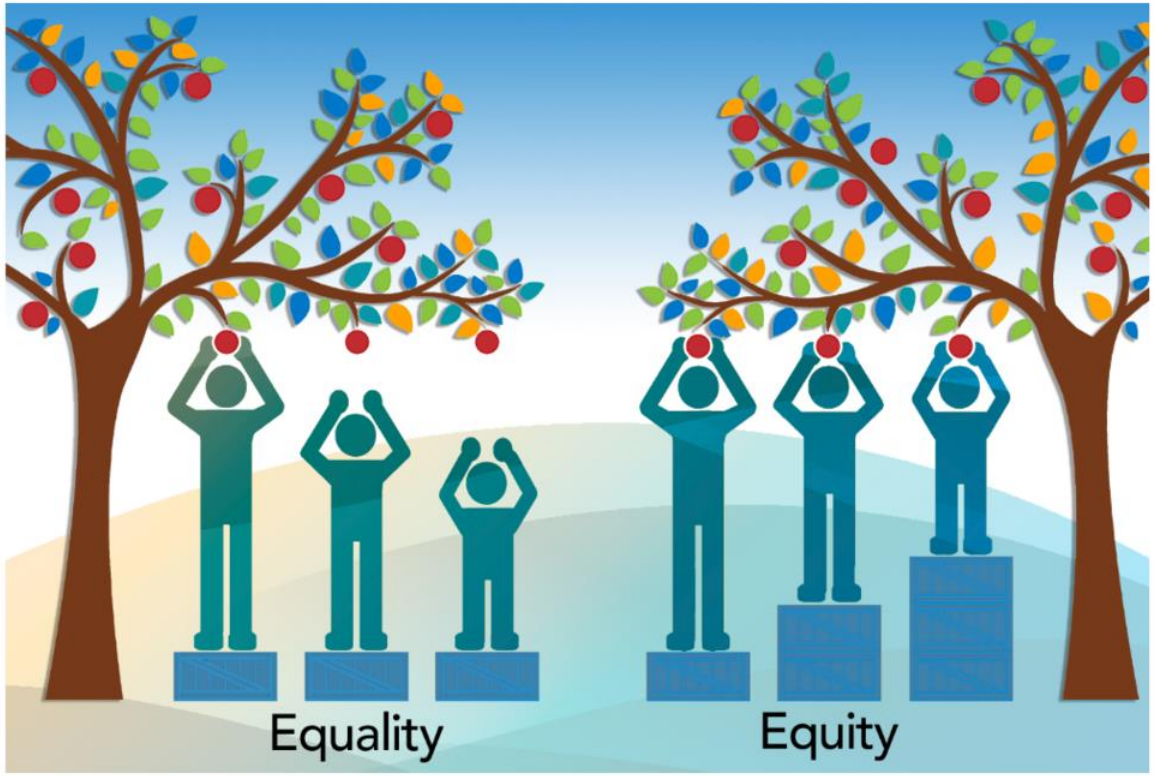


Student Mental Health Forum:

Health Equity approach to develop excellent services for all

Liz Lingard, 26 May 2022

Inequality

Unequal access to opportunities

Equality?

