Beyond Access: Exploring Living Environments and Mental Health Treatment Outcomes in Greater Manchester

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Acknowledgements

Thank you to the Fairer Health for All (FHfA) team for the opportunity to become a Fellow. Particular thank you to my mentor Ben Fryer, for your support along the way.

Thank you to the New Business Team at Home Group, for your support to facilitate my time to participate in this programme, and thank you to The Big Life Group (TBLG), particularly George Hatton and Nic Seccombe, for your input and support.

Thank you to the participants who so kindly gave up their time, including staff from the Wellspring Centre, Rethink, GM Poverty Action (now Resolve Poverty), Centre 42, The Shared Health Foundation, Living Well (Salford), and various NHS staff.

Finally, thank you to my fellow Fellows, for being a constant listening ear and reassuring presence throughout what has at times being a challenging process! Despite the increasingly difficult context we all work in, it has been refreshing to know there are brilliant people out there who are equally as passionate about challenging health inequalities, and doing the right thing for the people they support, in whatever capacity that may be. Wishing you all the very best in your future endeavours, and hoping our paths cross again.

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Executive summary

Project aim

I've spent my career in the housing and social care sector, and firmly believe our in-depth understanding of the people we support can make us well-placed to work with the NHS to create solutions to health inequalities and develop truly preventative models of community-based care. This starts with generating the data we need to develop cross-sector solutions. I'm particularly passionate about the relationship between poverty, mental health and access to services, so wanted use this as the basis for my project.

This broad theme was gradually narrowed down with the support of my mentor, the FHfA team, and interview participants, and was ultimately shaped by the availability of data, and organisation's willingness to share that data.

What did I do?

I partnered with The Big Life Group, a local charity who are commissioned by the NHS to deliver community-based mental health support across Greater Manchester. Working with their Informatics team, I analysed the treatment outcomes from their Manchester and Stockport services. The team converted postcode data to Index of Multiple Deprivation (IMD) deciles, which I then compared with their overall recovery rate, and recovery rates for Manchester and Stockport services. I also interviewed leaders from mental health charities across Greater Manchester.

What did I learn?

The data demonstrated that those living in areas with lower IMD rankings are less likely to be successfully discharged from the service. Those living in areas with higher IMD rankings were more likely to be successfully discharged.

This demonstrated a clear link between housing and health, and highlighted that the existing anti-poverty and multiple disadvantage strategies in GM, which largely focus on improving people's access to services, can go further. 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.

Has this changed how I work?

The Fellowship has given me a deeper appreciation of how leadership can facilitate systems change, whilst my new public health knowledge has allowed me to communicate better with professionals from different backgrounds.

I have a deeper appreciation of the challenges and barriers facing our NHS partners, and know how best to work with partners, and who we should be engaging with. Over the next few months, I'll be working with The Big Life Group and Home Group to build staff knowledge of public health and help them better identify opportunities for collaboration with NHS partners.

What happens next?

I'm really pleased to have been selected as a Core20PLUS5 Ambassador, part of the National Healthcare Inequalities Improvement Programme. As part of this project, I want to use a systems-change approach to explore opportunities for, and barriers to, collaboration, engaging with housing and health professionals at different levels of the system. Hopefully, this will help me better understand – and develop solutions to – some of the barriers I've come across during this process.

Most Greater Manchester boroughs have an anti-poverty strategy in place, or are in the process of developing one (Resolve Poverty, 2025). Most of these strategies - the Multiple Disadvantage Framework (GMCA/GMICP, 2025) in particular - state the importance of improving people's access to services, and getting a better understanding of how they experience, interact and engage with services. I hope my project has provided some insight that will be useful for those accountable for implementing and reviewing these policies going forwards, and highlights the challenges in gathering the insights needed to inform solutions.

Please note that this report is currently in draft stage, with the Qualitative element of the study still to be added, and the Solutions and Summary sections likely to be amended in line with the outcome of the Qualitative Study.

Introduction

The Greater Manchester (GM) Multiple Disadvantage Framework highlights the significant levels of multiple disadvantage across the area, and sets out a GM-wide approach to reducing this going forwards. The framework includes commitments to widening the participation of people with lived experience in recruitment, improving training for clinicians on poverty, multiple disadvantages and signposting routes, to exploring both access to, and experience of, services

Focusing on outcomes from a community-based mental health support service in both Manchester and Stockport, this project will explore the relationship between poverty and how people experience mental health services, and the outcomes they achieve. Through exploring the relationship between the recovery rate and IMD deciles of patients, this project will highlight how living environments shape not only how people access services, but how they experience them.

