# What can health settings do to tackle poverty?

A strategic partnership

NHS Greater Manchester | Resolve Poverty

## About us

**Resolve Poverty is a leading anti-poverty organisation that delivers locally and regionally focused anti-poverty activities across the UK.**

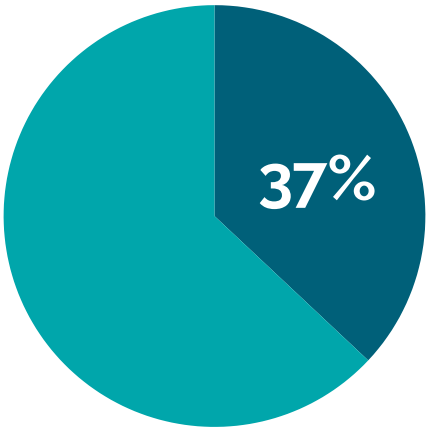
This guidance document intends to bring together the work that has taken place throughout the partnership between Resolve Poverty and NHS Greater Manchester (GM) Integrated Care Board (ICB) as a clear set of recommendations to ensure the design and delivery of health services and settings better support people experiencing poverty.

### Why focus on poverty?

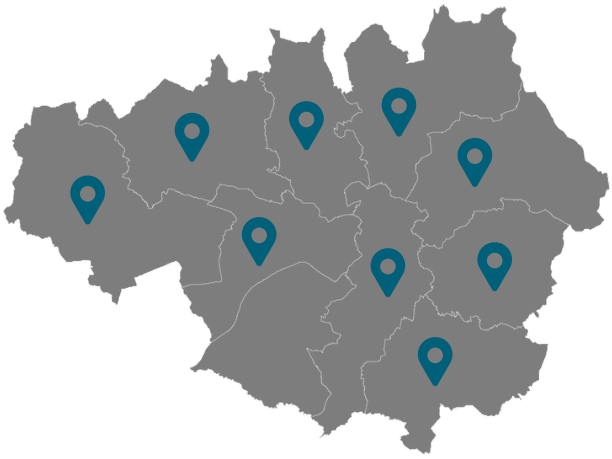
**Poverty and poor health are bidirectional in cause and effect: poverty is a key driver of poor health, and poor health is a key driver of poverty.**

Thus, those that experience poverty tend to experience poorer health outcomes and poor health outcomes can impact socio-economic status.

Poverty is a significant issue in Greater Manchester. Home to some of the UK's highest levels of poverty, 37% of children live in poverty across the city region and 9 of the 10 boroughs have child poverty rates1 higher than the national average (Resolve Poverty, 2024a).




**of children live in poverty across Greater Manchester**

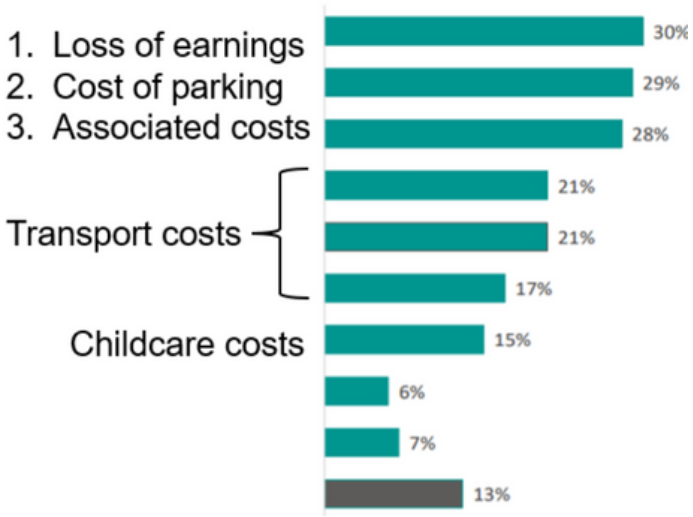


**9 of the 10 boroughs in Greater Manchester have child poverty rates higher than the national average**

**As well as taking a significant toll on individuals, poverty generates additional, preventable costs for the NHS.**

In 2016, the Joseph Rowntree Foundation (JRF) estimated the cost of poverty on healthcare (i.e., additional public spending due to greater health care need and use) at £29 billion, equivalent to £34 billion in today's prices (The King's Fund, 2024).

