Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 13 October 2021

Subject: Building Back Fairer in Manchester

Report of: Director of Public Health

Summary

Health inequalities are the avoidable disparities in health seen between different groups of the population. Longstanding health inequalities in Manchester were starting to get worse before the COVID-19 pandemic and are now worse as a result. The pandemic has also highlighted the added barriers to good health that some communities face as a result of prejudice and discrimination. Black, Asian and Minority Ethnic communities as well as Disabled people have been disproportionately affected by COVID-19. Improving population health whilst narrowing the gap between the healthiest and the least healthy in Manchester requires a collaborative approach between all organisations and agencies that have an influence on health – this is known as a Population Health and Wellbeing System. Proactive effort to address equality and inclusion will be fundamental to this, in order to ensure that no Manchester resident is left behind.

Recommendations

The Committee is asked to consider the report and note the next steps for addressing health inequalities in Manchester within the context of the COVID-19 pandemic.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
Creating the conditions for people to live healthier lifestyles (e.g. through enabling active travel, sustainable healthy food sources, reduced smoking) will impact not only on population health but also on the wider environment (e.g. reduced traffic congestion, improved air quality, support for local economy).

Our Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	

A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Contact Officers:

Name: Dr Cordelle Ofori
Position: Consultant in Public Health Medicine, Manchester City Council and Manchester Health and Care Commissioning
Telephone: 07903 272337
E-mail: cordelle.ofori@manchester.gov.uk

Name: Sharmila Kar
Position: Director of Workforce, OD & Inclusion, Manchester Health and Care Commissioning
Telephone: 07811 982287
E-mail: sharmilakar@nhs.net

Name: Dr Sohail Munshi
Position: Chief Medical Officer, Manchester LCO
Telephone: 07585 119327
E-mail: sohail.munshi@nhs.net

Background documents (available for public inspection): None

1.0 Introduction

Health inequalities - the avoidable disparities in health outcomes seen between different groups of people - have been brought into sharp focus by the COVID-19 pandemic. Over the course of the past 20 months, clear evidence has emerged of the disproportionate impact of the COVID-19 virus on particular groups, notably Black, Asian and Minority Ethnic people, people born outside the UK, disabled people and those at high occupational risk and/or in poverty. These groups were already known to experience poorer health and care outcomes before the pandemic.

They have also been shown to be more likely to contract Coronavirus and have a higher risk of mortality involving COVID-19. The full impact that the pandemic will have on the social determinants of health is yet to be seen, but it is already evident that some communities have been more adversely impacted than others.

The challenge of trying to improve the lives of those who face poor health as a result of the conditions in which they are born, grow, live, work and age is not new to Manchester. Local analyses of health outcomes and wider determinants of health in the late 1980s and early 1990s found a similar set of inequalities to those that exist today. Inequalities in health, wealth and experiences persist despite the City's strong economic growth and significant transformation over the past two decades. Sections of Manchester's population still experience poorer health outcomes than their peers in other parts of the country and many develop preventable health conditions a decade earlier than in other parts of the UK.

This report gives an overview of some of the current population health inequalities in Manchester and provides examples of how partners across our population health and wellbeing system work collaboratively to address them. The examples include a particular focus on social prescribing as requested by the committee. The report also covers the work of COVID-19 Health Equity Manchester (CHEM) and the important lessons learned for ongoing work to promote health equity in the City. Finally, it will summarise the next steps for Population Health Recovery within the context of the pandemic, and how Manchester will be responding to "Building Back Fairer in Greater Manchester" - the post-pandemic recommendations made for Greater Manchester as a Marmot City region.

2.0 Background

Manchester's Population Health Plan (2018-2027) describes the city's overarching plan for reducing health inequalities and improving health outcomes for Manchester residents. It sets out the ten-year vision for health and wellbeing, and the strategic priorities identified to support this vision which were informed by the 2010 Marmot Review "Fair society, healthy lives".

Manchester Population Health Plan 2018-2027

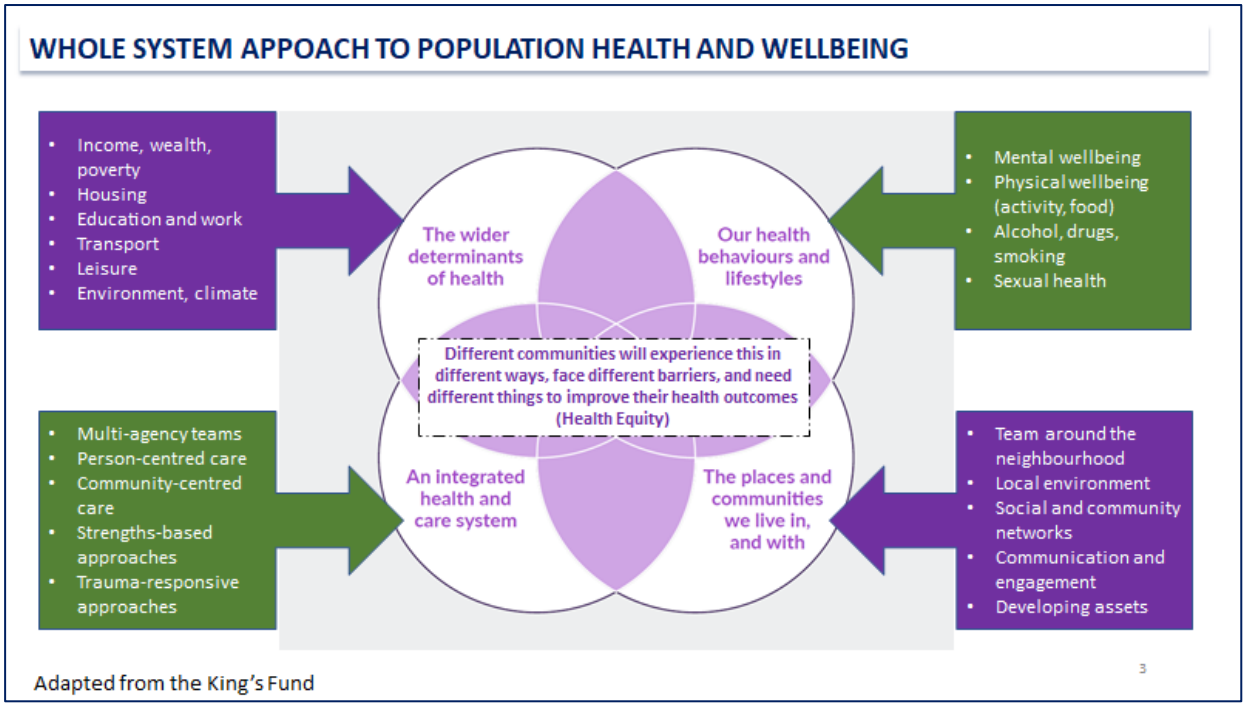
Strategic Priorities

- Improving outcomes in the first 1,000 days of a child's life
- Strengthening the positive impact of work on health

- Supporting people, households and communities to be socially connected and make changes that matter to them
- Creating an age-friendly city that promotes good health and wellbeing for people in mid and later life
- Acting on preventable early deaths

The delivery of this plan requires a whole system approach to population health and wellbeing, as depicted in the figure below. Simply put, the population health "system" is all the statutory and non-statutory organisations in the city that have an influence on population health, working together in a coordinated way to improve health outcomes. It is a response to the recognition that health and care services alone have an important but limited impact on population health. A collaborative approach is needed that addresses the social and wider determinants and makes the most of the wealth of resources within communities. Key to the success of this in Manchester has been the partnership working at city and place level between Manchester City Council, Manchester Local Care Organisation (MLCO), Manchester Foundation Trust (MFT), and Manchester Health Care Commissioning (MHCC) as well as continually evolving relationships with organisations in the Voluntary, Community and Social Enterprise Sector (VCSE).

