Greater Manchester Integrated Care Partnership Board

Date: 29th September 2023

Subject: Optimizing the Role of the NHS in Tackling Poverty

Report of: David Boulger – Assistant Director: Population Health (NHS GM)

SUMMARY OF REPORT:

1. In October 2022, the Integrated Care Partnership Board supported proposals to advance a programme of work aimed at optimizing the role of NHS GM in tackling poverty.

2. This report provides an update on that programme of work and covers:

   a) A summary of activity that has taken place at a pan-GM level.

   b) Examples of good practice from across localities and providers.

   c) A summary of the key findings of population-level survey activity and health and care staff survey activity undertaken by GM Poverty Action on behalf of NHS GM.

   d) A summary of the key findings from an independent review of the NHS GM approach to tackling poverty undertaken by GMPA.

   e) Proposals for the areas of focus for the remainder of 2023/24 and across 2024/25 and 2025/26.

RECOMMENDATIONS:

The Greater Integrated Care Partnership Board is asked to:

- Note the content of this report and breadth of activity taking place within the GMN health and care system to tackle poverty and mitigate the impact the poverty has on health outcomes and the utilisation of health and care services.

- Note the findings of the Independent Review and the surveys undertaken by GM Poverty Action.

CONTACT OFFICERS:

David Boulger – Assistant Director: Population Health (NHS GM)
Dr Claire Lake – Deputy Chief Medical Officer (NHS GM)
Paul Lynch – Director of Strategy and Innovation (NHS GM)

1. INTRODUCTION

1.1 Poverty is the single biggest driver of health outcomes and inequalities.

1.2 At the first meeting of the GM Integrated Care Partnership Board in October 2022, a paper was brought by the GM Population Health Board setting out proposals to optimize the role of NHS GM in tackling poverty a cause of poor health. The paper was strongly supported and serve as a catalyst for action over the past 12 months.

1.3 This update report provides:

- A summary of activity that has taken place at a pan-GM level.
- Examples of good practice from across localities and providers.
- A summary of the key findings of population-level survey activity undertaken by GM Poverty Action on behalf of NHS GM.
- A summary of the key findings from an independent review of the NHS GM approach to tackling poverty undertaken by GMPA.
- Proposals for the areas of focus for the remainder of 2023/24 and across 2024/25 and 2025/26.

2. PAN GM ACTIVITY UPDATE

2.1 Over the past 12 months, a considerable amount of activity has taken place under the joint leadership of the Population Health and Medical directorates within NHS GM, with the support and participation of a wide range of system partners, and underpinned by a new strategic relationship with **Greater Manchester Poverty Action (GMPA)**.

2.2 Some key activities that have taken place are as follows:

System Leadership

- NHS GM plays an active role in the GM Cost of Living Response Group, ensuring a whole system response to tackling financial hardship in GM.

- NHS GM has incorporated a priority action into the Joint Forward Plan to capture this activity within the core business of NHS GM.

Advice and Guidance

- NHS GM contributed to the development of the Helping Hand website hosted by the GMCA to ensure it provided advice and guidance to people in poor health, and advice and guidance that was aimed at preventing poverty becoming a source of poor health.

Raising Awareness / Training and Development

- NHS GM commissioned GM Poverty Action to develop and deliver '*Poverty Awareness*' training to a broad cross-section of NHS staff in GM. The first tranche of training was attended by 150 people between May and August and was well received.

- A further tranche of training has been commissioned which is aimed at reaching 400 people between October 2023 and March 2024.

- GMPA convened the first ever GM Socio-Economic Duty Summit in July 2023 with 3 expert speakers and over 50 attendees from across GM.

Independent Review

- NHS GM commissioned GM Poverty Action to undertake an independent review of the current NHS GM approach to tackling poverty and to make recommendations on where the approach could be strengthened. This included a literature review, a review of existing system documentation and engagement with key stakeholders.

- An interim report is included as **Appendix 1**, with the final report due in October 2023.

- An overview of the summary findings from the interim report are included in Section 4 of this report.

Population Survey

- NHS GM commissioned GM Poverty Action to undertake a survey of the GM Population which received 1000 responses from a diverse cross-section of the population.

- The findings from this survey are included as **Appendix 2** of this report.

- An overview of the findings from this survey are included in Section 5 of this report.

Staff Survey

- NHS GM commissioned GM Poverty Action to undertake a survey of the health and care workforce in GM which received 38 responses.

- The findings from this are included within the interim report, which is included as **Appendix 1**, but some key summary findings were as follows:

- The majority of health care professionals felt that tackling poverty was a highly important part of their role.

- The way in which they contribute to tackling poverty is wide-ranging, although some staff expressed a lack of awareness of what support was available for them to offer to patients.

- Almost 90% of staff felt that "*making sure services are accessible to people on low incomes*" was a highly important part of the NHS role in tackling poverty.

GM Residents Survey

- NHS GM have worked with the GMCA to include questions in the GM Residents Survey around experiences of poverty and the impact of poverty on health which will further strengthen our level of insight.

Focus Groups with People with Lived Experience

- GMPA, on behalf of NHS GM have carried out focus groups to gain insight into how NHS staff can better provide support to people experiencing socio-economic disadvantage.

- People with lived experience of poverty were recruited via community-based partners across GM.

- The focus groups involved 10 participants, spilt into two groups. Each group participated in two sessions – the first session explored "cost implications of accessing GM NHS health and social-care systems/services" and "financial support currently provided by GM NHS." The second session covered "NHS's role as an anchor institution – role of NHS staff/healthcare professionals in tackling poverty" and "physical and mental health impacts of financial crises/poverty."

