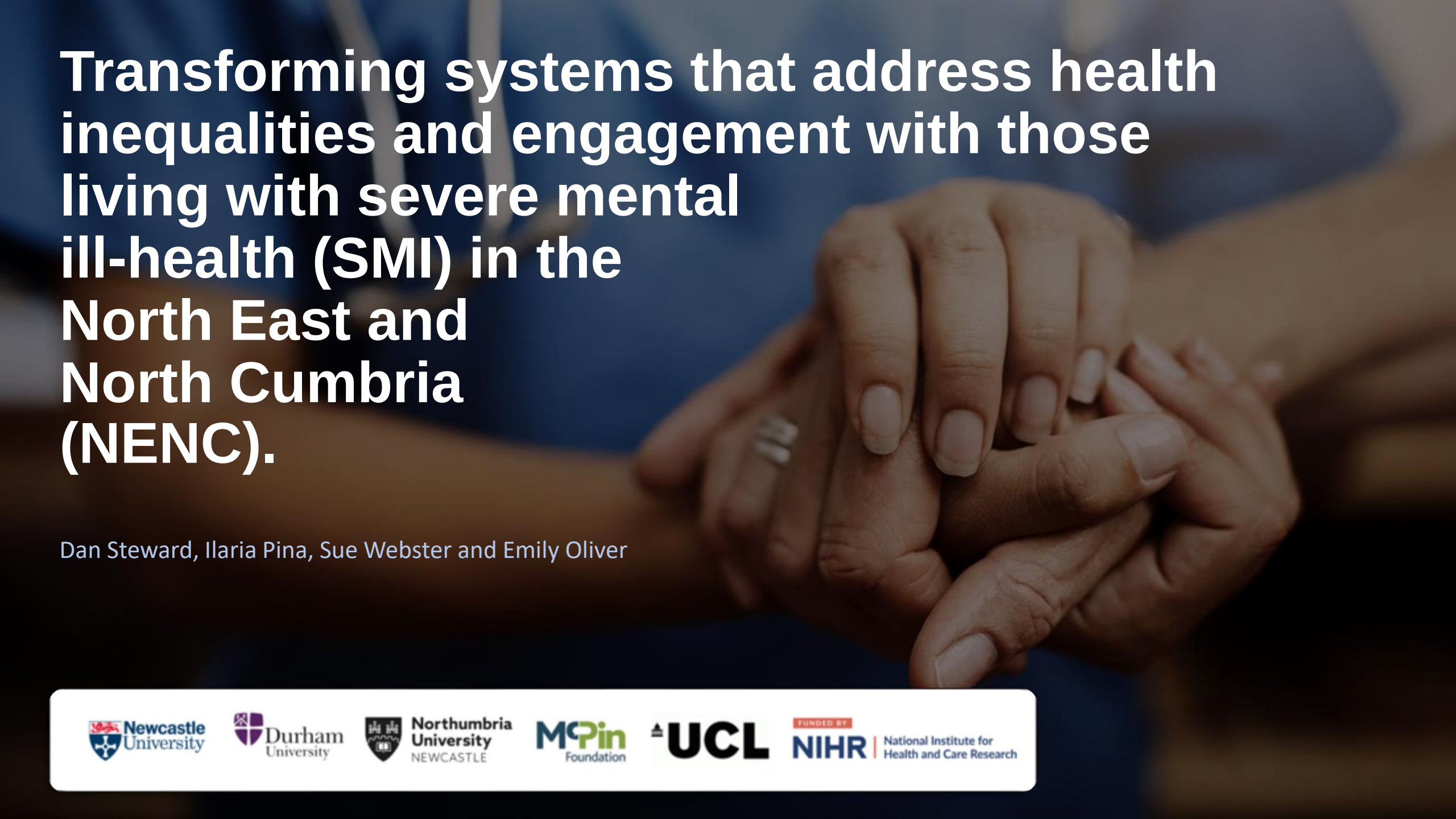
# Transforming systems that address health inequalities and engagement with those living with severe mental ill-health (SMI) in the North East and North Cumbria (NENC).

