Fairer Health For All

GM FEDS GREATER MANCHESTER TRAINING HUB

Greater Manchester Integrated Care Partnership

Cohort One Fellowship Celebration Event – Official Handbook

What is Fairer Health for All?

Greater Manchester Integrated Care Partnership

Fellowship Overview

The Fairer Health for All Fellowship is part of the Fairer Health for All Academy which promotes shared learning, innovation and collaborative leadership to addressing health inequalities.. It is open to individuals from diverse backgrounds and sectors, including clinical, non-clinical, managerial, support staff, and those working in the VCFSE sector. The fellowship aims to:

- Establish and nurture understanding of the learners' professional roles and opportunities to create Fairer Health for All.
- Educate learners on the policy and strategy context in Greater Manchester and identify the skills needed to successfully manage change in complex health and care and community settings.
- Refine learners' understanding of the social and commercial determinants of health and the importance of health equity, equality, and inclusion.

Fellows joined the programme with a project idea to be undertaken within their organisation, using their fellowship day each week to develop and deliver their project over the 12-month programme.

Cohort 1, which started on February 1, 2024, included 16 fellows (50% GPs and 50% from the VCFSE sector) from primary care and community settings. Fellows were given one day per week for tailored training and project work, with access to a Public Health mentor, quarterly peer support sessions, and Communities of Practice.

Additionally, Greater Manchester-specific Continuing Professional Development (CPD) sessions were delivered weekly during the first six weeks of the fellowship. These sessions were tailored to address regional public health challenges and priorities, ensuring that the fellows' learning was relevant and immediately applicable to their work.

Of these 15 fellows, 13 will be presenting at today's event.

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What is Fairer Health for All?

Greater Manchester Integrated Care Partnership

The GM Fairer Health for All Framework enables collaborative action to tackle inequalities in our neighbourhoods, workplaces and health and care settings.

- **Health and Care Intelligence Hub**
- **Fellowship Programme**
- **Locality Learning Hubs** Sharing learning about ***what works*** to tackle health inequalities, ***how*** and ***why*** so we can scale-up of effective approaches.
- **Toolkits and Resources to enable community led-health and well-being, enhance prevention and proactive care**

Brings together our ambitions and action from across the ICB on health inequalities into a single plan which is **Enabling Fairer Health for All in Action by:**

- **Strengthening Communities** (**Live Well**)
- **Accelerating prevention** (multi-year prevention plan)
- **CORE20PLUS5 - Improving access, experience & outcomes** of screening, early detection & treatment for underserved communities
- **Inclusion Health** (inclusive recovery for primary, elective and urgent care and digital inclusion)

- **Culture Change** - Connecting leaders and champions to grow a movement for change
- **Tailored Learning and Development Opportunities**– to enable shared learning and capture 'stories of change
- **Strengthening the role of the VCSE sector as strategic partner in the Population Health system**

Principles

- People Power
- Proportionate Universalism
- Fairer Health *with and for all*
- Representation
- Health Creating Places

Shared Ambitions and Targets: Outcome Metrics

1. Improve the Health & Wellbeing to narrow the gap in life expectancy and healthy life expectancy
2. Reduce unwarranted variation in health outcomes and experiences
3. Increased social & economic activity because of ill health
4. Reduce preventable or unmet health and care needs leading to reductions in health and care demand
5. Reduce the difference in life expectancy and the incidence of physical health conditions for people with SMI
6. Reduce infant Mortality

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Fairer Health for All Principles

The Fairer Health for All principles were co-designed by Greater Manchester partners and speak to how we will share risk and resources in a way that considers a strengths-led approach, building on the needs of individuals, communities and partnerships, and to collaborative decision making, so that resource can be targeted and tailored to achieve good health across diverse places and people.

People power

We will work with people and communities, and list to all voices – including people who often get left out.

We will ask 'what matters to you' and 'what has happened to you' as well as 'what is the matter with you'.

We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate universalism

We will co-design universal services (care for all) but with a scale and intensity that is proportionate to levels of need (focused and tailored to individual and community needs and strengths)

We will **change how we spend resources** – so more resource is available to keep people healthy and for those with greatest need.

Fairer Health for All is everyone's business

We will think about **inclusion and equality** of outcome in everything we do and how we do it

We will make sure how we work makes things better, and makes our environment better, for the future

We will tackle structural racism and systemic prejudice and discrimination

Representation

The mix of people who work in our **organisation will be similar to the people we provide services for.**

For example, the different races, religions, ages, gender, sexuality, disabled people and people with multiple servere disadvantages.