- The findings from these are included within the interim report include as **Appendix 1**.

Poverty-Proofing Health and Care

- NHS GM commissioned GM Poverty Action and Children Northeast to run a 'poverty proofing' testbed aimed at testing a methodology for assessing the extent to which our approach to provided health and care services to a cohort of the population mitigated or exacerbated poverty.

- The first test bed has commenced and is reviewing the experiences of "*pregnant women and their newly born child (the maternity journey and the first 12 weeks post-partum) who live in the most deprived 20% of Greater Manchester as identified through the Indices of Multiple Deprivation.*"

- The focus of the second test bed has not yet been confirmed.

- Both test beds will be completed during 2023/24.

- The learning from this activity will allow the formation of an NHS GM methodology / toolkit for reviewing services through a poverty *lens* which will be hosted on the Fairer Health for All Academy website and will be accessible to all health and care staff in GM.

High Energy Consumption Medical Devices in Domestic Settings

- NHS GM has engaged with GMCA and energy providers to ensure that individuals whose health needs require them to have high energy consuming medical devices in their homes, are not disproportionately affected by high energy costs.

- This has primarily involved working with a range of stakeholders to ensure that '*at risk*' individuals are able to access the financial and practical support that is available to them.

3. EXAMPLES OF GOOD PRACTICE IN LOCALITY AND PROVIDER SETTINGS

3.1 Whilst we are proud of the way in which NHS GM has led the way nationally in showing the role that the NHS can play in tackling poverty, it is important to recognise the wealth of good practice examples that exist within localities and providers, and which have often existed well in advance of this current piece of Pan-GM activity.

3.2 Some examples, which are by no means exhaustive, include:

- **Manchester Foundation Trust (MFT):**

  - MFT has been working with Citizens Advice on the trauma unit at MRI for a number of years, supporting patients with benefit, debt and other advice linked to their condition. This offer is now being expanded to include North Manchester General Hospital and will be available for all patients and staff. Funding applications are underway to develop this at other sites too, offering patients financial, housing, and other advice and support at the point of care. The impact will be evaluated. Previous work has shown significant benefits to patients in terms of claiming the correct benefits and helping manage debts. Feedback from

other Hospital Trusts suggests having advice workers on site may benefit patient flow and support discharge too.

- **Trafford Locality**:

  - Since January 2023, the Sale Central Primary Care Network (PCN) has worked with local voluntary, community, and social enterprise (VCSE) organisations to run regular drop-in sessions with a community health advisor aimed at people who face specific barriers when accessing traditional services, including those experiencing severe financial hardship. Working in partnership helps people get the advice needed to improve their health and wellbeing and to be linked to services that can support further including cost-of-living advice.

- **Stockport Locality**:

  - Stockport's Resident Advice and Support Team's (RAS) Cost of Living Helpline, which uses a "tell us once" approach to accessing advice, benefit checks, help with applications for benefits and warm referrals to relevant support services, is routinely used by NHS staff. A team of experts offering specialist casework to assist the most vulnerable residents with income maximisation, complex debt and benefit problems is also available. RAS Benefit Advisers also deliver outreach approach to support patients from their hospital ward, or their local community mental health outreach centre to ensure they get the best advice, quickly. This enables patients to leave hospital after long stays with the correct benefits in place.

  - The Council and NHS have jointly delivered a benefit uptake campaign building on successful Pension Credit uptake campaign, and the council is working on a pilot with the Heaton's GP Practice to promote Attendance Allowance to a target cohort of patients i.e., those with long-term limiting health conditions will be encouraged to contact the Cost-of-Living Advice Line for access to a full benefit assessments and support to apply.

- Benefit advisers are supporting patients with mental health needs from their hospital ward, or their local community mental health outreach centre to ensure they get the best advice, quickly and helping patients to leave hospital after long stays with the correct benefits in place.

- **Bury Locality**:

  - 3 anti-poverty summits have been delivered locally with all partners including Health, social care, housing, DWP, food banks, vol sector orgs and people with lived experience, across which we have collectively agreed our anti-poverty strategy and the use of our HSF (along with listening to lived experience).

  - Bury have implemented the Money Advice Referral tool in collaboration with GM Poverty Action and local VCSE partners.

  - Targeted support enabling provision of £306,600 of HSF beyond those receiving direct payments or direct provision from voluntary/community groups.

  - 36 voluntary groups applications supported through Cost-of-Living resilience payments with a total allocation of £80,414.

  - Increased the uptake of healthy start vouchers in Bury to 66% through working with Bury Market to provide more venues to use the vouchers (GM uptake is 61%) (https://www.burymarket.com/bury-market-news/nhs-healthy-start-success)

  - Supported the coordination of over 40 warm spaces in Bury.

  - Invested in a new software (ascendant) which helps to identify cohorts who are financially vulnerable.

- **Bolton Locality:**

  - Bolton has at least one Social Prescribing Link Workers (SPLW) based in each of its nine Primary Care Networks working with people from financially disadvantaged backgrounds – linking with them to services such as financial and debt advice, housing services and skills training.

- **Wigan Locality**:

  - TABA PCN (Tyldesley, Astley, Boothstown and Atherton) which has eleven practices in its network has implemented several initiatives to tackle health inequalities, one of which involved working with the charity Mind to increase the uptake of Severe Mental Illness (SMI) health checks through a more holistic approach to tackle then underlying problems affecting a patient, including any money worries.

4. GM POVERTY ACTION INDEPENDENT REVIEW

4.1 NHS GM commissioned GM Poverty Action to undertake an independent review of the current NHS GM approach to tackling poverty and to make recommendations on where the approach could be strengthened.