Dan Steward, Ilaria Pina, Sue Webster and Emily Oliver



# Background

## Health inequalities

The NENC has greater health inequalities and poorer outcomes than the rest of the UK, which are worsening.

## Higher physical health risks

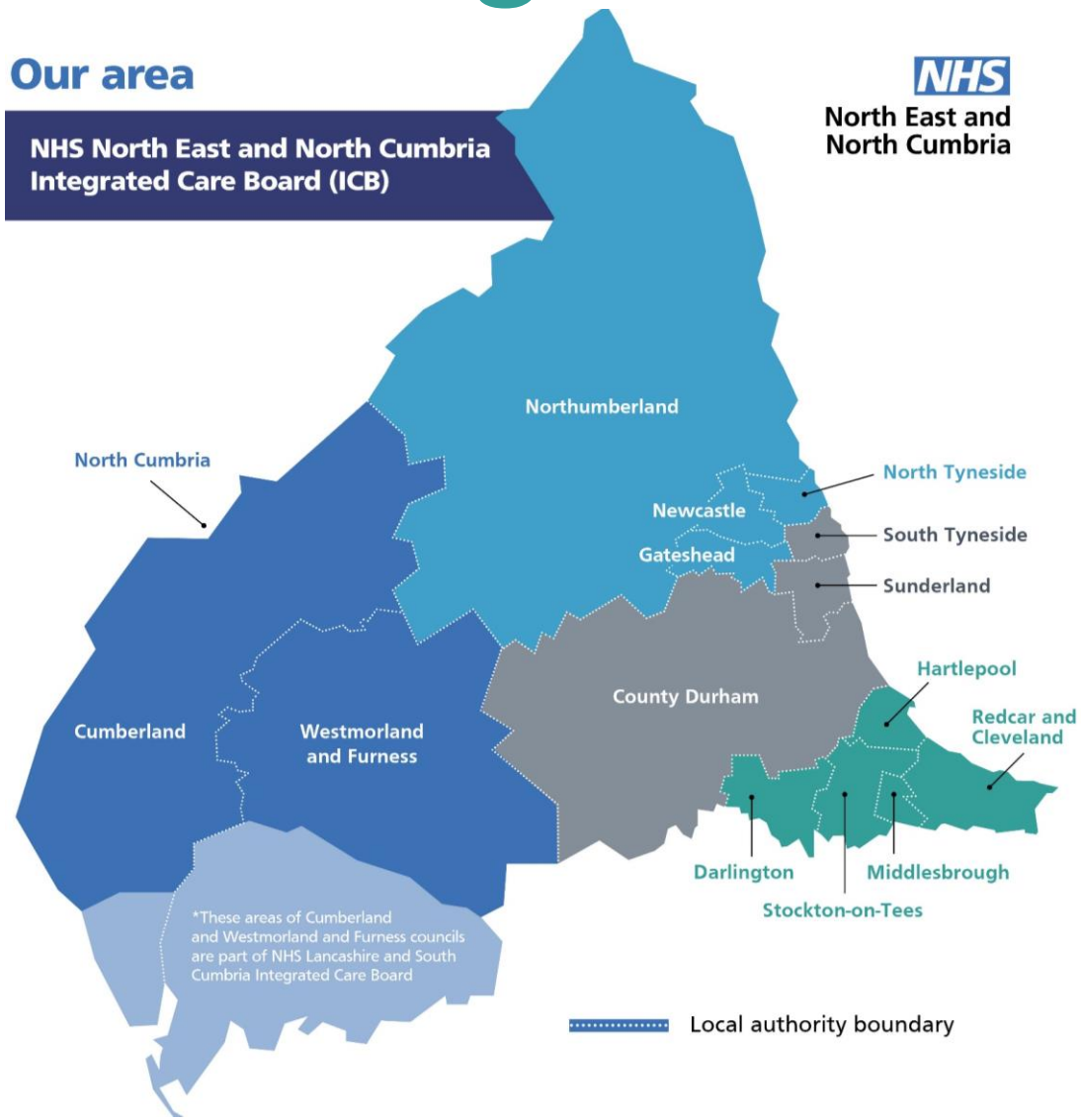
People with severe mental ill-health face triple the risk of physical health conditions.