Systems change

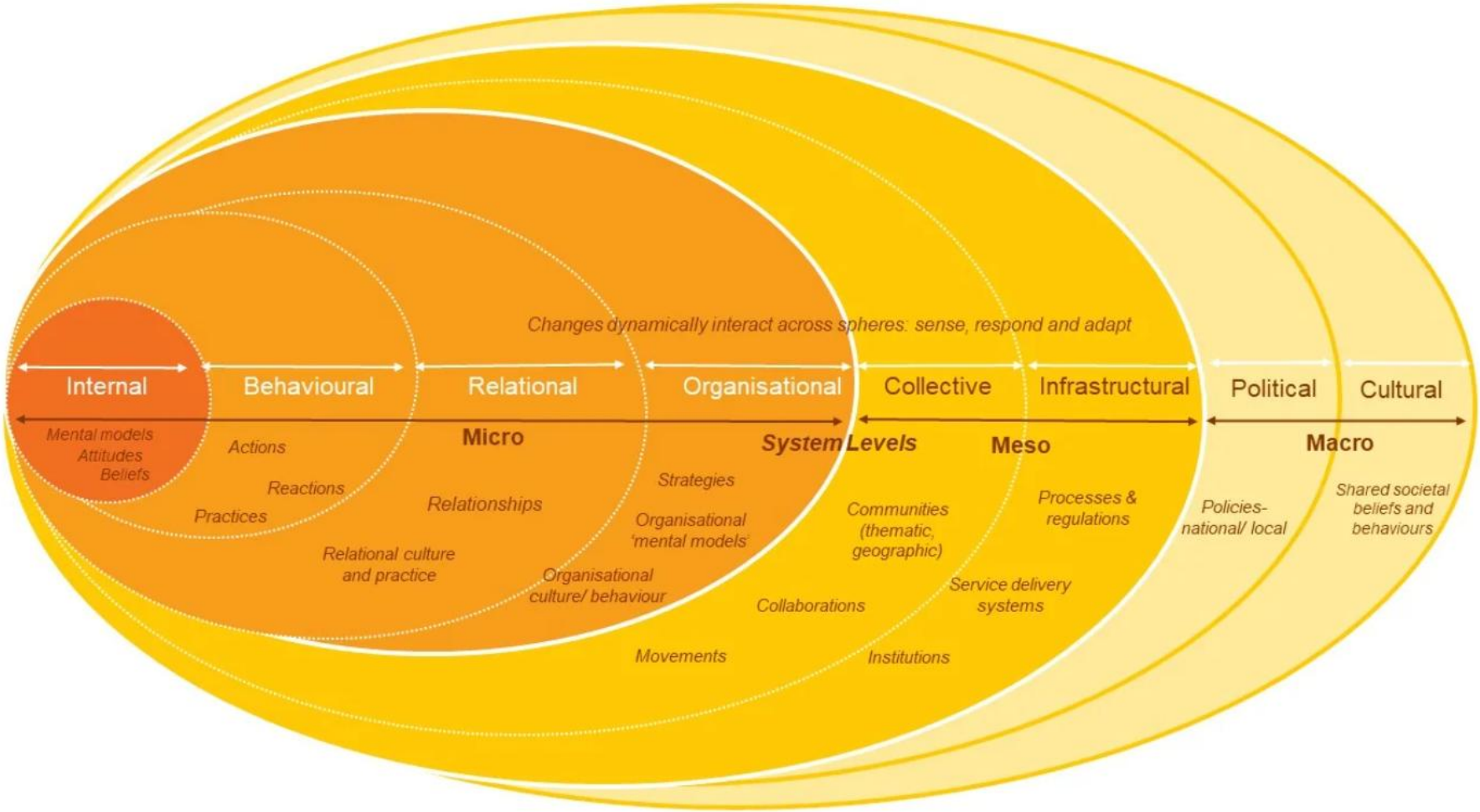
Systems thinking encourages us to examine complexity in the context of relationships, looking at, exploring and understanding how different parts of a system relate to each other, to identify where relationships can complement each other, or create conflict. This way of thinking can enable us to identify and get to the root cause of some of society's most significant challenges, whilst consideration of how we can create change at each 'level' of the system can allow us to create the change we need to meet these challenges (Public Health Scotland, 2025). This is called systems change.