4.2 The commission included a broad initial exploration of the GM health system's approach to poverty, reflecting on existing policy and good practice and reviewing this approach against recommendations made by the King's Fund in their publication – 'The NHS's Role in Tackling Poverty'.

4.3 An interim report is included as **Appendix 1**, with the final report due in early October 2023.

4.4 Some key summary reflections from the interim report are as follows:

- NHS GM has undertaken a range of actions that are aimed at tackling the impact of poverty on health outcomes and healthcare experiences, and these mirror some of

the Kings Fund recommendations and are acknowledged as position practice.

- However, NHS GM needs to maintain and intensify its efforts and adopt a strategic approach that builds on current successes and adds robustness to its anti-poverty initiatives.

- The focus on the role of NHS GM as a 'good employer' is positive, but the context for adopting good employer practices (including the real living wage) remains unclear.

- There is a need to ensure that people with lived experience of poverty have a much stronger voice in NHS GM decision-making and governance.

- There are tangible areas where NHS GM could go further, and these are set out within the key recommendations.

4.5 The key recommendations are that NHS GM should:

a) Develop a robust anti-poverty strategy, with a focus on:
   - Setting out a clear mission and vision.
   - Co-production with people with lived experience of socio-economic disadvantage.
   - Appropriate allocation of resources.
   - Cross-system collaboration.

b) Adopt the socio-economic duty.

c) Work with GMPA and the Greater Manchester Living Wage Campaign to realise good employment goals.

d) Prioritise ongoing poverty awareness training for senior and middle management, as well as widespread mandatory poverty awareness training for all NHS professionals, focussing on the NHS's role as a health service provider and employer.

5. POPULATION SURVEY FINDINGS

5.1 NHS GM commissioned GM Poverty Action to undertake a survey of the GM Population which received over 1000 responses.

5.2 The full survey findings are included as **Appendix 2**.

5.3 The key findings from the survey are as follows:

- Almost a third of respondents stated that concerns and/or difficulties with household finances 'always' or 'often' impacted their physical and/or mental health.

- For a significant proportion of the population, household income impacts upon their ability to access health and social care services with over 40% not having accessed an NHS service due to the cost implications.

- Most respondents felt that cost implications are not considered by the NHS, even though more than half felt that the NHS has a responsibility to assist patients who are experiencing financial hardship.

- The majority of respondents could not identify any NHS schemes or assistance that may enable them to get support with health and social care costs.

- Almost two thirds of respondents stated that they would not share concerns about their household financial situation with health and social care professionals, and 89% confirmed that they had never raised concerns about their household's financial situation with an NHS health and social care professional.

- There is significant variation in responses by age, gender, and ethnicity.

6. NEXT STEPS

6.1 The activity that has taken place over the past 18 months has provided a great deal

of learning and insight and has enabled the development of a future plan which builds upon the progress to date.

6.2 The proposed areas of focus for the next 3 years have been captured in the Joint Forward Plan Delivery Framework and are as follows:

a) **Strengthening the use of Data, Intelligence, and Insight:**

- 2023/24: Undertake comprehensive analysis to generate insight into the impact of poverty on health outcomes and health / care service activity in GM.

- 2024/25 and 2025/26: Harness the opportunities of the NHS GM data systems and the academic expertise in GM to develop increasingly innovative and experimental insight and evidence to support activity and strategy.

b) Optimizing the NHS GM strategic approach to Tackling Poverty:

- 2023/24: Complete the independent review of the NHS GM approach to tackling poverty and respond to findings as appropriate; Establish an NHS GM Tackling Poverty Task and Finish Group reporting into the NHS GM Population Health Committee.

- 2025/26: Undertake a review of the Tackling Poverty programme and develop a 3-year plan for 2026/7 to 2028/29.

c) Poverty Proofing Health and Care:

- 2023/24: Complete the two initial 'Poverty Proofing Health & Care' testbeds commissioned through GMPA by 31/3/23.

- 2024/25: Develop and implement an NHS GM Poverty Proofing Health and Care Toolkit within the FHFA Academy; Implement a further 6 poverty proofing reviews of key parts of the health and care system.

- 2025/26: Implement a further 6 poverty proofing reviews of key parts of the health and care system.

d) Raising Awareness across our Workforce:

- 2023/24: Complete phase 1 of the Poverty Awareness training programme which involves the provision of half day poverty awareness training to 550 members of the GM health and care workforce; Develop plans for a 4-tier approach to Poverty Awareness training and development consisting of online learning, poverty awareness sessions, specialist action learning workshops and communities of practice – hosted as part of the Fairer Health for All Academy.

- 2024/25: Host the first ever GM Poverty and Health Conference; Iteratively implement the 4-tier approach to Poverty Awareness training and development.

- 2025/26: Full delivery of the 4-tier approach to Poverty Awareness training.

e) Supporting People Experiencing Financial Hardship:

- 2023/24: Produce an options appraisal around the provision of Financial Hardship support services in health and care settings and agree a future direction of travel.

- 2024/25: Implement the findings of the Financial Hardship services options appraisal.

7. RECOMMENDATIONS

7.1 The Integrated Care Partnership Board are asked to:

7.1.1 Note the content of this report and breadth of activity taking place within the GMN health and care system to tackle poverty and mitigate the impact the poverty has on health outcomes and the utilisation of health and care services.

