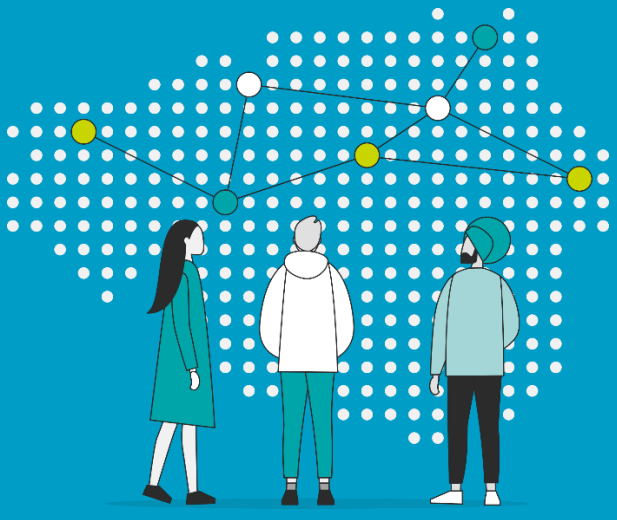
GREATER MANCHESTER POVERTY ACTION

The role of the NHS in Greater Manchester in tackling poverty

October 2023



About Greater Manchester Poverty Action

Greater Manchester Poverty Action (GMPA) is a recognised leader on poverty in the UK and exists to end poverty in Greater Manchester and beyond.

We deliver independent, evidence-based activities to address socio-economic disadvantage. These focus on maximising the financial resources available to households, amplifying the voices of people with lived experience of poverty, and working with our network to achieve meaningful change. This enables us to support organisations across sectors to effectively target resources and to achieve sustainable solutions to poverty through strategic, policy and programmatic responses.

With an extensive network of over 2,000 professionals and volunteers actively engaged in tackling poverty, we have a wealth of insights and understanding that allow us to deliver direct responses to poverty and provide valuable guidance and support to others. **To discuss this report, please contact Laura Burgess at:** laura@gmpovertaction.org.

Acknowledgments

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1.0 Introduction

1.1 Background – poverty in the UK and Greater Manchester

Poverty is a significant issue in the UK, with over one in five (22%) of the population living in relative poverty in 2021/22 (the most recent year for which data is available) – 14.4 million people (Department for Work and Pensions, 2023). The cost-of-living crisis continues to have huge implications across society and has acerbated the consequences of poverty, with many individuals and households "having to make difficult choices on what spending we prioritise" and some facing "increasingly bleak choices" (JRF, 2023).

According to the Resolution Foundation, "2022 was a disaster for UK living standards". As inflation reached a 41-year high in October 2022, real pay shrunk, and government support was not enough to prevent median household incomes from falling by 3 per cent in 2022-2023 (Resolution Foundation 2023). The cost-of-living crisis is affecting almost everyone, but some are much more deeply impacted than others, with working adults in lower-income households much more likely to report that they had tried to cut back "a lot" on spending and more likely to say that their "financial situation was worse since the start of 2022".

Poverty rates vary by the country's geography too, with Greater Manchester home to some of the highest levels of poverty and deprivation in the country. Poverty is a major issue in all ten of Greater Manchester's boroughs. GMPA's Poverty Monitor (2022) highlights that at least 620,000 people, out of a population of 2.8million, are living below the poverty line across the city region. A quarter of a million, one in three, children in Greater Manchester are living in poverty (after housing costs) and the child poverty rate across the city region is higher than the England and UK average (End Child Poverty, 2023). In addition, three of the 10 parliamentary constituencies and two of the 10 local authorities with the highest child poverty rates are within Greater Manchester (End Child Poverty, 2023).

There are clear associations between poverty and health: "poverty causes ill health, drives inequality in health outcomes and increases use of health services. In addition to the personal stress it causes, poverty is also expensive, in direct costs to the state and in lost opportunity and productivity" (The King's Fund, 2022). Evidence from the British Medical Association (BMA) suggests poverty can affect the health of people of all ages; poverty is associated with low birth weight and a higher risk of death in the first year of life, children living in poverty are more likely to suffer chronic disease and most individual long-term conditions are more than twice as common in adults from lower socio-economic groups (BMA, 2017).

The King's Fund and the Centre for Progressive Policy joined together in 2022 to explore how the health and care system can better respond to the causes and impacts of poverty, recognising that whilst the link between health and deprivation is widely documented, developing a health care system that considers socio-economic disadvantage is challenging for a number of reasons, including local institutional boundaries and information gaps. The literature review chapter of this report will

explore the King's Fund recommendations in more detail, but it is worth noting that the stubborn prevalence of poverty across Greater Manchester, the lack of a strategic focus on poverty at a city region-level and the creation of the NHS Greater Manchester Integrated Care Board (ICB) in July 2022 has provided an opportune moment for a deeper focus on exploring the role of the NHS in tackling poverty.

1.2 The Commission

Given the stubborn and high levels of poverty in Greater Manchester and associated consequences for the delivery of health and care services, GMPA was commissioned by Greater Manchester (GM) NHS to undertake a project looking at the role of the health and care system in tackling poverty throughout 2023.

The commission included a broad initial exploration of the GM health system's approach to poverty, reflecting on existing policy and good practice and at the same time reviewing this approach against recommendations made by the King's Fund in their publication – 'The NHS's Role in Tackling Poverty' (2021). It involved assessing the feasibility, value and desirability of GM NHS in developing an anti-poverty strategy and adopting and implementing the socio-economic duty.

This work forms the initial building block of NHS GM eventually developing a single shared narrative around the impact of poverty and health in GM, incorporating a clear articulation of the potential role the health system can play in tackling the issue. This will be facilitated through the advice and guidance of this report to NHS GM in relation to poverty and the cost-of-living crisis, and how it is incorporated into the GM Health and Care Strategy, the GM Build Back Fairer framework, and other GM Population Health Board responsibilities.

A key element of this commission is Poverty Awareness training, delivered to an initial cohort of managers and policy and strategy leads within the health system, with a view to evaluating and developing this training to a wider group of health and care professionals, tailored to certain specialisms, in the future. The training has been delivered alongside the development of this report and learning from the training is being reported to NHS GM separately.

A complementary ongoing commission is looking at how 'poverty proofing' could be applied to the health system in GM. Poverty proofing as a concept is about identifying the barriers people experiencing poverty may face in accessing services. The 'poverty proofing' aspect of this work is, in part, being carried out by Children North-East, a partner organisation of GMPA, who are experts in providing tailored guidance on what actions can support settings to minimise the impact of poverty on healthcare provision. A final report on an initial poverty proofing trial will be provided separately and will identify learning and outputs, culminating in considerations as to where this approach can sit alongside the recommendations set out in this report. Whilst this will be provided separately, some of the initial learning from the concept of poverty proofing is relevant to this report.

1.3 Aims of this report

This report responds to the following aims as described in the NHS GM 'tackling poverty' commission being delivered by GMPA:

- An initial exploration of the GM health system's approach to poverty, reflecting on existing policy and good practice, and reviewing this approach against recommendations made by the King's Fund;
- Assessment of the feasibility, value and desirability of GM NHS in developing an anti-poverty strategy;
- Consideration of whether GM NHS should adopt the socio-economic duty;
- Consideration of the the role and responsibility of NHS GM as an employer in tackling poverty.

1.4 Summary of recommendations

This report details a number of recommendations to NHS GM in order to position the organisation to effectively tackle poverty. Recommendations include:

Maximising the impact NHS GM can have on poverty as a major employer

- Ensure widespread adoption of the real Living Wage and adoption of the Good Employment Charter across NHS GM.
- Co-design Employment Support, prioritising genuine and sustained engagement with individuals with lived experience of socio-economic disadvantage and health inequalities so that employment support meets their needs. .
- Prioritise community engagement, especially in deprived postcodes, to ensure that workforce recruitment is inclusive and representative of Greater Manchester's diverse population.
- Build on the NHS GM employee benefits scheme to introduce more financial wellbeing support for the workforce.
- Additionally, consider how GMPA's Money Advice Referral Tools could be used more systematically across the system to support the financial wellbeing of staff.

NHS GM as an anchor institution

- Establish a consistent narrative in NHS GM to show a strong commitment to social and economic development, emphasising the importance of anchor practices to combat poverty.
- Integrate procurement data with local economic development strategies to boost the local supply chain.

- Adopt the GM social value framework, ensuring genuine commitment from suppliers to deliver real value without over-promising.

Action through the delivery of services

- Fund welfare rights, benefits and debt advice provision within health care settings, ensuring this approach is independently evaluated so that the evidence base for these services is strengthened.
- Work with GMPA to promote systematic use of the MARTs across appropriate health settings.
- Specifically, consider how financial wellbeing support can be delivered to people accessing mental health services.
- Prioritise working closely with provider trusts to amplify the awareness and use of hospital transport offers, ensuring those affected by the cost-of-living crisis do not miss appointments due to travel costs.
- Develop pilot programmes addressing cohorts of non-attendance within services due to socio-economic factors. For example, offering free transport to appointments, scheduling appointments within educational institutions where feasible, and diversifying ways parents can access clinical advice for their children.

Measuring what matters

- Collect, share, and refine poverty data to understand the areas in Greater Manchester that are experiencing heightened challenges.
- Work with GMPA to scale up the information available on the Hub about poverty in Greater Manchester and what more can be done at an organisational and system level, such as poverty awareness training materials.

Advocacy

- NHS GM should amplify its advocacy for social policy reforms, utilising its evidence base and collaborating with partner organisations and other integrated care services to challenge national policies perpetuating poverty and health disparities.

Mission statement

- Adopt a clear vision and mission that acknowledges the role of the health and social care system in addressing poverty as a critical determinant of health.

NHS GM leadership

- Strengthen leadership and accountability on poverty. Whilst the NHS GM board has a chief executive officer for population and health inequalities, there needs to be an anti-poverty lead with functional responsibility for addressing poverty.

Enhancing engagement with people with lived experience of poverty

- Increase the opportunities for lived experience participation, working with key non-statutory partners.
- Support GMPA to identify how a permanent lived experience of poverty panel would operate in practice and what mechanisms would be implemented to ensure it influences NHS GM policy and practice.

Adopting the socio-economic duty

- NHS GM should commit to voluntarily adopting the duty. GMPA can support effective implementation and provide guidance on what adopting the duty means in policy and practice, delivering the work in a staged process.

All of the above should be underpinned by the development of an NHS GM anti-poverty strategy that firstly defines poverty and its drivers, and targets the causes of poverty through actions responsive to the immediate cost-of-living crisis, as well as considering medium and longer-term actions.

2.0 Methodology

The following sets out the methodological approach taken to inform this report.

2.1 Literature review

A literature review was conducted to explore the role of NHS GM in addressing poverty through the lens of the recommendations made by the King Fund's report (action, awareness, and advocacy) as well as the feasibility and desirability of NHS GM developing an anti-poverty strategy.

This included the following:

- A review of existing public sector strategic approaches, including NHS strategic and policy approaches to poverty, work by the King's Fund, GMPA's report 'Local anti-poverty strategies: good practice and effective approaches', locality anti-poverty strategies and locality plans for health and care, and consultancy work GMPA delivered to the Greater Manchester Combined Authority (GMCA) on the strategic and policy role of combined authorities in addressing poverty, identifying and drawing on activity from other parts of the UK.
- A review of related literature, such as research reports, journal articles, and other sources to understand the role the health system can have in addressing poverty and the opportunities and challenges Integrated Care Services (ICS) face in how best to approach addressing poverty.
- A review of GM's health and care approach, including the GM Integrated Care Partnership (ICP) Strategy, Joint Forward Plan, GM People, and Culture Strategy, the GM Build Back Fairer framework, and other pieces of work of the GM Population Health Board to identify health and care system responses to poverty and the cost-of-living crisis.

2.2 Primary Research

Primary research was carried out to gain insight into:

a) how household income and cost implications impact accessibility of GM NHS health and social care services by service users;

b) the level of awareness of NHS assistance/schemes (particularly GM-wide) by the public and health and care professionals;

c) the level of assistance and responsibility that NHS health and care professionals can and should take;

d) the effects of financial headships on mental and physical health.

The research aims to extrapolate recommendations from the findings that will enable the NHS staff to provide better support to people experiencing socio-economic disadvantage.

The primary research was conducted through the following methods:

2.3 Survey of the GM general public

- Demographically representative survey distributed by Omnisis to 1000 respondents across all 10 GM local authorities.
- The survey focused on household income, cost implications and accessibility of GM NHS health and social care services, awareness of GM NHS assistance/schemes, the role that NHS health and care professionals can and should take regarding financial hardships, and the effect of financial hardships on mental/physical health.

2.4 Focus groups with people with lived experience of poverty across GM

- People with lived experience of poverty were recruited via community-based partners across GM. The focus groups involved 10 participants (spilt into two groups) that attended both focus group sessions, and 2 participants attended one session each (due to sudden issues/commitments). Focus group participants were recognised for their time in line with GMPA's approach to engaging people with lived experience of poverty in our work.
- Each group participated in two 1.5-hour sessions. The first session explored "cost implications of accessing GM NHS health and social-care systems/services" and "financial support currently provided by GM NHS." The second session covered "NHS's role as an anchor institution – role of NHS staff/healthcare professionals in tackling poverty" and "physical and mental health impacts of financial crises/poverty."

2.5 Survey of GM Health and Care professionals

- Survey targeted at health and care professionals across GM, sought from GMPA's network (via our fortnightly newsletter and direct emails to all those in our network working in health and social care).
- 38 respondents, with 25 (66%) from the public sector and 13 (34%) from the VCFSE sector.
- The survey aimed to gauge how health and care professionals and services are responding to poverty and the barriers they face in advancing anti-poverty work.

2.6 Semi-structured interviews

- Semi-structured interviews were held with representatives from NHS GM and from those working within the wider anti-poverty ecosystem to understand what can be done by NHS GM in terms of its role as an employer to tackle poverty across the city-region.

Confidentiality of all participants were considered, with the participants being made aware and asked to sign an agreement based upon the use and storage of their data, with the ability to withdraw from the research at any point. All data in the various outputs/reports has been anonymised, including no names being disclosed in any direct quotations utilised.

2.7 Research limitations

This report was produced with the best available information at the time of research. However, during the research process aimed at assessing the NHS GM approach to poverty, several limitations were encountered. The information available on the NHS GM website was, at times, insufficient, outdated, or lacked the necessary detail. It was challenging to yield a comprehensive understanding of the entire workings of the system, particularly because information was often buried and not clearly laid out on the website. These limitations might have led to potential gaps in our understanding, or interpretations based solely on the available content.

Addressing the limitations present, it is vital to highlight that there is limited academic literature and evidence focused on the role of integrated care services in addressing poverty. This shortage in research and evidence, particularly regarding the understanding of integrated care services' capacity and effectiveness in poverty alleviation, is largely due to the absence of thoroughly tested and specially tailored strategies, programmes, and initiatives.

Across the country, integrated care services find themselves at different points in their journey towards understanding and refining their role in addressing poverty. NHS GM, amidst the evolving ICS policy landscape, stands in a position not merely to lead but also to serve as a model for other integrated care services, enabling improvement across the system and the sharing of innovative approaches. By adopting the recommendations outlined in this report, NHS GM can ensure that a strategic approach to tackling poverty is embedded at the heart of how the system operates.

The following limitations should be considered for the primary research:

- **Limited sample size** – the sample size for the GM health and care professional survey was relatively small given the region-wide scope of the study and the size of the health and care workforce. Some areas of the city region were represented more than others among respondents. To overcome

this, we have sought to ensure that the findings consider the inputs from respondents working in all GM boroughs.

- **Limited access to data** – the scope of the commission meant there were limitations to the amount of data GMPA was able to gather. However, the research methods adopted enabled GMPA to gather representative insights from across the population (primarily through the residents' survey) and utilise GMPA's network, and the reach of partners to gain access to individuals with lived-experience of socio-economic disadvantage and people working within the health and care system.

3.0 Literature Review

In this chapter, we analyse the current approach NHS GM is taking to address poverty through the lens of the King's Fund recommendations. The King's Fund (2021) report 'The NHS's role in tackling poverty' highlights that the NHS can tackle poverty in three main areas:

1. Action - in relation to actions to mitigate the impact of poverty as well as actions to address the drivers of poverty;
2. Awareness - raising awareness of the impacts of poverty on people's health and access to care;
3. Advocacy - being a strong advocate for tackling poverty.

In the sections that follow, a detailed summary of each area will be provided. This includes identifying where NHS GM's current approach aligns, highlighting opportunities and recommendations for further development and identifying potential challenges.

The literature consulted for this analysis identifies key themes, initiatives, and policies relevant to NHS GM's role in addressing poverty. Our aim is to provide a comprehensive overview of the present landscape, equipping NHS GM with insightful perspectives to refine its anti-poverty approach, ensuring it is well-informed and effectively targets identified areas of improvement.

3.1 Action

In this section, we discuss the key actions NHS GM should take to address poverty. Our analysis acknowledges the significant efforts already in place across the system, however, we emphasise opportunities to enhance and expand upon this foundation, working for a more robust NHS GM response.

3.1a Maximising the impact NHS GM can have on poverty as a major employer

It is positive that NHS GM has a strong focus on maximising its role as an employer, with two of the missions in the ICP strategy explicitly focusing on employment, 'helping people get into, and stay in, good work' and 'supporting our workforce and our carers' with a dedicated GM People and Culture Strategy, which sets out the vision for the health and care workforce, with critical commitments on good employment, attraction and retention of the health and social care workforce closely aligning with the Greater Manchester Strategy. Additionally, these efforts are in the process of alignment and evaluation based on the benchmarks of the national Long-Term Workforce Plan.

Good employment and the real Living Wage

We are pleased to see that there is a commitment to increase membership of the Greater Manchester Good Employment Charter by organisations within NHS GM and it is positive to understand some boroughs have witnessed the 'domino effect' of membership by several primary care providers. It is also indicative of the value that NHS GM places on 'good' employment that there are representatives from NHS GM's People and Culture team on both the GM Good Employment Charter Board and the Living Wage Board.

Despite this, the context to which good employment practices have been adopted remains unclear. According to the Living Wage Foundation, only a limited number of NHS service providers in GM, for example Greater Manchester Mental Health NHS Foundation Trust and Salford Primary Care Together, are accredited real Living Wage employers and very few NHS organisations are members of the GM Good Employment Charter. Our primary research suggests poverty awareness training for middle management is crucial in making clear the link between low pay, poverty, and ill health which may then impact a person's ability to work.

Through our research, we have identified gaps that need to be addresses in order to reduce poverty. There is an increasing amount of evidence that paying the real Living Wage (rate set annually by the Living Wage Foundation, based on the true cost of living, unlike the government's National Living Wage; the statutory minimum rate of pay dependent on age, based on fluctuations in average earnings) has benefits to employers as well as its employees. The real Living Wage has lifted hundreds of thousands of people and families onto a wage that covers their everyday needs and can be credited with improvements to an employee's mental health and wellbeing. In current NHS pay scales, an employee earning below Band 2, spine point 3 is "paid a wage that does not support an employee's needs – a difference of more than £1,000 a year between the [real] Living Wage and what a low-paid employee earns each year" (Lewis, 2022). When considering NHS GM's role in tackling poverty, it is important to look at the impact paying the real Living Wage would have on staff, given the scale of employment across the city region and how many households are provided their income by the NHS.