Evenly distributed tools and assistance

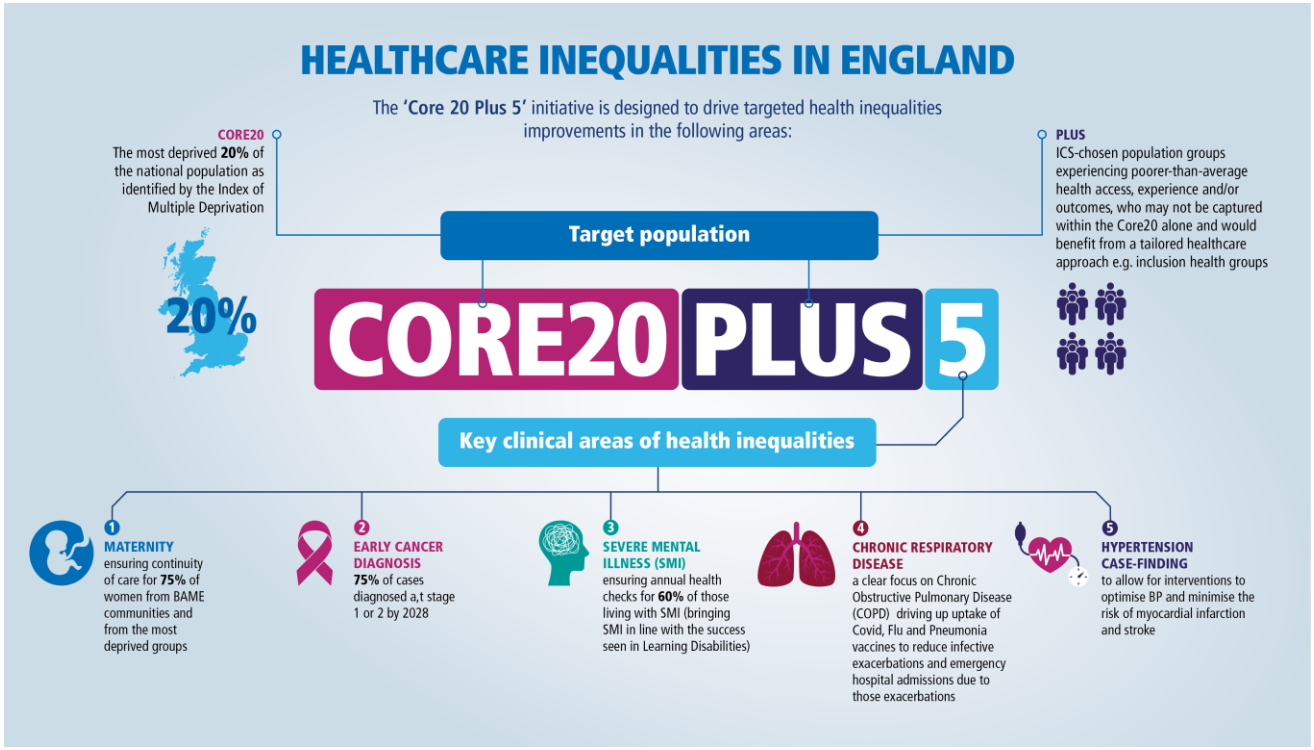
Equity

Custom tools that identify and address inequalilty

Justice

Fixing the system to offer equal access to both tools and opportunities

National policy context



Priority 1: **Restore NHS services inclusively** – with a focus on ethnicity and deprivation

Priority 2: **Mitigate against digital exclusion**

Priority 3: **Ensure datasets are complete and timely** - continuing to improve the collection and recording of ethnicity data in all health settings

Priority 4: **Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes** including a culturally competent approach to COVID & flu vaccination delivery, Continuity of Carer in maternity for targeted groups, a focus on LTCs and health checks for people with a LD and/or SMI

Priority 5: **Strength leadership and accountability** - including system Health Inequality SRO

"Exceptional health care for all with equitable access, excellent experience and optimal outcomes"

NHS England and NHS Improvement

Considerations: Life Course Approach

Greater focus on children and young people achieving the best start in life and supporting families and communities

Considerations: Care Pathway Approach

Address Health Inequalities across Care Pathways from prevention to highly specialised care

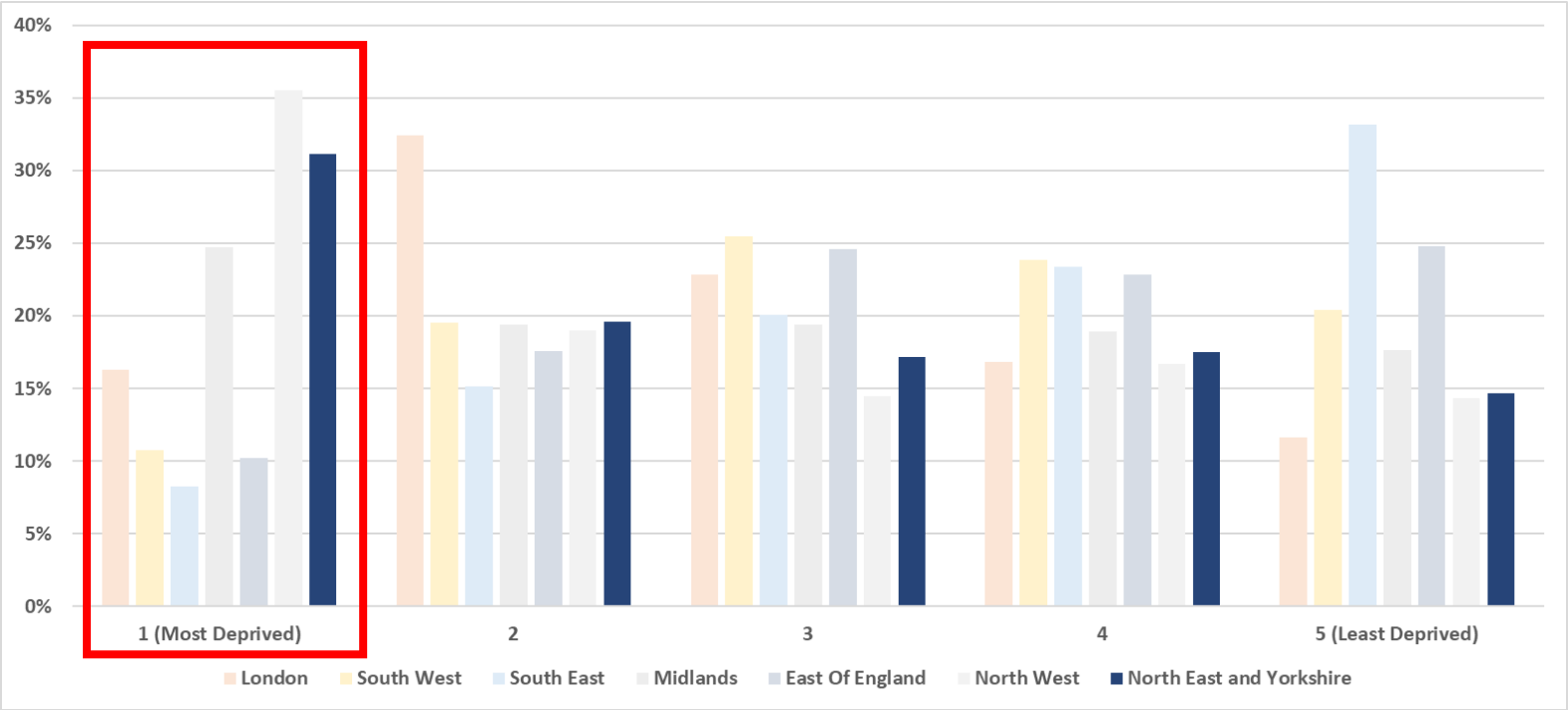
- Prevention – primary, secondary and tertiary initiatives
- Health Promotion and Health Improvement – embedded across the whole pathway of care
- Early detection of health conditions – including use of Imaging and Diagnostics as well as Screening Programmes
- Supported self management – requires capability, opportunity and motivation
- Healthcare services in primary, community and secondary care settings