We will create the space for people to share their unique voice and be involved in decision making.

Health creating places

As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

We will focus on place and **work collaboratively** to tackle social, commercial, economic and environmental determinants of health.

To read more about the Fairer Health for All Framework, use the QR code below to access the Academy website

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Our Fellows

Greater Manchester Integrated Care Partnership

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What is Fairer Health for All?

Greater Manchester Integrated Care Partnership

Agenda

Activity	Time
Welcome	12:30 – 12:45
Group 1 presentations - Access to Care • Laura Cousins: **Opportunistic increase of HIV testing** • Liam Hanley: **Smoking cessation campaign** • Saroja Forester: **School absenteeism**	12:45 – 13:15
Group 2 presentations – Tailored Health Care / Incl. Health • Beth Mitchell: **Programme supporting migrants** • Idowu Morafa: **Establishing holistic health centres** • Philippa Murphy: **Improve Awareness and Increase Engagement of Annual Health Checks in Young People with Learning Disabilities**	13:15 – 13:50
Networking	13:50 – 14:20
Group 3 presentations • Alice Coren: **Comparison of Community and Clinical Peer Support** • Pip Norris: **Targeted work absence support** • Suzie Carrier: **Improving Equitable Uptake of Breast Cancer Screening**	14:20 – 14:55
Group 4 presentations • Alex Guy: **Relationships between Social economic factors and NHS services and It's link to Mental Health, Poverty & Health Inequalities** • Hilaria Asumu: **Bridging the Gap in Reaching Black Ethnic Communities Unable to Access Services** • Tayyaba Kosar: **Food Poverty and the Impact on Long Term Health Conditions**	14:55 – 15:30
Networking	15:30 – 16:00

Laura Cousins

Job Title: Salaried GP
Abortion Care Doctor for NUPAS
Locality: Oldham
Project Title: Opportunistic HIV testing in Primary Care

Greater Manchester Integrated Care Partnership

Project Aim

I introduced opt-out HIV testing for all patients aged 15-65 having any blood test at my GP practice. Our HIV prevalence rate seemed low compared to GM, but I found that this was because of poor attendance at GUM clinics, where the data was being collected, rather than fewer of our patients having HIV. I wanted to roll out routine HIV testing somewhere that my patients would regularly attend, to improve testing coverage, in line with the UK goal of no new HIV cases by 2030.

What did I do?

I created an 'HIV pub quiz' event to gather information about what staff's knowledge and beliefs were around HIV. I then used this data to write a teaching and Q+A session, to ensure everyone felt comfortable with opt out testing, and able to answer patients' questions. I alerted all our patients of the change using accurx and put up information around the practice explaining the change. I regularly audited our testing data to try to locate barriers to testing and address these as they arose.

What did I learn

Thinking beyond the clinic room, to a more system-wide approach – something that isn't taught at medical school! This fellowship has helped me identify wider issues to tackle at my practice, including patient access, vaccination/smear uptake, etc. I am still working on some of the barriers to opt-out testing, such as the need for staff to manually request each HIV test. But finding out that these barriers exist - and having the time and space to think about how to tackle them - has been hugely important for me.

Has this changed how you work?

Definitely! As a GP, I am skilled at one-on-one problem solving but hadn't learned any public health for over 10 years, as it isn't part of our training. Being on the healthcare frontline and having knowledge about public health principles is hugely important. As well as my usual clinical work, I now audit all my own appointments and practice and use this data to directly implement change. Learning principles such as opportunity cost has been important too, as I had noticed issues with access to appointments but was unsure how to tackle them, and now I feel I have the tools to be able to do this.

What happens next?

Since I started my project, we have seen significant change. More patients are being tested for HIV, some are even requesting tests, and staff are confident in explaining the process. Our testing coverage has almost quadrupled from 4 to 15%, but there is still a way to go to cover everyone! As well as continuing with this project, I want to expand opt-out testing at other practices using my teaching programme. Stemming from this I am now also helping run a large access project at my practice, to identify issues with bookings, DNAs, and unnecessary appointments, and minimise our opportunity cost. I hope to continue to be a small disruptive cog in the primary care machine for a long time!