GMPA is realistic and understands the complexity of the ICS and the challenges in achieving widespread GM Good Employment Charter membership and Living Wage Foundation accreditation. At GMPA we run the Greater Manchester Living Wage Campaign which has unique links with the Living Wage Foundation, GMCA, Citizens UK as well as trade unions and other key stakeholders working in promoting good employment, unlike in other regions of the UK. As such, we believe we can offer more support and co-ordination in promoting these areas of employment that would make a significant difference to poverty across GM. With funding allocated to establish a Community of Practice for health and care employers to improve employment standards[1], we would be pleased to contribute by sharing our expertise on quality work practices and their role in addressing poverty.

Enhancing the scale of work and health programmes

It is welcome that working with the GMCA, NHS GM will continue to evolve the 'working well system', with a number of new services being put into place. However,

it is vital that employment support is not done to, but rather in collaboration with, those who have lived experience of socio-economic disadvantage and health inequalities. This is what is missing in national employment support. NHS GM and the GMCA should take an approach that involves people from the outset, committing to processes of engagement (rather than single events), and utilising insight from lived experience advisory groups (see: enhancing engagement with people with lived experience of poverty). The Clacton Place programme is a good example of how collaborative approaches can lead to transformative outcomes in the health sector. A key strength of this initiative lies in its commitment to integrating the voices of those with lived experience, thereby ensuring that interventions are grounded in the realities faced by the very communities they aim to support.

Case study: Clacton Place programme

Clacton Place is a programme that seeks to improve health outcomes through employment and skills. It involves a unique partnership between Suffolk and North East Essex ICS, the Department of Work and Pensions (DWP), Essex County Council, Tendring District Council, the community and voluntary sector, Breaking Barriers Innovations, Health Education England, NHS England and NHS Improvement.

The plan for 2022, as part of the Core20Plus5 programme, is to radically upscale lived experience work by bringing in more community and voluntary sector partners to recruit up to six cohorts of lived experience peer workers who will engage with a wide range of service users and local residents from groups that experience some of the worse health inequalities.

Over the coming year, the outcomes they are seeking to achieve include:

- Establishing a pipeline of good quality, sustainable jobs from anchor clusters that will act as a catalyst for change.
- Engagement with 400-600 residents on how these opportunities can be made accessible to all the population health inequalities groups.
- Securing employment and/or training opportunities for 60 peer researchers.
- Sustaining through Place and Community informed investment in the Health and Care Academy.

Reference: Bashford , J. (2022) Reducing health inequalities in Clacton-on-Sea, NHS England.

Growing and developing the workforce

It is positive that there is an active focus on developing GM's career approach to attract and support career development. NHS GM must target skills and opportunities to those who need them most, reaching out to communities and mapping the employment profile of providers' trusts to identify any deprived postcodes where trusts employ relatively few people. For example, the Birmingham

& Solihull ICS, in partnership with the Birmingham Anchor Institution Network, is leading a programme known as 'I Can' across all its employer providers. 'I Can' has engaged with over 3,000 jobseekers and offered more than 420 people a role. Roles include porters, theatre support workers, and healthcare assistants. It was recently shortlisted for a national award (University Hospitals Birmingham, 2023).

Furthermore, a key action in the Joint Forward Plan is adapting the recruitment process to provide alternative entry routes for diverse talent at all levels, this must include people experiencing socio-economic disadvantage. Adoption of the socio-economic duty will be instrumental within the recruitment process to ensure people with different economic backgrounds are given equal opportunities, fostering a workforce that truly reflects and understands the diverse challenges faced by Greater Manchester communities.

The Prince's Trust and LADbible Group's new 'Redefining 'Dream Jobs' research report (2023) highlights two-thirds of the 18- to 24-year-olds who were questioned for the research have lowered their career expectations, with the cost-of-living crisis, the state of the UK economy and their own mental health named as the biggest factors. It is more important than ever for NHS GM to develop its career approach reaching into communities, working with schools, careers, and education providers to engage with young people and school leavers to increase representation in healthcare professions. NHS GM should take proactive measures to address these concerns by showcasing the intrinsic value and fulfilment that comes with a career in health and care. This could involve spotlighting real stories of individuals who have found purpose and growth in the sector, as well as ensuring ongoing support and mentorship opportunities for those just starting their journey. By actively addressing the current sentiments, NHS GM can position itself as an employer of choice, appealing to the aspirations and needs of the younger generation.

Workforce financial wellbeing

A growing number of employees in NHS GM are facing financial difficulties, therefore it is essential for NHS GM to scale up its work to support employees and promote open dialogue about these challenges. We understand a key system priority for the People and Culture team 2023/24 is supporting localities in the development and delivery of their workforce plans, aligned to the People and Culture Strategy.

We welcome the latest version of the GM ICP Wellbeing toolkit launched in June 2023 to help support the health and care workforce in GM and the GM financial wellbeing pack, which includes links and resources to support money worries and includes information about GMPA's Money Advice Referral Tool (MART) (currently in place across six GM boroughs).

It is essential that NHS GM enhances its financial wellbeing support at a system level, especially during these challenging times. Access to staff benefits and flexible working options should be prioritised. Building upon the foundations set by the NHS Employee Benefits scheme – which already includes incentives such as the cycle-to-work scheme, car lease provisions, credit union access, and robust wellbeing support – can pave the way for a more comprehensive and supportive program for all staff members. Such an enhanced scheme not only addresses the immediate cost-of-

living crisis but fundamentally represents a more preventative approach, ensuring a long-term response to staff financial difficulties.

We acknowledge the immense pressures NHS organisations face, and not all organisations across the system will be in a position to provide the same level of support. However, our research indicates across the country NHS trusts have effectively repurposed funds and utilised available support from NHS England for wellbeing to strengthen their support for staff during the cost-of-living crisis.

There is no one-size-fits-all approach to financial wellbeing support, organisations must co-design offers that suit the needs of their workforce. However, through our research we have come across organisations offering the following:

- Early access to pay through Wagestream
- Hardship loans and low-cost crisis loans
- Debt management support
- Saving schemes
- Will writing services
- Financial education workshops
- Budget planning guidance
- Credit union membership
- Retirement planning support
- Loan shark awareness sessions
- Communication strategies, 'let's talk money'
- Support with travel expenses
- Staff discounts for employees of all health and care partners such as the blue light card

The following case studies exemplify proactive approaches that organisations have taken to directly address and alleviate the cost-of-living pressures faced by their employees. They highlight the adaptability and resilience of these organisations in creating meaningful solutions, tailored to their workforce's needs, and underscore the potential for broader adoption of such strategies within NHS GM.

Case study: West London NHS Trust.

West London NHS Trust developed a five-staged approach based on the results of a short financial wellbeing survey launched via Great with Talent in May 2022, to understand the impact of financial wellbeing on their staff and what would help them the most. This was made accessible electronically and in paper format. See figure 1 below.

Open up: Using the survey findings, the trust targeted interventions for specific

groups within their organisation and recognised the need to review support materials based on the findings. The results from the research were discussed at their leadership forum, within focus groups, and in-trust communications. The open communication aimed to remove stigma and ensure people felt safe and able to speak up.

Lead the way: Individuals requiring immediate support were directed to the organisation's NWL Keeping Well Hub. In response to broader concerns from the data, the trust offered various resources for managers. Training sessions were conducted to raise awareness of the impact of poor financial wellbeing on staff. Materials were also provided to assist managers in guiding staff to suitable support options.

Develop a practical plan: The trust developed a plan of financial wellbeing support based on the identified needs of the workforce. This includes an interactive financial wellbeing booklet, budget management workshops, as well as targeted assistance, such as improving nurse apprentice pay rates and offering backup and respite care for workers with elder care commitments. The results from the employee survey found that 32% of the workforce estates and facilities staff were skipping meals to help them support their families. They offered this group a free breakfast provision from August 2022 – March 2023.

Measure success: The Trust is evaluating the success of the interventions as part of their health and wellbeing and reward and recognition strategies. They will be looking at:

- Reviewing take up of 'Wage stream' and other interventions agreed as part of their plan.
- Reviewing attendance at financial awareness seminars.
- Reviewing the number of staff opting out of the NHS Pension Scheme (a quarter of respondents said they intended to opt-out).

Case study: NHS Leeds and York Partnership

NHS Leeds and York Partnership conducted a survey with staff in February 2022 to understand what support would help with the increasing cost-of-living crisis. They put together a comprehensive package of measures and, so far, they have invested £275,000 in initiatives. This has included: accessing wages early (staff can access Wagestream, there is a flat rate fee of £1.75, but the Trust has extended fee support), financial support fund (this dedicated fund is designed to support those experiencing an unexpected expense or a significant decrease in household income), money buddies (this offers free impartial independent debt advice to staff via phone calls and onsite meetings), extending the provision of food to support colleagues when on site (due to staffing challenges and rising living costs, measures are in place to provide ambient food at all sites for staff struggling to afford meals during shifts) and increasing the mileage rate to offset the rising price of fuel (The Trust agreed to temporarily increase the nationally agreed mileage rates). They have been shortlisted for this year's Chartered Institute of Personnel and Development (CIPD) People Management Awards for Best Health and Wellbeing initiative.

Case study: South Yorkshire and Bassetlaw ICS

South Yorkshire and Bassetlaw ICS has created a financial wellbeing web page with supporting resources on its workforce wellbeing website. They run a financial wellbeing programme, they worked with an independent provider to offer:

- Online workshops related to financial wellbeing
- 'Prepare for retirement' courses
- 20 minutes per person of free one-one advice from a financial advisor.
- Content and resources for the ICS workforce wellbeing website.

Maximising the role of the NHS GM as an employer: Recommendations

- Aim for Living Wage accreditation across all GM trusts, emphasising its positive impact on employee wellbeing. Ensure senior leaders in each organisation are on board with achieving accreditation and paying the Living Wage. Nominate a member of staff in each organisation to lead on accreditation.
- Partner with GMPA to set clear milestones, submitting approved milestones and Living Wage agreement to the Living Wage Foundation and leverage our expertise in promoting good employment practices.
- Co-design Employment Support: NHS GM, in collaboration with GMCA, should prioritise genuine and sustained engagement with individuals with lived experience of socio-economic disadvantage and health inequalities.

- Prioritise community engagement, especially in deprived postcodes, to ensure that workforce recruitment is inclusive and representative of Greater Manchester's diverse population.
- Strengthen ties with educational institutions, offering career talks, and interactive sessions to inspire young people and school leavers about the possibilities within the Greater Manchester healthcare sector. Showcase testimonials of individuals in health and care roles, highlighting the potential for growth, impact, and purpose in the sector.
- Build on the NHS GM employee benefits scheme to introduce more financial wellbeing support. This must involve consultations with staff to understand the effectiveness of the implemented measures, suggested improvements, and additions. Use this feedback to adapt and evolve the financial wellbeing support. Additionally, consider how GMPA's MARTs could be used more systematically across the system to support the financial wellbeing of staff.
- NHS GM should actively assist localities in the refinement of their workforce plans by emphasising the importance of developing robust financial wellbeing strategies. Addressing immediate cost-of-living concerns with short-term relief offers should be a priority. Moreover, to ensure the longevity and efficacy of these strategies, it's crucial to incorporate learnings and best practices from other regions, as detailed in this report. By doing so, NHS GM will be fostering a proactive approach, ensuring that employees are both supported in the present and safeguarded for the future.
- Increase the range of topics in the GM Workforce Wellbeing Programme on financial wellbeing such as budgeting, managing debt, utility costs as the autumn and winter periods approach to encourage staff to have conversations about financial wellbeing and ensure they are empowered to access the support available to them. Working with GMPA and other local organisations with the relevant expertise to deliver and facilitate sessions.
- Strengthen internal and external communication of financial wellbeing resources: Recognising the efforts to advertise wellbeing support within individual organisations and networks, it is crucial that the GM ICP webpage be more user-friendly in its presentation of information related to wellbeing support and access to relevant packs. This includes intuitive navigation and clear pointers to essential resources. In tandem with this, a robust communication and engagement strategy should be developed, catering to both internal organisational members and the broader public. NHS GM should encourage individual organisations to similarly strengthen communications of support packages available.

3.1b NHS GM as an anchor institution

One of the four core purposes of the ICS is to help the NHS support broader social and economic development. A wide range of system-level actions are taking place in GM to boost the local and regional economy and reduce socio-economic and health inequalities. However, we have identified that the ICS can further support and build a more systematic approach to social and economic development to make the GM population better and better off.

A report by Goodwin (2023) offers insight into how integrated care services can develop their potential as networks of anchor institutions. For NHS GM, there are a number of key takeaways that we have adapted that should be considered to move to a more connected anchor system.

Prioritisation of social and economic development

NHS GM should prioritise its social and economic development more explicitly. Going forward, there needs to be a more robust narrative that underlies the ICS commitment to social and economic development. One of the key GM ICP strategy missions is 'helping people get into, and stay in, good work', and the Joint Forward Plan highlights a key area of focus is 'increasing the contribution of the NHS to the economy' with an action of developing the NHS as an anchor system with the development of a GM NHS anchors network. We are aware NHS GM ICB is seeking a provider to give leadership to the NHS GM anchors network and programme, with one of the key priorities being to develop and implement vision, strategy, and targets for anchors' work within GM. There must be a coherent anchor vision that pledges to use anchor practice to tackle poverty.

Local supply chains

Enabling local enterprises to play a more significant role is another area where there can be a deeper focus. The GM anchors network is on the right path with its efforts toward local supply chain opportunities. To grow and develop this, the ICB must integrate procurement data into economic development practice. This means examining procurement data to pinpoint areas of spend that can be influenced and collaborating with local authorities to identify alternate suppliers, which involves local development officers liaising with local small businesses and social enterprises. A key area of focus could be exploring the feasibility of a local manufacturing offer for consumable items, which could be incorporated into supply chains (as the Covid-19 pandemic demonstrated that many SMEs could quickly adapt to provide the NHS with the necessary consumables). Furthermore, engaging organisations and building a shared commitment to tackling poverty by promoting the real Living Wage.

Community development workers

Another important area is exploring commissioning community development workers to support more inclusive economic development, working at a neighbourhood level to identify the community's needs.

Social value

It is also critical to unify approaches to securing social value. It is encouraging to see plans to adopt the GM social value framework. Reed et al. (2019) recommend that the NHS should apply social value principles across areas where the NHS has greater flexibility, such as hotels and catering, as social value tends to be primarily part of competitive tender processes. Social value should be a priority, but care

should be taken. Some suppliers might give a positive appearance but try to work around the system, over-promising the social value they will deliver.

NHS GM Assets

Finally, housing and planning policy plays a vital role in reducing the risk of poverty and health inequalities. While we understand the pressure to sell assets for profit, ICB partners should consider whether any extra land and property could be used for affordable commercial or residential development. This extra space could support local businesses and community use, helping to expand and grow the local economy. There are a number of examples across the country of the social and economic value of NHS organisations explicitly prioritising social value as part of decisions to sell land. For example, St Basil's Live and Work project in Sandwell, Birmingham (described below), NHS Property Services sold the former St George's Hospital site in Hornchurch for £40m (the most considerable reinvestment in the NHS through the sale of surplus land); 15% was allocated for social housing, and 1.6 hectares of land retained to host a new community health centre and using existing green space opening to the local community for example a primary care centre near Sunderland, staff worked with NHS Property Services and a local charity, Groundwork, to convert derelict space into a community garden and allotment.

Case study: St Basil's Live and Work project in Sandwell, Birmingham

Sandwell and West Birmingham Hospitals NHS Trust (SWBHT) as a major employer in the Sandwell and West Birmingham area, developed one of its vacant properties to create 'The Learning Works' which is a centre that delivers a range of widening participation community projects and provides information for local people on how to access training and careers in the trust run in connection with local education providers and the local Jobcentre Plus.

Another initiative developed is St Basil's Live and Work scheme which provides accommodation for young workers for less than £43 per week, inclusive of all bills, and is open to 16 to 24-year-olds in the West Midlands. The scheme is "benefit-free" which means that young people get the opportunity to live and work without having to rely on welfare benefits.

The accommodation, a former nurses block, is now home to 32 young people and is comprised of eight flats. Each flat has four bedrooms, with shared kitchen, dining and bathroom facilities. It's located only 20 minutes away from Birmingham City Centre with reliable transport links and good local amenities.

Sandwell and West Birmingham NHS Trust made the former nurse's block available to the scheme in 2014, at which point it had stood unused for 16 years. The trust now offers apprenticeships to live and work on-site. An apprenticeship at the trust lasts for 12 months and provides an opportunity for young people to experience work in several areas including finance, healthcare support, business administration, and physiotherapy support.

So far, the scheme has helped over 130 young people through apprenticeships. More than 100 of these have gone on to secure full-time work at the trust or other local organisations.

The building that houses these young people is now owned by the local NHS trust, repurposing part of the NHS estate. As well as the social impact, the economy has been positively affected through financial and social return on investment (£14 gained from every £1 spent).

Reference: Corben, S. (2023) How the NHS estate can help reduce health inequalities, NHS England.

NHS GM as an anchor institution: Recommendations

- Establish a consistent narrative in NHS GM to show a strong commitment to social and economic development, emphasising the importance of anchor practices to combat poverty.
- Integrate procurement data with local economic development strategies to boost the local supply chain, especially through collaborations with SMEs that have shown adaptability in crises.
- Adopt the GM social value framework, ensuring genuine commitment from suppliers to deliver real value without over-promising.
- Evaluate and repurpose available NHS GM land for affordable commercial or residential uses, supporting the local economy and community initiatives. Prioritise social value when making decisions related to land sales or usage.

3.1c Action through the delivery of services

Responding to the financial wellbeing of patients

It is positive to see in the GM ICP strategy, a key action as part of the mission to strengthen communities is to continue to develop the live well programme and social prescribing. With over 200 social prescribing link workers in GM working alongside GPs and other community organisations, there is significant potential for health services to respond directly to the financial wellbeing of patients. Additionally, we are pleased to see a commitment to enhancing the provision of welfare and debt advice and guidance services in health and care settings.

There is a growing interest in the delivery of welfare rights, benefits and debt advice services in non-traditional settings. GMPA's Money Matters programme (detailed below) illustrates the reach these initiatives are able to have when services are delivered in partnership with trusted settings located within the community.

Whilst evidence on the impact of delivering services that respond to the financial wellbeing of patients is limited, there are a range of examples where this is happening or where is has happened previously. For example, Great Ormand Street Hospital has funded a longstanding welfare rights service on site. This service is delivered by Camden Citizens Advice Bureau. Funding is directly linked to the

overwhelming evidence linking poverty and health inequalities. The service advices families accessing Great Ormond Street Hospital on a range of issues, including:

- Benefits
- Employment
- Housing and homelessness
- Landlord and tenant problems
- Debt and money management
- Community care, including Children Act assessments
- Immigration and asylum
- Specialist advice and casework for EEA and Swiss nationals.

Maternity Action works more broadly to promote and protect the rights of all pregnant women, new mothers and their families. This includes locating services within health settings.

The organic growth in use of GMPA's MARTs by health professionals in parts of GM illustrates the demand among health professionals to support patients with income maximisation and in accessing other services that address the underlying financial difficulties they are experiencing. The MARTs enable professionals and volunteers, who may lack limited knowledge of the benefits system and other services that respond to the financial wellbeing of individuals, to make effective referrals. The MARTs guide the user through a conversation with someone about their underlying financial difficulties, allowing them to confidently make a referral to an organisation that can help tackle these issues and maximise that person's income.

The MARTs are currently being used by a range of teams in the NHS in Greater Manchester including community link workers/social prescribers, mental health, maternity and health development. This approach though has been bottom-up and piecemeal, both geographically and in range of service users. Given the potential benefits to health of using the MART, we should seek a more strategic approach to determining which NHS services should use the tool and in embedding its use.