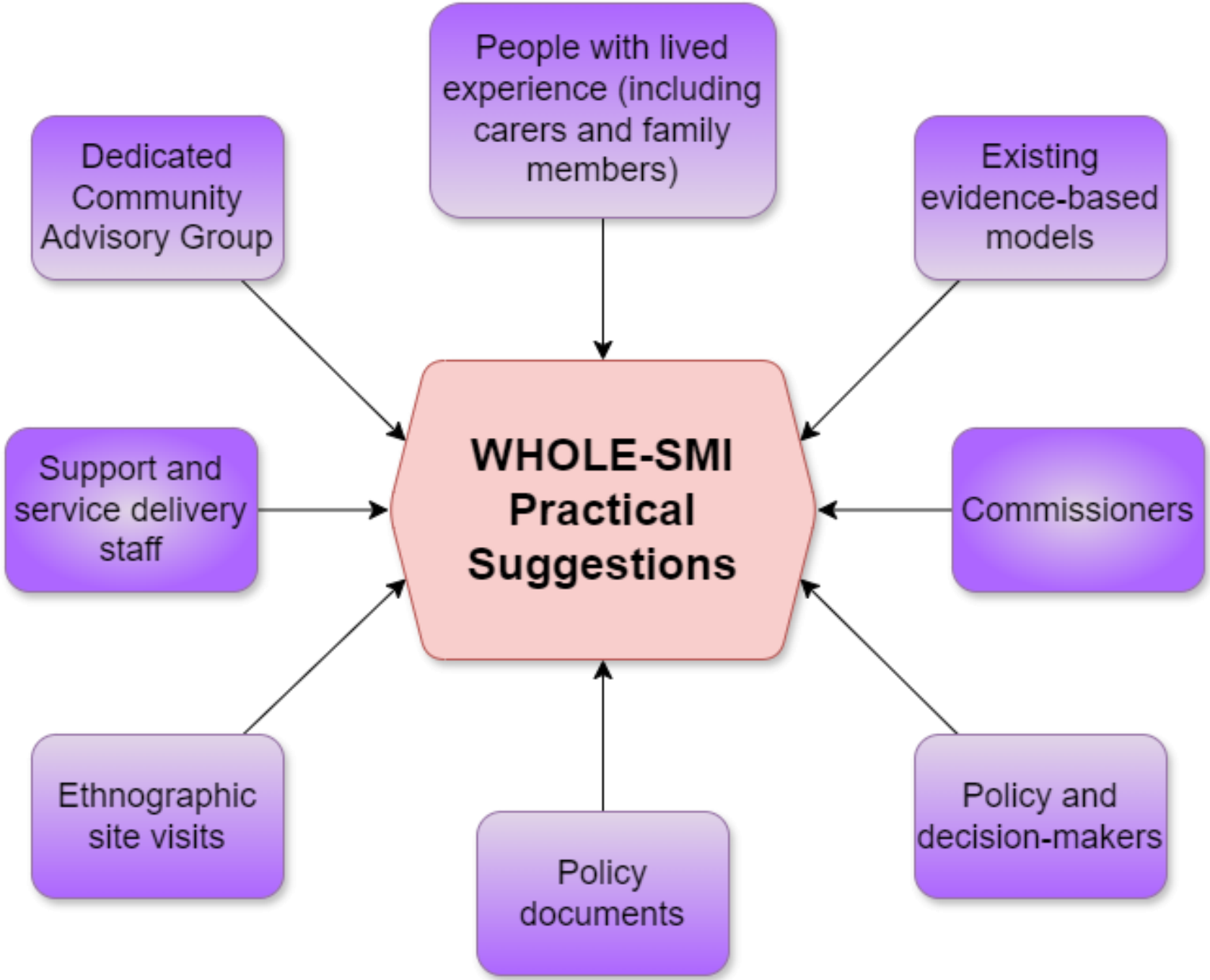
## Reduced life expectancy

On average, they die 15-20 years earlier than the general population.