Systems change can be depicted in a variety of different ways, although the Spheres of Systems Change model, from NPC (2025), allows us to easily identify the parts of a system, where they overlap, and how change occurs across different parts of the system. Drawn from previous models, including Bronfenbrenner's socio-ecological systems model, the Spheres of Systems Change emphasise that true change cannot take place unless it occurs at each and every level of the system.

Each of element of the system interacts with and influences others – change is a dynamic, two-way process, with change in one level leading to changes in another. Examples could include improvements in the availability of mental health services leading to a greater societal awareness, and therefore reduced stigma.

This provides a helpful framework for our thinking, to enable us to identify and explore gaps in the system, and to highlight those aspects that are already working well. As I conclude my research, I will replicate the diagram, showcasing which areas of the system in Manchester and Stockport have been identified as being particular barriers to good mental health outcomes, and highlighting those aspects of the system that have been shown to be working well.

Spheres of systems change – NPC, 2025



Initial findings

Semi-structured interviews, conducted online, were carried out with leaders from charities across Greater Manchester, which support people either facing financial hardship or poor mental health. A semi-structured approach was taken to avoid being too restrictive, and to allow participants to shape the research.

Participants included leaders from:

- A community-based welfare-rights service
- A drug and alcohol charity
- A community-based, multi-disciplinary mental health service
- A mental health charity for young people
- A charity providing mental health support for families affected by poverty

Themes included:

The accessibility of services

- The difference between the accessibility of NHS services, compared with those in the voluntary sector – e.g. more flexibility to reschedule appointments that were missed, greater ability to signpost/refer to other partners, where needs fell beyond their remit
- How a 'one front door' approach in the voluntary sector increased accessibility and improved outcomes
- Access to both VCSE and statutory sector support being generally good, but varying across boroughs
- The importance of taking services to communities, to mitigate barriers like poor access to transport and stigma

Barriers to accessibility and outcomes at an individual level

- People's experiences of services and support being highly specific, e.g. a support worker having a relationship staff at a particular Job Centre, and using this connection to create better outcomes for the people they support
- The influence of highly individualised factors, such as intergenerational poverty, trust and stigma, on people's ability/willingness to engage with support
- The need to refine our understanding of issues such as multiple disadvantage and barriers to access, to a more individual level
- Allowing choice of location of support and method of delivery creating better outcomes
- Careful use of language to encourage up-take, particularly where services rely on word-of-mouth

Pressures on the health, charity and other interrelated systems

- Social issues being discounted by NHS and statutory services, where the threshold for social care intervention is not met
- A perception that services in the charity sector are less able to manage risk well, despite evidence from contract monitoring that they are increasingly working with higher-risk groups
- Significant time being spent managing individual's expectations of/reactions to socio-economic stresses – e.g. supporting a person to cope following a negative housing or benefit-related decision
- The limited scope of mental health charities and professionals to influence socio-economic outcomes – e.g. writing a letter in support of a person's PIP claim

Key words and phrases used by interviewees have been incorporated into a wordcloud, illustrating how the systemic barriers highlighted co-exist alongside individual challenges, beliefs and experiences:

Quantitative study

TBLG collect a range of data, to help them to better understand the people who use their services and adapt their approach accordingly, and as required contractually. To explore how outcomes from their service differed according to levels of deprivation, I explored the recovery rate data from 2022 and 2023, for both Manchester and Stockport services. I selected these years as they allowed me to access a complete dataset from years in which the operation of the service was not affected by the Covid pandemic restrictions, although a comparison of outcomes from before and after the pandemic would also make for a valuable further study.

The recovery rate refers the percentage of people who have had at least 2 interactions with the service, and have subsequently been discharged. This excludes that those who have refused to engage, or have chosen to terminate their support. The number of people who completed treatment is subtracted from the number who were referred, resulting in the recovery rate, converted into a percentage.

Index of Multiple Deprivation (IMD) data ranks Lower-layer Super Output Areas (the smallest geographical unit used to measure census-level data), based on several domains of deprivation, including income levels, access to education and employment, and health and crime related inequalities. Each group is referred to as a 'decile' – these are ranked from 1 to 10, with 1 being amongst the most deprived small areas in the UK, and 10 being amongst the least deprived.