To read more about Laura's journey, scan the QR code or click the link below

Link to Website

2030 HIV, time's up! We urgently need your help to find and test everyone living with HIV in the UK.

Terrence Higgins Trust

Glodwick Medical Practice

Hope Citadel Healthcare

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Liam Hanley

Job Title: Health & Wellbeing Manager
Locality: Bolton
Project Title: Smoking Cessation Campaign

Greater Manchester Integrated Care Partnership

Project Aim

To significantly reduce smoking rates in Bolton, a critical public health priority, we will leverage the extensive reach, local expertise, and valuable insights of the VCSE sector. By harnessing their deep community connections and knowledge, we aim to implement targeted interventions and support services that effectively address smoking cessation and promote healthier lifestyles.

What did I do?

We adopted a collaborative approach involving Bolton Council, ABL (the company commissioned to deliver the smoking cessation programme in Bolton), and various groups from the VCSE sector. These groups received comprehensive training to engage in meaningful conversations with smokers, guiding them towards the programme and providing ongoing support throughout their journey. To further motivate the VCSE sector, we offered an incentive of £100 for each individual enrolled in the programme and an additional £100 for each successful quit. This strategy not only enhanced engagement but also ensured sustained support for participants aiming to quit smoking.

What did I learn

It is crucial that all partners are fully aligned from the outset. Challenges with funding streams and capacity led to significant delays between the initial briefing sessions for groups and the subsequent training they received. This resulted in a loss of momentum and some goodwill. To maximize positive outcomes in addressing health inequalities, it is essential to build relationships founded on confidence and trust in the process.

Has this changed how you work?

Building on previous partnerships, this initiative has further strengthened those relationships. Despite being in its early stages, the project is already showcasing the significant value of the VCSE sector's central role in engaging with communities to reduce health inequalities

What happens next?

We will apply the lessons learned from this collaborative approach between statutory and voluntary sectors, acknowledging that VCSE organisations can connect with individuals in ways that the health and social care system may not always achieve. By harnessing these strengths and adequately resourcing future partnership projects, we should aim to scale up the model and apply it to other areas of preventative healthcare.

To read more about Liam's journey, scan the QR code below

Link to Website

CVS

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Saroja Forester

Job Title: GP
Locality: Stockport
Project Title: Improving Attendance in Primary Schools

Greater Manchester Integrated Care Partnership

Project Aim

I was struck by the difference in healthy life expectancy between residents of Brinnington and other neighbourhoods in Stockport. Looking at wider determinants of health, I found one of the contributing factors could be poor attendance in the primary schools in Brinnington. By reducing absenteeism in primary schools, it is hoped that these children's short-term health (educational outcomes, social and cognitive development) and subsequent long-term socioeconomic opportunities and health will improve.

What did I do?

Following a literature review of the evidence around health benefits of good school attendance, I reached out to key stakeholders across education, primary care, Stockport Council, GMCA, VCSE groups and the local population to gather their thoughts and ideas on why attendance may be low in this area, and how it could be improved. I then formulated a logic model and worked on several activities, mostly focused on how we in primary care can best work with the education sector to help local families become aware of the broader health benefits of school and how best to support them in minimising time off school.

What did I learn

I learned that various sectors work extensively to improve family engagement with schools, but the health benefits of good attendance are not well known. Families want the best for their children but face many psychosocial challenges. Due to the project's limited timeframe, I focused on how primary care can improve collaboration with families and services to minimize school absences and increase nursery and childminder attendance to establish good routines early. I also addressed ways to help families access other support, recognising that school may be missed for reasons beyond ill health.

Has this changed how you work?

National guidelines on illnesses warranting time off childcare settings have been shared with schools, GPs, and community pharmacies in Brinnington and Stockport for consistent messaging. Teaching events for local pharmacists, Safeguarding Leads, and future GPs emphasized the health benefits of good school attendance and effective use of short consultations. Primary care, including dental and optometry colleagues, were informed about discussing attendance and advising on when children can return to childcare. Appointment systems were adjusted to minimize missed school time.

What happens next?

Attendance data is being analysed to see what impact the changes have made so far, but evidence of social and educational benefit will take around 5 years and long-term health benefit will take at least 20 years. It is hoped that the activities in this project will become embedded across Stockport as a whole and can then be cascaded across other boroughs of Greater Manchester. As the Children's Commissioner for England said in 2024: "Attendance is everyone's business"!

To read more about Saroja's journey, scan the QR code below

Link to Website

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Bethany Mitchell

Job Title: Operations Manager
Locality: Manchester
Project Title: Programme Supporting Migrants

Greater Manchester Integrated Care Partnership

Project Aim

This project explored health inequalities faced by asylum seekers in Greater Manchester. I aimed to establish clear pathways for those in temporary asylum accommodation, focusing on mental health, maternity care, sexual health, and infectious diseases. My goal was to improve healthcare access and reduce barriers, ensuring individuals have the information they need. I gained insights into how social inequalities like housing, finances, and education impact health. I aimed to create a support program providing a single point of access within asylum accommodation to help navigate healthcare systems and connect with the VCSE sector and charities.