Who is most at risk of facing Health Inequalities

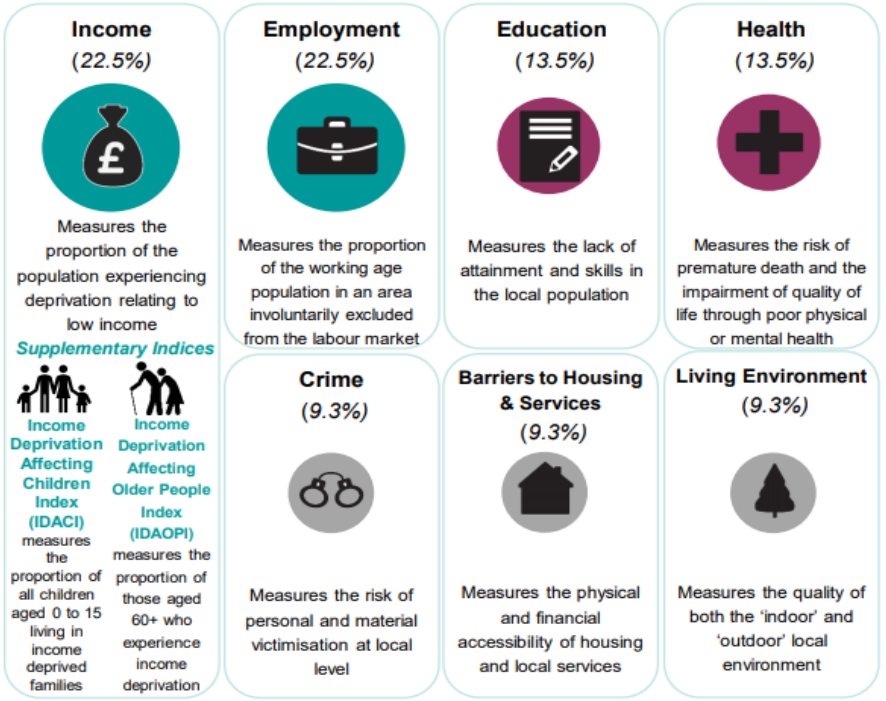
Protected characteristics	Socio-economic status/Geography	Others who face health inequalities:
• **Age** • **Sex** • **Gender reassignment** • **Disability: includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.** • **Marriage and civil partnership** • **Pregnancy and maternity: women before and after childbirth; breastfeeding.** • **Race and ethnicity** • **Religion and belief** • **Sexual orientation**	People who are living in: • Deprived areas • Remote, rural and coastal locations. • Overcrowded conditions • Poor quality housing • Prisons • Homeless people or those who experience homelessness People with limited income due to: • Unemployment / Inability to work • Employed on low incomes People with poor literacy or health literacy	Individuals who known to be/have: • clinically extremely vulnerable • long term health conditions • approaching the end of life • addictions / substance misuse problems • living with/recovering from mental health problems including dementia • serious mental illness • learning disability and/or autism • sensory impairment (e.g. vision/hearing) • Looked after/accommodated children & young people. • Carers: paid/unpaid including family members. • Those involved in the criminal justice system: offenders in prison/on probation, ex-offenders. • People being released early from prison • Gypsy, Roma and Traveller populations • Sex workers • Vulnerable migrants • Modern slavery victims • Critical Workers