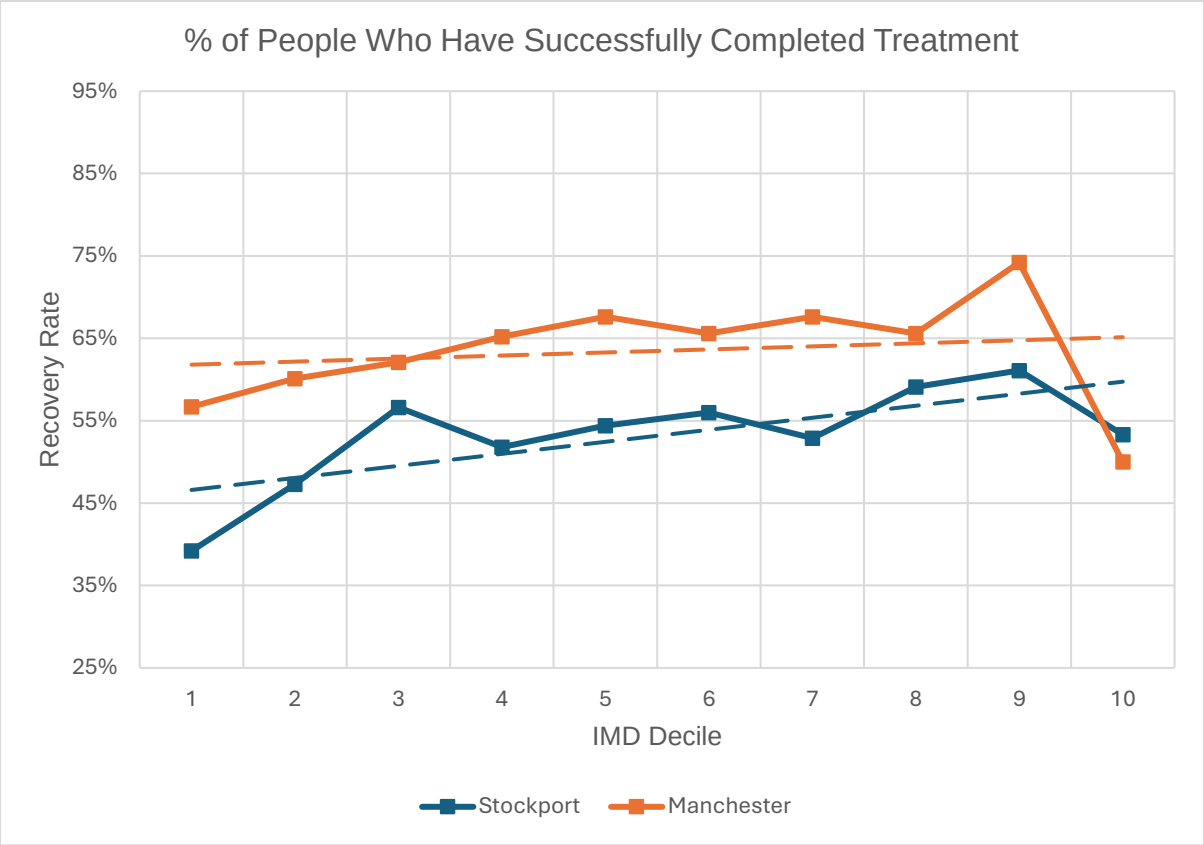
The below table sets out the number of referrals, and the number of patients who successfully completed treatment, grouped by IMD decile.

Table 1 – Referral and Recovery Data

Manchester 2022-2023				Stockport 2022-2023			
IMD Decile	Number referred	Number completing	Recovery rate	IMD Decile	Number referred	Number completing	Recovery rate
1	3096	1765	57%	1	551	215	39%
2	1238	743	60%	2	319	150	47%
3	1691	1049	62%	3	294	168	57%
4	1324	861	65%	4	444	231	52%
5	494	336	68%	5	313	169	54%
6	662	437	66%	6	205	115	56%
7	267	182	68%	7	390	207	53%
8	150	99	66%	8	262	155	59%
9	47	35	74%	9	319	195	61%
10	26	13	50%	10	371	197	53%