What did I do?

As Operations Manager for GTD HealthCare, I oversee the delivery of primary on-site healthcare for six asylum-seeking contingency hotels in Manchester, Trafford, and Stockport. I reviewed signposting resources available within our hotel settings, and found that Stockport has clear resources and support, whereas this was lacking in Manchester. I collaborated with local VCSE sectors and Manchester City Council to enhance support for refugees, migrants, and asylum seekers focusing on mental health, maternity care, sexual health, and infectious diseases. I developed a single point of access support service in each hotel by meeting with individuals twice monthly to offer support e.g., registering with a GP surgery and access to mental health support. I advised people how to use NHS apps and tools,

What did I learn

I have gained a clearer understanding of the health inequalities faced by asylum seekers in Greater Manchester and how to address them and how care pathways align with these needs. Language barriers and a lack of guidance for those with positive asylum claims, often leading to homelessness, are significant issues. I noted variation in infectious disease screening across hostel locations, which puts additional strain on the hostel primary care service. I have benefited from communities of practice and peer support sessions, enhancing my knowledge of population health and leadership. This has enabled me to tackle inequalities and address the wider determinants of health in my role.

Has this changed how you work?

Having completed the Public Health Level One Foundation Programme, this changed the way I work, as I felt I gained more knowledge and applied these to my everyday work. By keeping the core domains of public health in mind whilst working within health care / the community we can help promotion, prevention, and everydayion of all our local communities.

What happens next?

I will continue to use my knowledge and skills gained from my fellowship. I will embed my project into my current team by creating a care navigation role to continue the signposting and navigation support for our residents. GTD Health care have also applied for grant funding to offer mental health therapeutic support, and I will consider inequalities in how we mobilise this services. This will improve mental health and wellbeing of vulnerable asylum-seeking adults, as they progress through the asylum journey.

To read more about Beth's journey, scan the QR code below

Link to Website

gtd HEALTHCARE gtdhealthcare.co.uk

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Idowu Morafa

Job Title: Founder & Director
Locality: Greater Manchester Wide
Project Title: Holistic Healthcare Provider

Greater Manchester Integrated Care Partnership

Project Aim

My aim was to explore and establish a holistic Health Centre in underserved areas addressing health inequalities, promote sustainability, and foster community inclusion, focusing on accessible healthcare and education for marginalised and vulnerable populations.

What did I do?

I improved and enhanced collaborations, making Across Ummah a trusted community entity. By prioritising community needs, I addressed health disparities through innovative measures and partnerships with health sectors, GPs, PCNs, Mental Health teams, Social Services and marginalised communities. Surveys highlighted the need for cultural support, focusing on the Family and Youth Hub, Food Hub, and health issues like mental health, diabetes, and blood pressure. I analysed the feasibility of a holistic Cultural Centre across Manchester, continuously gathering feedback to develop impactful approaches and community education events. Advertisements, social media, and collaboration maximised outputs.

What did I learn

Trust and credibility are powerful tools for a change. Divergence of opinions in providing care for ethnic minorities and their needs are productive and effective life savers. Bridging the health gaps were possible by our ability to break down barriers such as communications (languages), fears, misconceptions and providing more culturally appropriate care plans. This improved sedentary lifestyles and responses of these groups to medical treatments and research uptake. Funding for these services are very tasking and daunting.

Has this changed how you work?

There has been an improvement in our care plans for our service users, collaborating with various health sectors and networking across and beyond Manchester. The holistic approach has extended my outlook to complement certain care plans that are being trivialised in the conventional NHS and social settings and used my diverse experiences mitigating the frustrations. Currently we are improving the services for the community and using qualitative and quantitative measures to validate and evaluate our progress.

What happens next?

The project will benefit from having a statutory centre, and constant flow of funding to continue to run more life-changing workshops and employ more staff, organise more training and improve the overall logistics. More collaborations with the GPs, PCNs and other health teams in documenting the referrals, data management GDPR, and communication processes that are being addressed. There is need for more PCNs and GPs to understand our holistic approach and connect more easily to create it as an alternative and complementary addition to the health care sector to help save and treat additional lives.