Core20 - North East and Yorkshire Region

Percentage of the population in IMD Quintiles: NHS Regions



7 Domains of Deprivation

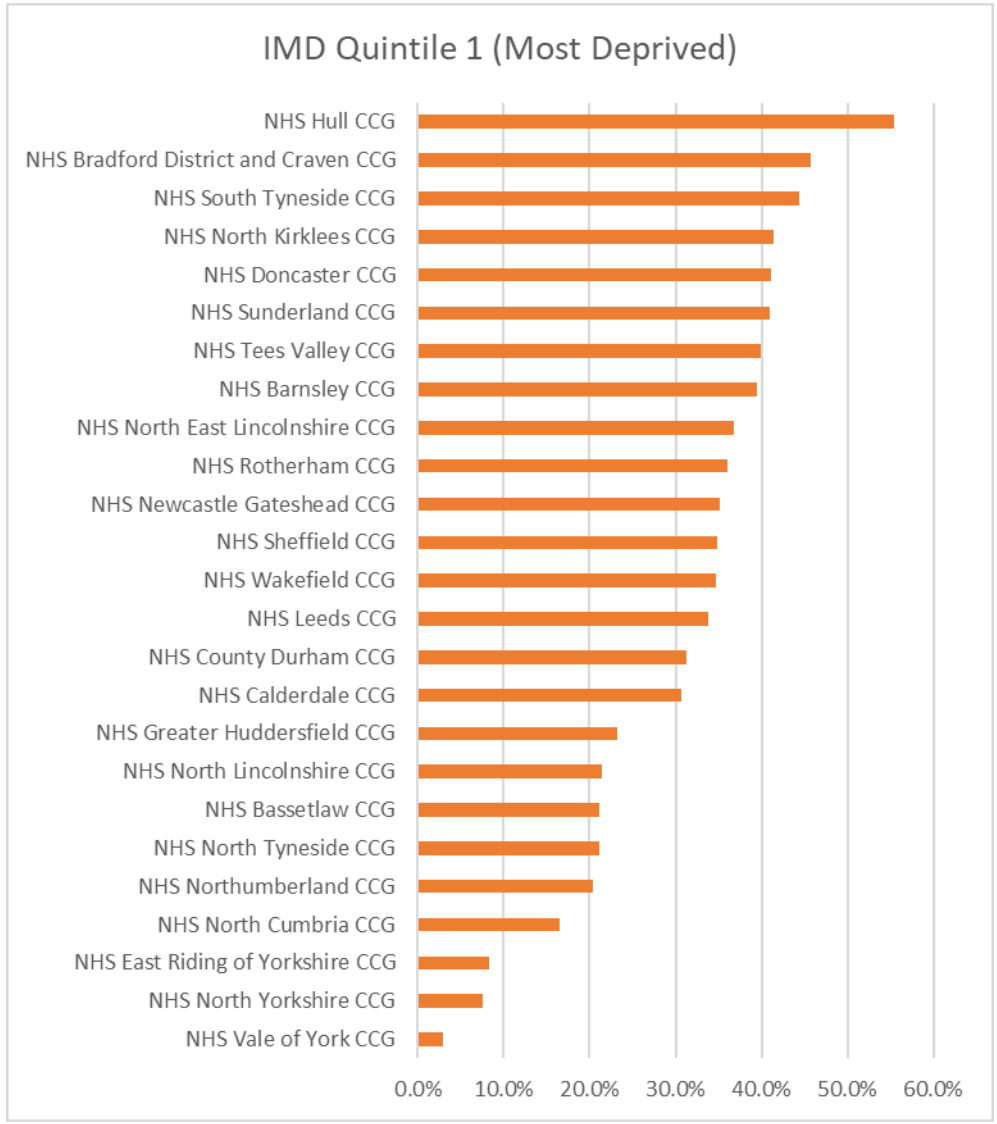


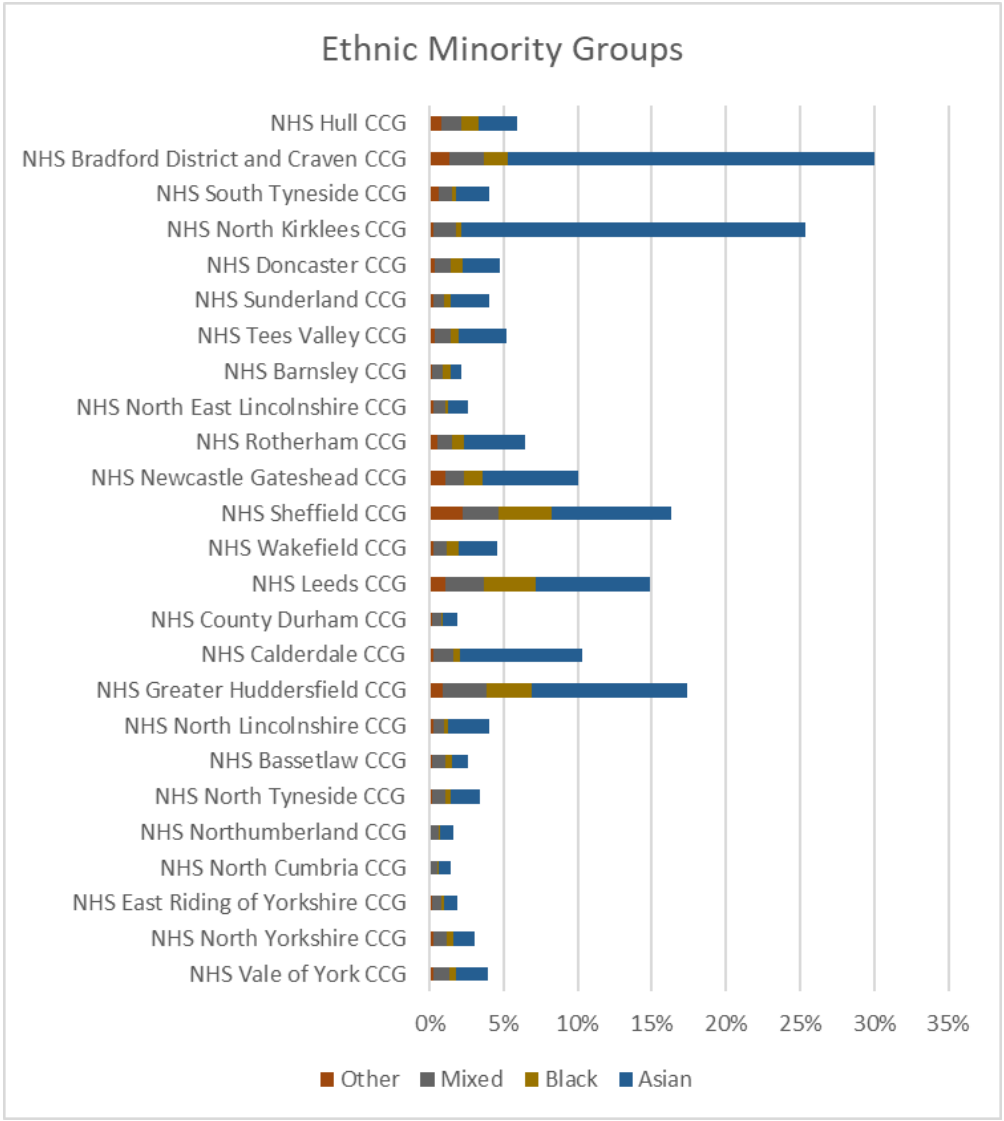
- English Indices of Multiple Deprivation (IMD) ranks each small area in England from the most to the least deprived. It takes into account wider determinants of health such as income, employment, education, crime housing and the living environment.