Additionally, It is well documented that partnerships between primary mental health care and advice services are effective in improving individuals' financial circumstances and mental wellbeing (Beardon et al; Beardon and Genn, 2018). The cost-of-living crisis is having a greater impact on the mental health of people with financial difficulties. Research from the Money and Mental Health Policy Institute (2022) highlights that in England alone over 1.5 million people are experiencing both problem debt and mental health problems. A report by Bond (2023) shows that giving people money advice alongside talking therapies could double recovery rates for people with debt and depression – and help an extra 27,000 people recover from mental health problems each year. This would generate significant healthcare savings for NHS GM.

Case study: GMPA Money Matters programme

At GMPA, we are working with schools across two of Greater Manchester's boroughs to provide financial advice and support to parents through our Money Matters Programme.

The aim of the programme is to increase benefit uptake and support parents with debt management advice by working with schools to identify parents who may not access financial support services through traditional routes..

Money Matters is being delivered by a Financial Inclusion Officer who is working with GMPA, on secondment from Citizens Advice. As a debt and benefit adviser, the Financial Inclusion Officer is well-positioned to directly advise families on their debt and benefits to improve their financial situation. Since June 2022 we have achieved more than £180,000 in gains for household incomes, with most of this total coming from ongoing benefits income.

An evaluation of the first 12 months of the programme found:

- There is a significant need for Money Matters and similar programmes, as many people who are eligible for benefits do not access support through traditional advice services and face multiple barriers in accessing support. Many families who benefited from Money Matters were missing out on income that they were entitled to and reported that they would not otherwise have accessed support.
- Money Matters was able to reach a diverse range of families from minorities who often are the most impacted by poverty. Of those supported, 80% were female parents or carers, 42% were living with a long-term health condition or disability and 49% were from a BAME background.
- Maximising household incomes was empowering for families who benefited from Money Matters. Families shared that it was a dignifying and empowering way for people to improve their financial situation and physical and mental wellbeing, with some subsequently gaining employment.
- Schools who engaged with the programme reported that academic performance and attendance have improved for students of families who benefited.
- The school and partner relationships developed, and subsequent school engagement, were crucial to the success of the programme, and to reaching families who may not otherwise have accessed support. School staff and families both highlighted the value of the FIO being physically present in the setting and being available to deliver face-to-face advice. These positive relationships took time to develop, yet also enabled the FIO to identify further promotion opportunities, including attending school holiday clubs and pop-up uniform shops to reach families.

Source: Internal GMPA programme evaluation, 2023

Accessibility of services

The cost- of-living crisis is making it difficult for people to access health and care services due to a number of barriers such as difficulty in being able to travel to healthcare facilities due to transport costs, digital exclusion restricting ability to book appointments and prescription charges.

We are aware NHS GM Place Based leads are engaging with provider trusts to explore how to increase awareness of, and utilisation of, hospital transport offers to ensure people do not miss appointments because of travel costs. Crucial to this is engaging people with lived experience of poverty to gain an understanding about awareness of patient transport services, travel reimbursement schemes such as Healthcare Travel Cost Scheme, and discounted travel services. These insights are vital to identify areas that could be enhanced and how trusts can better support patients. For example, in response to the challenges patients are facing, a number of hospitals are piloting a range of interventions to address the most common issues underlying non-attendance, including free transport to appointments (Sheffield Children's, Birmingham Women and Children's), appointments being made available in schools (Leeds Children's Hospital) and different approaches to parents being able to receive clinical advice (Great Ormond Street). Furthermore, it is important for NHS GM Placed Based leaders to engage with provider trusts to see if there is any further way to promote the availability of free parking for those with Blue Badges, frequent hospital visitors, and parents with hospitalised children. It is equally vital to consider digital alternatives where appropriate, like virtual appointments, especially for working individuals or those who face travel constraints.

It is encouraging to see that NHS GM has written to NHS England to advocate for a monthly payment plan to be introduced for the pre-payment prescription scheme to increase affordability. A report by Healthwatch (2023) recommends GPs should offer people over the counter medications on prescription where they consider patients' ability to pay is affected by significant social vulnerability. The report emphasises while this approach has always been available, NHS policy has discouraged this since 2018 as a cost-saving measure. Given the current economic challenges many are facing, it would be beneficial for NHS GM to actively endorse and promote this reconsidered stance.

Action through the delivery of services: Recommendations

- Fund welfare rights, benefits and debt advice provision within health care settings, ensuring this approach is independently evaluated so that the evidence base for these services is strengthened. In doing so, consideration should be given to the capacity demands currently facing the advice sector, specifically in respect of the limited availability of specialist advisers. It may be necessary for GM NHS to use its resources to grow an develop additional adviser capacity and to consider what role is has to play in funding advice provision in non-health settings.
- Work with GMPA to promote systematic use of the MARTs across appropriate health settings.

- Specifically, consider how financial wellbeing support can be delivered to people accessing mental health services.
- Prioritise working closely with provider trusts to amplify the awareness and use of hospital transport offers, ensuring those affected by the cost-of-living crisis do not miss appointments due to travel costs. It is essential to engage with communities, especially those with lived experiences of poverty, to understand and identify areas of improvement in transport offers.
- Develop pilot programmes addressing cohorts of non-attendance within services due to socio-economic factors. For example, offering free transport to appointments, scheduling appointments within educational institutions where feasible, and diversifying ways parents can access clinical advice for their children.
- In light of the current economic challenges, NHS GM should champion the initiative where GPs are encouraged to prescribe over-the-counter medications to those facing financial hardships.

3.1d Measuring what matters

Effective data collection is the foundation for understanding the policies and initiatives that contribute to the prevention, reduction, and mitigation of poverty. Having up-to-date quantitative data and qualitative insights from people and communities on poverty is crucial for guiding the efforts of NHS GM and its partners to identify emerging patterns in health and care demand. For example, to inform resource allocation across the system and target interventions by population need or area where poverty is causing the biggest impact on the health and care service.

The cost-of-living crisis has heightened the urgency to utilise data effectively. More than ever, there is a growing need to employ real-time poverty data to identify and address emerging areas of unmet needs quickly. It is positive to see in the GM ICP strategy a key equality objective is to 'improve the collection, analysis and application of quantitative and qualitative equalities-related information, insight and learning to enable targeted action where required'.

The GM Advanced Data Science Platform (ADSP) and the development of the co-designed GM Health and Care Intelligence Hub, which brings together data, community insight, population health management tools, web-based tools, and guidance, is a welcome initiative and a significant step in the right direction to support people in health and care to understand health inequalities better. It is also encouraging to see that cross-sectoral intelligence is available through the Hub, facilitated through the GM VCSE intelligence group, and increased investment in VCSE capacity and skills to collate and analyse data and insight.

The continued development and application of the record-level longitudinal linked dataset across health and care from these technologies, data from the GM shared care record combined with other health and care data available nationally and via local flows from providers is also encouraging. However, this work can be further built on investing in analytical capacity to ensure data is being used to inform action to address poverty and deploy more anticipatory care models.

There are a number of notable examples nationwide where data-driven approaches have played a crucial role in informing action on poverty. From these examples, valuable lessons can be derived to enhance NHS GM population health management and design and the development of future targeted programmes.

An illustrative case is the clinical prioritisation health equity tool developed at University Hospitals Coventry and Warwickshire NHS Trust (UHCW). This tool has been designed to prioritise waiting lists based on wider clinical and social needs (see below). Another example is the Bradford District and Craven Health and Care Partnership Reducing Inequalities in Communities (RIC) programme set up in 2019 as a five-year programme. The RIC programme follows a population health management framework, using data and knowledge about local communities to see where there are the greatest inequalities. The programme has been overseeing the delivery of 21 projects, established to improve equity of access, particularly for homeless people, asylum seekers, and vulnerable women in central Bradford. The support offered through this work includes specific clinics (utilising an outreach bus to improve access) and providing additional support to improve/maintain independence.

Case study: Clinical prioritisation health equity tool, University Hospitals Coventry and Warwickshire NHS Trust (UHCW)

University Hospitals Coventry & Warwickshire NHS Trust (UHCW) have developed a clinical prioritisation health equity tool to prioritise waiting lists based on wider clinical and social needs. The tool is designed to be used across whole waiting lists to reduce health inequality developing or widening because of conventional waiting list management, so has an impact at a population level. Factors that contribute to health inequalities are built into the tool as part of the prioritisation algorithm. The target population can be defined locally by any inequalities variable that is included in patient management systems e.g. IMD score, ethnicity, protected characteristics, geography, etc. This can be customised by clinical specialty to reflect the needs of their specific population group. The tool can be used to add weightings to anyone within the Core20PLUS5 group, as well as broader measures of health inequalities.

Conventional use of waiting list management by the time of wait alone risks increasing inequality and this tool enables all patients to benefit from NHS constitutional standards, yet within that, aims to reduce health inequality by clinically prioritising care based upon objective, evidence-based drivers of clinical outcome. Furthermore, it can impact the drivers of health inequality by enabling the social determinants of health to be factored into scheduling care for patients. A key strength of the tool is its flexibility - it can be used more broadly across the system for any priority clinical condition or population group that experiences health inequalities by including the relevant measures. All clinical areas can be accommodated, and the tool enables population health management via impact at the individual level.

Reference: Coventry and Warwickshire Health and Care Partnership (2022) Health Inequalities Strategic Plan 2022-27.

Poverty measures

It is vital that the GM Health and Care Intelligence hub includes poverty measures that capture and assess short-, medium--, and long-term outcomes. Fogden et al (2022) suggest integrated care services should balance three types of poverty measures:

- Locally determined metrics monitored by both the health and care system and public and third-sector partners. For example, working with local authorities and partner organisations to utilise data from local anti-poverty strategies to inform place-based work. In particular, local authorities have access to individual data that directly measures poverty, such as the number of people living in households claiming Housing Benefit and Council Tax Support.
- To capture medium-term outcomes, use indicators such as measures of the extent to which health and care services are reaching out to those in need, the housing status and condition of the communities that the health and care system serves, and the recruitment of people with lived experience of poverty.
- To frame longer-term objectives for poverty reduction and to direct service delivery using statistics available at a national level on the number of children living in relative low-income by local area. Relative poverty is defined as children living in households where the income is 60% or less of the average (median) household income (after housing costs) (DWP, 2022). This should be supplemented with a broader range of national data that can be disaggregated locally.

Measuring what matters: Recommendations

- It is imperative that NHS GM and partners consistently continue to collect, share, and refine poverty data to understand the areas in Greater Manchester that are experiencing heightened challenges. By doing so, a more systematic understanding of the issue can be established, allowing for the development of enhanced and targeted approaches. Collaborative efforts in this regard will not only provide a clearer picture of the prevailing situation but also foster a unified approach to addressing the complexities of poverty.
- Work with GMPA to scale up the information available on the Hub about poverty in Greater Manchester and what more can be done at an organisational and system level, such as poverty awareness training materials.
- Engaging local citizens is important to improve the data that is available to the NHS GM and other local actors, NHS GM needs to increase public awareness about the use of its data and why data sharing can lead to better outcomes for the health and care service.

3.2 Advocacy

Central to actions across the NHS GM system to address poverty is the role of advocacy. NHS GM needs to strengthen its role in advocating for wider social policy change, working with partners to call out the government over the deep-rooted, structural issues driving poverty and health inequalities in Greater Manchester. Moreover, NHS GM should work with other integrated care services across the country to challenge the government's national policies and raise awareness about the consequences of long-term inaction on poverty and the cost-of-living crisis on the health and social care system.

A strong evidence base on the following should support this:

- Complete and consistent data on local poverty rates (using those metrics available at a local level), its drivers, and use population health management and data and intelligence.
- Pressures on current NHS services, resources, and the health and care workforce
- The potential gains associated with poverty alleviation.

Advocacy: Recommendation

NHS GM should amplify its advocacy for social policy reforms, utilising its evidence base and collaborating with partner organisations and other integrated care services to challenge national policies perpetuating poverty and health disparities.

3.3 Awareness

Strengthening awareness within the NHS GM system is fundamental to improving healthcare outcomes. Effective awareness hinges on recognising and valuing the lived experiences of those in poverty. In this section, we will highlight the pivotal role of NHS GM in intensifying its mission and ensuring the meaningful participation of individuals with lived experience of poverty in shaping the healthcare system supporting by committed and active leadership and effective implementation of the socio-economic duty.

3.3a Mission statement

NHS GM must set out the ICS commitment to tackling poverty and clearly define the health and social system's role, working in partnership with internal and external stakeholders and people with lived experience of poverty. This is the cornerstone for action as demonstrated by GMPA's 2023 report 'local anti-poverty strategies: good practice and effective approaches'. It is vital to ensure a shared understanding to serve as a reference for efficient and effective solutions and to signal across the system that poverty is everybody's business.

Mission statement: Recommendation

Adopt a clear vision and mission that acknowledges the role of the health and social care system in addressing poverty as a critical determinant of health.

3.3b NHS GM leadership

Active, committed leadership on poverty is required to drive change, coordinate strategic and policy responses, and provide a clear point of contact and accountability route for external stakeholders. We understand that NHS GM is required to have in place an executive board member with explicit responsibility for reducing health inequalities. However, poverty is a long-standing issue, and to drive change and co-ordinate anti-poverty activity, there needs to be a senior leader who is allocated an explicit anti-poverty portfolio responsibility.

There may be a question around the purpose of an anti-poverty lead when poverty is a cross-cutting issue already considered across NHS GM management remit. Our work with local authorities on the development and implementation of local anti-poverty strategies has demonstrated the importance of having a lead for anti-poverty to drive action to address poverty:

- Creating momentum and enthusiasm and maintaining focus on poverty internally and externally.
- Securing buy-in from external stakeholders from different sectors in the development and implementation of an anti-poverty strategy.
- Raising awareness among local communities about what work is being done to address poverty.
- Ensuring effective operational working delivery of the intended outcomes of an anti-poverty strategy.
- Build cultural change to strategically embed poverty and avoid poverty being included under the catch-all of 'inequality', where it has a tendency to get de-prioritised.

NHS GM leadership: Recommendation

- Strengthen leadership and accountability on poverty. Whilst the NHS GM board has a chief executive officer for population and health inequalities, there needs to be an anti-poverty lead with functional responsibility for addressing poverty.

3.3c Enhancing engagement with people with lived experience of poverty

People with lived experience of poverty must have a voice in NHS GM decision-making processes and governance, in order to counter the inverse care law, whereby those who need services the most are the least likely to receive them and least likely to feel safe to participate. Several health and care settings across the country, like

Norfolk and Waveney Community Voices (see below), demonstrate commendable community engagement practices. Nonetheless, many of these initiatives often face the challenge of short-termism. NHS GM should glean insights from these pilots to establish a sustainable infrastructure.

Case study: Norfolk and Waveney Community Voices

Norfolk and Waveney ICS are working with their local voluntary, community and social enterprise (VCSE) sector and district councils to pilot a new community engagement programme, which has been running since 2022.

Community Voices works with trusted local communicators to speak with communities who do not engage easily with local health services, including people affected by substance misuse and poor mental health. Listening to and learning from voices in these communities helped system partners to develop targeted resources, such as online information and subject-specific webinars, with messaging built around the issues identified through the feedback.

In Great Yarmouth, community champions are averaging around 100 conversations a month through their trusted network of 29 'go to people' across 11 community organisations. This builds on the COVID-19 related community engagement and communication work with the most hard-to-reach vulnerable residents who felt isolated during the pandemic. Using local insight and needs, two community operated food clubs were established to help make a difference to the lives of people in the area.

Norwich City Council have developed a live data feed that focuses on key neighbourhoods in their community, such as those affected by substance misuse and poor mental health. The data gives an indication of how positively or negatively an issue is being talked about within a community and how important this issue is on the ground. Responding to issues identified from this data and building it into how they plan and deliver services, Norwich is designing training that gives their trusted communicators practical tips on how to have specific conversations around mental health, bereavement, addiction and improving individuals' overall wellbeing.

Norfolk and Waveney ICB are creating an 'insight bank' as part of the Community Voices project. They're working with the University of East Anglia (UEA) to look at the best way to collect, store and use this anonymised, qualitative data as this will empower systems to move beyond information about treatment and services, to hear people's whole lived experience.

Reference: NHS England (2023) Case study: Norfolk and Waveney Community Voices – the power of shared insight across partners in an integrated care system.

There has been considerable work across the system to involve people and communities, with different parts of the ICS having their own participation, legal duties and responsibilities, and we are aware there are plans to develop a longer-term partnership approach to engagement. These legal duties, strong relationships within the system, and existing communications and engagement practices provide a

platform to be built on to improve engagement with people with lived experiences of poverty at the system level.

Below, we set out the following recommendations to be considered to enhance engagement with people with lived experiences of poverty, building on the national ten principles developed by NHS England (2021):

Enhancing engagement with people with lived experience of poverty: Recommendations

Increase the opportunities for experts by experience participation, working with key non-statutory partners. There needs to be a permanent structure such as an 'ICS lived experience advisory group' to ensure that people with lived experience of poverty have the opportunity to influence strategy and planning and support service design and transformation. This would require a commitment to sufficient funding, resources, training, and support to do so meaningfully and effectively. This would form one part of effectively implementing the socio-economic duty (see adopting the socio-economic duty, below).

NHS GM to support GMPA to identify how the panel would operate in practice and what mechanisms would be implemented to ensure it influences policy. This would involve the following steps:

- Establishing a community of practice around the co-production agenda to develop, learn from what works, and build on the assets of all ICS partners to develop a lived experience charter that would form part of the development and implementation of the NHS GM anti-poverty strategy.
- Toolkit and resources to support the workforce to engage with people with lived experience and deprived communities.
- Co-production delivery plans across the system.

3.3d Adopting the socio-economic duty

At GMPA, we believe NHS GM should voluntarily adopt the socio-economic duty to improve health outcomes for people and communities who experience socio-economic disadvantage in Greater Manchester. This would bring NHS GM into line with a growing number of public bodies in GM who have adopted and are actively implementing the duty, including Transport for Greater Manchester and five local authorities.

The socio-economic duty is a powerful tool available to public authorities to address socio-economic inequality and a central component of a strategic approach to tackling poverty.

The duty, contained in Section 1 of the Equality Act 2010, requires public authorities to actively consider the way in which their decisions increase or decrease inequalities that result from socio-economic disadvantage. Successive governments have chosen not to enact the duty, and socio-economic disadvantage is often missing from equality impact assessments that include consideration of other protected characteristics. In the absence of action at a UK government level, equivalent

legislation has been introduced in Scotland (known as the "Fairer Scotland Duty") and Wales.

The duty has not been enacted in England, but there has been voluntary adoption by many local authorities and some other public bodies. Our research found that in 2021, one in seven local councils had voluntarily adopted the duty, and over half were 'acting in the spirit of the duty' by considering socio-economic status in equality impact assessments for strategic decision-making and policy development.

At GMPA, we have been working with local and combined authorities and other public bodies to voluntarily adopt the duty and maximise the impact it can have through effective implementation. Through voluntary adoption, public bodies are beginning to evidence the positive impact the duty can have on the lives of the people they serve. Our report, 'The Socio-economic duty in action: Case Studies from England and Wales' produced with Just Fair, brings case studies from local authorities and public bodies in England who have voluntarily adopted the socio-economic duty and from the Welsh Government, who implemented the duty in Wales in 2021. The report finds that the impacts across England and Wales include encouraging more people into employment, addressing the cost-of-living crisis, preventing increases in school meal prices, and responding to the Covid-19 pandemic.

Below, we provide an example of adoption in the health and social care system in Wales. This example showcases the duty's role in shaping an organisation internally but also projecting a focus on tackling socio-economic disadvantage in the wider community.