## Access barriers

Existing support pathways for physical health promotion have variable uptake.






WHOLE-SMI

**Phase 1**

Mapping the service delivery landscape and community needs.

**Phase 2**

Mapping pre-implementation processes.

# Pause for thought

- Increased uptake isn't always an indicator of successful initiatives (e.g. AHC)
- Think about and start/reignite conversations.
- Mental ill-health doesn't discriminate
- What groups of people are excluded or not engaging?
- What are the reasons?
- Think about ways around this - what can we collectively do to and how we might adapt our services to reach those that might really benefit from them?

# Who and why?

More women than men

People living in remote, coastal and rural communities

Older adults

People from deprived areas

Members of LGBTQIA+ community

People from different ethic and religious communities

Unemployed

Homeless

Refugees

# Who and why?

Delivery factors – workforce/funding/timetabling/referral processes

Accessibility/provision

Cultural differences

Language barriers

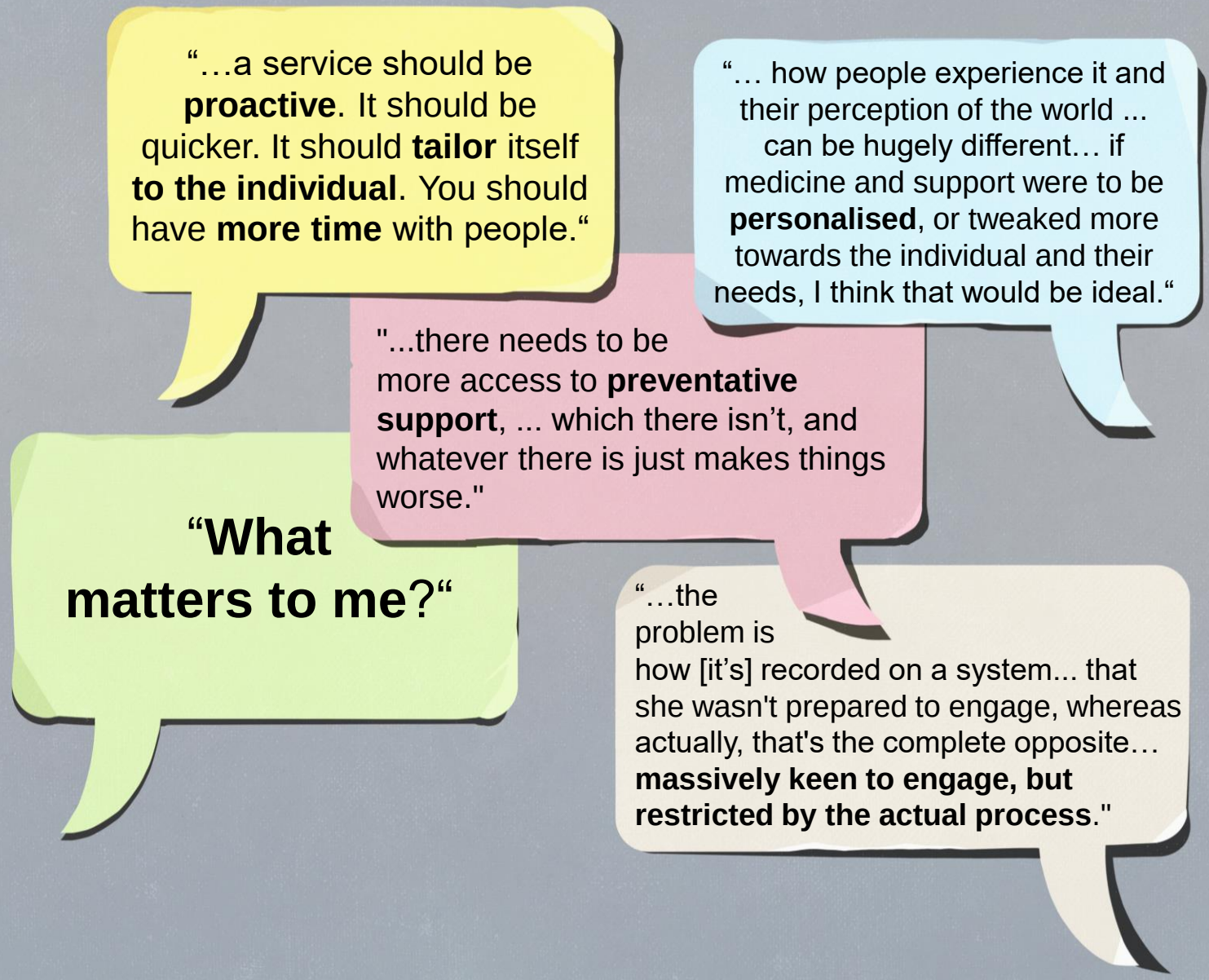
People of working age (younger adults)