The recovery rates for patients, based on the IMD decile in which their home address was situated, for both Manchester and Stockport services, is as follows:

Graph 1 – Recovery Rates/IMD Deciles for both Manchester and Stockport

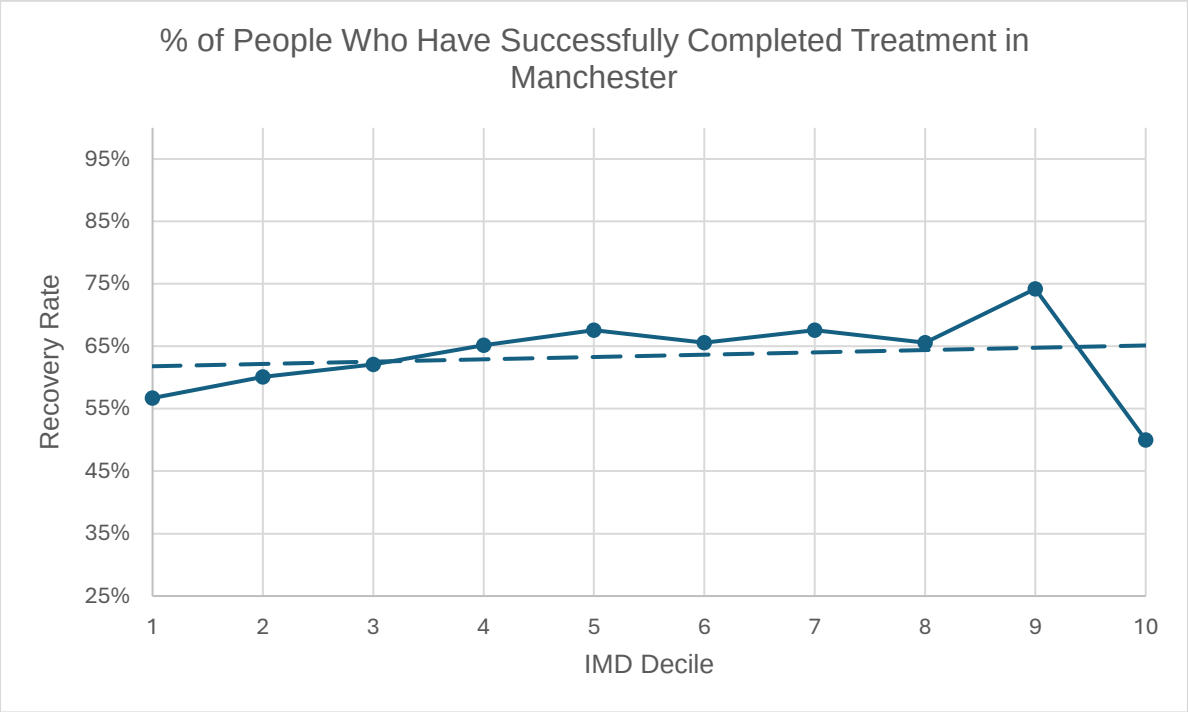


The data shows that across both Manchester and Stockport, there is generally a positive correlation between the IMD decile of an individual's home, and the likelihood of a successful recovery from TBLG's mental health service. Significantly, those in Manchester experienced a higher recovery rate – with those living in an area of Manchester with an IMD Decile of 1 having a recovery rate 18% higher than those living in the same decile in Stockport.

Data from both Manchester and Stockport services shows greater variation towards the lowest and highest rankings, with both 'levelling off' towards the more central deciles (4-7). Whilst a positive correlation was seen throughout, notably, the recovery rate of patients in an IMD decile of 10 decreased significantly in both Manchester and Stockport, although it is noted that the number of people referred to the service and living in decile 10 in Manchester is particularly low. As these outliers warrant further exploration beyond the scope of this research, I have removed this data from subsequent analysis.