Case study: Welsh Government

Following the adoption of the duty at the national level in 2021, the Welsh Government conducts Integrated Impact Assessments for strategic decisions which now includes considerations of socio-economic disadvantage. The impact of the duty has been particularly visible in centring considerations of socio-economic disadvantage during Covid-19 and in the changing healthcare landscape.

Vaccination Transformation Programme

Consideration of the duty was a central element of the Vaccination Transformation Programme in 2022. The Welsh Government recognised that equitable uptake of vaccination is needed across societies in Wales so that individuals, families, and communities are protected from the harms of vaccine-preventable disease. Reducing the inequities in access to key preventative healthcare was therefore central to the Welsh Government's design of their future strategy for vaccination in a post-Covid-19 context.

The Vaccination Transformation Programme was co-produced with key stakeholders. Task and finish groups supported the design and development phases of the programme – one of which was focused on inclusion and engagement, with a particular focus on vaccine equity. Equity was a design principle of the programme, embedded in all workstreams.

The resulting National Immunisation Framework (NIF), published in October 2022,

requires all Health Boards in Wales to prepare a Vaccine Equity Strategy. These strategies, which consider socio-economic disadvantage alongside protected characteristics and under-served groups, will be supported by a programme of work to address inequitable vaccine uptake, including by socio-economic status.

The national Vaccination Equity Strategy for Wales also sets out to reduce low uptake among deprived communities by a variety of means, including improving accessibility and affordability by creating local vaccination hubs on well-travelled transport routes.

By using the duty and co-production in designing the NIF, the Welsh Government has developed a framework directly contributing to reducing the inequalities of outcome in health and access to healthcare that result from socio-economic disadvantage.

A Healthier Wales

In 2018, the Welsh Government's A Healthier Wales, aimed to develop a seamless local health and social care model focussed on health and wellbeing, prevention, and accessibility. A transformation programme, comprising twenty six actions centred around four strategic visions, supports A Healthier Wales in developing a new model of care.

Integral to this model of care is the reduction of health inequities, which is included as one of the four strategic visions in the transformation programme. In addition, one of the twenty six actions is given over to tackling inequalities, although this goal has also been embedded across the programme in a whole systems approach. A new NHS Health Inequalities Group has been established to maximise the contribution of the NHS to tackling health inequalities. It will focus on service planning and delivery and be an example for the wider public sector.

Making the case for adoption of the duty

The connection between economic inequality and discrimination on the grounds of specific characteristics protected by the Equality Act 2010 is well established. Reducing these inequalities is simply not possible without considering socio-economic status.

The lack of a national political strategy for addressing poverty or dealing with the consequences of socio-economic inequality leaves local public bodies dealing with the fallout. A challenge for financially constrained public bodies such as NHS GM is establishing effective strategies and mechanisms that prevent decisions from compounding poverty, minimise the impact of socio-economic inequalities, and prevent and reduce poverty (rather than just alleviate it). The duty provides a lever to help public bodies think about how they address these challenges in a systematic way.

Additionally, adopting the duty aligns with the strategic approaches of Greater Manchester's public bodies and reinforces the broader, extensive anti-poverty work happening in the region. Given that a general election is required to take place within the next 15 months, there is potential for the duty to be officially enacted in the near

future. By proactively adopting and implementing this duty, NHS GM positions itself as a leader in national best practices, irrespective of whether the duty becomes a mandatory legal requirement or remains voluntary.

Finally, it is crucial to emphasise that the socio-economic duty complements existing duties, bringing added value to the efforts of the NHS GM in reducing inequalities of outcome related to socio-economic disadvantage. The duty is one of a series of duties in England that are instrumental in enabling public bodies to work proactively towards advancing equality and combating inequalities.

In this context, the ICB should be particularly cognisant of the overlapping yet distinct relationship with the Public Sector Equality Duty.

	Equality Act 2010: The Socio-Economic Duty	Equality Act 2010: Public Sector Equality Duty
Scope of the duty	Socio-economic disadvantage	Individuals and groups with protected characteristics
Required application of the legal duty	Strategic decisions	Proposed policies and practices
Outcomes in relation to equality	Reduce inequalities of outcome related to socio-economic disadvantage	Eliminate unlawful discrimination Advance equality of opportunity Foster good relations
Outcomes in relation to health and wellbeing	Reduce inequalities in health and wellbeing outcomes related to socio-economic disadvantage. Remove barriers to access to health services linked to socioeconomic disadvantage	Prevent negative impacts on health arising from discrimination Remove barriers to access to health services and other opportunities that influence health and wellbeing outcomes
The NHS 2022/23 priorities and operational planning guidance outlines that Integrated Care Systems have four strategic purposes, with one key goal being to address inequalities in outcomes, experience, and access. The socio-economic duty will significantly bolster and add value to this objective.		

Figure 1: Mapping the duties and expected health and equality outcomes. Adapted from Public Health Wales.

What does the adoption of the duty mean in practice?

To genuinely embed the duty and prevent it from becoming a tick-box exercise, a dedicated and multi-layered approach is needed to ensure its incorporation leads to real systemic changes. The following gives an overview of what implementation involves in practice:

- **Meaningful impact assessments:** Formally incorporate poverty and socio-economic disadvantage, alongside the existing nine protected characteristics in the Equality Act 2010, in equality impact assessments, equality plans, and the broader decision-making process and strategies. However, while the focus of the duty is at the strategic level, consideration should not be restricted only to high-level decision-making. The aim should be for consideration to be mainstreamed during project/service development and day-to-day frontline service delivery, as highlighted by the case studies below. This approach should add to, but must not detract from, compliance with the Public Sector Equality Duty contained in the Equality Act 2010.
- **Using data effectively:** NHS GM should commit to using a range of relevant data (that it already has available in most cases), including quantitative and qualitative, to inform the implementation of the socio-economic duty and develop clear success criteria to measure the impact of the implementation.
- **Having visible leadership:** Meaningful implementation of the duty requires strong and visible commitment from the NHS GM board as part of a broader cultural shift that embeds the priority to tackle socio-economic disadvantage at all levels of NHS GM. There need to be champions for the duty at a board level and organisational.
- **Working in partnership with people with lived experience of poverty:** Recognise the value of engaging with people with lived experience of socio-economic disadvantage and commit to finding new and sustainable ways to incorporate diverse expertise in policymaking to achieve successful outcomes (see 3.3c).
- **Engaging with key local stakeholders:** Collaborate with residents, civil society, and voluntary and community sector organisations to build awareness and understanding of the socio-economic duty and people's lived experience of socio-economic disadvantage and its impact on health outcomes, facilitate participative consultation, and develop strategies to tackle socio-economic disadvantage together.
- **Ensuring access to justice and monitoring impact and compliance**: Identify what works through monitoring and evaluation, skill-sharing, and innovation and introduce mechanisms that can embed accountability for the implementation of the socio-economic duty.

. Adopting the socio-economic duty: Recommendation

- NHS GM should commit to voluntarily adopting the duty. GMPA can support effective implementation and provide guidance on what adopting the duty means in policy and practice, delivering the work in a staged process.

Socio-economic duty implementation

At GMPA, we recognise the unique challenges that come with implementing the socio-economic duty, particularly considering the scale and intricacy of NHS GM. We can support the tailored adoption and implementation of the socio-economic duty, for implementation at both the system and organisational level. Our approach is structured in two stages, as detailed below:

Stage One: assessment of organisational readiness, data, training, and toolkit

The first stage will focus on evaluating NHS GM's readiness to incorporate socio-economic duties into its systems and processes.

An assessment will be made to clarify the scope of the duty on policies and practices. Furthermore, the existing anti-poverty efforts, policies, and procedures of NHS GM will be reviewed to offer guidance on how they can be improved to address socio-economic issues more effectively. NHS GM will be supported to gather, understand, and use data as an efficient tool for informed decision-making around the adoption of the duty. Training sessions will be conducted to ensure awareness and understanding of the duty at all levels of the organisation, explaining its importance and how it plays a role in tackling poverty. A toolkit will be provided with resources like template policies, examples of successful implementations, strategies, and tools to ensure the duty's adoption results in maximum impact.

Stage Two: strategic partnership, lived experience engagement and networking

In the second stage, the emphasis will shift to a long-term strategic partnership with GMPA. This involves assisting in piloting the implementation of the duty in specific target areas, assessing the impact of the duty, and reviewing outcomes or changes that arise from considering socio-economic disadvantage. The objective is to ensure that all strategies are regularly evaluated for their effectiveness against socio-economic disparities. In tandem with this, there will be a development of a working group comprising of members from the organisation and community and a broader local network, encompassing different sectors, to support and continually assess the implementation of the duty. There will also be a strong focus on engaging with individuals who have lived experiences of poverty. Training will be provided on how best to engage these individuals, and their insights and feedback will be gathered to inform and refine strategies for the duty's implementation

4.0 Primary research findings

As part of this commission, GMPA undertook several methods of primary research to assess the role of NHS GM in tackling poverty. These included a survey of Greater Manchester residents (see appendix 1 for the list of questions used), focus groups of people with lived experience of poverty, a survey of Greater Manchester Health and Care professionals (from both the public and VCSE sectors) (see appendix 2 for the list of questions used).

Below is a thematic summary of the findings of this research structured into four key themes:

- Household income, cost implications and accessibility of GM NHS health and social care services
- Awareness of GM NHS assistance/schemes
- Assistance and responsibilities of NHS health and care professionals
- Effect of financial hardship on mental/physical health

Within these themes, the overall key findings from each relevant question are highlighted from the GM resident survey, the GM health and professionals survey, and the focus groups for the lived experience of poverty focus in this section. The findings from the GM resident survey are further broken down by age, local authority, household income and ethnic background, where distinctions within demographics are significant.

The findings from the primary research reinforce the need for a number of the recommendations set out in the literature review. The findings also demonstrate the need for a strategic approach to tackling poverty to be introduced and embedded across NHS GM. This is further elaborated on in chapter 5.

4.1 Household income, cost implications and accessibility of GM NHS health and social care services

Greater Manchester resident survey:

The extent to which household income impacts accessibility to NHS health and social care services

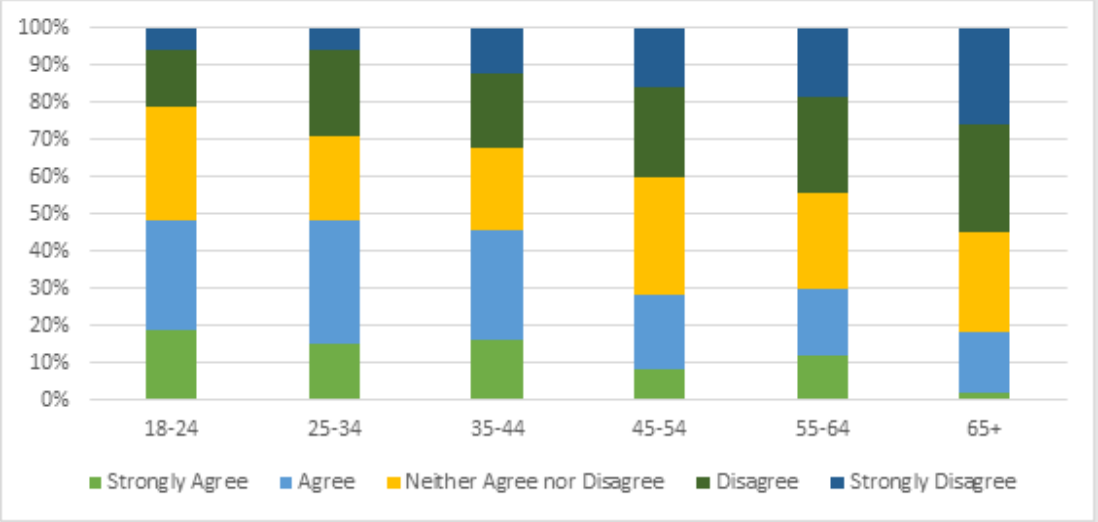
Overall 39% of all respondents either agree or strongly agree that their household income impacts their ability to access NHS health and social care services.

Age

As age increases, the percentage that disagrees/strongly disagrees that their household income impacts their ability to access NHS health and social care increases and the percentage that agrees/strongly agrees decreases, as seen in Chart 1. The 18–24-year-old age category has the highest percentage of those who strongly agree that household income impacts their accessibility to NHS health and social care services (19%) whilst the 65+ age category has the lowest percentage (2%). Inversely, the 65+ category has the greatest percentage of individuals that

disagree (29%) and strongly disagree (26%), whilst the 18-24-year-olds make up the lowest percentages in those categories (15% and 6% respectively).

Chart 1: Age of GM residents and the extent to which they agree that household income impacts accessibility to NHS health and social care services



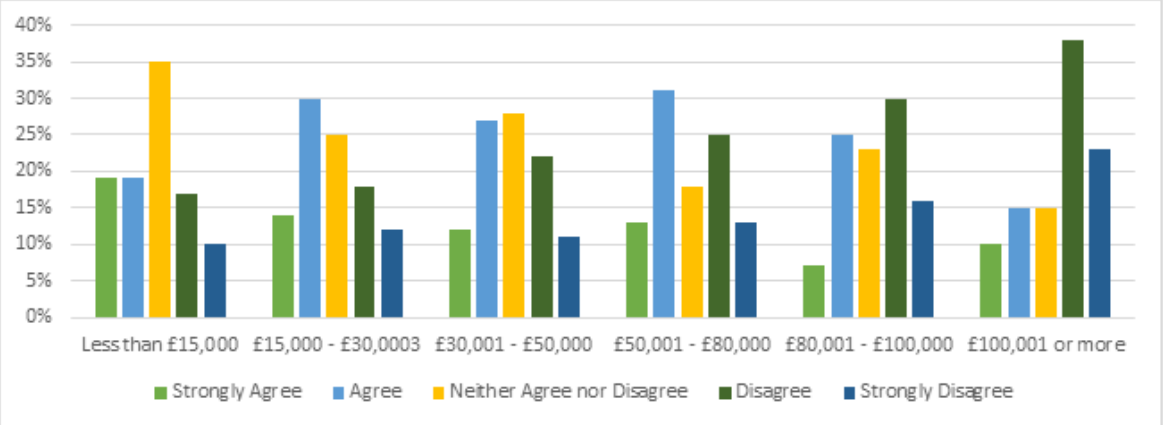
Local Authority

Across all local authorities in Greater Manchester, Salford ranked the highest for those who strongly agree that their household income impacts their ability to access NHS health and social care services (27%) by a large margin, compared to the other local authorities, with Manchester ranking the highest in those that agree (32%), followed closely by Bolton, Rochdale, and Wigan (31%, 30%, and 29% respectively). Amongst those who disagree that household income impacts their ability to access NHS health and social care services, Oldham and Bury have the highest percentage of individuals that disagree and strongly disagree, respectively.

Household Income

In terms of household income, as household income increases, the percentage of those who disagree/strongly disagree that their household income impacted their accessibility to NHS health and social care services increases, whilst the percentage of those that agree/strongly disagree decreases, as highlighted in Chart 2. The income bracket of 'less than £15,000' has the highest percentage of those that strongly agree to the statement (19%) amongst all income brackets, whilst the income bracket of '£100,001 or more' has the highest percentage of those that disagree (38%) and strongly disagree (23%) with household income impacting their ability to access NHS health and social care services.

Chart 2: Household income of GM residents and the extent to which they agree that household income impacts accessibility to NHS health and social care services



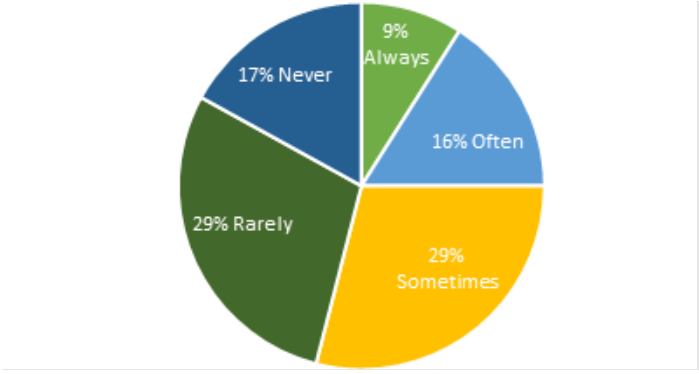
Ethnicity

In general, individuals from a black and minority ethnic (BAME) background were more like to agree/strongly agree that their household income impacts their ability to access NHS health and social care services, compared to their white counterparts. Asian/Asian British respondents make the highest percentage of those that strongly agree (24%) and Black African/Caribbean/Black British have the highest percentage that agree (48%) amongst all ethnicities. In contrast, 24% of those identifying as white disagree, whilst having the highest percentage of individuals that strongly disagree (14%) amongst all ethnicities.

The extent to which cost implications are considered by NHS health and social care professionals

Overall, as seen in Chart 3, most respondents believe that cost implications for patients (such as time away from work, distance from your house, childcare responsibilities, parking etc.) are not always being taken into consideration by the NHS, with cost implications being taken in account either 'sometimes' (29%) or 'rarely' (29%).

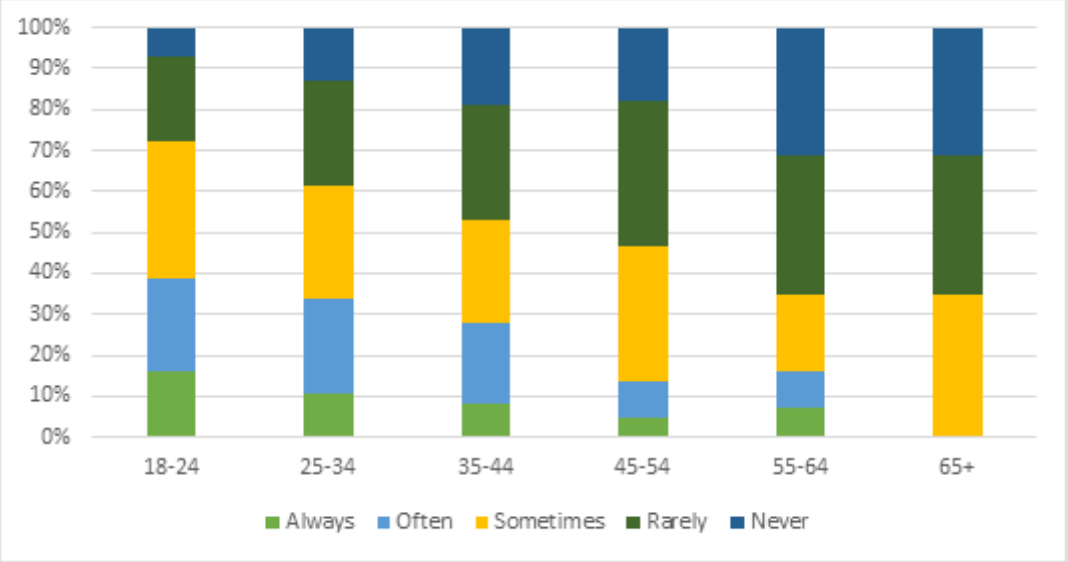
Chart 3: GM residents on how often their cost implications are considered by NHS health and social care professionals



Age

As the age of the respondents increased, the percentage of individuals that have 'always' or 'often' felt that cost implications are taken into consideration by NHS health and social care professionals (when appointments are scheduled) decreases – as identified in Chart 4 – whilst the percentage of those that have 'rarely' or 'never' experienced costs being taken into account by NHS professionals increases – with no individuals 65+ stating that cost implications are 'always' or 'often' taken into consideration by NHS professionals, whilst the group holding the highest percentage of those that have 'never' felt that cost implications are taken in consideration (in conjunction with the 55–64 age group, at 31%).