Figure 1. Whole system approach to population health and wellbeing



2.1 What health inequalities look like for Manchester's population

For many years the health of people in Manchester has generally been worse than the England average across a range of outcome measures. However, a worsening of health outcomes in Manchester was starting to become apparent in the years prior to the start of the Coronavirus (COVID-19) pandemic in 2020. Analysis of data on (i) trends in Gross Value Added (GVA) - a measure of the value of goods and services produced by an area - and (ii) all age all-cause mortality rates showed that, whilst the

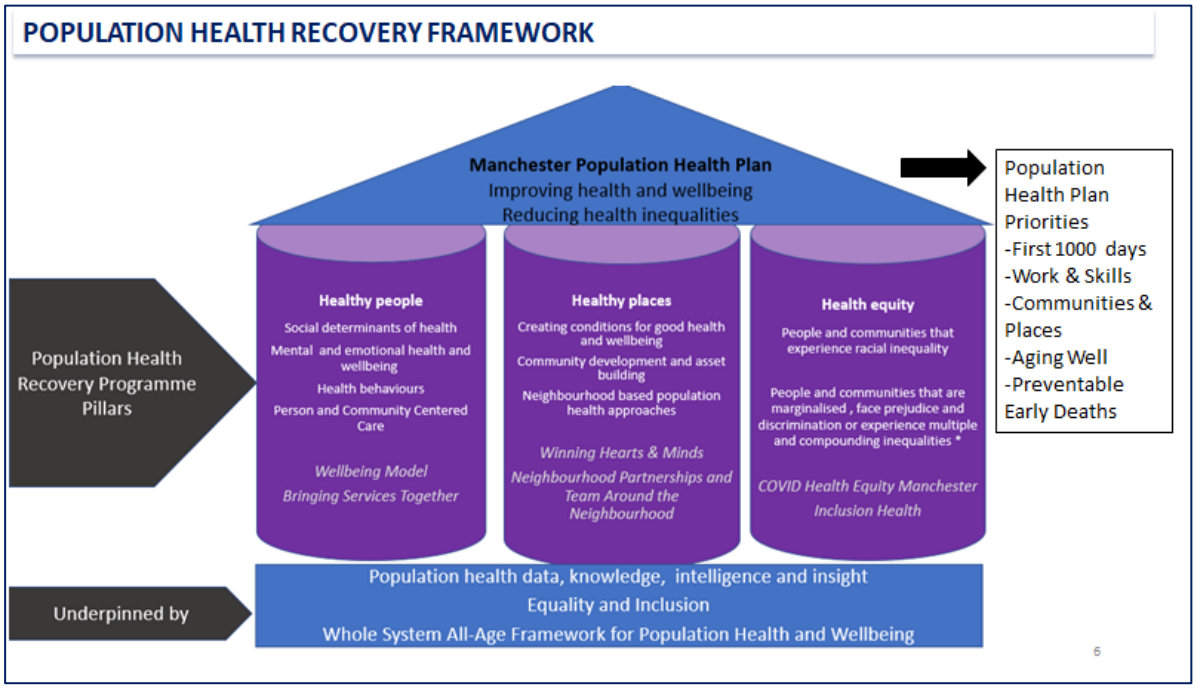
economy of Manchester was continuing to grow, improvements in all-cause mortality had stalled and had returned to the levels seen 10 years previously.

The pandemic has had the effect of accelerating and strengthening that pre-existing trend. Recently published data on life expectancy at birth over time in Manchester compared with England shows that life expectancy has fallen (i.e. got worse) for both males and females in Manchester in the 3-year period 2018-20 compared with the previous period of 2017-19. However, data for the 3-year period 2018-20 combined does not fully reflect the impact of the pandemic on life expectancy. Local calculations show that life expectancy at birth for Manchester residents has fallen by 3.1 years for men and 1.9 years for women in 2020 compared with 2019. In absolute terms, 568 more men and 295 more women died in 2020 compared with 2019.

2.2 Population Health Recovery Framework

Manchester's Population Health Team is developing a recovery framework for population health with three pillars that capture the underpinning reasons for poor health outcomes among different groups of people. This is to ensure that the issues within each of these themes are given equal attention, whilst working alongside partners and stakeholders to address the wider determinants of health and deliver the Population Health Plan.

Figure 2 Population health recovery framework



2.2.1 Healthy People

This theme recognises the impact of social disadvantage and socio-economic circumstances on health outcomes. Income, housing, work, environment, and transport access and conditions impact on physical and mental health and wellbeing, and people's ability to lead a 'healthy lifestyle'. These 'wider determinants of health'

are often experienced cumulatively, and impact more people in areas of socioeconomic deprivation, leading to health inequalities. The State of the City Report (2021) found that in Manchester as a whole:

- The number of households residing in temporary accommodation has increased significantly over the past five years, from 406 households (end of March 2015), to 2,193 (end of March 2020).

- 41.8% of children aged under 16 in Manchester are living in poverty (around 46,700 children), compared to 30% in England as a whole (End Child Poverty Coalition, 2019/20). Approximately two thirds of those children are in a family where at least one parent is working.

- 38.8% of children who qualify to receive free school meals in Manchester have not achieved a good level of development at the point of starting school compared with 32.5% of other children.

- Of the working-age population, 50 to 67-year-olds are the most acutely affected by low level skills, making it harder for them to be part of the city's economic growth. There is a much higher proportion of residents aged 50–64 in the city with no or low qualifications (32.2%) compared to the England average (21.6%).

Dealing with challenging social circumstances make it more difficult to adopt and maintain healthy habits or behaviours. Smoking, poor diet, physical inactivity and high alcohol consumption increase the risk of preventable disease and reduce life expectancy. In Manchester as a whole:

- 42% of Year 6 children are overweight or obese, compared to 35.2% in England as a whole (National Child Measurement Programme, 2019/20).

- 18% of adults (aged 18+) are current smokers, compared to 13.9% in England as a whole (PHE Local Tobacco Control Profiles, 2019).

- The rate of hospital admission episodes for alcohol-related conditions is 775 per 100,000 population, compared to 664 per 100,000 in England (PHE Local Alcohol Profiles, 2018/19).

- 26.5% of adults are physically inactive, compared with 22.9% in England (PHE Physical Activity data, 2019/20).

2.2.2 Healthy Places

This theme recognises the geographical inequalities within Manchester and between Manchester and other parts of the region and country.

People living in the most disadvantaged areas of the country are more likely to experience inequalities in relation to healthcare access and involvement, and poorer health outcomes. Disadvantage is defined by the Index of Multiple Deprivation (IMD), which ranks areas according to a range of indicators – income, employment,

education, skills and training, health and disability, crime, barriers to housing and services, and living environment. Overall, Manchester ranks as the sixth most deprived local authority area in England and is the most deprived local authority area in Greater Manchester.

IMD uses smaller geographical areas (Lower Super Output Areas (LSOAs)) to describe the level of deprivation within each local authority area. In Manchester, 43% of LSOAs are in the most deprived 10% of LSOAs in England. There are no Manchester LSOAs in the least deprived 10% of LSOAs. Of the core cities, only Liverpool has a higher proportion of LSOAs in the most deprived 10% in England. Within Greater Manchester, Manchester has the highest proportion of LSOAs in the most deprived 10% in England. Trafford and Stockport have the least, with 5% and 9% respectively of LSOAs in the most deprived 10% in England.