7.1.2 Note the findings of the Independent Review and the surveys undertaken by GM Poverty Action.

Appendix 1 – GM Poverty Action independent review of the NHS GM approach to tackling poverty and financial hardship: Interim Report

GMPA Interim Report:

Exploring the role of Greater Manchester NHS in tackling poverty,

September 2023

Overview

Greater Manchester Poverty Action (GMPA) has been commissioned by Greater Manchester (GM) NHS to undertake a project looking at the role of the health and care system in tackling poverty over a six month period.

The commission includes a broad initial exploration of the GM health system's approach to poverty, reflecting on existing policy and good practice and reviewing this approach against recommendations made by the King's Fund in their publication – 'The NHS's Role in Tackling Poverty'. It involves assessing the feasibility, value and desirability of GM NHS developing an anti-poverty strategy and adopting and implementing the socio-economic duty, a tool by which public bodies can ensure decisions they make take into account the needs of people experiencing poverty.
This work will develop into producing a single shared narrative around the impact of poverty and health in GM, incorporating a clear articulation of the potential role the health system can play in tackling the issue. This will be facilitated through advice and guidance to NHS GM in relation to poverty and the cost-of-living crisis, and how it is incorporated into the GM Health and Care Strategy, the GM Build Back Fairer framework, and other GM Population Health Board responsibilities.

A key element of this commission is Poverty Awareness training, delivered to an initial cohort of managers and policy and strategy leads within the health system, with a view to evaluating and developing this training to a wider group of health and care professionals, tailored to certain specialisms, in the future.

A final, ongoing part of this commission is looking at how 'poverty proofing' could be applied to the health system in GM. Poverty proofing as a concept is about identifying the barriers people experiencing poverty may face in accessing services. A 'poverty proofing'

pilot will be carried out by Children North-East, a partner organisation of GMPA who are experts in providing tailored guidance on what actions can support settings to minimise the impact of poverty on healthcare provision. A final report for the poverty proofing element of the commission will be provided separately and will identify learning and outputs, with next steps and recommendations based on this work to be developed by GMPA and the GM Population Health team. These activities will create space for exploring how the concept can be developed in a way that meets the needs of GM NHS and complements the recommendations made by GMPA in respect of the health system's role in tackling poverty.

Introduction

This paper presents a selection of key findings and recommendations from the literature review and primary research. Although it does not encompass the entirety of the research, this overview offers a preliminary insight into the broader dimensions of the work, with a final report set for delivery in October.

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

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

The strategy should focus on:

- Setting out a clear vision and mission, developed in conjunction with partners and people with lived experience of poverty about the role of NHS GM in addressing poverty and ways of working.
- Enhancing capacity and capabilities throughout the system, ensuring that resources and expertise are appropriately allocated and maximised.
- Sharing good practice and learning among health and care teams.

- Championing cross-system collaboration ensuring that addressing poverty is a prioritised objective.

Primary research

As part of this commission, GMPA undertook several methods of primary research to assess the role of NHS GM in tackling poverty. These included a survey of GM residents, focus groups of people with lived experience of poverty, a survey of NHS professionals and interviews with key stakeholders, as well as observing training. A full methodology will be supplied in the final report.

Below is a thematic summary of the findings of this research and recommendations gleaned.

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

Amongst the general public across Greater Manchester (from 1000 survey respondents):

- 39% of all respondents either agree or strongly agree with household income impacting their ability to access NHS health and social care services.
- Most respondents believe that cost implications for patients are not always being taken into consideration by the NHS, with cost implications being taken in account either ‘sometimes’ (29%) or ‘rarely’ (29%).
- 41% of respondents identified as not having accessed an NHS service or amenity due to cost implications, identifying cost implication to be a significant barrier in NHS GM.
- 31% of respondents agree or strongly agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years, whilst the majority (46%) neither agreed nor disagreed with the statement.

Amongst health and care professionals from both the public and VCSE sectors in Greater Manchester (38 respondents in total):

- "Making sure services are accessible to people on low incomes" is the most popular 'highly important' option amongst health and care professional for health services to address poverty, with 89% of respondents ranking it a '5' (i.e. highly important).

The following key points were highlighted from the lived-experience focus group (with 12 participants from across Greater Manchester):

- In accessing healthcare services, all answering participants mentioned transport costs as a key barrier, many referencing the cost-of-living crisis and fear of elongation of treatment through missing appointments. Some participants mentioned digital costs, childcare costs, and costs specific to individuals that are undocumented and/or are seeking asylum.
- All answering participants highlighted the lack of adequate and/or effective communication by NHS staff with patients being a significant barrier to accessing NHS systems/services, specifically on the lack of regard for specific healthcare needs/circumstance (particularly mental health) and a work culture than is more reactive than pro-active and is not based on empathy/compassion as it should be. Other participants identified accessibility of information, digital exclusion, lack of consistency of care between boroughs, and a lack of adequate/effective communication within/between NHS and/or Health and Care staff as other key barriers.
- All answering participants believe that cost implications of accessing health and social care systems/services should be considered by the NHS.