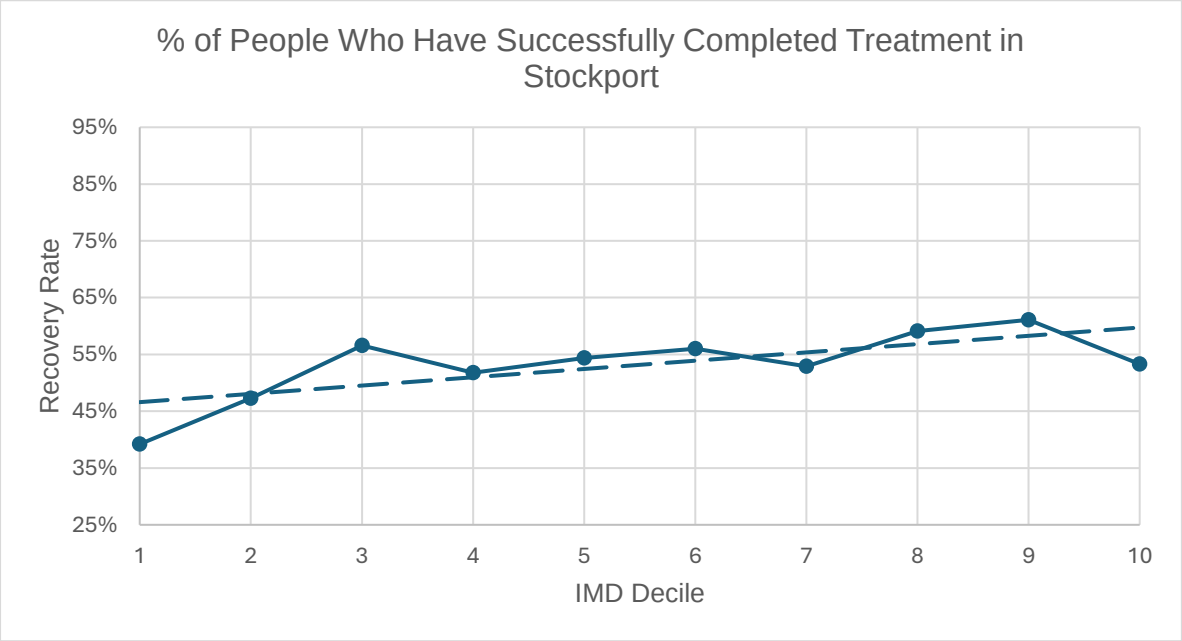
The recovery rates for patients, based on the IMD decile in which their home address was situated, for the Manchester service, is as follows:

Graph 2 – Recovery Rates/IMD Deciles for Manchester



The recovery rates for patients, based on the IMD decile in which their home address was situated, for the Stockport service, is as follows:

Graph 3 – Recovery Rates/IMD Deciles for Stockport



When presented separately, in particular, these graphs highlight how patient's experiences of the service differs between boroughs – with a greater variation in outcomes among the patients from Stockport (22% difference between the highest

and lowest recovery rate), than from Manchester (17% difference between the highest and lowest recovery rate) (outliers removed). This warrants further exploration which is beyond the scope of this research, and is worth considering alongside the differences in referral numbers across both boroughs and deciles – with Manchester referring significantly more patients living in a decile 1 area, and significantly less in a decile 10 area. This disparity should be considered alongside population data for the areas respectively.

Whilst I am unable to explore the reasons underpinning the pattern identified in the absence of an outcome from the qualitative interviews, the correlation could be considered to highlight the inverse care law.

Due to the need to maintain confidentiality for the people they support, TBLG were unable to provide data at a postcode level - instead, postcodes were grouped by IMD decile. Whilst I would be unlikely to have the capacity to address this within the remit of this study anyway, this could be a significant next step for this research. Exploring data at more local level can provide a more in-depth explanation for these results, by allowing consideration of factors such as access to transport, employment and community groups, crime rates, and housing quality. Further research could consider the results through an intersectional lens, exploring

Qualitative study

To enable greater depth of analysis, I will be completing interviews with 2 members of the TBLG team. This will enable me to unpick some of these results in greater detail, and consider the extent to which their lived experience of working in the service aligns with the data.

Summary

In summary, the data supports the views identified in the semi-structured interviews – that highly individualised factors, like where someone lives, influences how they experience services. This goes beyond the focus on improving access, and begins to shed some light on the next steps highlighted in these strategies – getting a better understanding of individual's experiences.

Returning to the Spheres of Systems Change, it's clear that, at a macro and meso level, policies, systems and processes, and the values that influence them, are aligned to the shared goal of tackling poverty and reducing the poor health outcomes that affect those experiencing it. This is evident through the extent of the commitment across the system - with all but one of the GM boroughs having an anti-poverty strategy in place, and examples like the Deprivation Training Scheme for GPs. The existence of organisations like 10GM exists to foster collaboration, and equips those in the VCSE sector with the resources, skills and relationships needed to contribute to the development of these strategies at a GM-level.