Poverty has a direct impact on the ability of local people to access NHS services, as shown by the statistics on the following page (Source: GM Residents' Survey (July 2024)).


For more in-depth analysis of poverty rates and other related statistics across the Greater Manchester city-region, please visit the North West Poverty Monitor (Resolve Poverty, 2024a).

All-in-all, the links between poverty and health are unambiguous: "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, [both] in direct costs to the state and in lost opportunity and productivity" (The King's Fund, 2022). Equipped with the correct knowledge and tools, NHS GM can mitigate, reduce and prevent the effects of poverty on health. Our recommendations seek to do just this.

## Recommendations

**The following recommendations were developed by Resolve Poverty for NHS GM to guide the design, delivery and evaluation of health services and settings to ensure they consider the needs of people experiencing socio-economic disadvantage and, in doing so, remove barriers they face in accessing healthcare.**

NHS GM is unique amongst ICBs and Integrated Care Partnerships (ICPs) in that it has made an explicit commitment to "enhance the role of NHS GM in tackling poverty as a driver of poor health" in its strategy and Joint Forward Plan (Greater Manchester Integrated Care Partnership, 2023). It is crucial therefore that this commitment is realised through properly planned and executed service delivery.

### 1. Leadership and workplace culture

**Strong leadership that places priority on tackling poverty is necessary to effectively develop and deliver services that respond to the needs of people experiencing poverty.**

Most directly, a visible, senior leader within the service or setting with explicit responsibility for anti-poverty work sends a message to staff and patients that supporting people experiencing poverty is a priority. More widely, leadership helps to mobilise resources and generate culture change.

Embedding poverty reduction in organisational priorities, ensures that it informs decision-making, models a commitment to tackling poverty and fosters an environment where staff feel empowered to act. To maximise efficacy, it is crucial to set clear expectations, recognise and promote impactful work, and ensure poverty awareness is integral to both strategic and operational planning.

Equally important, however, is that responsibility for anti-poverty work does not sit solely with managers and strategic decision-makers. Recognition of poverty as a cause of ill health and a driver of health inequality must be shared by managers and frontline delivery staff alike. Failure to do so risks focus on poverty being reduced to tokenism or a box-ticking exercise.

In order to equip stakeholders with the knowledge they need to tackle poverty, Resolve Poverty has delivered Poverty Awareness Training to over 1,300 NHS Greater Manchester staff and Integrated Care Partners from June 2023 to April 2025. The training explores the relationship between poverty and health, and the steps that NHS colleagues can take to make a difference. Poverty Awareness Training is delivered in two parts, covering practical support and strategic responses to poverty.

Quotes from training:

> ***I have learnt a lot about what is happening across Greater Manchester to raise awareness in the community***

> ***Well produced, informative and empowering***

> ***The course provided me with more information on poverty and what to do if a client needs support***

> ***[The training] provided me with a better insight into how poverty affects people in general and the impact on NHS services***

To find out details about our upcoming training dates, please visit our website, or email training@resolvepoverty.org for more information.


## 2. Co-production

**People with lived experience of poverty must have their voices heard in decision-making.** Services must be designed in collaboration with those with lived experience of poverty to ensure that the needs of the communities they intend to serve are met.

Lived experience engagement brings value not only to communities but also to organisations and society more widely.

Lived experience engagement should be done in a meaningful and consistent way, where individuals are compensated for their time and expertise. Services should develop an overarching set of principles to guide lived experience engagement, and specific iterations should be developed for each engagement based on their specific purpose. The aim of the engagement, as well as its intended outcomes or outputs should be precise and clear, both to participants and the commissioning organisation.