Chart 4: Age of GM residents and how often their cost implications are considered by NHS health and social care professionals



Local Authority

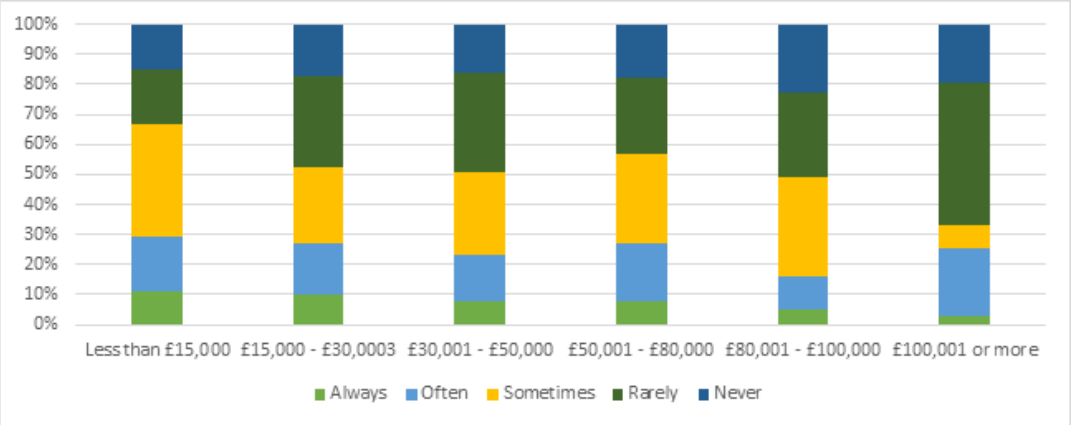
The local authority with the highest percentage of individuals that felt that cost implications are 'always' considered by NHS professionals when appointments were scheduled is Salford (20%), whilst the local authority with the highest percentage that felt that they are 'often' considered was Manchester (21%). On the other hand, the local authority with the highest percentage of individuals that felt that cost implications are 'never' considered or 'rarely' considered by NHS professionals were Rochdale (31%) and Bury (42%) respectively.

Household Income

The income brackets of 'less than £15,000' and £15,001-£30,000 have the highest percentage of individuals that believed that cost implications were 'always' considered (11% and 10% respectively) by NHS professionals when appointments were scheduled, whilst the '£100,001 or more' income bracket has the lowest

percentage of those that believe that cost implications were 'always' considered (3%), as seen in Chart 5. Correspondingly, those with an income of '£100,001 or more' have the highest percentage of those that felt that cost implications were 'rarely' considered (48%) across the income brackets.

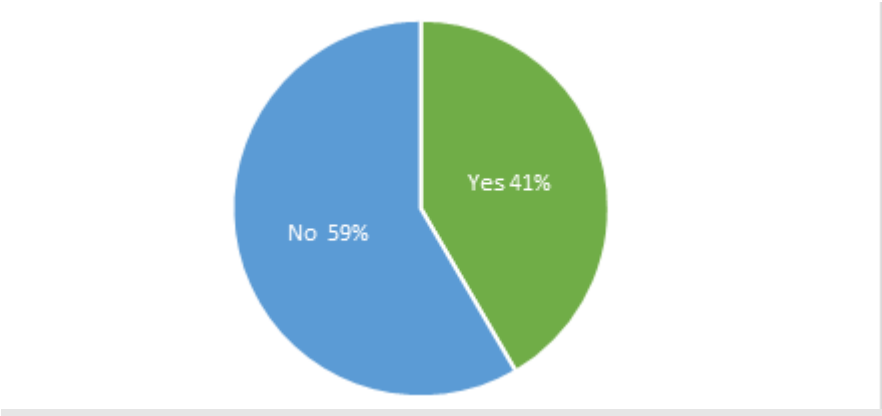
Chart 5: Household income of GM residents and how often their cost implications are considered by NHS health and social care professionals



Instances of not accessing NHS health and social care service or amenity due to cost implications

Overall, Chart 6 showcases how 41% of respondents identified as to not having accessed an NHS service or amenity due to cost implications (such as time away from work, distance from your house, childcare responsibilities, parking etc.), identifying cost implication to be a significant barrier in NHS GM.

Chart 6: GM residents on having faced circumstance where they could access NHS health and social care service or amenity due to cost implications

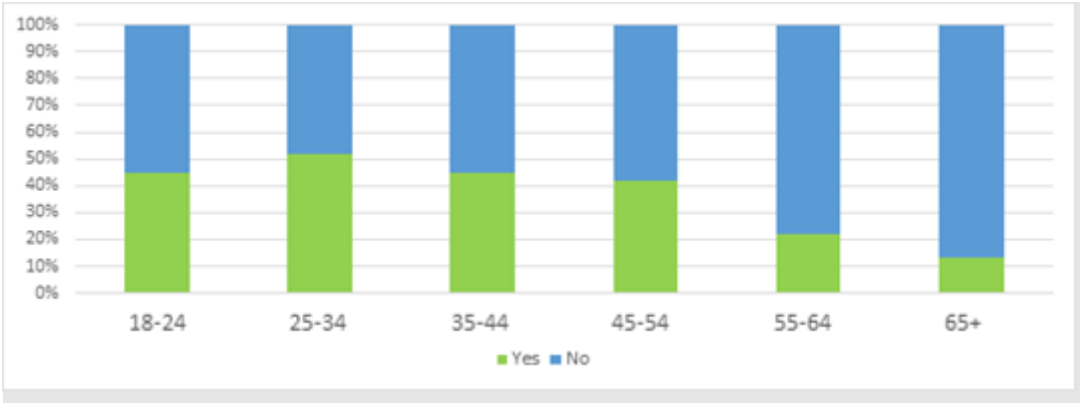


Age

As age increases, the percentage of individuals that answered 'yes' to not

accessing an NHS service or amenity due to cost implications decreases, as seen in Chart 7. The 25-34 age group has the highest percentage of individuals identifying to having not accessed a service/amenity due to cost implications (52%), whilst the 65+ age group has the lowest percentage of individuals facing such circumstance (13%).

Chart 7: Age of GM residents and having faced circumstance where they could access NHS health and social care service or amenity due to cost implications



Local Authority

Salford has the highest percentage of individuals that have not accessed an NHS service or amenity due to cost implications (51%), being the only local authority with the majority having their accessibility impacted by cost implications. Rochdale, on the other hand, has the lowest percentage of individuals having been impacted by such accessibility issues (31%).

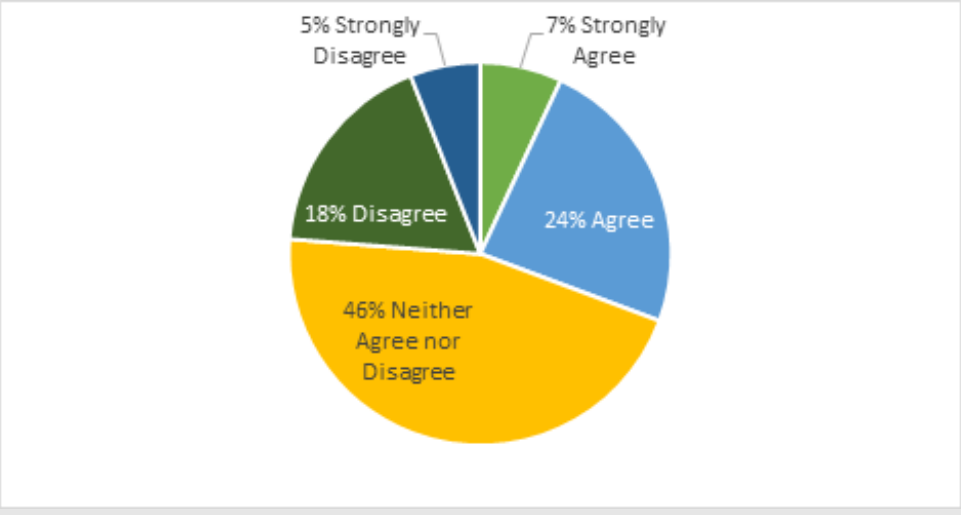
Ethnicity

Fewer individuals who identified as white stated that their accessibility to NHS services/amenities had been impacted by cost implications (39%) compared to those that identified as non-white – with 50% of mixed/multiple ethnic groups, black African/Caribbean/black British, and other ethnic groups identifying not having accessed an NHS health and social care service or amenity due to cost implications, as well as 54% of Asian/Asian British.

The extent to which NHS health and social care services in GM have improved in accessibility to those facing financial hardships over the past two years

Overall, as showcased in Chart 8, 31% of respondents agree or strongly agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardship over the past two years (since the publishing of the King's Fund report on 'The NHS's role in tackling poverty: Awareness, Action and Advocacy (2021)), whilst the 46% neither agreed nor disagreed with the statement.

Chart 8: GM residents on the extent to which NHS health and social care services in GM have improved in accessibility to those facing financial hardships over the past two years



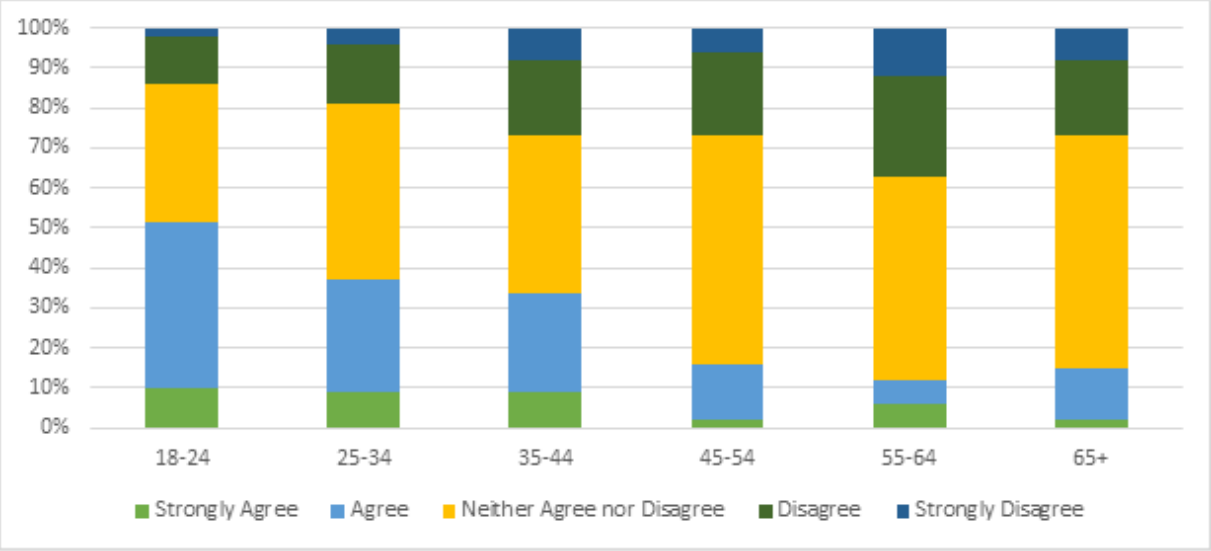
Gender

A greater percentage of men agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years than women that agree (30% and 17% respectively).

Age

The 18-24 age group has the highest percentage of individuals that 'strongly agree' and 'agree' that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years (10% and 42% respectively) amongst the age brackets. In contrast, the age group of 55-64 year olds has the highest percentage of individuals that both 'disagree' and 'strongly disagree' (25% and 12% respectively) amongst all the age groups. However, overall, all age groups (bar 18–24-year-olds group) 'neither agree nor disagree' that NHS health and social care services in Greater Manchester becoming more accessible to those facing financial hardships over the past two years, as seen in Chart 9.

Chart 9: Age of GM residents and the extent to which they believe that NHS health and social care services in GM have improved in accessibility to those facing financial hardships over the past two years



Local Authority and Household Income

The trend of the majority of individuals neither agreeing nor disagreeing that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years continues across the local authorities and household income demographics, as seen in Chart 10 and Chart 11.

Chart 10: Local Authority of GM residents and the extent to which they believe that NHS health and social care services in GM have improved in accessibility to those facing financial hardships over the past two years

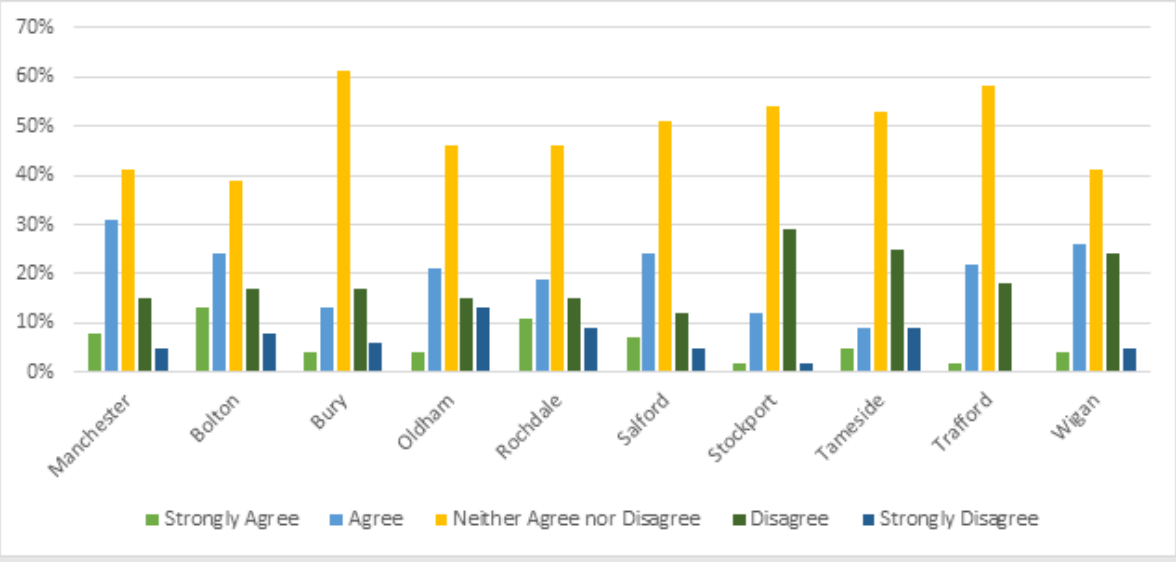
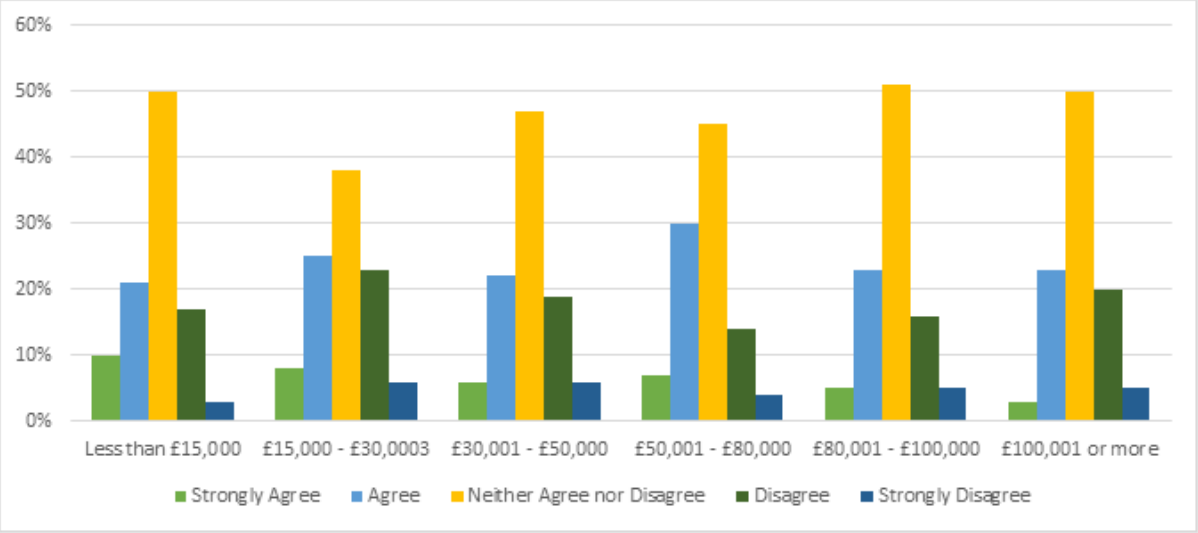


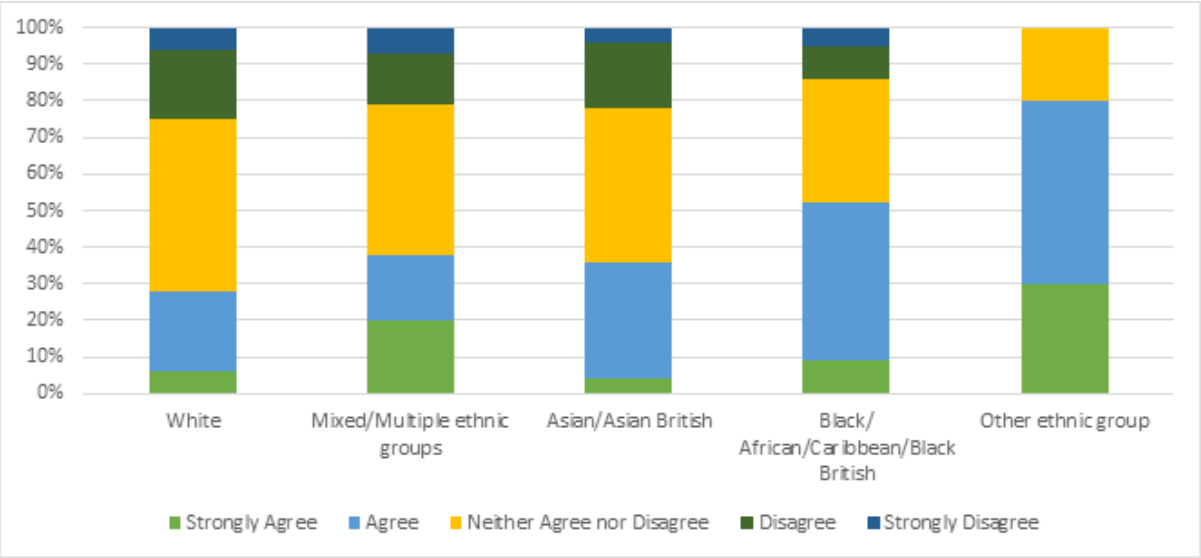
Chart 11: Household income of GM residents and the extent to which they believe that NHS health and social care services in GM have improved in accessibility to those facing financial hardships over the past two years



Ethnicity

Across ethnicities, those who identified as white are least likely to agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years compared to other ethnicities, as seen in Chart 12. Altogether, 28% of those that identified as white strongly agree and agree compared to those of mixed/multiple ethnic groups (38%), Asian/Asian British (36%), black African/Caribbean/black British (52%), and other ethnic groups (80%).