The benefits of Manchester's population and economic growth in recent years have not been felt equally by all sections of the population or areas of the city, and economic improvements have not been matched by a narrowing of inequalities within Manchester. In addition to the gap in health outcomes between Manchester and England as a whole, there are also significant differences within the city. Figures show that there are 3.5 times as many premature deaths (deaths under the age of 75) in the most deprived parts of Manchester (primarily in the northeast of the city and in parts of Wythenshawe) compared with the least deprived parts. The latest data for 2017-19 shows that life expectancy is 8.1 years lower for men and 7.3 years lower for women in the most deprived areas of Manchester than in the least deprived areas.

2.2.3 Health Equity

The third theme recognises the groups of people and communities that face additional multiple and compounding barriers, prejudice or discrimination owing to factors such as race, sexual orientation, disability and migrant status. This includes the NHS definition of “inclusion health groups” such as refugees and asylum seekers; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; and sex workers.

Often, these barriers are experienced alongside other factors that lead to health inequalities. For example, some groups with protected characteristics can experience health inequalities over and above the general relationship between socio-economic status and health. People who are socially excluded also often experience multiple overlapping risk factors for poor health (e.g. socio-economic conditions, violence, adverse childhood experiences) and experience stigma and discrimination that impacts on their access to, and involvement with, health care. People in ‘inclusion health’ groups can suffer from multiple physical and mental health issues which can lead to poor health outcomes and premature mortality, contributing significantly to overall health inequalities.

Manchester has a diverse population, with around 30% of the population from Black, Asian and Minority Ethnic (BAME) groups, compared to around 15% in Greater Manchester and around 13% in England as a whole. The city also contains a diverse mix of religions and faith groups. Data from the 2011 Census (the latest

comprehensive survey of the population), shows that around 49% of people who chose to answer the question identified themselves as being Christian and 16% as being Muslim, with smaller, but still significant, proportions of people identifying themselves as being from the Buddhist, Hindu, Jewish and Sikh faiths. Data from the most recent Census are pending, but local intelligence suggests that the number of people from different minority ethnic groups and different faith groups will have increased significantly over the last decade.

Based on the best available research, it can be estimated that around 39,000 people in Manchester identify as Lesbian, Gay or Bisexual (LGB) and 5,500 identify as trans. However, the true figure is likely to be higher as Manchester has a thriving LGBT community in the city centre which is likely to attract Lesbian, Gay, Bisexual and Trans (LGBT) people to live and work in the city and its surrounding areas.

According to the Health Survey for England 2016, around 9% of the population aged 16-64 in Manchester is estimated to have a "moderate or serious physical impairment" [sic]. If this proportion is still true, it would equate to around 35,250 people living in the city. The ONS annual population survey suggests that in the period April 2020 to March 2021, there were 21,700 people who were unable to work due to long term sickness - 22.7% of the working age population. Data from the Quality and Outcomes Framework (QOF) for 2019/20 indicate that there were around 3,250 people with a learning disability registered with GP practices in Manchester. (Note: This includes people living outside of the Manchester City Council boundary).

2.3 Health equity and the impact of the COVID-19 Pandemic

National data indicate that during the first wave of the pandemic (roughly defined as January to September 2020), the rate of death involving COVID-19 was highest in Black African, Bangladeshi, Black Caribbean and Pakistani ethnic groups. In the second wave of the pandemic (September 2020 onwards), most Black and South Asian ethnic groups remained at higher risk of death than White British people, even after adjusting for other risk factors, such as occupation, living arrangements and pre-existing health conditions.

Locally, we have consistently seen higher than average case rates among Pakistani, Bangladeshi, Black African and Black Caribbean population groups. Across the course of the pandemic, just under 43% of confirmed cases of COVID-19 with a known ethnic group code have been in people from a non-White British group. By far the largest proportion of cases in people from a non-White British group, were in Pakistani people (12% of all cases with a known ethnic group code). These figures will be affected by differences in people's willingness to record their ethnic group and, more importantly, by differences in uptake of the various testing options that are available.

Data from Manchester's hospitals show people from a non-White British group have also been more likely to require critical care on admission to hospital. In terms of mortality rates, although the absolute numbers were relatively small, people of Caribbean, Irish and Chinese backgrounds were more likely to die than White British people if they were admitted to hospital with COVID. This might be in part due to the

proportion of older people from these ethnic groups, as age is the biggest risk factor for dying from COVID-19.

Routine monitoring of case rates by ethnic group shows that the number of confirmed cases of COVID-19 per 100,000 population is currently falling across all ethnic groups, although case rates remain higher in Black African and Black Caribbean groups as well as in Pakistani and Bangladeshi populations compared with the White British population.

Disabled people have also been disproportionately affected by the pandemic. During the first wave of the pandemic, the risk of death involving COVID-19 was 3.1 times higher for more-disabled men and 3.5 times greater for more-disabled women, compared with non-disabled men and women. Men and women with a medically diagnosed learning disability had a 3.7 times higher risk of death involving COVID-19 compared with people who did not have a learning disability.

Some groups of occupations have continued to have high rates of death involving COVID-19 over the entire time period of the pandemic when compared with rates among those of the same age and sex in the population. These include people working in routine, manual and service occupations (e.g. construction workers and cleaners), caring, leisure and other service occupations (e.g. nursing assistants, care workers, and ambulance drivers) and transport drivers (e.g. taxi or bus drivers). There are large numbers of people working in some of these occupations in Manchester, including a disproportionately high number from some Black, Asian and Minority Ethnic groups.

The State of the City 2021 report starts to describe the impact the pandemic has had on the social determinants of health in Manchester. The impacts of the prolonged economic shutdown experienced throughout 2020 and early 2021 are far-reaching and have disproportionately affected specific sectors of the economy and resident groups. The unemployment count has significantly increased, with the true impact unlikely to be seen until the end of the furlough scheme. Residents in insecure work have experienced greater uncertainty and may not have been protected by Government support schemes. In addition, over-50s, younger workers, Black, Asian and Minority Ethnic workers, and women have been disproportionately impacted by unemployment resulting from the pandemic. Employees in the gig economy and other forms of self-employment have also been exposed to greater levels of risk, with remote working not available across all sectors.

COVID-19 has resulted in a significant rise in poverty, evident by a 90% rise in the number of unemployed people claiming benefits between March and May 2020. Levels of worklessness in the city fell steadily between February 2013 and November 2017, from 60,871 to 45,278 and then increased to 56,785 in February 2020. However, due to the rising levels of unemployment during the COVID-19 pandemic, the out-of-work benefits claimant count increased significantly to 74,649 in May 2020, with a further increase to 76,358 by November 2020. It is worth noting that not everyone who is out of work claims an out-of-work benefit and the number of residents who are out of work is likely to be much higher, particularly in the 18 to 24-year-old age group.

The COVID-19 pandemic has also had a major impact on the delivery of education for children and young people in the city. As well as the cancellation of national assessments and exams (including GCSEs and A levels), schools were closed for most pupils. Due to high infection rates in the city during the autumn term, many pupils in Manchester missed significant amounts of schooling. Since schools welcomed all children back following the second lockdown in March 2021, attendance has been good, however the long-term impacts particularly for children who are living in poverty, and experiencing other disadvantages, are yet to be seen and will need to be considered in the plans for recovery.

3.0 Delivering the Population Health Plan – Examples of collaborative working

Delivery of the plan has required a collaborative effort from organisations and agencies across the health and care, local government and broader public sector partners as well as the Voluntary, Community and Social Enterprise sector. Examples of how various partners have worked collaboratively to address health inequalities in Manchester are described below.

3.1 Improving outcomes in the first 1,000 days of a child's life

The first 1,000 critical days, from pregnancy up to the age of two, is a peak period of nurturing and growth for the brain to achieve its optimum development. The foundations of physical, emotional, social and cognitive health and development are all set early - starting in the womb - and a poor start can have a lifelong negative impact on mental and physical health and brain development, including childhood obesity, educational attainment and future economic status.