There is no 'right' process, nor a 'one size fits all' approach, but key questions to be considered when designing meaningful lived experience engagement may include:

- **Will the group meet more than once and, if so, how regularly?**
- **Will members build relationships with one another?**
- **Will the group determine the priorities and questions that are considered?**
- **Who determines group membership?**
- **Was the group recruited from existing networks?**
- **Were people with lived experience involved in the process from the outset, i.e., during the design stage?**
- **Did they determine the purpose, time, depth and membership?**
- **Will the findings and/or outcomes be owned by people with lived experience?**
- **What will happen after the work has ended?**
- **What do members expect will be the legacy and outcomes?**
- **What is the longer-term commitment from us and partners?**

Individual settings could establish their own 'Patients' panel', or similar, to review and contribute to the planning of services so that their experiences and opinions are reflected. Together with Resolve Poverty, NHS GM is piloting a lived experience participation fund for people with experience of poverty to be financially reimbursed for their involvement in Population Health Programmes, as a means of increasing participation and co-production.

### Case Study: Norfolk and Waveney Community Voices

Norfolk and Waveney ICS are working with local Voluntary, Community and Social Enterprise (VCSE) sector partners to engage with individuals who local health services traditionally find it more difficult to engage , including people affected by substance misuse and poor mental health. Listening to and learning from these partners has enabled the development of specific resources with messaging built around the issues identified through the feedback.

### Case Study: Trafford Poverty Truth Commission

Trafford Poverty Truth Commission (PTC) launched in May 2022 and published its final report in March 2023. It was formed of Commissioners who were resident in the borough of Trafford and have lived experience of poverty, and leaders from the public, private and voluntary sectors in the borough. Throughout the project, participants formed relationships and explored the causes of poverty and its effects.

## Case Study: Trafford Poverty Truth Commission (continued)

The PTC considered the health and social care system in discussions, and some of the overarching themes that emerged in relation to health included:

- Lack of understanding about medications and their purpose
- Poor communication between multiple specialists or hospital settings
- Limited access to personal health records impacts claims for benefits
- Inconsistent knowledge on complaint procedures (e.g. PALS helps once but doesn't improve systemic issues)
- Rigid, automated appointment scheduling that doesn't consider patients' circumstances
- Challenges with coordinating appointments across regions (e.g. Salford, Manchester, Trafford)
- Cost barriers, such as transport expenses and internet access for appointment booking
- Public transport restrictions (e.g. bus passes are not valid before 9:30 AM)
- Difficulties with hospital car parking, blue badge applications, and accessing digital services
- Low health literacy and language barriers worsen patient experience
- Simple actions, like flexibility in scheduling, had significant positive effects on patient experience.

In developing its recommendations, the PTC acknowledged most poverty solutions lie with central government, but suggested actions that could be taken locally to help alleviate poverty. These actions included:

- ☑ **Improve how Trafford residents access services – including a 'One Stop Shop' where residents can access information and advice.**
- ☑ **Continue to use the voice of people with lived experience [of poverty] in the development of policy and services in Trafford – embedding the PTC model across Trafford.**
- ☑ **Make public transport truly accessible for everyone.**
- ☑ **Tackle mental health and isolation.**

### 3. Accessibility

**In designing settings, services and clinics, due regard must be given to the accessibility of such services by people experiencing poverty.**

Additional costs such as transportation, car parking and arranging childcare may be prohibitive to people on very low incomes, preventing their access to necessary healthcare.

**Location of services:** priority should be given to community spaces and co-locating services in places where the public generally frequent, such as shopping centres, community hubs and urban centres so that people can access health care during their day to day lives.

**Scheduling:** patients should be offered a choice of times, and services should be planned during the day, evenings and weekends to maximise patients' options. Services should also be mindful of long waiting times and that some patients may have no choice but to bring children along with them.

**Communication:** patients should be made aware of how they can access any offers of support for people experiencing poverty, such as hospital transportation, free prescriptions, dental care and the Healthy Start scheme.