Awareness of GM NHS assistance/schemes

Amongst the general public across Greater Manchester:

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

Amongst health and care professionals from both the public and VCSE sectors in Greater Manchester:

- Directly assisting and/or supporting patients facing poverty via various tools, programmes and schemes (e.g., vouchers, social prescribing, helping with or directing to services helping with benefits/household income etc.) is the most popular option amongst health and care professionals in enabling the NHS to respond to poverty.
- Many respondents stated that they helped tackle poverty in their role through multiple ways. The majority (42%) stated that they directly assist/support individuals via in-house tools, programmes, and/or schemes, such as giving vouchers, offering advice (etc.) whilst 37% of respondents stated to actively put-in or change structures, systems and/or procedures – such as more effective teamwork and exchange of information, reducing barriers/accessibility issues caused by poverty, staff training to awareness/knowledge on poverty (etc.) – to better accommodate those facing poverty.
- Similarly, 39% of respondents stated that their organisation directly assists/supports individuals in-house, and 37% of respondents stated that their organisation actively seeks to put-in or change structures, systems and/or procedures to better accommodate those facing poverty. However, 21% of respondents – namely some from the NHS – were unaware of what their organisation does overall in responding to poverty outside their role/area, highlighting a need for an overall anti-poverty strategy (particularly by larger and more complex organisations such as the NHS).

The following key points were highlighted from the lived-experience focus group:

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

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

Amongst the general public across Greater Manchester:

- 54% agree or strongly agree that NHS health and social care professionals have a responsibility to assist patients with financial hardship.
- Almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals.
- Of those who feel comfortable in sharing concerns about their household's financial situation with an NHS professional, the majority (76%) were happy to share such concerns with their GP.
- A vast majority (89%) stated that they have never raised concerns about their household's financial situation with an NHS health and social care professional.

Amongst health and care professionals from both the public and VCSE sectors in Greater Manchester:

- More than half (58%) identified tackling poverty to be 'highly important' to their role, whilst only 3% identified it as 'not important'.
- The need to tackle poverty to effectively meet the primary aims/objectives of the health and care professionals' job role (e.g. providing effective healthcare, ensuring accessibility to services/systems etc.) was the most popular reasoning (34% stating as such) as to how poverty was relevant to the respondents' job roles.
- 71% of respondents stated that there are opportunities for them/their organisations to respond to poverty that aren't being currently realised. 18% of respondents do not know whether there are such opportunities present, whilst 8% state that there are no such opportunities at all.
- 79% of all respondents view a "lack of adequate funding for services" as a highly significant barrier to health and care services aiming to tackle poverty. In the following open-ended question, 21% of respondents identified the lack of appropriate/adequate focus, awareness, or understanding of poverty and how to tackle it, being a barrier for health and care services in seeking to tackle poverty.

The following key points were highlighted from the lived-experience focus group (with 12 participants from across Greater Manchester):

- All answering participants believe that the NHS is not providing adequate financial assistance in this cost-of-living crises, instead highlighting a decrease in free services offered and staff becoming more understaffed and overworked.
- A majority of participants stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals, with only a couple stating that they would only be comfortable with their GP/family doctor. However, a majority of participants were also agreeable to having NHS approach them regarding their financial situation (to initiate a process of getting help/support), but only under particular conditions around anonymity/semi-discreteness and the staff having soft-skills and emotional intelligence. Some stated they would not want to be approached, or were unsure about being approached or not, because of stigma and how well the NHS can deliver on it with its current resource/capacity issues.

Effect of financial hardship on mental/physical health

Amongst the general public across Greater Manchester:

- 31% of all individuals state that concerns and/or difficulties with household finances ‘always’ or ‘often’ impacts their physical and/or mental health.

The following key points were highlighted from the lived-experience focus group (with 12 participants from across Greater Manchester):

- All answering participants expressed strongly regarding concerns about/difficulties with households finances impacting their physical and/or mental health. The inverse was also found to be true, with participants stating the cyclical nature of dire financial circumstance and physical and mental health.

Recommendations can be found at the end of this interim report.

Analysis of NHS GM against King's Fund recommendations

Please note this literature review offers a preliminary insight and does not encompass all the areas explored. The full report will delve deeper, providing additional case studies and detailed analysis.

The King's Fund (2021) report highlights that the NHS can tackle poverty in three specific ways:

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

Below, we outline examples from our research of key findings and recommendations to be considered by NHS GM.

Action

Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. One of the four core purposes of the ICS is to help the NHS support broader social and economic development. A wide range of system-level actions are taking place in GM to boost the local and regional economy and reduce socio-economic and health inequalities. However, we have identified that the ICS can further support and build a more systematic approach to social and economic development to make the GM population better and better off.

A report by Goodwin (2023) highlights recommendations on how ICS can develop their potential as networks of anchor institutions. Summarising the recommendations and

adapting to the NHS GM context, we outline the following key takeaways and insights that should be considered to move to a more connected anchor system:

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

- Enable local enterprises to play a more significant role: we are pleased to see a pivotal priority to the GM anchors network developing and implementing local supply chain opportunities. To grow and develop this, the ICB must integrate procurement data into economic development practice.

Goodwin (2023) suggests that to integrate procurement data into economic development practice, the ICB should:

- Examine procurement data to pinpoint areas of spend that can be influenced and collaborate with local authorities to identify alternate suppliers, which involves local development officers liaising with local small businesses and social enterprises. A key area of focus could be exploring the feasibility of a local manufacturing offer for consumable items, which could be incorporated into supply chains (as the Covid-19 pandemic demonstrated that many SMEs could quickly adapt to provide the NHS with the necessary consumables). Moreover, this is a further opportunity to engage organisations and build a shared commitment to tackling poverty by promoting the real Living Wage.