- Nationally, if we rank these small areas from most to least deprived and then put them equally into 5 groups this would mean there were 1 in 5 people (20%) living in each IMD quintiles. However, each region of England has different proportions of people in each quintile and the chart above highlights that **in NEY, about 3 in 10 people (31%) live in the most deprived areas.**

- There is wide variation within our region ranging from **4% of York** living in the most deprived quintile to **55% of Hull**; even within York and less deprived areas there will be variation with small pockets of very deprived communities.

Demographic variation across CCGs



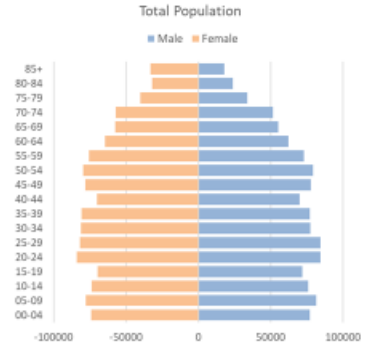


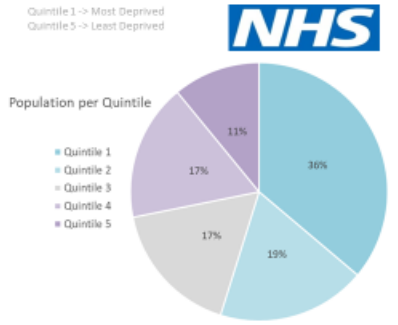
Variation in Age Profiles by Deprivation Quintile for the 3 Y&H Integrated Care Systems

ICS Demographics

The population in West Yorkshire and Harrogate ICS is higher in the most deprived quintiles than in the least. 55% of the population in this system is in Quintiles 1 and 2, and 28% of the population is in the least deprived quintiles (17% in quintile 4 and 11% in quintile 5).

The less deprived quintiles tend to have a higher proportion of residents aged over 40 than the most deprived quintiles, as illustrated below.



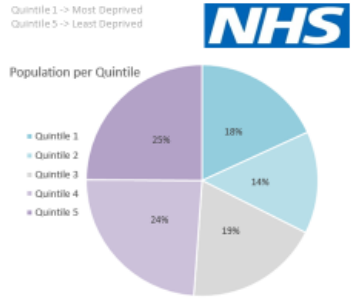


Data displays: Population Sizes | Data Source: 2019 ONS Mid-Year Pop Estimates/2019 English Indices of Deprivation

ICS Demographics

The population in Humber, Coast and Vale ICS is higher in the least deprived quintiles than in the most. 49% of the population in this system is in Quintiles 4 and 5, and 32% of the population is in the most deprived quintiles (18% in quintile 1 and 14% in quintile 2).

The less deprived quintiles tend to have a higher proportion of residents aged over 40 than the most deprived quintiles, as illustrated below.

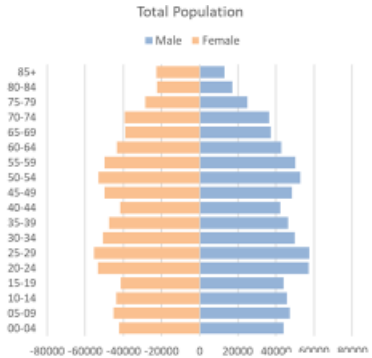


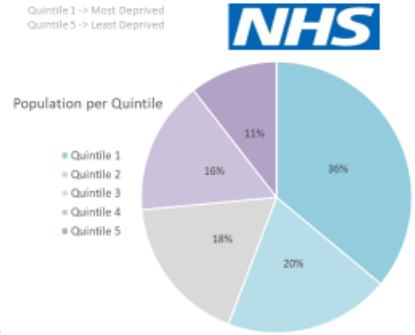
Data displays: Population Sizes | Data Source: 2019 ONS Mid-Year Pop Estimates/2019 English Indices of Deprivation

ICS Demographics

The population in South Yorkshire and Bassetlaw ICS is higher in the most deprived quintiles than in the least. 56% of the population in this system is in Quintiles 1 and 2, and 26% of the population is in the least deprived quintiles (16% in quintile 4 and 11% in quintile 5).