To read more about Idowu's journey, scan the QR code below

Link to Website

Across Ummah
Combating Problems in Society

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Lindsey Kent

Job Title: Salaried GP
Locality: Manchester
Project Title: 'Take Part, Take Heart' – Reduction in CVD

Greater Manchester Integrated Care Partnership

Project Aim

The project was initiated to tackle the pressing issue of cardiovascular disease (CVD), which remains a leading cause of premature death and health inequalities in Greater Manchester. The project specifically focused on the Black African and Caribbean community, a population disproportionately affected by CVD and healthcare disparities, and hypertension which is a major risk factor for heart attacks and strokes.

What did I do?

The project aimed to reduce cardiovascular health inequalities by:

- Conducting mutual learning events between healthcare professionals and the BAC community.
- Training clinicians to improve culturally sensitive communication and care.
- Running outreach events for blood pressure checks and education.
- Co-developing health curricula and educational resources with BAC leaders.
- Using data-driven targeting to identify high-risk populations.

What did I learn

- The importance of culturally tailored healthcare interventions in building trust and engagement within the BAC community.
- Clinicians are learning how to better understand and address cultural barriers to care, leading to more inclusive healthcare practices.
- Community feedback underscored the necessity of ongoing dialogue and collaboration for effective health interventions.

Has this changed how you work?

The project is improving communication and trust between clinicians and the BAC community. Clinicians now employ more culturally sensitive approaches, resulting in greater participation in health initiatives and better hypertension awareness within the community. The collection of educational resources for patients and clinicians ensures continuous access to health information, reinforcing long-term health improvements.

What happens next?

Future plans, if funding identified, include:

- Expanding outreach efforts into spaces of frequent community use and integrating digital health tools to sustain engagement.
- Continuous professional development will be maintained to ensure the skills and knowledge gained are preserved and expanded.
- Collaboration with BAC leaders and community members will continue, ensuring the sustainability and growth of educational resources and healthcare initiatives.

To read more about Lindsey's journey, scan the QR code below

Link to Website

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Philippa Murphy

Job Title: GP Partner
Locality: Oldham
Project Title: Improve Awareness and Increase Engagement of Annual Health Checks in Young People with Learning Disabilities

Greater Manchester Integrated Care Partnership

Project Aim

To develop an initiative which will raise awareness of annual health checks amongst young people with learning disabilities and will contribute to increasing the number of people on the learning disability register and attending for annual health checks in Oldham.

What did I do?

I delivered sessions to students at local colleges which aimed to provide them with the knowledge and confidence to seek and attend annual health checks. The sessions included small group work, larger group discussions and an informal opportunity to look at medical equipment/roleplay annual health checks and answer questions. Students were provided with a 'letter to my GP' template to assist them in approaching their GP's to ask to be on the learning disability register and invited for annual health checks.

What did I learn

I learnt about the importance of key partners collectively sharing resources and approaches that have been identified or developed through initiatives such as my own and about the significant impact that a personable approach can have on influencing change. I was privileged to gain a valuable insight into the lives of young people with learning disability and specifically the barriers to accessing healthcare which many experience.

Has this changed how you work?

This fellowship has pushed me out of my comfort zone and allowed me to network with other professionals across all sectors. In doing so it has broadened my understanding of public health and the powerful impact of collaborative working. It has encouraged me to be more pro active in identifying issues relating to health inequality and considering ways in which I can contribute to tackling them alongside others.

What happens next?

The initiative has demonstrated an effective approach to increasing awareness and uptake of annual health checks. Data will be collected in April 2025 to further assess how the initiative has contributed to increasing the number of people on the learning disability register in Oldham and the number attending for annual health checks. The colleges I have worked alongside are considering how this approach can be used to incorporate learning about annual health checks into the curriculum for students in future years. The 'letter to my GP' template is available to be shared with schools, colleges and charities/organisations who can encourage people with learning disabilities to seek annual health checks.

To read more about Philippa's journey, scan the QR code below

Link to Website

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Alice Coren

Job Title: Founder & Director
Locality: Wigan
Project Title: Comparing Community and Clinical Peer Support

Greater Manchester Integrated Care Partnership

Project Aim

I wanted to look at how community-based peer support could be beneficial for people at risk of poor mental health and health inequalities in Wigan, with a particular focus on women.

What did I do?

I aimed to compare community peer support initiatives with Wigan's Living Well, focusing on benefits for women. I examined Remade Wigan and Community Corner, gathered women's perceptions, and discussed peer support with other organizations. I also reviewed UK-wide examples and insights from Living Well pilots. To deepen my understanding, I completed an ABCD course, participated in a local ABCD network, and are concluding a Train the Trainer Ripple Mapping course.