**Inclusivity:** consideration should be made to those people whose first language may not be English and who may need assistance with interpreters and reading material in other languages, as well as individuals who may struggle with literacy and do not have the reading skills needed to understand communications from the NHS.

### 4. Integration of Welfare Services

**There is growing interest in the delivery of welfare rights, benefits and debt advice in non-traditional settings, and there is an opportunity for health settings in Greater Manchester to explore the impact this may have on their patients.** There is potential for settings to partner with welfare rights advisers, to offer advice, guidance and support in settings such as doctors' surgeries, family hubs and other trusted institutions that patients are used to and feel comfortable in visiting.

### Case Study: Great Ormond Street Hospital

Great Ormond Street Hospital has funded a long-standing welfare rights offer, in conjunction with Camden Citizens Advice on site in their settings. Funding is directly linked to the overwhelming evidence of the links between poverty and health inequalities, and families accessing the service can seek advice on a range of issues, including benefits, employment, housing and debt.

### Case Study: Resolve Poverty Money Matters Programme

Resolve Poverty, partnered with Citizens Advice, delivers benefits and debt advice in schools across Greater Manchester. The aim of the programme is to access and support families who are struggling with living costs who may not seek support from traditional routes. An evaluation of the programme found that 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. Since June 2022, the programme has seen over £400,000 in income gains for families, mainly through previously unclaimed benefits.

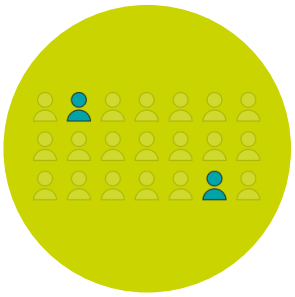
### Case Study: Resolve Poverty Money Matters Programme (continued)

Whilst Money Matters to date has operated via education settings, health settings and services could trial a rollout in collaboration with Resolve Poverty to establish whether the programme could be as successful in supporting people on low incomes in healthcare settings as it has been in education.

### Case Study: Resolve Poverty's Money Advice Referral Tool (MART)

The Resolve Poverty Money Advice Referral Tool (MART) is a resource intended to be used to support people experiencing poverty to access advice about financial support. Poverty is fundamentally due to a lack of money, and whilst poverty may be split into 'food poverty' or 'fuel poverty' or 'furniture poverty', ultimately all poverty stems from people having insufficient money to live by societal norms. Whilst emergency support such as food banks can help people in the short term, the underlying money issues need to be addressed to avoid people becoming reliant on crisis support measures.

The aim of the MART is to help organisations to support people to maximise their household income, by guiding them through a conversation about their financial difficulties and signposting them to organisations that can help with matters such as benefit checks, applications and other associated support. The MART can be used by health workers to support patients experiencing poverty to make referrals to support organisations.



## 5. Employment practices

**NHS GM is a major employer across the city region, with around a quarter of a million paid employees and almost half a million volunteers (Greater Manchester Integrated Care Partnership, 2022), working across a multitude of areas and grades in the organisation.** We estimate that around 14% of the working population across the city region are employed by the NHS (Work Foundation, 2023).

When considering the role of health services and settings in resolving poverty, it is simplistic to consider their responsibilities purely as a health and services provider. Instead, due regard should be given to these settings' role as an employer and how they can best support their employees who are experiencing poverty or struggling with the cost of living.