There is a larger proportion of young people (0-14s) in the most deprived quintile compared to the others.





Data displays: Population Sizes | Data Source: 2019 ONS Mid-Year Pop Estimates/2019 English Indices of Deprivation

Understanding information and ability to engage in communicating with healthcare providers

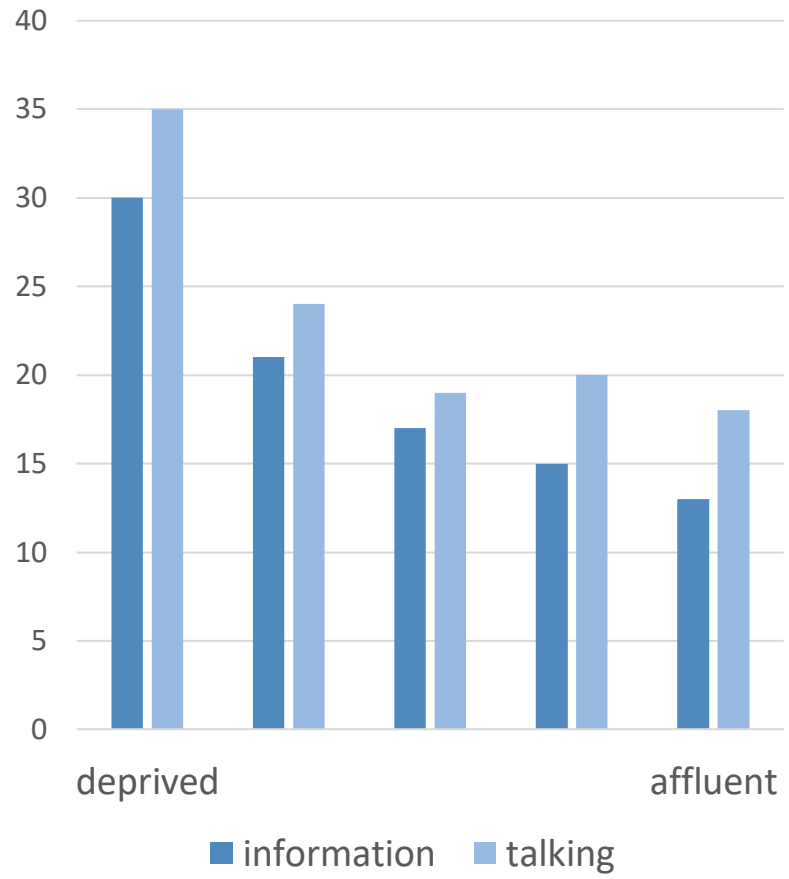
Survey of British Population (2018)

Lower health literacy is linked to:

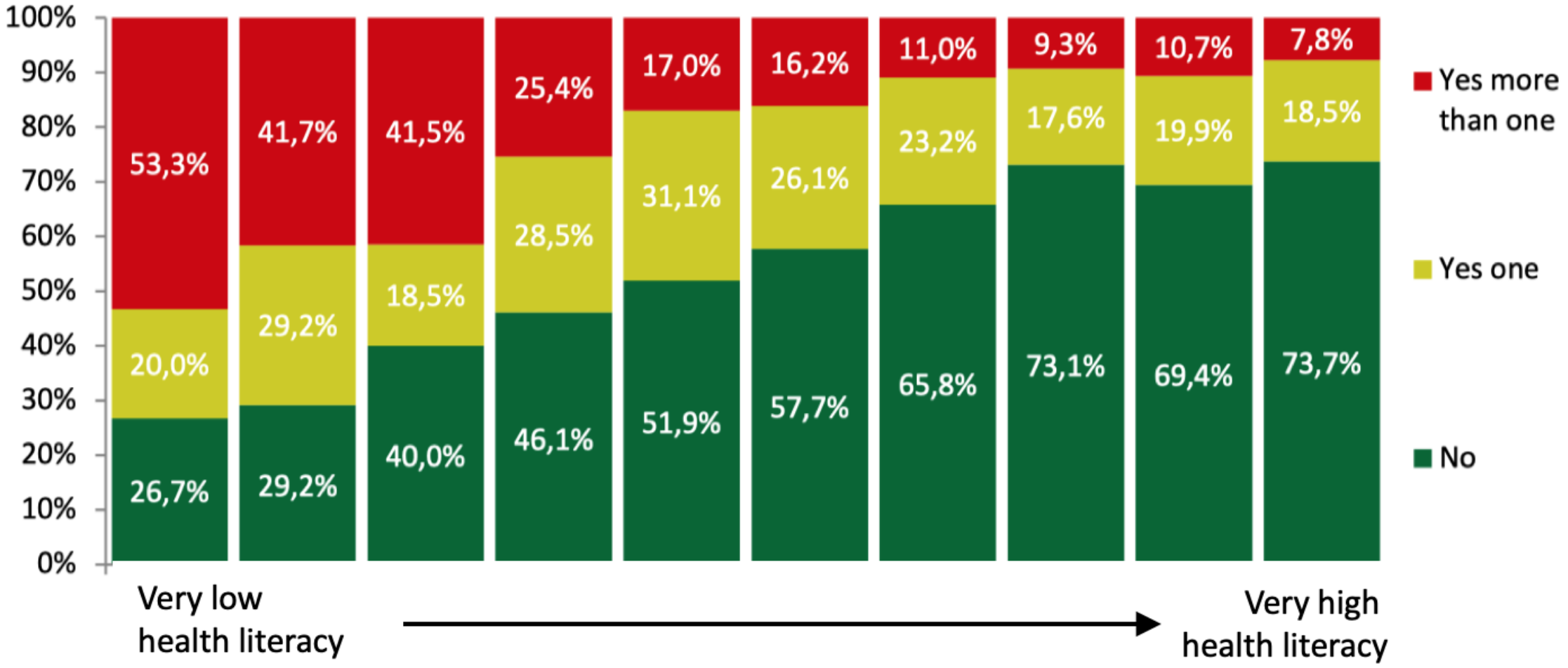
- Most socially deprived
- No educational qualifications
- Black Asian and Minority Ethnic communities
- Had a limiting health condition or disability