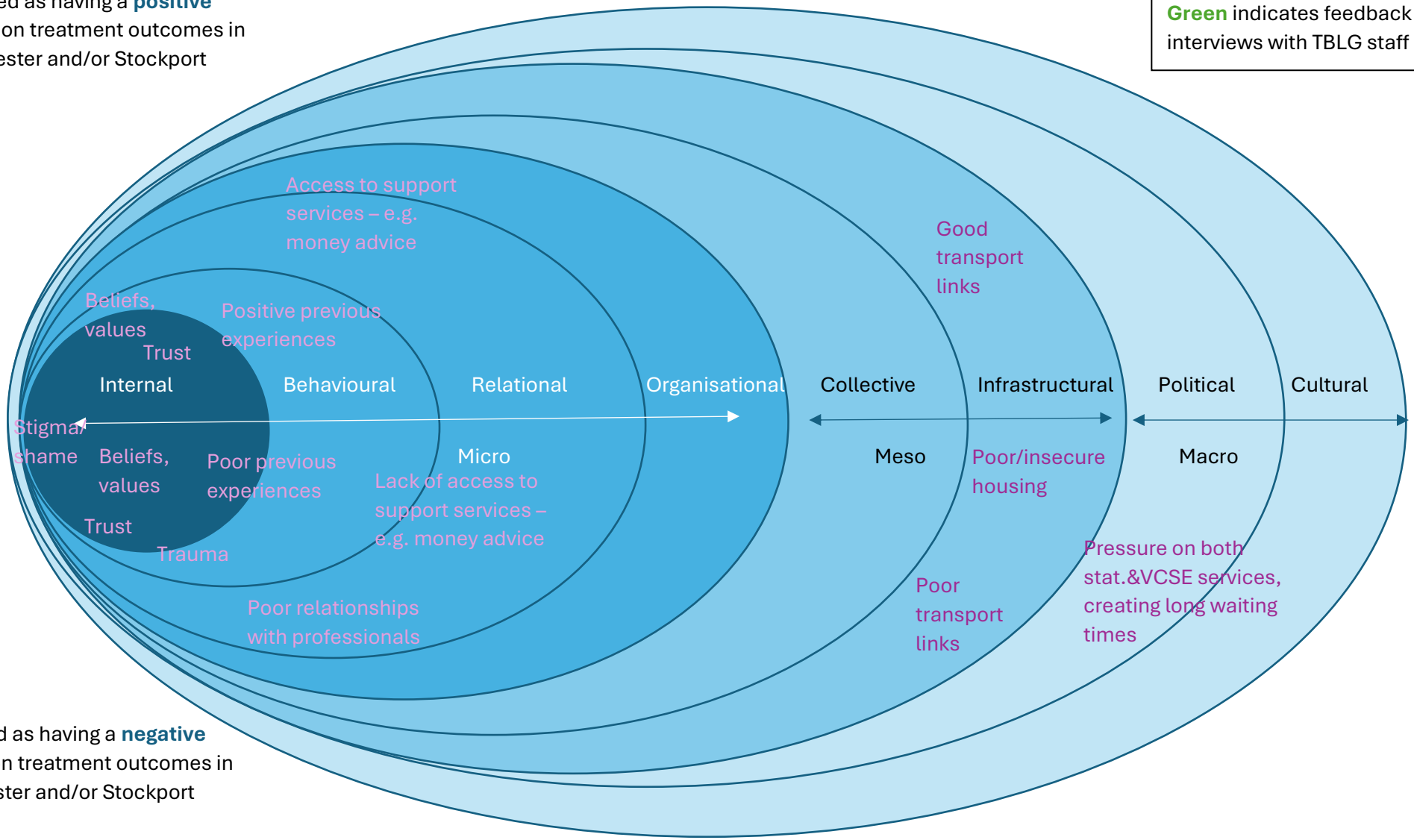
However, a better understanding of the internal, behavioural and relational factors that shape people's lives is needed. I look forward to completing interviews from those working in both the Manchester and Stockport services, to attempt to shed further light on this.