What did I learn

I have gained insights into the complexities of health and funding systems, recognizing the challenges of implementing simple ideas. Sharing women's stories in the community has proven essential for fostering connections and a relational future. This period allowed you to reflect on diverse operational contexts, despite the shared goal of improving lives. Additionally, I contemplated cultural differences between community-based and NHS-based systems, leading to the development of stories, practice examples, and a clearer understanding of the importance of resourcing community peer support.

What happens next?

This journey has empowered me to confidently engage in discussions with public health and senior leadership representatives, expanding my sphere of influence beyond my workshop. It has reinforced my conviction that a community-driven and asset-based approach is essential for fostering positive change in Wigan. This experience has also strengthened my commitment to creating peer support spaces for women in our community, recognizing that these spaces are not merely beneficial, but essential for their well-being.

Has this changed how you work?

We are organising a learning event to share the stories of how we have developed associational spaces within our communities and the insights gained through peer support. I will present evidence of the impact of our workshop community work through our ripple mapping training and provide oversight of other ripple maps from various community activities. Our established relationships with public health and adult social care enable us to invite services into the community to co-create innovative solutions for Wigan. We aim to collaborate with medical services, statutory bodies, and academics to build a robust evidence base that persuades traditional funders to trust communities to deliver their own support.

To read more about Alice's journey, scan the QR code below

Link to Website

ReMade Wigan

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Pip Norris

Job Title: First Contact Practitioner
Advanced Clinical Practitioner
Locality: Greater Manchester Wide
Project Title: Targeted Work Absence Support

Greater Manchester Integrated Care Partnership

Project Aim

To tackle economic inactivity to improve health outcomes and reduce inequality. The target group was patients who are registered with Tregenna Medical Practice, in Wythenshawe, who are off sick, at risk of falling out of work, or economically inactive.

What did I do?

Using a service improvement model, we implemented three Plan-Do-Study-Act (PDSA) strategies:

PDSA 1. Developed a simple referral pathway to the Growth Company (GC). A social enterprise who delivers work and health programmes to support people into work and people who are struggling with employment due to a health condition

PDSA 2. Trained GP and clinic staff at Tregenna Medical Practice on the benefits of work well input and the risks of re-issuing repeat fit notes.

PDSA 3. Created a text response for fit-note requests and a questionnaire for patients to offer work well input and referrals to GC.

PDSA 4. Text a questionnaire to all patients registered at the practice to offer work well input and a referral to the Growth Company. Results demonstrated sound implementation from June to November 2024, with 36 referrals made in total.

What did I learn

Work is crucial for health outcomes. Manchester's economic inactivity has worsened since the pandemic, affecting quality of life. We must rethink health management at the population level to ensure equity. Patient questionnaires revealed concerns about managing health at work and openness to access support. GP engagement was challenging, highlighting the need to disrupt entrenched systems for a proactive, effective health system.

Has this changed how you work?

I always consider health inequality as a barrier to engagement. For some communities' health care is not accessible or realistic. I hope to redesign the delivery of musculoskeletal (MSK) services. I am motivated to act now and try to do things differently. I value the importance of the patient's voice and lived experience. Community engagement is key, and we must work collaboratively with communities to improve the health inequality gap and not widen it.

What happens next?

This pilot project was used as part of the NHS GM national Work-Well partnership vanguard site to collaboratively deliver low intensity, evidence-based work and health support for the Manchester Foundation Trusts MSK waiting list. The project runs until March 2026, and we are committed to a joint partnership to do things differently.

To read more about Pip's journey, scan the QR code below

Link to Website

GM FEDS GREATER MANCHESTER TRAINING HUB

Suzie Carrier

Job Title: Salaried GP
Locality: Salford
Project Title: Improving Equitable Uptake of Breast Cancer Screening

Greater Manchester Integrated Care Partnership

Project Aim

I aimed to understand the population served by Ordsall Health Surgery and their health disparities. Salford South-East PCN had prioritised improving breast screening uptake as the PCN inequality focus for the year and coordinated a working group to facilitate this. As a working group, our goal was to identify and overcome barriers to breast screening to enhance uptake during the September 2024 screening period.

What did I do?