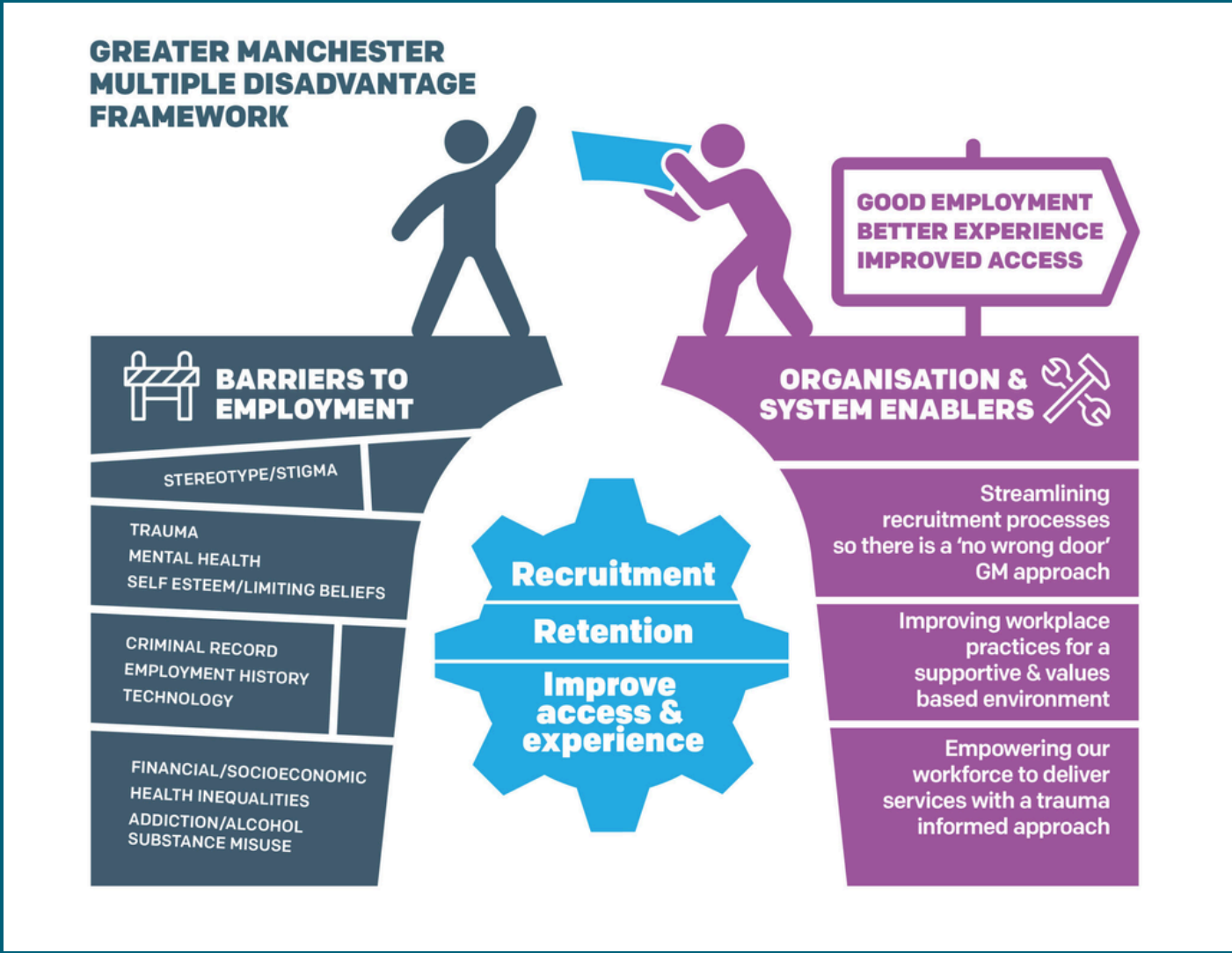
Around two-thirds of working-age adults in poverty live in a household where somebody works, demonstrating that poverty amongst the working age population is a significant issue (The Jospeh Rowntree Foundation, 2025). For work to be a route out of poverty, it needs to be good, well-paid work. Any employment support should be co-designed with employees with lived experience of socio-economic disadvantage and health-inequalities so that it meets their needs.

Settings should pay the Living Wage and accredit to the Living Wage Foundation, ensuring employees are paid an hourly rate that reflects the real cost of living. They should also affiliate to the Greater Manchester Good Employment Charter, proving that their employment practices are fair and meet the standards of a good employer.