3.1.1 Manchester Settlement – Creating Cycles of Community Change for Families in North Manchester

Manchester Settlement is a multi-service community charity that has been working alongside the communities of North Manchester for 130 years. The charity delivers services for children, young people, families and isolated adults, to address needs, build on strengths, support activation and facilitate community involvement.
The charity has used investment from the Population Health Fund to collaborate with a range of local partners, utilising community bases. As a nursery/early years/wrap-around childcare provider they have used their long-established reach into the community and local schools to establish what might best be described as a Partnership Children's Centre that makes the most of strong community collaborations.

- A BAME led community organisation has been very successful at breaking down barriers such that families feel more confident to take part in the wide partnership offer.

- Volunteer parents have been trained by the National Childbirth Trust as mentors for new parents.

- Parents have volunteered at, and benefitted from, wider community services (The Food Pantry, Wellbeing Women's Groups).

- Creche facilities have enabled parents to attend appointments or courses such as ESOL.

- A housing association provides drop-in financial advice.

The partnership programme has become so busy that the charity took over the day to day running of a mothballed Children's Centre enabling many more parents and community organisations to collaborate, network and co-produce. This additional centre now hosts child and parent activities across 4 days per week.

3.1.2 Partnership working with hospital maternity services to reduce smoking in pregnancy in Manchester

In 2017, Manchester's Director of Public Health agreed that Manchester should implement the Greater Manchester Smoking in Pregnancy Programme. The operational changes needed to implement the pathway have been challenging but resolved by close working between the Population Health Tobacco Lead, MHCC Medicines Optimisation Team, the Greater Manchester Making Smoking History Team and Maternity Services in Manchester. To date, the programme has been funded by the Population Health Team and Greater Manchester Health and Social Care Partnership.

An element of this programme is an 'Incentive Scheme' which targets a defined group of vulnerable women who are smoking whilst pregnant, such as those living in areas of very high deprivation, areas of highest smoking prevalence and those who smoked during their last pregnancy. Many pregnant smokers in the city meet the criteria for this scheme.

This pathway offers not only stop smoking support, but also enhanced maternity support, within the standard maternity care pathway. The specialist support goes to three months postpartum; it offers monthly contact and appointments and aims to be flexible to meet the woman's needs and unique circumstances. If women remain 'smoke free' they can claim shopping vouchers to support their everyday needs. This programme dovetails with our multi-agency Smoke Free Homes workstream, which aims to ensure a healthy environment for mother and baby in the long term.

Outcome:

Manchester Smoking at Time of Delivery Rates (SATOD) are 9.6%, which is better than the national average of 10.4%. We believe this demonstrates the effectiveness of our approach. In Quarter 1 of 2021/22, the Manchester Smoking in Pregnancy Service achieved a quit rate (carbon monoxide validated) of 77% (National Institute for Health and Care Excellence (NICE) guidance stipulates a minimum quit rate of 35%). Our aspiration is to embed this programme into mainstream maternity provision and funding arrangements.

3.2 Strengthening the positive impact of work on health

The Marmot Review outlines the links between work, health, and social inequalities. Being in good employment can protect health and wellbeing, whilst unemployment can have short and long-term effects on health and is linked to increased rates of long-term conditions, mental illness, and unhealthy lifestyle behaviours. Access to good quality work (i.e.sustainable, offering a living wage, with opportunities for development and flexibility to balance work and family commitments, and protection against adverse working conditions) is central to reducing health inequalities and improving health and wellbeing.

3.2.1 Be Well – A social prescribing and health coaching service provided by The Big Life Group

Be Well is Manchester's citywide health coaching, social prescribing and wellbeing service commissioned by the population health team. Big Life Group is the lead provider for the service, working in partnership with a range of other organisations (Pathways CIC, Northwards Housing/Yes, One Manchester, Southways Housing, Wythenshawe Community Housing Group, and Citizens Advice Manchester) who deliver aspects of the service. The service also partners with a range of community-based organisations to support delivery of Be Well services within community settings.

The purpose of Be Well is to support improvements in physical and mental health and wellbeing, and reduce health inequalities, for individuals and communities. Be Well workers provide person-centred, holistic support, tailored to the needs and goals of each individual. This support enables people to increase resilience, live healthier lifestyles, improve mental health and wellbeing, address 'social determinants' needs (such as work, housing, money and family issues), and connect to networks of ongoing support.

The Be Well service works closely with primary care services in Manchester. Practices have a named Be Well contact, and a range of primary care practitioners, including GPs, can make referrals to the service. Referrals can also be made by Integrated Neighbourhood Teams. Be Well also employs and manages Social Prescribing Link Worker roles on behalf of 10 of the 14 Primary Care Networks in Manchester, ensuring that these roles are integrated with the social prescribing and wellbeing infrastructure for the city.

Referrals to Be Well come to a single point of contact, where holistic person-centred assessments are carried out to understand individuals' strengths, needs, goals and motivation, and a personalised support programme is developed based on these. Ongoing one-to-one support is then provided through a social prescribing link worker, health coach or work and health coach, depending on the needs/goals of the individual.

Social prescribing link workers provide 'lower intensity' support to build knowledge, skills and confidence and connect with community groups and networks.
Health coaches provide this support alongside 'higher intensity' motivational interventions to support people to address more complex social, non-medical and

lifestyle issues, including drawing in additional support from specialist services when needed.

Work and health coaches support people to maintain or return to employment while managing their health conditions, and support with a range of employment-related issues including finding work, managing Covid-related work issues, accessing psychological or physiotherapy support for common work-related health conditions, returning to work after a period of unemployment, and accessing training/volunteering to develop skills.

Since the Be Well service became operational citywide in late 2018, it has received nearly 15,000 referrals. Monthly referrals to the service have increased by around 20% in 2021, indicating an increased need for the service as a result of the wider impacts of the Covid-19 pandemic. Approximately 75% of people supported by the service need 'higher intensity' support for a range of issues, with 50% of service users receiving support for work-related health issues.

An independent evaluation of the Population Health Prevention Programme (of which the Be Well service is a part) is in progress. Interim findings indicate that in terms of wider outcomes and impact, Be Well is:

- Reaching its target population of individuals from the most deprived areas within the city, and individuals from diverse backgrounds (indicating impact on health inequalities).

- Supporting a much larger number of individuals with more complex/wider-ranging needs than originally anticipated when the service was designed and working flexibly to tailor support appropriately (indicating need for more intensive support in addition to social prescribing).

- Achieving very good outcomes for service users in terms of physical and mental health and wellbeing, work-related health and connection to community networks.

- Achieving good outcomes in support of the wider health and care system through robust primary care pathways to support patients with wider needs and reduce pressure on primary care, and through reducing Accident and Emergency attendances.

Escaping the legacy of the pandemic: Clare's Be Well journey

Mum of four, Clare's life unravelled when the pandemic hit.

"With the first lockdown I'd been furloughed. It gave me time to think about a lot of things, bringing back memories that I didn't want to be brought back. My mental health went on a downward spiral, I was hoarding and not cleaning, and my children were really unhappy. I was at one of my lowest points and I didn't think I'd be able to drag myself out of it."
Talking to Bernadette Chapman, a Be Well Employment Coach, proved a turning point.

While Clare tackled her hoarding with the Early Help service at Northwards Housing, Bernadette began to help unpick the money and family worries swirling around her mental health issues.