I collaborated with a working group from Salford South-East PCN, Public Health Inequalities Improvement Team (PHIIT), Salford Health Improvement Team and the Manchester Breast Screening Programme. We analysed screening data and gathered insights from various questionnaires, leading to the development of several approaches: staff training, community education events, targeted screening endorsements and advertisements, media coverage, transport initiatives and follow-up with non-attenders of screening. We adapted screening endorsement messaging into our most spoken languages. Ordsall Health Surgery saw an increase in breast screening uptake compared to the previous screening cycle, from 48% to 64%.

What did I learn

Changing health-related fears and attitudes towards screening is challenging in a short time. Despite efforts, many still cited fear or anxiety as their reason for not attending appointments. Feedback showed improving health literacy and supporting patients with informed decision making was more impactful than incentivising screening. I also learned about my working style and the value of stepping outside traditional methods and my comfort zone to bring about change.

Has this changed how you work?

This project has expanded my horizons, allowing me to collaborate with external teams and integrate more with public health and my practice's PCN. I've become more aware of barriers to primary care services, and I am committed to addressing them.

I now consider how practice workflows might impact patient access, especially for those facing barriers. Despite increased breast screening coverage, our rates are still below the national target. We plan to evaluate and refine our approaches for future screening cycles.

What happens next?

The project faced significant challenges due to outdated IT systems in the Breast Screening Programme, there is a planned digital transformation in 2025. Approaches have been shared within our PCN and with other local PCNs to highlight effective strategies. Once we have the final uptake numbers across the PCN practices and have analysed the impact of follow-up approaches with non-attenders, we will establish protocols for future screening periods based on these insights and adapt to the planned digital transformation in the Breast Screening Programme. We are also planning a future women's health event in February 2025, inviting patients from recently screened practices, to improve health literacy around women's health issues and address screening fears.

To read more about Suzie's journey, scan the QR code below

Link to Website

ORDSALL HEALTH SURGERY

Salford South East Primary Care Network

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Alexandra Guy

Job Title: Strategic Partnerships Lead
Locality: Greater Manchester Wide
Project Title: Exploring Living Environments and Mental Health Outcomes

Greater Manchester Integrated Care Partnership

Project Aim

I have dedicated my career to the housing and social care sector, and I firmly believe that our comprehensive understanding of the individuals we support positions us uniquely to collaborate with the NHS in addressing health inequalities and developing truly preventative models of community-based care. This initiative begins with the generation of essential data to create cross-sector solutions. I am particularly passionate about exploring the intersection of poverty, mental health, and access to services, and I used this focus as the foundation for my project.

What did I do?

I collaborated with The Big Life Group, a local charity commissioned by the NHS to provide community-based mental health support across Greater Manchester. In partnership with their Informatics team, I conducted an analysis of treatment outcomes from their Manchester and Stockport services. The team converted postcode data into IMD deciles, which I then compared with overall recovery rates, as well as specific recovery rates for the Manchester and Stockport services. Additionally, I conducted interviews with leaders from various mental health charities across Greater Manchester

What did I learn

The data revealed that individuals residing in lower IMD areas are less likely to be successfully discharged from the service, whereas those in higher IMD areas have a higher likelihood of successful discharge. This finding underscores a clear connection between housing and health, indicating that the current anti-poverty and multiple disadvantage strategies in Greater Manchester, which primarily focus on improving access to services, can be further enhanced. Whilst at a system-level, policies and processes are in place to ensure people in poverty can access services, individual factors – like where someone lives – can influence how they experience services, too.

What happens next?

I am honoured to have been selected as a Core20PLUS5 Ambassador, as part of the National Healthcare Inequalities Improvement Programme. Through this project, I aim to employ a systems-change approach to identify opportunities for, and barriers to, collaboration by engaging with housing and health professionals at various levels of the system. This initiative will hopefully enable me to better understand and develop solutions to some of the barriers I have encountered during this process.

Has this changed how you work?

The Fellowship has deepened my understanding of how leadership can drive systems change, while my enhanced public health knowledge has improved my ability to communicate with professionals from diverse backgrounds. I now have a greater appreciation of the challenges and barriers faced by our NHS partners and understand how to effectively collaborate with them and identify key stakeholders for engagement. In the coming months, I will be working with The Big Life Group and Home Group to enhance staff knowledge of public health and help them better identify opportunities for collaboration with NHS partners.