Chart 12: Ethnicity of GM residents and the extent to which they believe that NHS health and social care services in GM have improved in accessibility to those facing financial hardships over the past two years

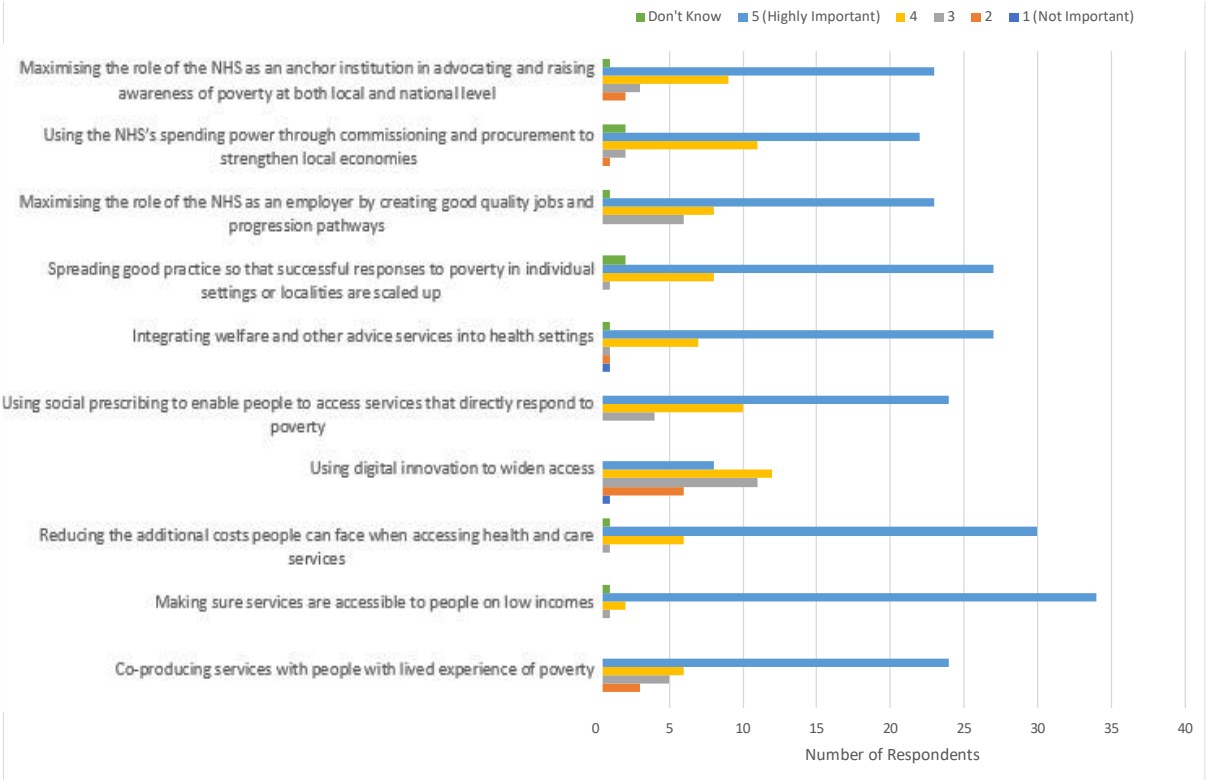


Greater Manchester Health and Care professionals survey

Health and care professionals on addressing poverty via health and care services

As seen via Chart 13, "Making sure services are accessible to people on low incomes" is the most popular 'highly important' option amongst health and care professional for health services to address poverty, with 89% of respondents ranking it a '5' (i.e. highly important). In general, all statements, excluding "using digital innovation to widen access", have a significant majority of '5's - i.e. are viewed as highly important in terms of maximising the way health services address poverty.

Chart 13: GM health and care professionals on the relative importance of various methods used in tackling poverty in health and care services



In the following open-ended question, directly assisting and/or supporting patients facing poverty via various tools, programmes and schemes (e.g., vouchers, social prescribing, helping with or directing to services helping with benefits/household income etc.) is the most popular option amongst health and care professionals in enabling the NHS to respond to poverty – with 26% of all responses stating the need for this. This is followed closely by the need to ease restrictions/barriers currently within health and care services/systems for greater accessibility to those from disadvantaged backgrounds, with 24% of all responses stating the need for this.

Lived-experience focus group

Lived experience of poverty and its impact on accessibility of health and care services

In accessing healthcare services, all participants mentioned transport costs as a key barrier, many referencing the cost-of-living crisis and fear of extending treatment through missing appointments. Some participants mentioned digital costs, childcare costs and costs specific to individuals that are undocumented and/or are seeking asylum.

> "I have a car that I can use to get to the hospital, but the cost of parking is so expensive that even if I have enough to get petrol for the car, I won't have the funds for the parking, it's extortionate, sometimes it's £10 for an appointment." (JO)

All answering participants highlighted the lack of adequate and/or effective communication by NHS staff towards patients being a significant barrier to accessing NHS systems/services, specifically the lack of regard for direct healthcare needs (particularly mental health) and a work culture that is more reactive than pro-active and is not based on empathy/compassion, as participants believe it should be. Other participants identified accessibility of information, digital exclusion, lack of consistency of care between boroughs, and a lack of adequate/effective communication within/between NHS and/or Health and Care staff as other key barriers.

> "When I was in Salford, it was fantastic. I used to be able to claim my petrol expenses back, because I can't use public transport because of the damage to my spine, so I can only drive or get taxis. I used to get my travel expenses refunded, [but] I don't here, there's a lot here that I don't get entitled to, so I struggle sometimes to get to the hospital. Sometimes I've had to rearrange my appointments because I'm skint and I haven't got the money for petrol." (LH)

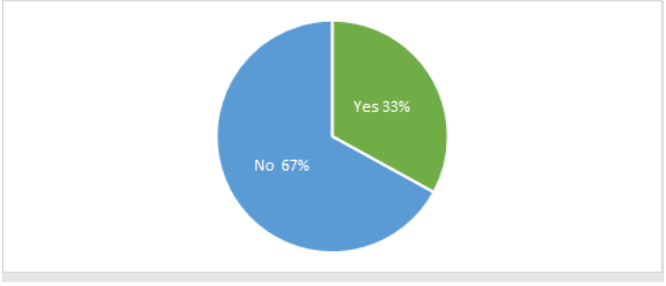
All answering participants believe that cost implications of accessing health and social care systems/services should be considered by the NHS.

4.2 Awareness of GM NHS assistance/schemes

Greater Manchester resident survey

Overall, two-thirds of all respondents could not identify any NHS schemes or assistance (such as help with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs (as seen in Chart 14).

Chart 14: GM residents on the awareness of NHS schemes or assistance they may be entitled to

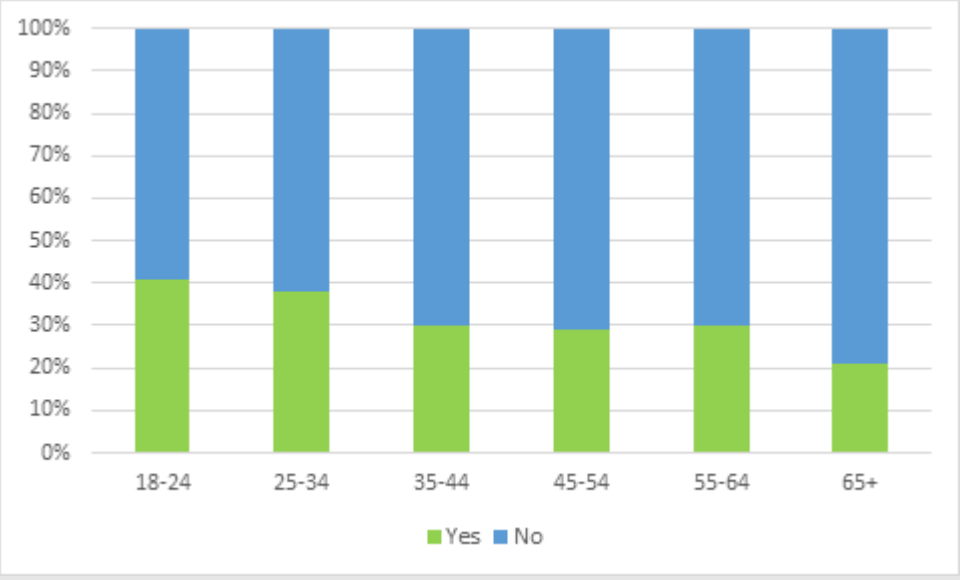


This trend is consistent across gender and household income demographics – with two-thirds of respondents not knowing any NHS schemes or assistance. However, some distinctions were seen across different age groups, local authorities, and ethnicities.

Age

As age increases, the awareness of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs decreases, as noted in Chart 15. The 18-24 year-olds age group has the highest percentage of those who are aware of NHS schemes or assistance that support with health and social care costs (41%), whilst the 65+ age group has the lowest percentage (21%).

Chart 15: Age of GM residents and their awareness of NHS schemes or assistance they may be entitled to



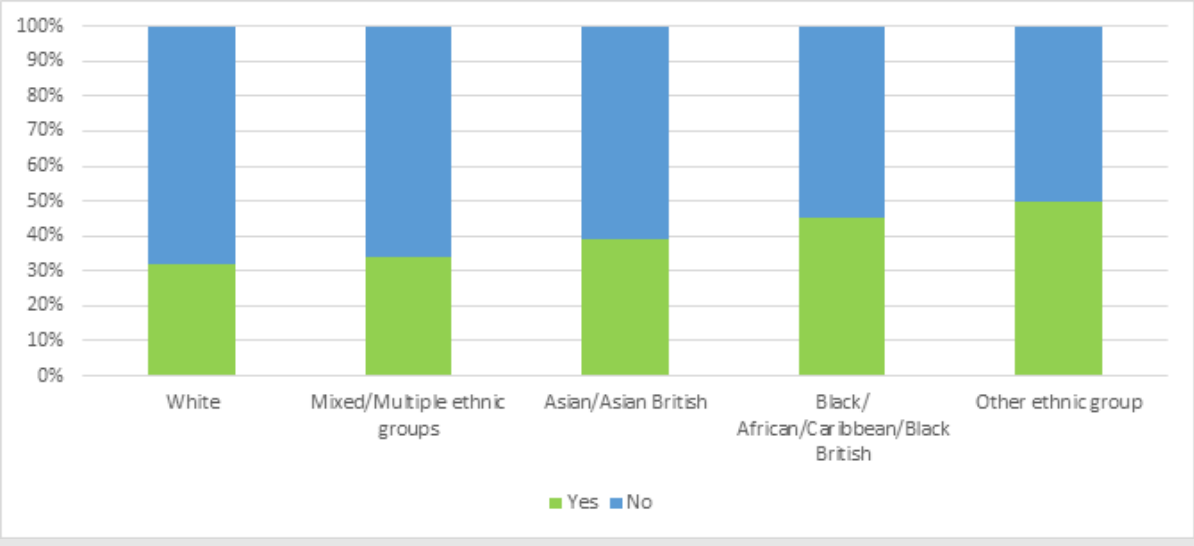
Local Authority

Bolton and Manchester have the highest percentage of individuals that are aware of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs (40% and 39% respectively), whilst Trafford has the lowest percentage of those who are aware (20%).

Ethnicity

Those who identified as white are the least aware of any NHS schemes or assistance (32%) compared to other ethnicities, with those identifying with the other ethnic groups category having the greatest awareness (50%), followed by those in black African/Caribbean/black British (45%), Asian/Asian British (39%), and then mixed/multiple ethnic groups (34%).

Chart 16: Ethnicity of GM residents and their awareness of NHS schemes or assistance they may be entitled to



Greater Manchester Health and Care professionals survey

Awareness of health and care professional on assistance/schemes within their health and care organisations that respond to poverty

39% of respondents stated that their organisation directly assists/supports individuals in-house, and 37% of respondents stated that their organisation actively seeks to introduce or change structures, systems and/or procedures to better accommodate those facing poverty. However, 21% of respondents – namely some from the NHS – were unaware of what their organisation does overall in responding to poverty outside their role/area, highlighting a need for an overall anti-poverty strategy (particularly by larger and more complex organisations such as the NHS).

Lived experience focus group

Lived experience of poverty and the awareness of assistance/schemes tackling poverty in health and care settings

The majority of participants had no knowledge of any scheme or support provided by the NHS to help overcome barriers caused by poverty. A few participants knew of some travel cost reimbursement schemes, social prescribers, and prescription certificate schemes. All highlighted that awareness of these things was a result of 'word of mouth' rather than direct information from health and care professionals.

> "The only way I have known about social prescribers is because I have been involved with the Poverty ruth Commission and Poverty Action Network. But our GP services don't tell us about this, they don't give the information that they have got and that they should be providing to the service users; they're not doing that." (YM – G1.P1)

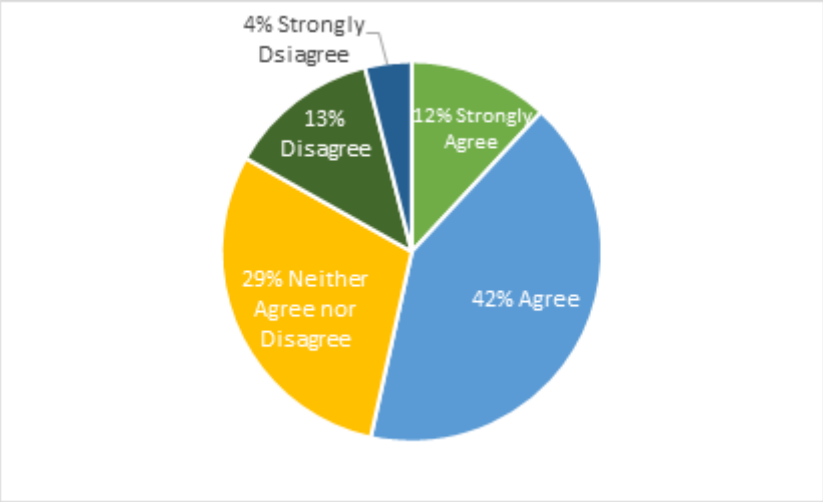
4.3 Assistance and responsibilities of NHS health and care professionals regarding financial hardships

Greater Manchester resident survey

The perceived responsibility of NHS professionals on assisting GM residents with financial hardship

Overall, 54% agree or strongly agree that NHS health and social care professionals have a responsibility to assist patients with financial hardship, as seen in Chart 16.

Chart 16: GM residents on the extent to which NHS professionals have some responsibility in assisting patients regarding their financial hardship



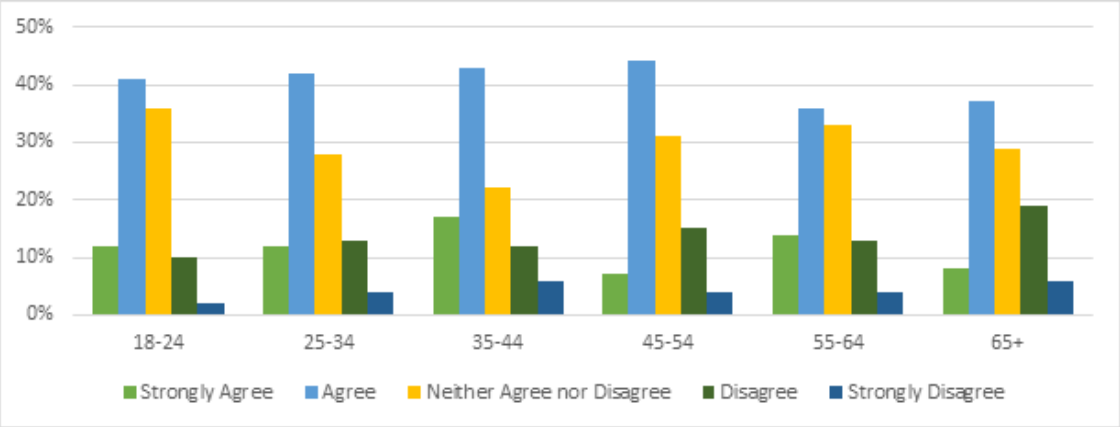
Gender

Men are more likely to agree to some extent (strongly agree or agree – at 13% and 43% respectively) that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships than women (who strongly agree or agree at 11% and 40% respectively).

Age

As seen in Chart 17, across different age groups, the 35–44 year olds had the highest percentage of individuals amongst all age groups that strongly agree (17%) and agree (43%) that NHS health and social care professionals have the responsibility to assist patients regarding financial hardship. On the other hand, the 65+ age group has the highest percentage of individuals that generally disagree (19% disagreeing and 6% strongly disagreeing) across the age groups.

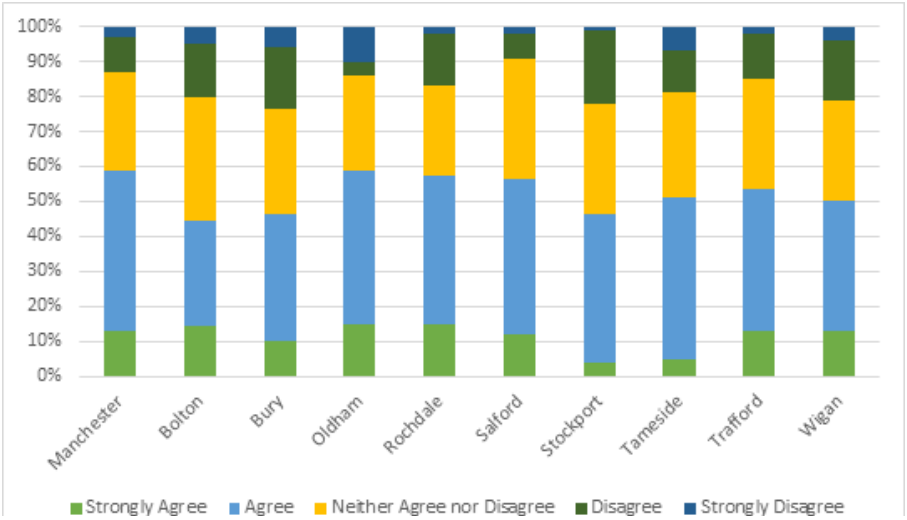
Chart 17: Age of GM residents and the extent to which they believe that NHS professionals have some responsibility in assisting patients regarding their financial hardship



Local Authority

Across all local authorities (except Bolton), the most popular response to whether NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships was 'agree'. Oldham and Rochdale have the highest percentages of individuals that agree (strongly agree – 15% for both, and agree – 44% and 43% respectively), whilst Stockport has the highest percentage of individuals that disagree with the statement (21%), as showcased in Chart 18.

Chart 18: Local authority of GM residents and the extent to which they believe that NHS professionals have some responsibility in assisting patients regarding their financial hardship

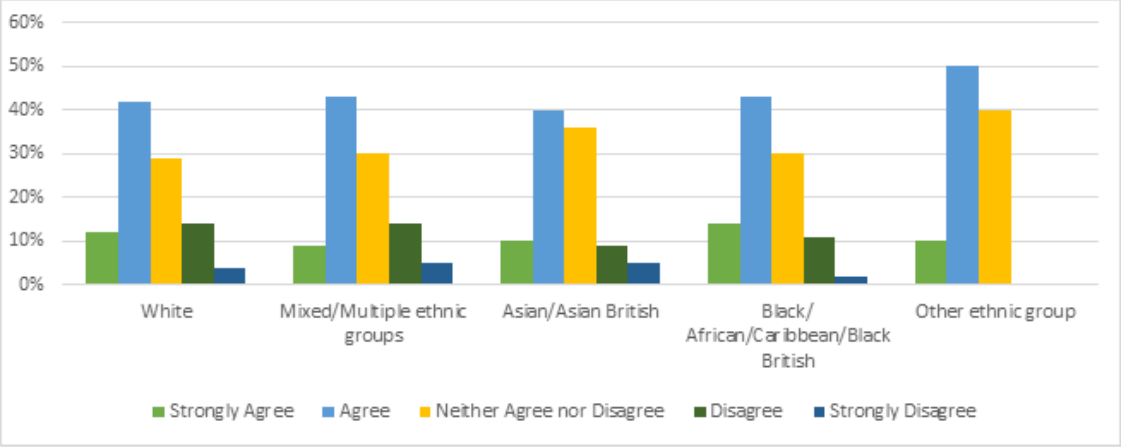


Ethnicity

At least 40% of respondents from each ethnicity agree that NHS health and social care professionals have the responsibility to assist patients regarding financial

hardship, as seen in Chart 19. Those from a white or mixed/multiple ethnic groups have the highest percentage of those who disagree (both 14%), whilst those in other ethnic groups have no respondents that disagree with the statement.