With Clare struggling to make ends meet on furlough, Bernadette encouraged her to get money advisors from her local housing office involved who helped get money towards fuel bills and looked into tax credits for her daughter. Clare used her local food bank for the first time too. “After Bernadette gave me the link for stop smoking and I have gone from forty cigs a day to about five, saving me loads of money as well.”

Besides signposting Clare to the counselling services available locally from Self Help and Mind, Bernadette was also there for the whole family to lean on as one of Clare’s children took on the challenges of a new gender identity and college by helping them get in touch with local LGBT support groups, apply for a free bus pass and get a bursary.

“She was there to help with just everything really – it’s not just been with my mental health or the money issues I’ve had, or food issues because I’ve not been able to feed the kids. It’s been absolutely everything.

It’s given Clare the space she needed to start to move on with her life again. She’s back in work now, has become a grandma for the fourth time and has just successfully completed a parenting course too.

“I am feeling better than I have done in a long time. My children can see how much happier I am now to what I was 12 months ago. I feel nothing can bring me down no matter what it is.”

3.3 Supporting people, households and communities to be socially connected and make changes that matter to them

The conditions into which people are born, grow, live, work and age - the social determinants of health - are largely responsible for the gap in health outcomes between the healthiest and least healthy in society. These conditions such as good work, education, housing and social connections have a much larger influence on a population’s health and wellbeing than healthcare services. Connected communities where people feel valued and involved in decisions that affect them and have a greater sense of control over their daily lives, can have a positive impact on people’s health and wellbeing. Communities may be groups of people living in the same place or people that share a common identity, experience or interest.

3.3.1 Manchester Local Care Organisation (MLCO) – A neighbourhood-based model of delivery

The MLCO Prospectus written in 2016 defines a clear objective for the MLCO to embed a neighbourhood-based model of delivery. This set out a requirement for MLCO to develop and implement a neighbourhood model to bring together a range of community-based health, care and prevention services, organised around general

practice within 12 neighbourhoods across the city, to focus on the needs of the local population and individuals more effectively.

It was envisaged that this would mean empowering communities, framing issues at a neighbourhood level and building community confidence and capacity, to reduce the gap in health inequalities. In response to this, in April 2018, MLCO was established to improve the outcomes and lives of people living in Manchester by focusing on wellbeing and reducing health inequalities. Reducing inequality remains a core strategic objective for the organisation and its entire operating plan is built from this fundamental principle.

MLCO's neighbourhood plans, developed annually, are the cornerstone of their approach and each tackle a suite of issues that are particular to that local population. These objectives are identified within neighbourhoods and respond to issues that require local intervention to improve population health outcomes that are particular to that neighbourhood.

To enable MLCO to deliver an increasingly targeted response to addressing health inequality in Manchester it has established a Population Health Management Board which brings together partners from across the city to identify opportunities and mobilise appropriate responses. It is expected that this forum will be the platform from which the majority of all MLCO responses to addressing health inequalities will be built.

To ensure that Manchester can deliver equitable and accessible vaccination programmes, MLCO continues to work extensively to engage those communities that are seldom heard. 'Seldom heard' refers to to underrepresented groups of people who are potential service users, but who are difficult to involve in public participation and whose voices therefore go unheard and their needs unmet. As the Committee is aware, the current pressures on the health care system mean it is more important than ever we make every effort to deliver an effective immunisation programme. Over the course of the last 12 months this has included both Covid and influenza vaccines. One of the key responsibilities of neighbourhood teams in Manchester is their focus on prevention. As such the neighbourhood teams have delivered a targeted local approach to vaccinations (with partners including primary care) within those neighbourhoods.

Beyond neighbourhood working, MLCO's Long Term Conditions (LTCs) programme has been mobilised with two key objectives. First, moving care and support upstream into neighbourhoods and communities, and second, tackling and reducing the long-standing inequalities in LTC outcomes we see across Manchester. Covid-19 has had a huge impact on health and care services and continues to have a disproportionate impact on people from minority ethnic communities, and people living with chronic diseases, such as Type 2 Diabetes. Using data collected in Primary Care, we can now analyse and see differences in Diabetes prevalence and hospital activity by ethnicity in a Neighbourhood or Primary Care Network area, for example. Using a population health management approach, we have started a project to look at and tackle entrenched inequalities in Diabetes outcomes for people from an African Caribbean and Black British background in one of our neighbourhood areas as an early adopter of this change in approach.

3.3.2 Manchester Foundation Trust - Senior Adult Service

The Trust's Senior Adult Service is one of the largest in the North West, consisting of 22 Consultant Geriatricians working closely with multi-disciplinary teams. This includes the Older Person Assessment and Liaison (OPAL) service. OPAL provides a consultant-led multidisciplinary assessment for older patients living with clinical frailty and multiple health conditions. OPAL includes a dedicated Frailty Unit, called Opal House, at Wythenshawe, and in-reach to other clinical services.

OPAL patient case study

X, aged 78, had a history of Cerebral Palsy and schizophrenia, and received a fractured neck of femur after a fall. X was admitted to Wythenshawe Hospital on the general frailty surgical admission pathway. Alongside their assessment for their fall, there was consideration of all their needs, based on previous admissions to hospital medication and social history, their clinical frailty scale and a cognitive assessment.

The OPAL team completed an assessment which helped ensure a holistic individual approach to their care. X was treated for a fractured neck of femur and was subsequently admitted to Opal House. This facility provides care for older frail people who require functional, cognitive, and social assessments to support safe discharge. X was initially very distressed and would not engage with staff. However, work with X identified that their concern was not about clinical issues but was about what had happened to their dog.

The Opal House team engaged with the hospital care navigators, who linked with X's community mental health worker. Staff could then reassure X that their dog was being cared for, and from that, built a strong rapport, which enabled further assessments and appropriate discharge planning. Taking the time to understand X's perspective and concerns was key to progressing their successful discharge.

3.4 Creating an age-friendly city that promotes good health and wellbeing for people in mid and later life

Older people can face a number of challenges around social inclusion as they move into later life including poor or inadequate housing, declining economic activity, deteriorating health and risks of social isolation and loneliness. The suitability and age-friendliness of neighbourhoods is a key factor in determining outcomes for older people, both in terms of their lived experience and their health and wellbeing. Older people experience high levels of economic disadvantage. Being in good employment beyond the age of 50 not only supports financial resilience but also promotes positive emotional wellbeing and opportunities to remain socially connected. Employment in people over 50 further functions as a key asset that is strongly predictive of improved health expectancy.

3.4.1 Age Friendly Benches - Manchester City Council councillors, neighbourhood officers, Buzz neighbourhood health workers and communities working together

For people to age well they need to feel their environment supports them to access services, shops and amenities in their local area, along with sustaining social connections. Being able to achieve this can depend on local infrastructure and people's ability and confidence to navigate where they live.

Resting points along walking routes have been identified by the World Health Organization (WHO) as being a significant urban feature which promotes this. Average healthy life expectancy in Manchester is 57 years old, so for many people 200m (often less) is the distance they can walk before needing to rest. As people age this can be a severe limiting factor in being able to get out of their homes, increasing the risk of social isolation and physical deconditioning.

In 2019, Council Neighbourhoods Service officers worked with residents in Whalley Range to install 12 age friendly benches at key locations across their neighbourhood, connecting residents to shops, transport and local amenities. Older residents selected the locations and were involved in the design of the seating.

Due to the success of the scheme, Buzz, working with Neighbourhoods and older people have gone on to fund an additional 32 benches across another four clusters. Buzz Neighbourhood Health Workers, Council Neighbourhood Officers, local councillors and community organisations mapped amenities and tested potential seat locations and routes by walking them. They then consulted older people via local age friendly networks and community organisations to make sure they had got it right. Older residents have told us how important the age friendly benches have been in enabling them to enjoy walking where they live, to connect with local services, shops, and parks, for example, without the need to spend money on taxis which they may have previously had to rely on. Age friendly benches stimulate social encounters and informal conversations across the generations, while also becoming informal meeting places for older residents. Travel restrictions during Covid have also meant many older residents have found themselves even more limited to their immediate neighbourhood. Initiatives such as the *Chatty Bench* have helped encourage connections with others, benefiting mental health and wellbeing.