- 1 in 5 said 'some difficulty understanding written information' **ooooo**
- 1 in 4 said 'some difficulty discussing health concerns with doctors or nurses' **oooo**

(Simpson 2020)



Health Literacy and Long Term Conditions

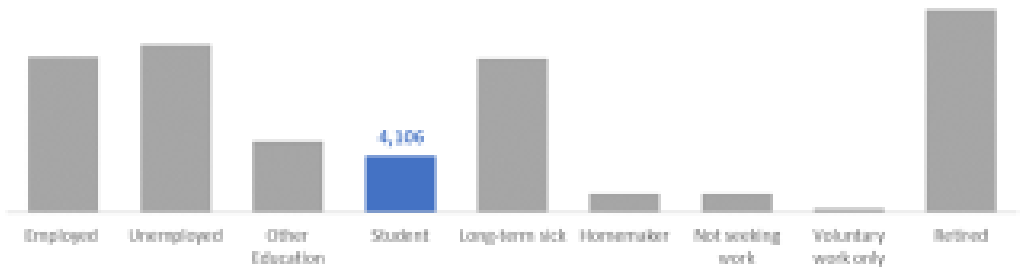


European health literacy survey 2012

Mental Health Services Dataset (MHSDS)

In 2021/22 140,585 individual patients were referred into Mental Health Services in the Yorkshire and Humber area.

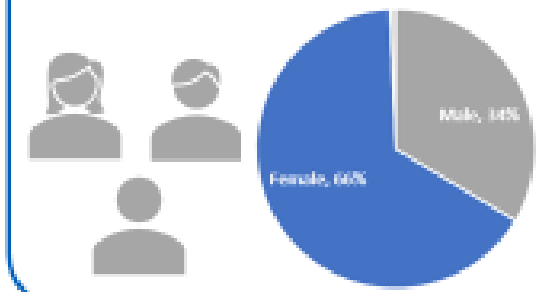
Of the patients with recorded employment status information, **3%** are students. In 2020/21, **4%** of the UK's population was made up of students*.



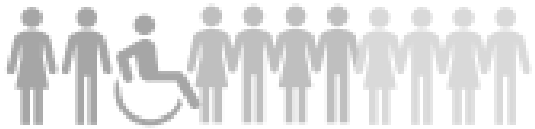
NHS

Data used is from the MHSDS, and identifies distinct patients only, rather than distinct referrals. Mental Health activity may therefore be higher than shown where patients have multiple referrals.

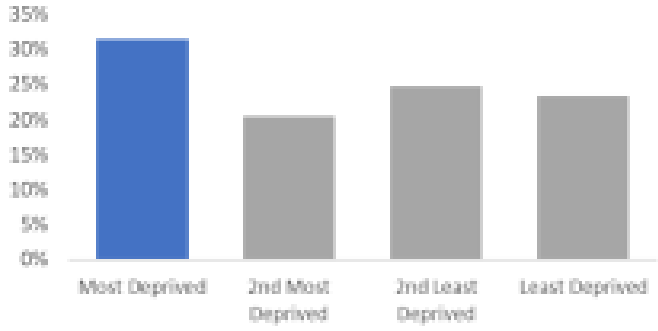
66% of students referred were **female**, and **34%** were **male**. **1%** of students referred to Mental Health services gave an answer of 'neither male nor female'.



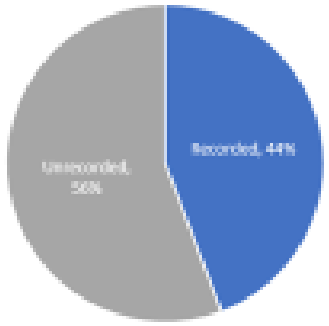
11% of patients had an Ethnic Category other than 'White – British', and **19%** were 'Unknown'. Pakistani is the most commonly recorded Minority Ethnicity Category.



31% of students referred to Mental Health Services are resident in the Most Deprived areas in the UK. Other areas account for between 20% and 25% of student activity each.



Data quality in this area is poor, with less than 50% completeness for employment status recording.