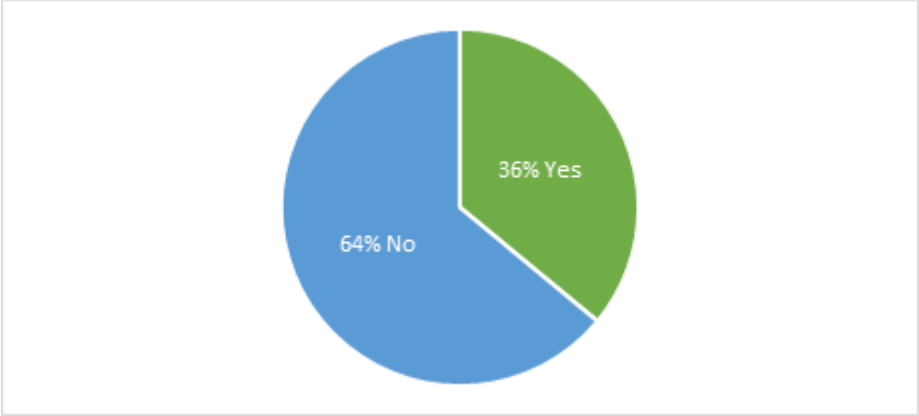
Chart 19: Ethnicity of GM residents and the extent to which they believe that NHS professionals have some responsibility in assisting patients regarding their financial hardship



Preferences of GM residents on raising financial concerns with NHS health and care professionals

Overall, almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals, as seen in Chart 20.

Chart 20: GM residents on whether they would raise concerns about their household's financial situation with NHS health and social care professionals



Gender

A greater percentage of men (38%) would share their financial concerns with NHS professionals than women (33%).

Age

From the 18-24 age group to the 55-64 age group, as age increases, the percentage of individuals willing to share concerns about their household's financial situation with an NHS professional decreases; with 43% of individuals in the 18–24-year-old age group willing to share, compared to 30% in the 55-64 year-old age group. However, individuals in the 65+ age group had a higher percentage of individuals (39%) willing to share their financial concerns with NHS professionals than all other age groups, bar 18–24-year-olds.

Local Authority

Across all local authorities, the majority of individuals are not willing to share their financial struggles with NHS professionals; Oldham has the highest percentage not willing to share (73%) and Manchester having the lowest percentage (58%).

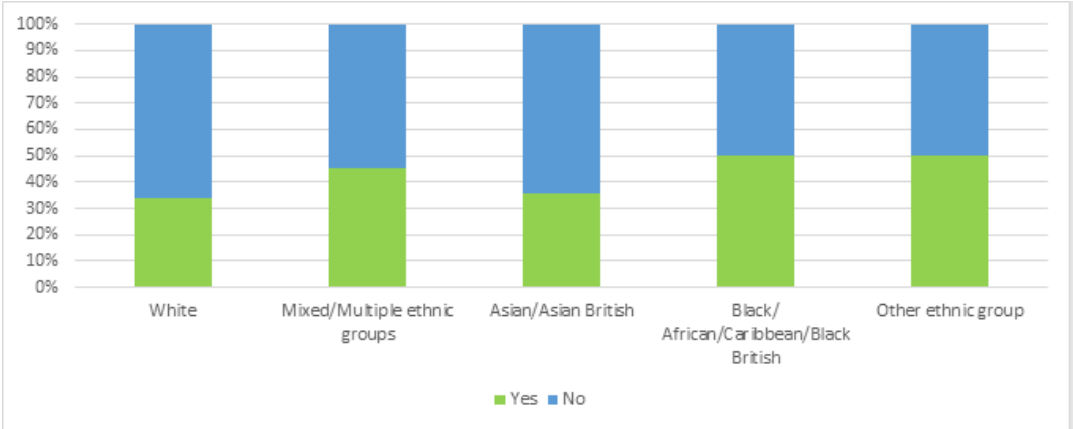
Household Income

Similarly, the majority of those that are not willing to share their financial struggles with NHS professionals applies across all income brackets (with at least 60% saying 'no') – with the '£100,001 or more' income bracket having the highest percentage stating so (73%).

Ethnicity

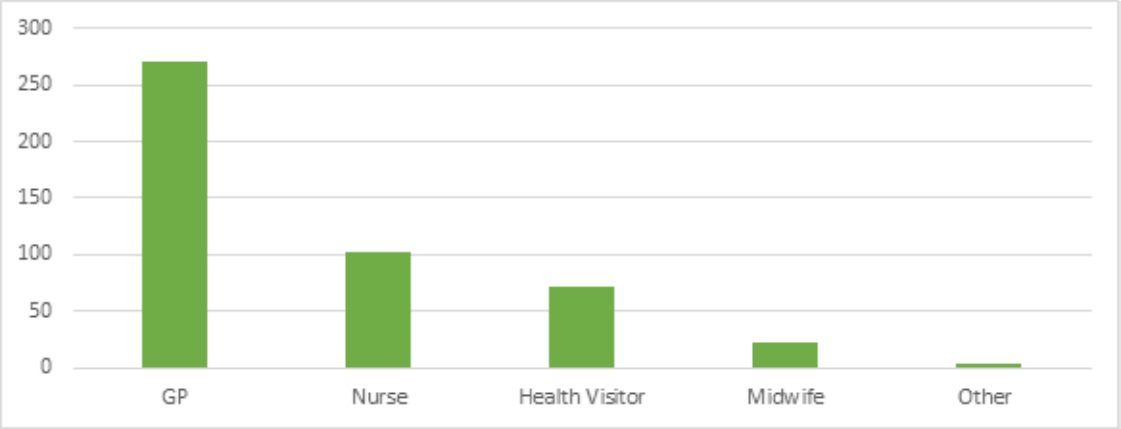
The majority of individuals who identify as either white, Mixed/multiple ethnic backgrounds, or Asian/Asian British stated that they would not raise their household financial concerns with NHS professionals (as seen in Chart 21) - those identifying as white having the highest percentage (66%) amongst the three groups. Those that who identify as black African/Caribbean/black British and other ethnic groups had an equal percentage of individuals willing to share their financial concerns with NHS professionals to those not willing to share (i.e. 50%).

Chart 21: GM residents on whether they would raise concerns about their household's financial situation with NHS health and social care professionals



Of those who feel comfortable in sharing concerns about their household's financial situation with an NHS professional (357 respondents), the majority (76%) were happy to share such concerns with their GP, followed by Nurse (29%), health visitor (20%), then midwife (6%) – as seen in Chart 22.

Chart 22: GM residents and preferences of healthcare professional(s) on raising financial concerns

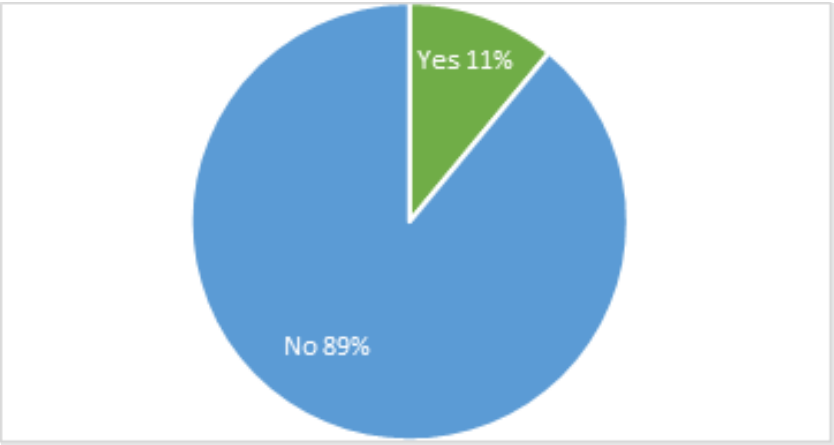


The general trend regarding the preference of the type of NHS healthcare professional amongst all demographics – age, gender, local authority, household income, and ethnicity – matches that of the general population with regards to the GP being the NHS health and social care professional individuals would be most comfortable discussing their financial concerns with.

GM residents on having raised concerns with NHS health and care professionals

Overall, as seen in Chart 23, a vast majority (89%) state that they have never raised concerns about their household's financial situation with an NHS health and social care professional.

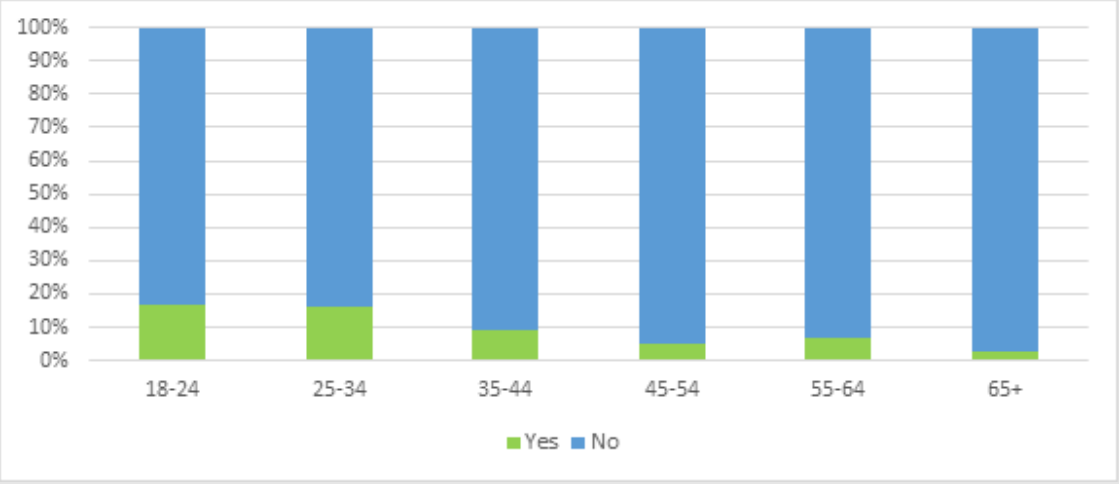
Chart 23: GM residents on having raised household's financial situation with an NHS health and social care professional



Age

Across the age groups, the percentage of individuals stating that they have never raised concerns about their household's financial situation with an NHS health and social care professional incrementally increases as age increases, as showcased in Chart 24. The 18-24 year-old age group has the highest percentage of those who raised concerns about their household's financial situation with an NHS professional (17%), whilst the 65+ age group has the lowest percentage (3%) of individuals that who raised concerns about their household's financial situation with an NHS professional.

Chart 24: Age of GM residents and having raised household's financial situation with an NHS health and social care professional



Local Authority

The local authorities with the highest percentage of individuals that have expressed their financial concerns to NHS professional are Bolton (16%) and Manchester (15%), whereas the local authority with the lowest percentage of individuals expressing their financial concerns is Trafford (2%).

Ethnicity

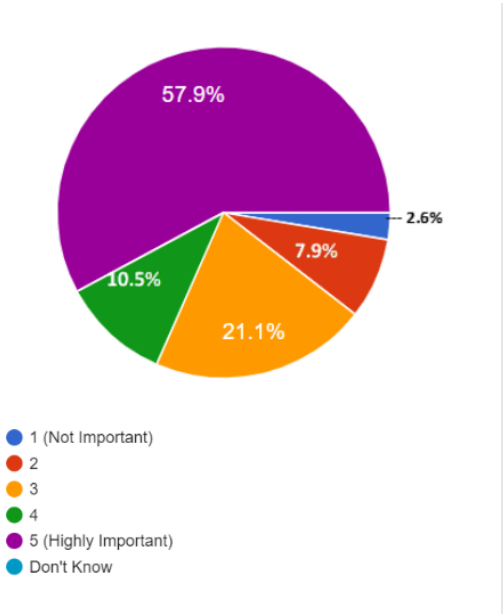
The ethnic group with the highest percentage of individuals that raised their financial struggles with NHS professionals are those that identified as black African/Caribbean/black British (23%). The ethnicity that has the lowest percentage of those that shared their financial situation with NHS health and social care professionals are mixed/multiple ethnic groups (9%), followed closely by white (10%) and other ethnic groups (10%).

Greater Manchester Health and Care professionals survey

Health and care professionals on the importance of, the prevalence of, and existing barriers to tackling poverty in their role and organisation

More than half (58%) identified tackling poverty to be 'highly important' to their role, whilst only 3% identified it as 'not important', as seen in Chart 25.

Chart 25: GM Health and care professionals on the importance of tackling poverty to their role



The need to tackle poverty to effectively in order meet the primary aims/objectives of the health and care professionals' job role (e.g. providing effective healthcare, ensuring accessibility to services/systems etc.) was the most popular reasoning (34% stating as such) as to how poverty was relevant to the respondents' job roles.

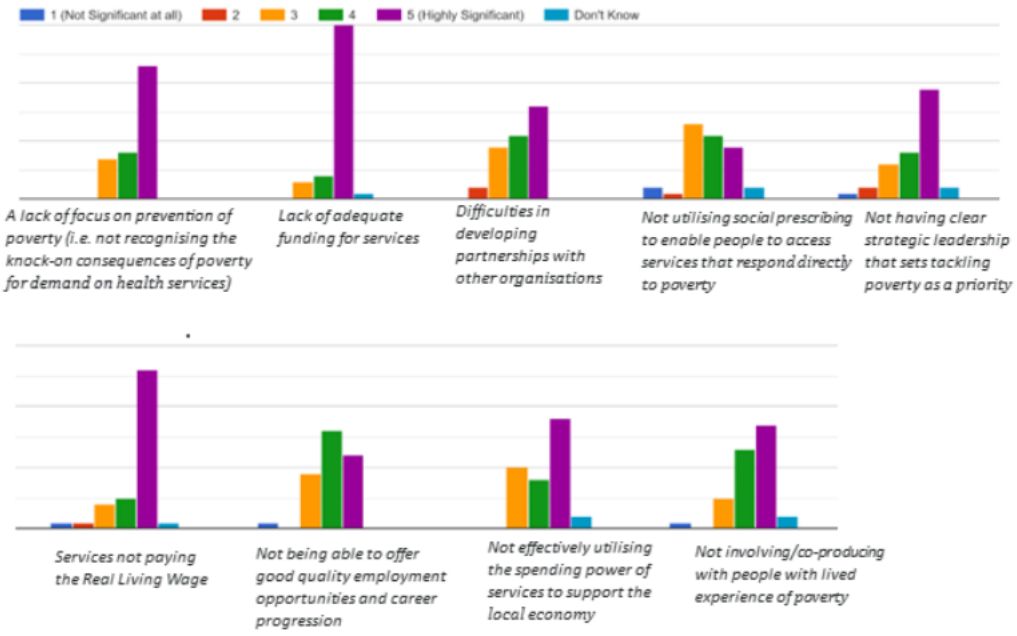
Many respondents stated that they helped tackle poverty in their role through multiple ways. 42% stated that they directly assist/support individuals via in-house tools, programmes, and/or schemes, such as giving vouchers or offering advice, whilst 37% of respondents stated to actively introducing or changing structures, systems and/or procedures – such as more effective teamwork and exchange of information, reducing barriers/accessibility issues caused by poverty, staff training to awareness/knowledge on poverty – to better accommodate those facing poverty.

71% of respondents stated that there are opportunities for them/their organisations to respond to poverty that aren't currently being realised. Most of the individuals that agree are either generally aware and open to new creative solutions/ideas being presented/undertaken (26%) or are eager to see improvements being made to existing actions/strategies/systems in tackling poverty (including expanding existing projects/networks) (26%). A lesser number agrees that opportunities to respond to poverty are present but are either presented by a lack of funding or resources (8%) or the lack of strategic focus placed on such issues by their role/organisation (11%). 18% of respondents do not know whether there are such opportunities present, whilst 8% state that there are no such opportunities at all.

79% of all respondents view a "lack of adequate funding for services" as a highly significant barrier to health and care services aiming to tackle poverty, as seen in Chart 26. This is followed by "services not paying the real Living Wage" (68% of all respondents ranking it as highly significant). In general, all statements – excluding "not utilising social prescribing to enable people to access services that respond

directly to poverty" and "not being able to offer good quality employment opportunities and career progression" – have a majority of '5's - i.e. are viewed as highly significant in terms of posing a barrier to health and care services aiming to tackle poverty. "Not utilising social prescribing to enable people to access services that respond directly to poverty" was seen as the least significant, with 34% of respondents labelling it as a '3' (i.e. neither significant or insignificant) in being a barrier to health and care services in tackling poverty.

Chart 26: GM Health and care professionals on the relative significance of various barriers to tackling poverty in health and care settings



In the follow-up open-ended question, 21% of respondents identified the lack of appropriate/adequate focus, awareness, or understanding of poverty and how to tackle it, being a barrier for health and care services in seeking to tackle poverty. This is followed by the barrier of professionals being unable to deal with the unique circumstances of individuals (e.g. disability, mental health, asylum status etc) or the specific needs of local areas due to financial/resource restraints, with 18% of respondents stating as such. Digital exclusion, lack of political will and/or effort by local authorities and/or government, and financial constraints faced by patients in accessing health and care were also identified as popular responses (with 8% of respondents for each response respectively).

Lived-experience focus group

Lived experience of poverty and raising financial concerns with health and care staff

All participants believe that the NHS is not providing adequate financial assistance in this cost-of-living crisis, instead highlighting a decrease in free services offered and services becoming more understaffed and remaining staff becoming overworked and therefore not being approachable for additional help.

> "They don't get what people are going through. So, they judge. And they're not there to judge. They're there to help, to serve…I think it depends on who you are and whether you're willing to be embarrassed. Cause, sometimes it is embarrassing [asking for financial support]. I think the compassion isn't there for them to be able come and ask you things in a manner that makes you feel comfortable enough to share." (TM)

> "I do think the NHS should be contributing to costs. A lot of people have difficulty getting to appointments. Even things like blood tests which used to be carried out in the doctor's surgery, are now carried out in town, which is either a bus or a car journey. If you can't get help getting to your blood test, you can't go to the local surgery now – things like that need to be addressed." (JO)

A majority of participants stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals, with only a couple stating that they would only be comfortable with their GP/family doctor. However, a majority of participants were also agreeable to having NHS approach them regarding their financial situation (to initiate a process of getting help/support), but only under particular conditions around anonymity/semi-discreteness and the staff having soft-skills and emotional intelligence. Some stated they would not want to be approached, or were unsure about being approached or not, because of stigma and how well the NHS can deliver on it with its current resource/capacity issues.

4.4 Effect of financial hardship on mental/physical health

Greater Manchester resident survey

The impact of financial hardship on GM resident's physical and mental health

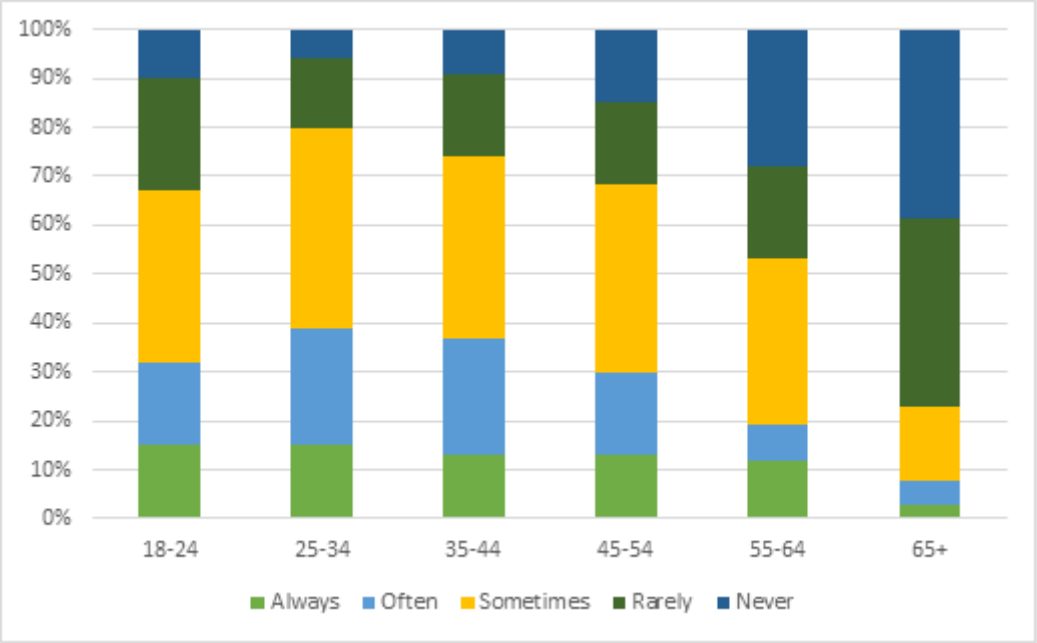
Overall, 31% of all individuals state that concerns and/or difficulties with household finances 'always' or 'often' impacts their physical and/or mental health, with over a third (36%) of individuals stating that concerns about and/or difficulties with household finances 'sometimes' impacts their physical and/or mental health.