Buzz are working with the Council to explore future opportunities for funding and expansion of the scheme, with plans to create local walking and seating maps, numbered benches and dementia friendly signposting, and incorporating benches into health walks.

3.4.2 COVID-19 and Social Exclusion: Experiences of older people living in areas of multiple deprivation

Population Health's Age Friendly Manchester (AFM) programme were co-sponsors and collaborators with Manchester University in commissioning a longitudinal study into the impacts of Covid-19 on people aged over 50 living in areas of multiple deprivation. Other partners in the work included, amongst others, the Greater Manchester Combined Authority, Centre for Ageing Better, the Manchester BME Network, and the LGBT Foundation. The research was unique in capturing the changing experience and responses of this group over the course of a year.

The study examined the impact of COVID-19 through the experiences of 21 organisations working with older people, many from the voluntary sector, and 102 older people aged 50 and over, the majority of whom were interviewed three times during 2020 and early 2021. The study sample comprised four ethnic/identity groups: African Caribbean, South Asian, White, and LGBT+.

Organisations were asked about how COVID-19 had affected ways of working, and support provided to older people. Older people were asked about the impact of, and response to, social distancing.

Research highlighted issues around decline in mobility, and physical and mental health; changing social and family relationships; increased feelings of loneliness; the importance of faith; the value of green space and inequality of access; and the vital role of technology. The report makes several policy recommendations across these areas which focus on the crucial role of neighbourhoods and place-based solutions.

3.5 Taking action on preventable early deaths

It has been reported that just three lifestyle behaviours - tobacco use, unhealthy diet and a sedentary lifestyle - increase the risk of developing the four long-term conditions that are associated with a large majority of preventable deaths and health inequalities: cardiovascular disease (CVD), cancer, respiratory disease and diabetes. Creating the conditions and providing the support for people to stop smoking, eat healthy food and become more physically active will have a big impact on population health. Detecting illnesses early with the right treatment and support can also halt the progression of disease or minimise the impact of ill-health on a person's quality of life.

3.5.1 Population Health Approach to Diabetes – Manchester Local Care Organisation (MLCO)

The Long-Term Conditions (LTCs) programme has two key objectives

1. Moving care and support upstream into neighbourhoods and communities.

2. Tackling and reducing long-standing inequalities in LTC outcomes in Manchester.

COVID-19 has had a huge impact on health and care services and continues to have a disproportionate impact on people from minority ethnic communities, and people living with chronic diseases such as Type 2 Diabetes.

It has been recognised that COVID has interfered with the annual GP checks and hospital outpatient appointments that are an important part of the care for people with Diabetes. As services are reimagined and redesigned in new forms, such as digital, it is more important than ever that we do not further exacerbate existing inequalities. Using data collected in primary care, we can now analyse and see differences in Diabetes prevalence and hospital activity by ethnicity in a specific area, such as a neighbourhood or Primary Care Network.

Using a population health management approach, MLCO has started a project to look at and tackle entrenched inequalities in Diabetes outcomes for people from an African, Caribbean or other Black British background. One of our neighbourhoods is an early adopter of this change in approach.

Through the project MLCO will work collectively with citizens, patients and professionals together, to understand what is strong and supports Black British people with diabetes to remain healthy and well, which we should support and encourage. The team will also look at current services and provision and consider what needs to be different. Working with people and community groups, they will co-create and deliver an action plan of change to improve health outcomes and reduce Diabetes inequalities.

3.5.2 Saint Mary's Managed Clinical Service - improving maternal and neonatal outcomes for women from Black, Asian and minority ethnic groups

Research shows that maternal and neonatal outcomes in a baby's first 1,001 days (from conception to age 2) are significantly worse for women from Black, Asian and minority ethnic (BAME) groups. Pregnant women from BAME groups are also more likely to be admitted to hospital with COVID-19.

The Chief Midwifery Officer for England set out the following actions in June 2020 to help address these emerging inequalities:

a. increasing support for at-risk pregnant women,
b. reaching out and reassuring pregnant BAME women with tailored communications,
c. minimising the risk of Vitamin D deficiency, and
d. gathering accurate data.

Saint Mary's Hospital maternity services worked with the Local Maternity System and Maternity Voices Partnerships (MVPs) to respond to this. The MVPs are maternity service user groups with Chairs who represent local communities.
Outcomes included:

- Developing bespoke information for clinicians about the increased risk for women from BAME backgrounds.

- Supporting clinicians in adopting appropriate admission and escalation practices for women from BAME backgrounds who present with COVID-19 symptoms.

- Working with other regional maternity service providers to co-produce ten key messages, in several different languages, to promote safe maternity care.

- Providing midwives with QR codes on fobs, which women could scan with their smartphones to easily access helpful digital resources.

- Ensuring that Vitamin D is discussed when women are first seen in pregnancy and prescribing of higher doses for those women at increased risk from deficiency.

- Ensuring that pregnant women are receiving comprehensive information about vaccination for COVID-19 to support informed choices on vaccination. This included holding community engagement events with MVPs and voluntary sector organisations.

4.0 COVID-19 Health Equity Manchester

The impacts of COVID-19 have been felt particularly acutely in Manchester because of the unique demographic, cultural and socio-economic characteristics of the local population. Throughout the pandemic there has been a focus on using the latest evidence, data and community insight in order to understand and respond to the existing and newly emerging health inequalities in the city.

Figure 3. Factors that that meant Manchester was hit harder by COVID-19

COVID-19 Health Equity Manchester (CHEM) was set up in July 2020 in response to the disproportionate impact that was increasingly evident in some of Manchester's communities. The group aims to achieve its objectives through collaborative whole system working, influence and advocacy as well as direct actions through its programme of work. The programme objectives are captured below.

Figure 4. COVID-19 Health Equity Manchester objectives

4.1 Vaccine Equity

CHEM has been acutely aware of the need to ensure that vaccine implementation does not exacerbate pre-existing health inequalities. National, regional and local evidence demonstrates that minority ethnic groups are disproportionately affected by COVID-19, and that there is an intersectional dimension to these inequities (the compounding effects of ethnic group, age, sex, occupation, deprivation etc.). A UK survey undertaken in December 2020 (at the beginning of the vaccination roll-out), found that Black British, African, Caribbean, Bangladeshi and Pakistani populations stated that they were less likely to receive a COVID-19 vaccine (if offered) compared to people from a white ethnic background. This 'intent' to take up vaccination followed a historical trend of lower vaccine uptake (non-COVID-19) in ethnic minority groups. Cohort studies using data from G.P.s demonstrated consistently lower 'flu and pneumonia vaccine uptake in Black African and Black Caribbean populations compared to the White population. People of Pakistani origin also had significantly lower uptake.

Building on this national evidence, and incorporating local intelligence, projects and programmes of work have been undertaken through CHEM to understand the views, needs and barriers to vaccine uptake. These projects have been instrumental in developing targeted interventions to increase vaccination uptake across ethnic minority groups across Manchester (such as developing culturally competent information and holding 'pop-up' vaccination clinics in places of worship). Recognising Manchester's unique characteristics, considerable effort was undertaken at the beginning of the vaccination programme to develop a suite of profiles which monitored vaccination uptake by ethnicity, sex, age, and deprivation decile. At the beginning of the vaccination roll-out programme, the data indicated

wide variation in uptake for different ethnic groups. In recent months, there has been a substantial narrowing of the gap; reversing the trend seen early on. Uptake in Bangladeshi and Pakistani people now exceeds the city average; both ethnic groups now have one of the highest uptake percentages, only marginally less than the White population.