- Explore commissioning community development workers to support more inclusive economic development, working at a neighbourhood level to identify the community's needs.
- Unify approaches to securing social value: it is encouraging to see plans to adopt the GM social value framework. Reed et al. (2019) recommend that the NHS should apply social value principles across areas where the NHS has greater flexibility, such as hotels and catering, as social value tends to be primarily part of competitive tender processes. Social value should be a priority, but care should be taken. Some suppliers might give a positive appearance but try to work around the system, over-promising the social value they will deliver.
- Give the local NHS greater control of land: housing and planning policy plays a vital role in reducing the risk of poverty and health inequalities. While we understand the pressure to sell assets for profit, ICB partners should consider whether any extra land and property could be used for affordable commercial or residential development. This extra space could support local businesses and community use, helping to expand and grow the local economy. For example, Reed et al. (2019) outline examples of some NHS organisations explicitly prioritising social value as part of decisions to sell land. For example, NHS Property Services sold the former St George's Hospital site in Hornchurch for £40m (the most considerable reinvestment in the NHS through the sale of surplus land); 15% was allocated for social housing, and 1.6 hectares of land retained to host a new community health centre. Furthermore, they describe how some NHS sites have an existing green that they have open to the local community and others are working to develop green space on unused land. For example, at a primary care centre near Sunderland, staff worked with NHS Property Services and a local charity, Groundwork, to convert derelict space into a community garden and allotment. The space is now used to run a gardening course as part of a community mental health recovery programme.

Maximising the role of the NHS as an employer / good employment

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

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

However, the context to which good employment practices have been adopted remains unclear. According to the Living Wage Foundation, only one NHS service provider from GM, the Greater Manchester Mental Health NHS Foundation Trust is an accredited Living Wage employer and very few NHS organisations are members of the GM Good Employment Charter. Our primary research suggests poverty awareness training for middle management is crucial in making clear the link between low pay, poverty and ill health which may then impact a person’s ability to work.

Through our research, we have identified gaps that need to be built on to reduce poverty. There is an increasing amount of evidence that paying the ‘real’ Living Wage (rate set annually by the Living Wage Foundation, based on the true cost of living, unlike the government’s National Living Wage; the statutory minimum rate of pay dependent on age, based on fluctuations in average earnings) has benefits to employers as well as its employees. The Living Wage has lifted hundreds of thousands of people and families onto a wage that covers their every day needs and can be credited with improvements to an employee’s mental health and wellbeing. In current NHS pay scales, an employee earning

below Band 2, spine point 3 is “paid a wage that does not support an employee’s needs – a difference of more than £1,000 a year between the Living Wage and what a low-paid employee earns each year” (Lewis, 2022). When considering NHS GM’s role in tackling poverty, it is important to look at the impact paying the Living Wage would have on staff, given the scale of employment across the city region and how many households are provided their income by the NHS.

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

Enhancing the scale of work and health programmes

It is welcome that working with the Greater Manchester Combined Authority (GMCA), NHS GM will continue to evolve the ‘working well system’, with a number of new services being put into place. However, it is vital that employment support is not done to, but rather in collaboration with, those who have lived experience of socio-economic disadvantage and health inequalities. This is what is missing in national employment support. NHS GM and the GMCA should take an approach that involves people from the outset, committing to processes of engagement (rather than single events), and creating a lived experience advisory group (described elsewhere in the document).

Growing and developing the workforce

It is positive that there is an active focus on developing GM’s career approach to attract and support career development. NHS GM must target skills and opportunities to those

[1] https://democracy.greatermanchester-ca.gov.uk/mgCommitteeDetails.aspx?ID=426

who need them most, reaching out to communities and mapping the employment profile of providers' trusts to identify any deprived postcodes where trusts employ relatively few people. For example, the Birmingham & Solihull ICS, in partnership with the Birmingham Anchor Institution Network, is leading a programme known as 'I Can' across all its employing providers. 'I Can' has engaged with over 3,000 jobseekers and offered more than 420 people a role. Roles include porters, theatre support workers and healthcare assistants. It was recently shortlisted for a national award (University Hospitals Birmingham, 2023).

Awareness

Mission statement

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

Recommendation

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

Enhancing engagement with people with lived experience of poverty

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

There has been considerable work across the system to involve people and communities, with different parts of the ICS having their own participation legal duties and

responsibilities, and we are aware there are plans to develop a longer-term partnership approach to engagement. These legal duties, strong relationships within the system, and existing communications and engagement practices provide a platform to be built on to improve engagement with people with lived experiences of poverty at the system level.

Recommendations

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

- Increase the opportunities for experts by experience participation, working with key non-statutory partners. There needs to be a permanent structure such as an 'ICS lived experience advisory group' to ensure that people with lived experience of poverty influence strategy and planning and support service design and transformation. This would require a commitment to sufficient funding, resources, training, and support to do so meaningfully and effectively. This would form one part of effectively implementing the socio-economic duty (discussed elsewhere in this paper). NHS GM to support GMPA to identify how the panel would operate in practice and what mechanisms would be implemented to ensure it influences policy. This would involve the following steps:
    - Establishing a community of practice around the co-production agenda to develop, learn from what works, and build on the assets of all ICS partners to develop a lived experience charter that would form part of the development and implementation of the NHS GM anti-poverty strategy.
    - Toolkit and resources to support the workforce to engage with people with lived experience and deprived communities.
    - Co-production delivery plans across the system.

Adopt the socio-economic duty

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

The duty, contained in Section 1 of the Equality Act 2010, requires public authorities to actively consider the way in which their decisions increase or decrease inequalities that result from socioeconomic disadvantage. Successive governments have chosen not to enact the duty, and socioeconomic disadvantage is often missing from equality impact assessments that include consideration of other protected characteristics. In the absence of action at a UK government level, equivalent legislation has been introduced in Scotland (known as the “Fairer Scotland Duty”) and Wales.

The duty has not been enacted in England, but there has been voluntary adoption by many local authorities and public bodies. At GMPA, we have been working with local, combined authorities and other public bodies, such as housing associations, to increase the awareness and voluntary adoption of the duty as a means of creating better outcomes for those with lived experiences of poverty.