Similarly, the interviews also highlighted the pressures on services in the VCSE sector. TBLG is not exempt from these pressures, and is delivering vital NHS contracts in an increasingly challenging context. The organisation continues to use research/data to evolve the service it provides - but equally cannot be expected to tackle the challenging housing contexts of the people it supports in isolation.

Systems change map – qualitative interviews/feedback

Purple indicates feedback from initial interviews
Green indicates feedback from interviews with TBLG staff *(TBC)*

Identified as having a **positive** impact on treatment outcomes in Manchester and/or Stockport



Identified as having a **negative** impact on treatment outcomes in Manchester and/or Stockport

Solutions and recommendations

Awareness of the complex interrelation between housing and health is increasing – the development of ICBs recognised the role of anchor institutions in contributing to better health, whilst the Better Social Housing Review and Awaab's Law place greater emphasis on joint working, recognising this interaction.

In Greater Manchester, the Focused Care service, from the Shared Care Foundation, could be one of these solutions. The models involves a Focused Care Practitioner working people and families to 'unpick situations, assessing need and using local health and community contacts in order to begin to bring stability to an often chaotic situation', complementing treatment/support from services such as GPs, health visitors, and/or community mental health teams. Beginning in Oldham, Focused Care is now in place across 80 GP surgeries across Greater Manchester, with a focus on the most deprived areas. The service has received vast praise for its model, and its ability to work with people with the highest level of need, those previously considered 'hard to reach'. Significantly, this service is designed to supplement existing care, provided by the NHS or commissioned providers – demonstrating that personalised support, beyond the scope of that provided by clinicians, is vital in creating good outcomes.

A Liverpool housing association is trialling embedding data on living conditions into NHS records, allowing GPs and other health professionals to identify when joint intervention may be necessary, or when health needs may impact housing, or vice versa. It is believed that sharing information on living conditions, accessibility and localities in this way will enable health and housing professionals to better address the health inequalities experienced by social housing tenants and highlight areas for collaboration – e.g. when a patient is waiting on adaptations to be made to their home to meet their mobility needs.

Despite the pressures on both VCSE and NHS services, collaboration emerges as a theme – a key driver that can create better outcomes. In a time of financial challenges for everyone delivering vital services to vulnerable people, information is increasingly required to justify action – so collecting data which explores these impacts can be the catalyst to create systems change.

Reflection

Whilst the project was a useful learning experience and generated some valuable insights, it's important to recognise that the limited scope of the project presented a number of barriers, influencing both the quality of the research and its outcome.

The process was challenging for a variety of reasons – particularly the fact I did not have access to a budget to support the research, and was unable to obtain ethical clearance – as the results are not intended to be generalisable, the project did not fit either academic or NIHR definitions of 'research'. These reasons, combined with my position as a housing professional, approaching unknown partners to discuss poverty and mental health, meant I struggled to build trust. This was further complicated by the fact I did not have an NHS email address, so could not guarantee the security of the correspondence being sent to me.

From both a moral and practical standpoint, engaging people with lived experience throughout the research process is considered best practice. Due to not having access to a budget (to reimburse people for their time, or fund their expenses), I did not feel it was appropriate to do so in this case – it could have made the research exploitative, compromising individual's mental and emotional health and increasing pressures on the VCSE services I was seeking to highlight. As a result, I hope the insights go on to generate further research, which does engage with people affected by these issues, in a fair, non-stigmatising and genuinely co-productive way.

Despite its limited scope, the research highlights a link between living environments and mental health treatment outcomes, and provides prompts for further research. Whilst non-exhaustive, the following could generate further valuable insights:
- exploring the link between mental health treatment outcomes and housing quality/type/ownership
- exploring the link between mental health treatment outcomes and environmental factors – e.g. crime and anti-social behaviour rates, transport links
- examining the extent to which mental health treatment outcomes vary based on urbanity/rurality, and linking this to access to other services, e.g. GPs/pharmacies, community groups, etc.
- examining treatment outcomes to explore if outcomes vary dependent on intersectional identity factors

This project could also provide a useful basis for exploration of outcomes from other NHS services – such as comparing delayed discharges or screening uptake alongside IMD data.

In my capacity as a Core20PLUS5 Ambassador, I hope to build upon these learnings, examining how issues like trust, and opportunities for cross-sector communication, can create or mitigate barriers for collaboration between housing and health professionals at different levels of the system.