Age

As age increases, the percentage of individuals that believe that concerns and/or difficulties with household finances impacts their physical and/or mental health decreases, as identified in Chart 27. The age groups 18-24, and 25–34 have the highest percentage of individuals that believe that concerns and/or difficulties with household finances 'always' impacts their physical and/or mental health (15%). Similarly, 25–34 year olds have the highest percentage that believe that concerns and/or difficulties with household finances 'often' or 'sometimes' impacts their physical and/or mental health (24% and 41% respectively), whilst having the lowest percentage of individuals that believe such concerns 'rarely' or 'never' impact their physical and/or mental health (14% and 6% respectively). Conversely, the 65+ age group has the lowest percentage of individuals that 'always', 'often', and 'sometime'

relate with the statement (3%, 5%, and 15% respectively), whilst having the highest percentage that 'rarely' or 'never' does (39%).

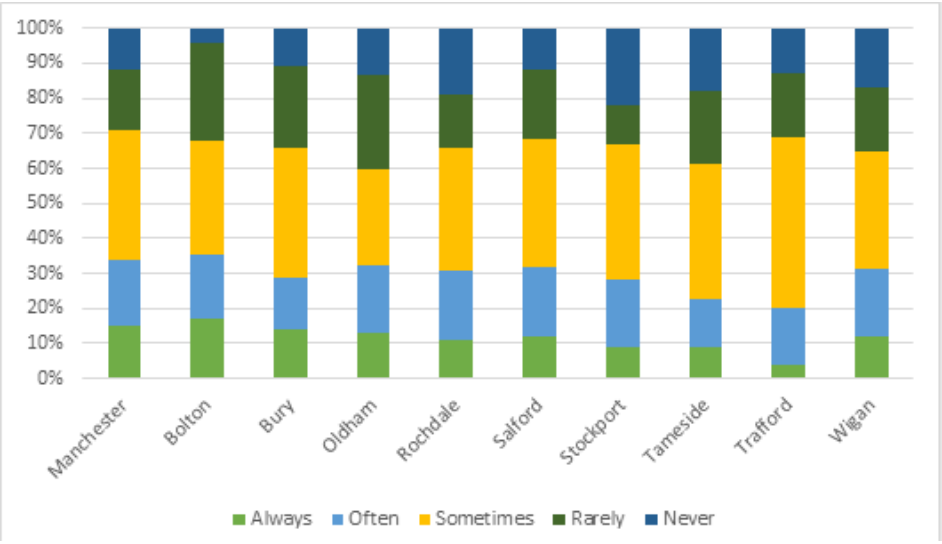
Chart 27: Age of GM residents and the impact of concerns/difficulties with household finances on physical and/or mental health



Local Authority

As seen in Chart 28, Trafford has the lowest – and a significantly lower – percentage of individuals (compared to all local authorities) that 'always' and 'often' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (20% combined). On the other hand, Bolton has the highest percentage that 'always' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (17%).

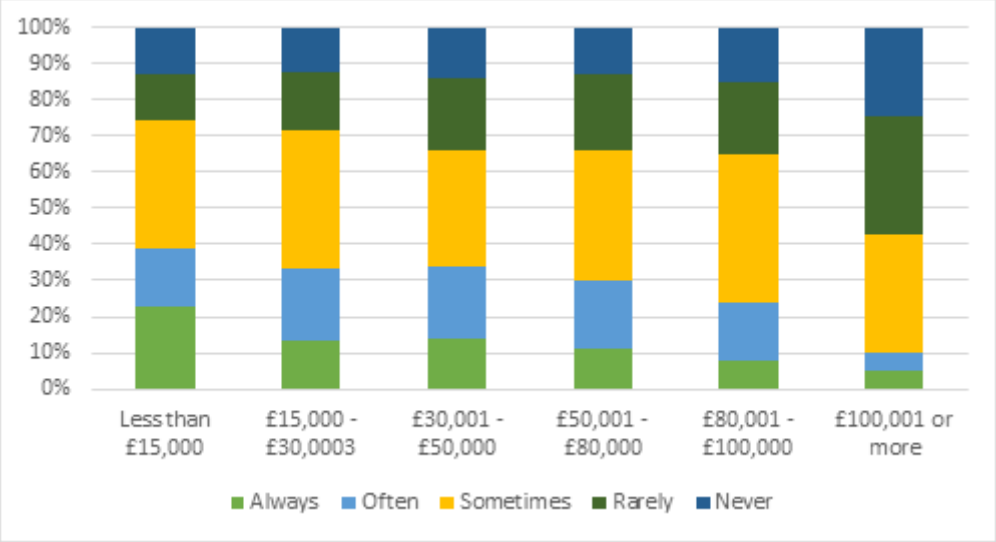
Chart 28: Local Authority of GM residents and the impact of concerns/difficulties with household finances on physical and/or mental health



Household Income

As household income increases, the percentage of those that experience the impacts or concerns about and/or difficulties with household finances on physical and/or mental health decreases, as evident via Chart 29. The lowest income bracket of 'less than £15,000' has the highest percentage of individuals that 'always' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (23%), whilst the '£100,001 or more' income bracket has the lowest percentage of such individuals (5%). The income bracket '£100,001 or more' has the highest percentage of individuals that 'rarely' and 'never' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (33% and 25% respectively).

Chart 29: Household income of GM residents and the impact of concerns/difficulties with household finances on physical and/or mental health



Ethnicity

Individuals identifying from mixed/multiple ethnic groups have the highest percentage of individuals that 'always' related to the statement (23%). Black African/Caribbean/black British individuals have the highest percentage of those who 'often' related to the statement (20%). However, those identifying as other ethnic groups have the highest percentage of those who 'rarely' and 'never' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (50% and 30% respectively).

Lived-experience focus group

Lived experience of poverty and the impacts on physical and mental health

All participants expressed strong opinions regarding concerns about/difficulties with household finances impacting their physical and/or mental health. The inverse was

also found to be true, with participants stating the cyclical nature of dire financial circumstance and deteriorating physical and mental health.

> "Yes, concerns about or difficulty with household finance does impact your physical and your mental health, because your mental health has a knock-on effect to physical health. Like I come out in a rash on my hands that makes my hands swell, crack, and I can't touch anything, because I stressed myself…I wake up some days, I think: what day is it?…Because I don't know how long I've got left of the week and it's that waking up in that pure panic of…How am I going to manage?…that is how it is; we don't live, we exist. We get through the week, we get through that month, we get through that year, and then it starts again. Every day your feet hit the ground and already your mind is racing on what you're going to do and how you're going to survive." (TM)

5.0 A strategic approach to tackling poverty

This report's literature review findings highlight a range of policies, initiatives, and actions being taken across NHS GM to address poverty. However, our primary research stresses the importance of making NHS GM more poverty-focused in its approach and operations. Addressing poverty should be a top priority, with an ambitious vision for substantial poverty reduction within the partnership.

NHS GM needs to maintain and further intensify its efforts, especially in light of the pressing challenges presented by the cost-of-living crisis. Moving forward, NHS GM must adopt a strategic approach to tackling poverty that builds on current successes and adds robustness to its anti-poverty initiatives. Central to this progression should be formulating an anti-poverty strategy, with an action plan outlining short-, medium-- and long-term actions.

Why is a strategic approach necessary?

The renewed focus on integration as a result of the Health and Social Care Act 2022 and the wider policy landscape of growing interest and the need for local public bodies to take action to address poverty provides an important policy opportunity that should not be wasted. The position around tackling poverty has rarely been as high as it is now. Through GMPA's work and the commitment of local political leaders and other stakeholders, there is a strong desire to address poverty in the city region. It has been positive to see a growth in public bodies showing an interest or developing strategic responses to poverty and policies and practices that address poverty.

Whilst many of the main drivers to tackle poverty lie with central government, there is no national anti-poverty agenda. A common challenge for local public bodies is a lack of support or direction as to how they can tackle poverty. In Greater Manchester and beyond, local councils have introduced anti-poverty strategies drawing on GMPA's anti-poverty framework.

Our work on local anti-poverty strategies has shown the value of a strategic approach in three specific ways:

- Firstly, they set clear objectives and identify how these objectives will be achieved, underpinned by a shared understanding of poverty and its causes.
- Secondly, they improve coordination and empower key local stakeholders to do more to address poverty, as there is a coherent framework helping to marshal limited resources and capacity and fostering a collective determination to address the issue across partners.
- Thirdly, they increase accountability for action as they provide measurable targets to understand if the actions set out are making a difference, but there is an emphasis on longevity and the ability to learn as the strategy progresses.

Central to the development and implementation of local anti-poverty strategies, ensuring partners are transparent and open regarding priorities and pressures has

been essential to building the trust required to forge meaningful collaborations and achieve common goals.

At GMPA, leveraging our expertise and networks, we intend to support NHS GM in the strategic utilisation of all available levers to maximise its contribution to addressing poverty, ensuring that working together across system partners leads to clarifying priorities and establishing a coherent set of shared goals.

NHS GM must adopt a long-term view and strategic focus on addressing poverty to shift the dial on the socio-economic determinants of health. Given the crowded landscape filled with competing priorities and barriers, adopting an ambitious yet realistic outlook on what can be accomplished within specified timescales and available resources is paramount. A strategic approach is not only vital for fostering a shared understanding among partners but also pivotal to fortifying and augmenting existing anti-poverty activities in Greater Manchester, thereby contributing to a sustainable anti-poverty ecosystem.

Our report highlights a real opportunity to build on and enhance existing work, leveraging the long-term relationships between GM institutions to create a shared strategy, vision, and set of shared outcomes. This will pave the way for the system to fully realise its potential in achieving the core purposes of ICS and the triple aim set out in the 2022 act, synchronising with broader local anti-poverty strategies and actions, and fostering more inclusive health and care services that are easily accessible.

Recognising barriers

Navigating the crowded landscape of health and care presents distinct challenges, particularly when the focus turns toward prioritising, planning, and allocating resources appropriately, especially in addressing poverty. In the current climate of tightening finances, increased demand, and rising cost pressures, we understand the widespread fears, concerns, and risks to the financial sustainability of NHS GM and key partners, including local government. It has been central to our work to be realistic about the implications for what the system can achieve; we are aware that NHS GM, on its establishment, inherited a system budget deficient of over £500 million (out of a total budget of £6.5 billion). Furthermore, there has been a 26% real-terms per person cut in the value of the public health grant to local authorities between the initial allocations for 2015/16 and 2023/24 (Finch and Vriend, 2023).

While the merit of a preventive focus is widely acknowledged, the reality of scarce resources and immediate pressures have often deprioritised long-term initiatives in favour of short-term solutions. This is a recurring theme, happening time and time again in health policy. As the Hewett Review (2023) aptly points out, there is a risk that preventive strategies and addressing health inequalities might be treated as 'nice-to-haves', only to be considered once immediate pressures have been addressed. Complicating the path to substantive progress within the GM context are pervasive barriers. These include political short-termism, courage, and a noticeable lack of political will to address poverty effectively. Further, our healthcare system's cultural expectations lean heavily towards immediate fixes, while media scrutiny tends to spotlight NHS performance, often overlooking wider determinants of health and the NHS's pivotal role in addressing poverty.

Despite the current challenges, pressures, and barriers that lie ahead, the imperatives to act have never been clearer, presenting a vital window of opportunity that necessitates immediate action. Now more than ever, there is a need to shift the focus to a strategic approach, particularly in light of the compelling insights and recommendations yielded from this report.

NHS GM is well-positioned not only to invest but also to spearhead a strategic approach to forge coherence in policy and priorities at a system and organisational level over the medium and long term. Such an approach will yield benefits across time and place. The key to this change is using evidence, embracing innovative methods, allowing experimentation, and sharing best practices. Using the practical recommendations and proposal for an NHS GM anti-poverty strategy in this report, we illuminate a viable path forward, embedding a proactive and sustainable approach to managing resources and initiatives.

The Strategy

The development of a dedicated NHS GM anti-poverty strategy is not intended to sit in isolation and repeat activity that other plans and strategies include. Instead, it aims to impart greater consistency, ensure close co-ordination of policy, and instil a sense of direction for NHS GM and its partners, guiding NHS GM's approach to poverty and guaranteeing the sharing, adding, and amplifying of efforts in the city region.

- Develop an NHS GM anti-poverty strategy that firstly defines poverty and its drivers, and targets the causes of poverty through actions responsive to the immediate cost-of-living crisis, as well as considering medium and longer-term actions. Local authorities and other partners in GM have well-established anti-poverty strategies and programmes. The integration of actions at an NHS GM system and organisational level will bring added value and enhance these existing approaches. Ensuring the strategy fits well into the GM anti-poverty ecosystem will foster coordination across partners, prevent siloed working, and make clear the role and efforts of NHS GM.
- To hold the system accountable externally and bolster existing efforts to tackle poverty, develop an NHS GM anti-poverty task force (this should involve relevant internal and external partners such as GMCA, local authority anti-poverty leads, VCSE sector, clinicians, and people with lived experience of poverty) to define the strategic vision of the strategy and the nature and role of each partner in addressing poverty. This will include, for example:
    - Developing a GM narrative on poverty and health.
    - Developing a permanent structure for lived experience engagement and co-production, such as 'ICS lived experience advisory group' to ensure that people with lived experience of poverty influence strategy and planning and support service design and transformation.
    - Identifying gaps and where work at an NHS GM system and organisational level can add value using this report's recommendations as a foundation.

- Strengthen leadership and accountability on poverty: whilst the NHS GM board has a chief executive officer for population and health inequalities, there should also be an anti-poverty lead with functional responsibility for addressing poverty. Alongside this, the establishment of appropriate governance structures, such as a strategic leadership group, to provide internal oversight on actions related to addressing poverty moving forward.
- Adoption and implementation of the socio-economic duty: NHS GM should commit to voluntarily adopting the duty. GMPA can support effective implementation and provide guidance on what adopting the duty means in policy and practice, delivering the work in a staged process.
- Metrics for measuring impact: building upon current initiatives like those at the GM Health and Care Intelligence Hub, the NHS GM Population Team, collaborating with partners across the system, should devise a clear set of metrics. This will enable the monitoring and evaluation of the strategy's impact and progress through both qualitative and quantitative methods.

Conclusion

Poverty is a significant, pervasive problem in the UK at the moment, exacerbated by the current cost-of-living crisis. Greater Manchester is home to some of the highest concentrations of poverty and deprivation across the country, with at least 620,000 people out of a population of 2.8 million living in poverty and poverty is a major issue in all ten of Greater Manchester's boroughs.

GMPA's research shows that NHS service users across Greater Manchester are struggling with the cost-of-living, and its impact on household finances has meant a staggering number of households reported not having accessed an NHS service or amenity due to cost implications. Overwhelmingly, the public in Greater Manchester weren't aware of NHS schemes or assistance they could access to get support with health and social care costs, but they were clear: NHS health and social care professionals have a responsibility to assist patients experiencing financial hardship.

NHS GM should be commended for commissioning this report and the background research; it is important to recognise an organisation for examining its own position in the fight against poverty. The introspection that NHS GM has shown by commissioning this piece of work demonstrates a clear understanding that the NHS is well positioned to support residents across Greater Manchester who are experiencing, or at risk of experiencing poverty and it is hoped that this report represents the beginning of the organisation's journey towards a systematic overhaul to make supporting people in poverty a central priority.

GMPA is well placed to hold an ongoing relationship with NHS GM in order to support progress of this report's recommendations.

Appendix 1: GM Residents' Survey Questions

Q1. To what extent do you agree that your household income impacts your ability to access NHS health and social care services?

Q2. Do you feel that cost implications (such as time away from work, distance from your house, childcare responsibilities, parking etc.) are taken into consideration by NHS health and social care professionals when appointments are scheduled?

Q3. Have you ever not accessed an NHS health and social care service or amenity due to cost implications (such as time away from work, distance from your house, childcare responsibilities, parking etc.)?

Q4. Are you aware of any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs?

Q5. To what extent do you agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years?

Q6. To what extent do you agree that NHS health and social care professionals have some responsibility to assist patients regarding their financial hardships?

Q7. If you had concerns about your household's financial situation, would you raise these with NHS health and social care professionals?

Q8. You said if you had concerns about your household's financial situation, you would raise these with NHS health and social care professionals (based on the previous question). Who would you feel most comfortable discussing your financial concerns with?

Q9. Have you ever raised concerns about your household's financial situation with an NHS health and social care professional?

Q10. Do concerns about and/or difficulty with household finances impact your physical and/or mental health?

Appendix 2: Health and Care Professionals Survey Questions

Q1. There are a range of ways in which the health service can tackle poverty. On a scale of 1-5 (where 1 is 'not important' and 5 is 'highly important'), how important do you think the following are in terms of maximising the way health services address poverty?

- Co-producing services with people with lived experience of poverty
- Making sure services are accessible to people on low incomes
- Reducing the additional costs people can face when accessing health and care services

- Using digital innovation to widen access
- Using social prescribing to enable people to access services that directly respond to poverty
- Integrating welfare and other advice services into health settings
- Spreading good practice so that successful responses to poverty in individual settings or localities are scaled up
- Maximising the role of the NHS as an employer by creating good quality jobs and progression pathways
- Using the NHS's spending power through commissioning and procurement to strengthen local economies
- Maximising the role of the NHS as an anchor institution in advocating and raising awareness of poverty at both local and national level

Q2. What else is important to you in respect of enabling the NHS to respond to poverty?

Q3. On a scale of 1-5 (where 1 is 'not important' and 5 is 'highly important'), how relevant is tackling poverty to your role?

Q4. In what ways do you help to tackle poverty in your role?

Q5. Thinking about the organisation you work for as a whole, in what ways does it currently respond to poverty?

Q6. Are there opportunities for you and your organisation to respond to poverty that aren't currently being realised?

Q7. One a scale of 1-5 (where 1 is 'not significant at all' and 5 is 'highly significant'), please indicate how significant a barrier the following are to health and care services trying tackling poverty:

- A lack of focus on prevention of poverty (i.e. not recognising the knock-on consequences of poverty for demand on health services)
- Lack of adequate funding for services
- Difficulties in developing partnerships with other organisations
- Not utilising social prescribing to enable people to access services that respond directly to poverty
- Not having clear strategic leadership that sets tackling poverty as a priority
- Services not paying the Real Living Wage
- Not being able to offer good quality employment opportunities and career progression
- Not effectively utilising the spending power of services to support the local economy
- Not involving/co-producing with people with lived experience of poverty

Q8. What other barriers for health and care services seeking to tackle poverty are you aware of?

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