It is crucial to emphasise that the socio-economic duty complements existing duties, bringing added value to the efforts of the NHS GM in reducing inequalities of outcome related to socio-economic disadvantage. The socio-economic duty is not an isolated duty. Instead, it is one of a series of duties in England which are instrumental in enabling public bodies to work proactively towards advancing equality and combating inequalities.

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

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

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

Case study

We launched our new report in July ‘the socio-economic duty in action: case studies from England and Wales’. Our report, produced with Just Fair, brings case studies from local authorities and public bodies in England who have voluntarily adopted the socio-economic

duty and from the Welsh Government implemented the duty in Wales in 2021. The report finds that, across England and Wales, the duty is being used to tackle inequality in a wide range of areas, including recruitment, addressing the cost-of-living crisis, preventing increases in school meal prices, and responding to the Covid-19 pandemic.

Below, we provide an example of adoption of the socio-economic in Wales in the health and social care context.

Welsh Government

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

Vaccination Transformation Programme

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

The Vaccination Transformation Programme was co-produced with key stakeholders. Task and finish groups supported the design and development phases of the programme – one of which was focused on inclusion and engagement, with a particular focus on vaccine equity. Equity was a design principle of the programme, embedded in all workstreams. The resulting National Immunisation Framework (NIF), published in October 2022, requires all Health Boards in Wales to prepare a Vaccine Equity Strategy. These strategies, which consider socio-economic disadvantage alongside protected characteristics and under-served groups, will be supported by a programme of work to address inequitable vaccine uptake, including by socio-economic status.

The national Vaccination Equity Strategy for Wales also sets out to reduce low uptake among deprived communities by a variety of means, including improving accessibility and affordability by creating local vaccination hubs on well-travelled transport routes. By using the duty and co-production in designing the NIF, the Welsh Government has developed a

framework directly contributing to reducing the inequalities of outcome in health and access to healthcare that result from socio-economic disadvantage.

A Healthier Wales

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

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

Recommendation

NHS GM should commit to voluntarily adopting the duty. GMPA can support effective implementation and provide guidance on what adopting the duty means in policy and practice delivering the work in a staged process. (In the forthcoming full report, we will provide an in-depth outline of this staged process, offering further details about what this means for NHS GM).

Advocacy

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

A strong evidence base on the following should support this:

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

Conclusion

As mentioned at the outset, this interim report is provided to give an overview of the primary and secondary research undertaken as well as a selection of the key findings and recommendations thus far.

The key recommendations GMPA has identified for NHS GM in its approach to tackling poverty include:

- Developing a robust anti-poverty strategy, with a focus on:
    - Setting out a clear mission and vision;
    - Co-production with people with lived experience of socio-economic disadvantage;
    - Appropriate allocation of resources;
    - Cross-system collaboration.
- Adopting the socio-economic duty.
- Work with GMPA and the Greater Manchester Living Wage Campaign to realise good employment goals.
- Prioritise ongoing poverty awareness training for senior and middle management, as well as widespread mandatory poverty awareness training for all NHS professionals, focussing on the NHS's role as a health service provider and employer.

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Appendix 2 – GM Poverty Action: Survey of GM residents experiences of poverty and its impact on health outcomes, health service access, and health service experience.

NHS SURVEY RESULTS FINDINGS

Sample Size and Demographics

- **Total sample:** 1000 respondents

- **Gender**: 54% Male (544), 45% Female (454), and <1% Other (1)

- **Age**: 19% 18-24 (191), 23% 25-34 (226), 21% 35-44 (210), 20% 45-54 (198), 11% 55-64 (113), and 6% 65+ (62).

- **Local Authority Area:** 40% Manchester (400), 9% Bolton (93), 7% Bury (71), 5% Oldham (52), 5% Rochdale (54), 4% Salford (41), 9% Stockport (89), 6% Tameside (57), 5% Trafford (45), 10% Wigan (98).

- **Household Income:** 11% 'Less than £15,000' (109), 27% £15,000-£30,000 (271), 28% £30,001-£50,000 (279), 18% £50,001 - £80,000 (181), 6% £80,001-£100,000 (61), 4% '£100,001 or more' (40), and 6% 'I don't know/prefer not to say' (59).

- **SEG (Socio-Economic Grade)** *(system of demographic classification based on occupation):* 39% AB (*higher and intermediate managerial, administrative, professional occupations) (*389), 30% C1 (*supervisory, clerical & junior managerial, administrative, professional occupations*) (296), 13% C2 (*skilled manual occupations*) (129), 19% DE (*semi-skilled & unskilled manual occupations, Unemployed and lowest grade occupations*) (186)

- **Ethnicity:** 77% English/Welsh/Scottish/Northern Irish (765), 1% Irish (7), <1% Gypsy or Irish Traveller (2), 3% Other White Background (25), 1% White and Black Caribbean (14), 1% White and Black African (8), 1% White and Asian (13), 3% Indian (30), 4% Pakistani (41), 1% Bangladeshi (11), 1% Chinese (10), 1% Other Asian Background

(8), 4% African (36), <1% Caribbean (4), <1% Other Black/African/Caribbean Background (4), 1% Arab (7), 1% Any Other Ethnic Group/Mixed/Multiple Ethnic Background (12), <1% Prefer Not to Say (3).

Key Findings Summary

The following key findings are taken across the whole sample of 1000 respondents (bar question 8) – for specific findings pertaining to certain demographics, please view the in-depth analysis of each of the questions.