## Case Study: Greater Manchester Access

NHS GM and the Greater Manchester Combined Authority (GMCA) have partnered to develop a toolkit which contains a 'multiple disadvantage framework' intended to be used to provide good, permanent work opportunities for people at risk of negative health and wellbeing outcomes associated with being unemployed. The toolkit covers barriers to decent employment for people at risk of multiple disadvantages and suggests solutions to overcome these barriers, such as where to advertise roles, considering the length of application process, and appropriate support needed for once a person is in post.

**Source: Greater Manchester Access**




## Case Study: NHS GM & Metro Moneywise

NHS GM has partnered with Metro Moneywise, an employee-based, member-owned credit union that operates across Greater Manchester. This partnership offers affordable savings and loans across the NHS GM workforce and can help colleagues consolidate existing debt at affordable rates, which is deducted via payroll or direct debit. The savings option allows NHS GM colleagues to save up for a 'rainy day' or future plans, whilst contributing to the credit union fund to support other members across GM.

## 6. The Socio-Economic Duty

**The socio-economic duty is contained within Section 1 of the Equality Act 2010 but was never passed into law by successive governments.**

If enacted, it would require public bodies, such as the health service, to consider how their decisions increase or decrease the inequalities arising from socio-economic disadvantage.

Put simply, it would require health services to consider how their decisions impact people experiencing poverty, in a similar way to how they are duty-bound to consider other inequalities under the Equality Act 2010.

Whilst the socio-economic is not law, some public bodies across the country have chosen to voluntarily adopt the duty, embedding the consideration of people in poverty in their decision-making structures.

Nine of the ten local authorities in Greater Manchester have adopted the socio-economic duty, positioning the city-region as a leader across England, where the national average for councils' voluntary adoption sits at just 22% (Resolve Poverty, 2024b). In addition to the widespread adoption amongst local councils, Transport for Greater Manchester has also adopted the duty. This is emblematic of a significant commitment amongst the public sector in the city-region to recognising socio-economic disadvantage as an equalities issue.

Resolve Poverty is currently working with NHS GM to understand how and when the system overall may adopt the duty, but individual settings and services may wish to expedite this process and adopt it sooner themselves, placing a focus on the experiences and barriers of people in poverty to accessing health care. Settings would need to formally incorporate socio-economic disadvantage and poverty alongside the existing nine protected characteristics in the Equality Act 2010 in equality impact assessments and equality plans. For more detail on the socio-economic duty, its purpose and how to incorporate it into existing structures, please click here.

### Case Study: Transport for Greater Manchester

Transport for Greater Manchester (TfGM) formally adopted the socio-economic duty in August 2022. Formal adoption has lent greater focus to TfGM's existing efforts to reduce socio-economic disadvantage in Greater Manchester and encouraged proactive consultation with people with lived experience of socio-economic disadvantage.

Since the adoption of the duty, TfGM has worked to embed the voices of people with lived experience of socio-economic disadvantage into strategy design. They are in the process of engaging with a poverty reference group on a new customer charter, a collection of commitments which underpins Greater Manchester's new integrated transport network, the Bee Network. This group will be engaged alongside other lived experience groups that work with TfGM. The focus on socio-economic disadvantage has also extended directly to other reference groups, for example, TfGM will actively consider socioeconomic disadvantage alongside other characteristics when selecting new members for the refreshed Disability Design Reference Group. Intersectionality around protected characteristic groups is key to delivering an inclusive and accessible transport system for the people of Greater Manchester.

## 7. Good Practice Sharing

**Good practice sharing in the NHS is crucial to supporting patients who are experiencing poverty.** Sharing successful practice across settings and services within NHS Greater Manchester allows for the rapid dissemination of interventions that can be proven in improving the health and lives of people experiencing poverty.