Differences persist between uptake across some ethnic groups. Across the city, uptake in Black African and Black Caribbean ethnic groups remains below the city average. Evidence from a range of engagement activities (detailed below) revealed that the reasons for low uptake are numerous and multi-faceted. Acting on this evidence and insight from community activities, several place-based, targeted interventions are in development. Uptake will continue to be monitored as booster and seasonal vaccinations are rolled out.

4.2 Other CHEM Activities

CHEM has supported partners to deliver a range of activities which are targeted at communities that have been disproportionally affected by the COVID 19 pandemic. Examples of these activities include:

4.2.1 Sounding Boards

The main functions of the Sounding Boards are to:

- Bring together a group of people that can act as a voice for their communities.
- Give the communities they represent a voice in the development and delivery of CHEM's programme of work.
- Identify and share what the priority issues and concerns are for the communities they represent.
- Share their views on how statutory sector initiatives and activities might inadvertently impact adversely on different communities and provide potential solutions.

Working with Sounding Boards, CHEM has been able to offer targeted conversations for priority groups such as care staff and pregnant women regarding the vaccine.

4.2.2 CHEM Targeted Fund 21/22

After the initial funding allocated to voluntary sector and community groups in 2020/21, another round of funding has begun, based on different criteria but still supporting the communities most impacted by COVID-19. The aim of the funding for this round is:

- To engage with specific groups and communities to understand what is important to them, and how we can reduce the spread of COVID-19, severe illness and death in those communities.

- To create conditions that enable residents to make informed decisions about living safely and well with COVID-19. This can include vaccinations, testing, etc and COVID-19 safety in the community.

- To improve vaccine coverage and COVID-19 safety amongst specific Manchester communities.

- To support specific groups with the immediate indirect consequences of COVID-19 e.g., mental health, domestic violence & abuse, income loss etc.

The criteria for this funding round were widened to include organisations who worked with:

- Communities that experience racial inequality.

- Communities that experience racial inequality with a focus on young people.

- Communities that experience racial inequality with a focus on women and girls.

- People who do jobs that are at high risk – care workers, taxi drivers, security, hospitality.

- Disabled People's groups and communities.

- Inclusion health groups - New or undocumented migrants, Asylum Seekers and Refugees, Gypsies.

- Travellers and Roma, Sex Workers.

- LGBTQIA+ Communities that experience racial inequality.

Applications are currently being processed and successful organisations will be allocated funding in October.

4.2.3 British Muslim Heritage Centre Worker

In Autumn of last year one in five of all Manchester's COVID-19 cases were among Pakistani people. Men were especially at risk and many of the engagement activities at the time predominantly involved women. Acting on this, the British Muslim Heritage Centre (BMHC) was commissioned to support the public health COVID-19 messaging with the Muslim community, to share the messages and encourage the community to take a safe and considered approach to COVID-19. Outcomes included:

- Disseminated messages/communications from CHEM to the wider Muslim community.

- Organised the translations of the message for radio and other audio media into community languages.

- Established an Imam Network, terms of reference developed and approved.

- Established Muslim Community and Charitable Organisations Network.

- Involved the BMHC Board of Trustees to facilitate communications to their communities.

- Creation of the 'Young Aspiring Leader' programme.

4.2.4 MLCO Health Development Coordinators recruit Cultural Connectors

The Health Development Coordinators (HDCs) who cover Hulme, Moss Side, Rusholme; Ardwick and Longsight; Gorton and Levenshulme; Cheetham and Crumpsall were funded to do some specific targeted work in their neighbourhood to ensure the correct Covid information was shared.

Known as "COVID Connectors" or "Community Connectors", the projects were to find volunteers within communities to support messaging via trusted sources and people who had standing and respect within the communities. All four areas had great success working in partnership with local VCSE organisations to create approaches that worked well for the communities. The four areas used a mixture of methods to get the messages into the community. These included: doorstep conversations; engagement at venues in the community such as schools, places of worship, supermarkets, parks and local events; using local knowledge to inform activity and recognition of those who volunteered and supported the activities. The learning that came from these activities was similar for all areas:

- Being visible and working in partnership with communities build trust.

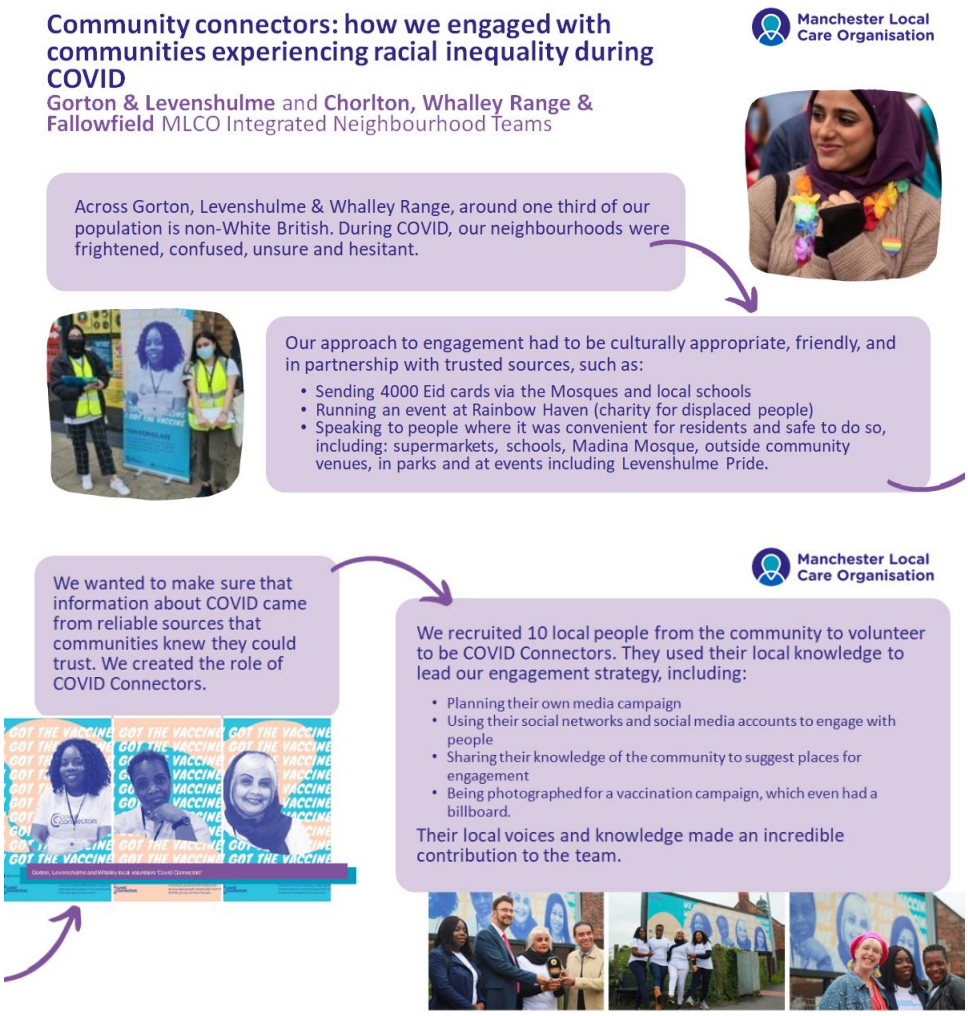
- Engagement and communication are key in order to support members in communities when making decisions regarding COVID-19.