To read more about Alex's journey, scan the QR code below

Link to Website

home group

GM FEDS GREATER MANCHESTER TRAINING HUB

Hilaria Asumu

Job Title: Founder/CEO, WSH BME Kidney Network
Locality: Greater Manchester Wide
Project Title: Bridging the Gap in Reaching Black Ethnic Communities Unable to Access Services

Greater Manchester Integrated Care Partnership

Project Aim

The project aimed to address healthcare and service access disparities faced by Black ethnic communities in Salford, focusing on new immigrants and refugees. These groups often encounter language barriers, cultural misunderstandings, and systemic mistrust of public services. The objectives were to:

- Empower communities with knowledge about available services.
- Build trust between service providers, especially GPs, and the community.
- Facilitate collaboration between local councils, public services, and community organizations.

What did I do?

We organised two key community events to engage Black ethnic communities and highlight healthcare, housing, and social services. We distributed culturally relevant materials and provided a space for open discussion. The first event showcased public services and created a platform for dialogue. However low turnout revealed gaps in communication and outreach strategies, as well as community mistrust and lack of awareness. The second event was organised in partnership with a local church, a trusted hub for the Black ethnic community. Using a familiar venue helped foster trust and encourage participation. The church's involvement increased credibility and attendance, and culturally tailored messaging resonated better with attendees.

What did I learn

- **Trust and familiarity:** Partnering with trusted community institutions, like churches, enhances outreach and engagement due to their credibility.
- **Tailored communication:** Community members respond better to culturally and linguistically specific materials and presentations.
- **Collaboration:** Working with council officers, faith and community leaders, and community groups creates a broader, more effective support network.
- **Continuous improvement:** Low turnout at the first event provided insights, leading to a more successful second event. Feedback loops are essential for refining strategies.
- **Multifaceted barriers:** Addressing language differences, mistrust, and cultural misunderstandings requires a holistic approach combining education, relationship building, and structural changes.

Has this changed how you work?

This experience has significantly changed my approach to community engagement. I now prioritize partnering with trusted community institutions, like churches and local leaders, to enhance credibility and reach. Cultural sensitivity is crucial, and understanding the unique needs of different groups ensures that all interventions are appropriate and accessible.

What happens next?

The next phase will focus on sustaining and expanding the project with continued collaboration with the Equalities Team at Salford City Council, local churches, community leaders, and organizations like Salford CVS to reach more Black ethnic community members. I am also developing an app to track service use rates, event attendance, and community feedback. I

To read more about Hilaria's journey, scan the QR code below

Link to Website

WSH BME KIDNEY
WARRIORS, SURVIVORS & HEROES BME KIDNEY NETWORK

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Tayyaba Kosar

Job Title: Systems Change Facilitator
Locality: Tameside
Project Title: Food Poverty and the Impact on Long Term Health Conditions

Greater Manchester Integrated Care Partnership

Project Aim

- Pilot a project in Tameside to enhance cross-organisational collaboration, raising awareness of support services and opportunities to mitigate food poverty and improve health outcomes.
- Establish a working group to share resources, learning, and signpost services.
- Create a resource directory for organizations to refer residents to services that promote physical activity, healthy eating, and mental well-being.
- Improve connectivity between groups in Ashton, increasing access to ongoing projects and services for Ashton and Tameside residents.
- Share information to ensure immediate support for those affected by food poverty without requiring them to conduct their own research.

What did I do?

Conducted a mapping exercise to assess awareness of available resources among those affected by food poverty in Ashton.

Developed a signposting resource listing food and health-related projects in Ashton, including food pantries, food banks, and cooking classes, to be distributed in high-traffic areas like GP surgeries and food banks.

What did I learn

With the rising cost of living, many people remain unaware of available local resources. Constantly changing projects and services make it difficult to stay informed in Ashton. Limited funding and capacity hinder groups from starting new projects, and overutilisation with existing initiatives across Tameside leads to hesitation in participating in new campaigns.

Has this changed how you work?

- From this project I have also learned that a reliance on others for a project can hinder success. It is essential to have a sense of ownership of a project without having to rely on the hard work of others to find success, especially on a project around food poverty.
- I have a much better understanding of the landscape in Tameside and with any new projects, I can assess the need and demand for a project in Tameside before starting anything new. I am much more aware of how ownership of a project is important and reliance on others for collecting data, taking part in a new project is unlikely due to other commitments groups have.

What happens next?

- The resource will be distributed in food banks, sports centres, community centres, and GP surgeries. This short-term project will last only a few months due to the constantly changing groups.
- I will monitor the uptake of services since the resource's development, expecting increased utilisation.
- To keep food and health topics prominent, I will incorporate these themes into the agendas of established network meetings, enabling other groups to learn about available resources in Tameside and facilitate in-person signposting.

To read more about Tayyaba's journey, scan the QR code below

Link to Website

action together

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