Tackling poverty-related health issues often requires innovation and community-based approaches that develop from grassroots engagement (see point 2, 'Co-Production', above). Sharing good practice ensures that time, funding and expertise are not misspent trying to 'reinvent the wheel', but instead settings build on tested and proven models, leading to more cost-effective solutions and better outcomes for patients experiencing poverty.

It is important that good practice sharing includes public and VCSE sector partners to ensure collaboration across localities, given the complex nature of the causes and drivers of poverty.

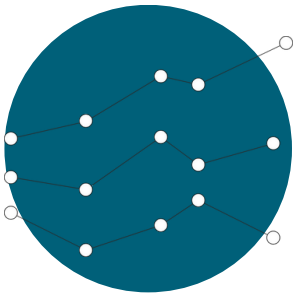
NHS colleagues are encouraged to utilise the Fairer Health for All website. Fairer Health for All is a webpage that can be accessed by NHS staff, colleagues and partners across GM, where examples of good practice, helpful resources and tools are shared for the benefit of NHS colleagues to equip them with the skills and knowledge needed for supporting people experiencing poverty through the delivery of services and to provide advice and guidance on how to collaborate, share and learn across the system.

### Case Study: NHS GM Tackling Poverty Delivery Group

The NHS GM Tackling Poverty Delivery Group was established in 2024 to provide a strategic forum for NHS GM and its partner organisations from across the ICS to drive the Joint Forward Plan ambition to 'enhance the role of NHS GM in tackling poverty as a driver of poor health'. The Group, made up of representatives from across the system, meets on a bi-monthly basis in order to co-ordinate targeted interventions and activity to address poverty in GM. Reporting to, and taking direction from, the GM Population Health Committee, the Group's remit includes effective delivery and progress against the Tackling Poverty Key Deliverables, as agreed in the Population Health Business Plan 2024/25 and also functions as an information sharing forum, ensuring connectivity of programmes of work across the ICS.

### Case Study: Greater Manchester Live Well Financial Resilience Group (formerly Cost of Living Response Group)

The Greater Manchester Live Well Financial Resilience Group (formerly Cost of Living Response Group) is a group convened by the Greater Manchester Combined Authority (GMCA), attended by representatives of all ten local authorities that make up the GMCA and their VCSE partners. Originally convened in rapid response to the Covid-19 pandemic in order for councils and partners to share good practice in supporting vulnerable residents, following the subsequent cost-of-living crisis it became a forum where councils could discuss and share general anti-poverty measures, learn from their peers and implement changes that had been tried and tested in neighbouring councils. Meeting roughly every 8 weeks, the forum allows colleagues from across the city region to learn more about what is working well in certain areas and to take away practice to be considered.



## 8. Metrics of Success

**In all anti-poverty work, it is important to highlight at the outset how the setting or service will monitor the success or otherwise of any specific activity.** Monitoring progress and evaluating the impact of any anti-poverty work is extremely challenging because poverty has many drivers, and its impacts are felt differently by different people. However, for the work to be effective, there needs to be well-designed ongoing monitoring and evaluation in order to understand if activity is achieving its intended aims.

Success will look different for each setting and service embarking on anti-poverty work, but clear metrics should be established and settings should consider both quantitative and qualitative data. It is especially important that they do not underestimate the importance of qualitative data and the lived experience of service users.

In their report, Poverty and the Health Care System, the King's Fund (2022) consider poverty measures through three types:

- **Metrics to frame longer-term objectives for poverty reduction and prevention:** using the Children in Low Income Families (CILIF) data to provide insights for direct service delivery, with the acknowledgement that intervention in childhood is crucial for positive health outcomes.
- **Metrics to capture medium-term outcomes:** such as whether services are reaching those in need; recruitment of people with lived experience of poverty and from deprived communities; and the housing status and conditions of the communities the service supports.
- **Locally determined metrics:** monitored by both health services and their VCSE partners. Services could consider measures such as appointment attendance figures, vaccine uptake, referrals to support services, etc. as local measures to indicate they are reaching individuals in need.

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