- Having native speakers to support those for whom English is not the first language can be more useful than written translations.

- Representation matters in the volunteer and work groups and creates trust
- Data - understanding the numbers and being able to use them to target effectively.

- Doing things differently based on your audience.

Figure 5 MLCO Integrated Neighbourhood Teams engage communities that experience racial inequality



4.2.5 Covid Chats

Covid Chat is a simple idea to support communities and neighbourhoods, that have been disproportionately affected by Covid-19. The project aims to find volunteers and champions at a community level that look and sound like the communities they represent, to be able to have strength-based person-centred conversation about what is important to them to stay safe and well with Covid-19.

Manchester took the approach to work with VCSE organisations that already had the networks and relationships with the communities that had been identified: Pakistani, Bangladeshi, African Caribbean and Black African, and Disabled People.

Manchester has established a network of Chat Coordinators who work with identified communities through schools, churches and community networks to recruit and train volunteers to have chats with those living and working in the community. A chat may be a one off or maybe two or three conversations.

The team has recruited 60 champions who have attended the bespoke training package delivered through Manchester Adult Education Service. Champions and coordinators are delivering chats via What's App groups, 1:1 in person, and in group settings.

As there were already established relationships with the Local Care Organisation in Cheetham and Crumpsall, this neighbourhood became an early adopter of Covid Chats. Strong leadership at a neighbourhood level, bringing people and organisations together, while not easy, has given the opportunity to build trust and collaborate, avoid duplication and share resources.

The success of the programme is based on the relationships we develop with each other as organisations, and the trust we build in our communities and neighbourhoods, to enable people to share their worries/concern/fears about living with Covid.

Covid Chats has successfully supported and added value to existing programmes across Manchester. When Manchester became an Enhanced Response Area, Chat Coordinators and Champions' ability to provide a safe space for individuals to speak to someone who understands their culture, speaks their language, and listens has proven to be incredibly powerful. Recipients of a Covid Chat have said they felt listened to and have welcomed the conversations in all settings. In some instances, the chat has prompted them to take measures to protect themselves and their community, such as receiving their first Covid-19 vaccination.

5.0 Manchester Health and Care Commissioning (MHCC) – addressing health inequalities in health and care

In response to the Public Health England report of June 2020 'Understanding the impact on communities that experience racial inequality', MHCC developed a detailed 'Addressing Inequalities' programme plan. The NHS Planning guidance for 2021/22, and more recent guidance on the transition to the Integrated Care System (ICS), has further prioritised this work, as has the City's Covid Recovery Framework for Health and Care. The plan addresses the following;

- Improved demographic data collection.
- Community research to inform service delivery.
- Improved access, experience & outcomes.
- Culturally competent workforce risk assessment.
- Culturally competent education & prevention.
- Target culturally competent health promotion & disease prevention.
- Ensure that recovery plans reduce inequalities caused by wider determinants.

Whilst there is increasing interest in and understanding of how the social determinants of health influence health, and how to address this in health care, Manchester has also focused on identifying racism and other forms of discrimination as root causes of health inequities. The approach taken has been to address this with residents, patients and workforce by adopting the four principles outlined below.

- Clarifying our locality stance and values.
- Communicating our messages and ensuring two-way communication.
- Connecting with our people by talking openly, creating an environment of compassion, respect and safety, and to share experiences and learn from each other.
- Committing to sustained action, visible leadership and a willingness to change.

As a universal service and gateway to wider health and care services, the work that has been delivered across primary care is critical to the implementation of the whole of the Addressing Inequalities programme. Addressing inequalities is at the heart of The Primary Care Quality Resilience and Recovery Scheme. There are now increased targets for collection of ethnicity, faith and spoken language data which will support targeted interventions and monitoring of referrals to hospital services. The vaccination programme, which all practices have supported, has raised awareness of the need to collect demographic information such as language spoken. This has been critical to engagement. An education programme underpins delivery and builds on a strong track record in the city of inclusion and equalities training for primary care. There will also be funding for clinical time to act to reduce health inequalities by focusing on the people who have not attended or come forward for review, and to reduce variation in outcomes for people based on ethnicity, deprivation or other protected characteristics.

Community research to inform service delivery has been delivered through the Covid Health Equity Manchester Sounding Boards. Recent examples include the development of the 'Long Covid' service in the city. Whilst this is a national service, Manchester is building on feedback from the Disabled People's Sounding Board to ensure that communications are in accessible formats and that practitioners understand and address the needs of neurodiverse people and people with learning disabilities within the local delivery plan.

The work that is being done to increase diversity of decision-making and experience to inform the delivery of major programmes such as North Manchester General Hospital is just one way of improving patient and public experience and outcomes. In relation to the workforce, MHCC is continuing with its comprehensive development programme on equality and inclusion– both within the workplace and in the work delivered. Tackling Structural Racism & the Impact on Health Inequalities is being delivered to Senior Managers who are using the learning to shape their future programmes. All staff have also been given the opportunity to attend 'Allyship' workshops to help address racism and 'Civility' – Dignity at Work' training, both of which have been very well received by staff.

6.0 Next Steps – Building Back Fairer

6.1 Marmot Task Group and refresh of Manchester's Population Health Plan

In order for the activities that address the social determinants of health to have maximum impact for individuals and communities, the partners in the city will need to work as a collective system, to ensure every resident has the opportunity for better health and support.

The City Council, as part of its civic leadership role, is ideally placed to harness the collective strengths of organisations and sectors across the city to address the wider determinants of health.

The Director of Public Health will establish and lead a focused task group to respond to the recent Marmot Report with a clear action plan relating to the wider determinants. This work will feed into the refresh of the Manchester Population Health Plan from April 2022.

The refreshed plan will also include a strengthened approach to health equity in response to the systemic inequalities for certain communities highlighted by the COVID-19 pandemic and identify actions to address health inequalities that have been significantly exacerbated by the pandemic.

6.2 Delivery of Manchester's Population Health Recovery framework and associated flagship programmes

Manchester's Population Health Recovery Framework (see Figure 2 on page 6) will support the delivery of the Population Health Plan with a focus on three pillars of work within the context of the COVID-19 pandemic. Each pillar has a "flagship" programme of activity to address the root causes and wider determinants of health inequalities alongside the broader partnership working to create the conditions for healthy lives. The programmes are summarised in the appendices and further details can be made available from the Population Health Team. In brief, these programmes are:

1. Manchester's Wellbeing Model – a framework for services and approaches to improving the wellbeing of Manchester's residents based on the level of support people need to look after their own health and wellbeing.

2. Winning Hearts and Minds - working in and with communities to improve heart and mental health across the city, with a particular focus on North Manchester.

3. COVID-19 Health Equity Manchester: Addressing the disproportionate adverse impact of COVID-19 on specific communities in Manchester and ensuring the legacy of COVID-19 is that lessons learned are implemented and improve the broader health outcomes of these communities.

6.3 Equality and Inclusion

In order to fully realise and sustain health equity outcomes from opportunities created for individual people and communities, a robust approach to Equality and Inclusion is needed. Prejudice and discrimination at an institutional and structural level result in environmental, social and economic differences that impact people's health, leading to health inequity. The impact of racial discrimination in particular, on health outcomes, is a lesson learnt from the COVID-19 pandemic that must not be lost. This needs to be a system wide and collaborative approach which is overseen by the Manchester Partnership Board.

Furthermore, as the NHS moves through Integrated Care System reform, equality, inclusion and addressing inequalities will need to be embedded into foundations for the new structures and priorities set out for Manchester and Greater Manchester.

7.0 Recommendation

The committee is asked to consider the report and note the next steps for addressing health inequalities in Manchester within the context of the COVID-19 pandemic.