Family responsibilities

Mobility issues

Confidence issues

# Quotes highlighting patient needs



| PROBLEM | PRACTICAL SUGGESTIONS |
| --- | --- |
| **Diagnostically driven service entry criteria and eligibility can be exclusionary.**<br>- **Individuals are falling through the cracks between referrals**<br>- **PH promotion support is not always accessible for those who might need it** | - More **flexible** entry pathways and multiple referral routes e.g., Allow community organisation and self-referrals; Following up on referrals<br>- Consideration around **choice of language** to reduce stigma/over-medicalised terms (CVD risk, checks etc. 'Conversation')<br>- Who isn't presenting? Who are we missing? - Looking at effective uses of **community outreach**. |

| PROBLEM | PRACTICAL SUGGESTIONS |
| --- | --- |
| **Fragmented and disjointed care experiences**<br><br>- **Physical health not well integrated with Mental Health support services**<br>- **'Postcode lottery'**<br>- **"We keep having to repeat our story"** | - **Joined up ways of working and multi-disciplinary approaches** to be able to provide **proactive and holistic care**<br><br>- Better **communication and collaborative links** across remits and between different services (informal community of practice)<br><br>- **Community-based presence in non-clinical spaces** (particularly important in rural/remote/coastal locations)<br><br>- Consistency in workforce and **fostering trust/rapport** e.g., Investment in more **peer support worker**-orientated roles<br><br>- **Centralised prioritising** |

| PROBLEM | PRACTICAL SUGGESTIONS |
| --- | --- |
| **Services tend to be very reactive rather than proactive with a "one size fits all" approach** | - Allow **re-engagement and flexible entry opportunities**<br>- **Individually-tailored holistic approaches** to care – embedded in evidence-based programmes available elsewhere (e.g., PRIMROSE)<br>- Empower individuals to be **active-decision makers** in their own realistic care plans<br>- **Creative commissioning of services** |

# Concluding remarks

- **Encourage difficult conversations –** talk about what does not work and challenge behaviours and attitudes in the system.
- **Communities of best practice**.
- **Open to new ways of working and collaborating** across healthcare settings (primary, secondary, community-based and voluntary organisations etc).
- Recognising and addressing **individual differences and needs.**
- Recognising and addressing **changing needs over time.**
- **Smaller-scale adaptations** are achievable and sustainable.
- **Reallocation of resources** where they're needed the most.

Any questions?

WHOLE-SMI

**Dan Steward**

Research Assistant

Newcastle University

dan.steward@newcastle.ac.uk

# Thank you