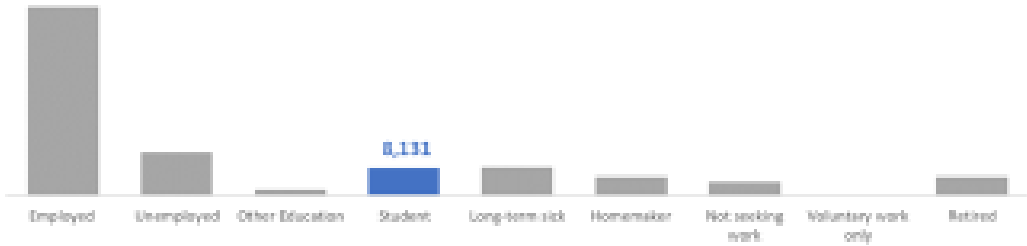


Students are identified as those with a recorded employment status of 'Student' (code – 3), and are between the ages of 16 and 24.
*https://commonslibrary.parliament.uk/research-briefings/cbp-7857/

Improving Access to Psychological Therapies Dataset (IAPT)

In 2021/22 141,472 individual patients were referred into Talking Therapies in the Yorkshire and Humber area.

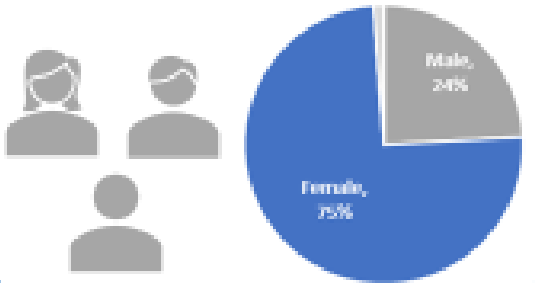
Of the patients with recorded employment status information, **6%** are students. In 2020/21, **4%** of the UK's population was made up of students*.



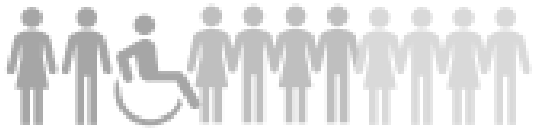
NHS

Data used is from the IAPT Dataset, and identifies distinct patients only, rather than distinct referrals. IAPT activity may therefore be higher than shown where patients have multiple referrals.

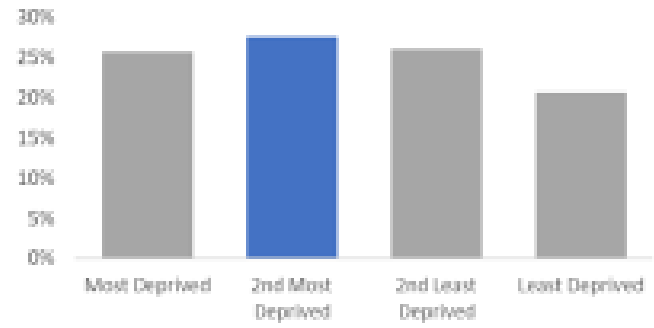
75% of students referred were **female**, and **24%** were **male**. **1%** of students referred to Mental Health services gave an answer of 'neither male nor female'.



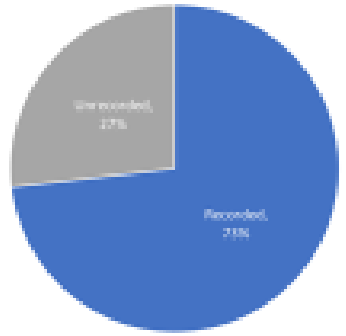
23% of patients had an Ethnic Category other than 'White – British', and **5%** were 'Unknown'. Pakistani is the most commonly recorded Minority Ethnicity Category.



28% of students referred to IAPT are resident in the Second Most Deprived areas in the UK. Other areas account for between 21% and 26% of student activity each.



Data quality in this area is poor, with less than 73% completeness for employment status recording.



Students are identified as those with a recorded employment status of 'Student' (code – 3), and are between the ages of 16 and 24.
*https://commonslibrary.parliament.uk/research-briefings/cbp-7857/

What we need to always consider:

- **Understand all groups accessing services most at risk of health inequalities** - people with protected characteristics, those living in deprivation and/or remote rural areas and inclusion health groups.

- **Population health management approach** to view data by these groups to understand variation in access, experience and outcomes to identify priority areas for action and monitor progress

- **Co-production of healthcare services** so that evidence based interventions are delivered in acceptable, accessible and affordable ways (patient preferences, health literacy levels, digital inclusion, culturally competent services, reasonable adjustments for LD&A, consider geography, transport & cost of travel)

- Need for **proportionate universal approaches tailored to the needs of the population** i.e. weighted funding, heightened/targeted service provision.

- **Public comms to achieve awareness** – co-produced with patients and communities and in accessible formats based on literacy levels as well as being culturally appropriate

- **Link with key people in NHS regional and local teams, Public Health in OHID and Local Authorities and wider partners across the Region/ICSs** when you need support to fully understand these issues

What we can do as individuals and teams to reduce Health Inequalities?

Challenging ourselves to create an optimal system culture which seeks to reduce health inequalities by really listening to those with lived experience to find solutions.

Speak out about our own experiences of Health Inequalities and the impact this has had on us as an individual, our family and friends and the wider community to help co-produce solutions.

Take time to ask key questions before we embark on any decision, initiative or approach to make sure we are not inadvertently widening health inequalities and always continually seeking to find ways to reduce them.

Make a pledge **to Listen, Learn and Level up Student Mental Health services**