Household income, cost implications and accessibility of GM NHS health and social care services *(Q1, Q2, Q3, Q5)*

- 39% of all respondents either agree or strongly agree with household income impacting their ability to access NHS health and social care services.
- Majority of the respondents allude to cost implications not often being taken into consideration by the NHS, with individuals stating cost implication being taken either 'sometimes' (29%) or 'rarely' (29%).
- 41% of respondents identified as not having accessed an NHS service or amenity due to cost implications, identifying cost implication to be a significant barrier in NHS GM.
- 31% of respondents agree or strongly agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years, whilst the majority (46%) neither agreed nor disagreed with the statement.

Awareness of GM NHS assistance/schemes *(Q4)*

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

Assistance and responsibilities of NHS health and care professionals regarding financial hardships *(Q6, Q7, Q8, Q9)*

- 54% agree or strongly agree that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships.

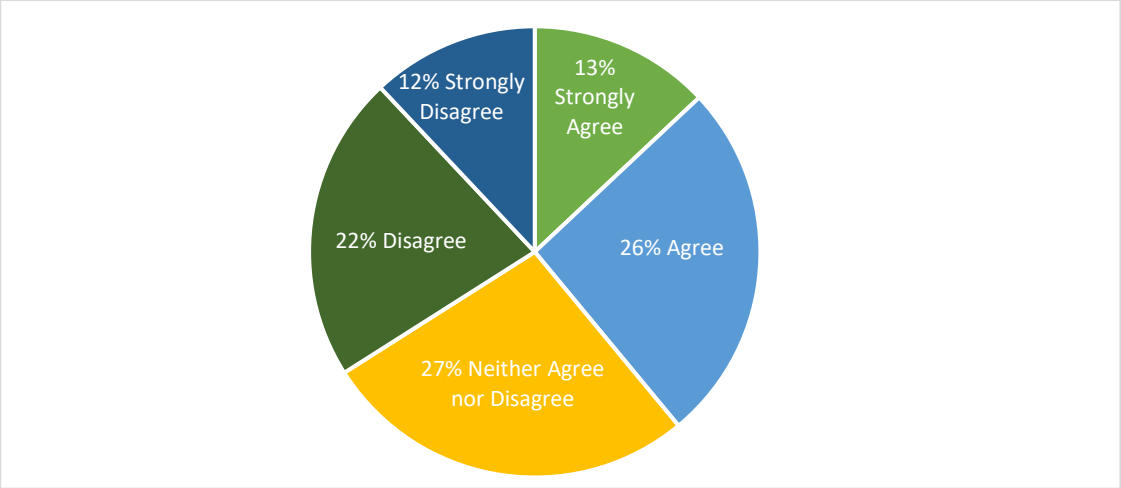
- Almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals.
- Of those who stated to feel comfortable in sharing concerns about their household's financial situation with an NHS professional, the majority (76%) were happy to share such concerns with their GP.
- A vast majority (89%) stated that they have never raised concerns about their household's financial situation with an NHS health and social care professional.

Effect of financial hardships on mental/physical health *(Q10)*

- 31% of all individuals state that concerns and/or difficulties with household finances 'always' or 'often' impacts their physical and/or mental health.

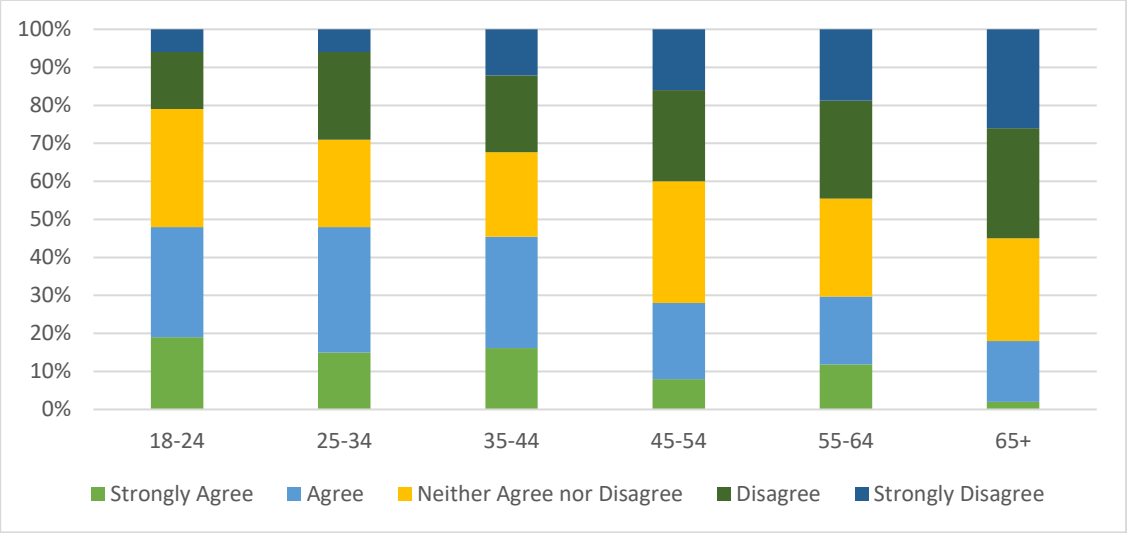
Q1. To what extent do you agree that your household income impacts your ability to access NHS health and social care services?

- **1.1 Total sample:** 13% strongly agree with household income impacting their ability to access NHS health and social care services, 26% agree (thus a majority agreeing in general (39%)), 27% neither agree nor disagree, 22% disagree, and 12% strongly disagree.

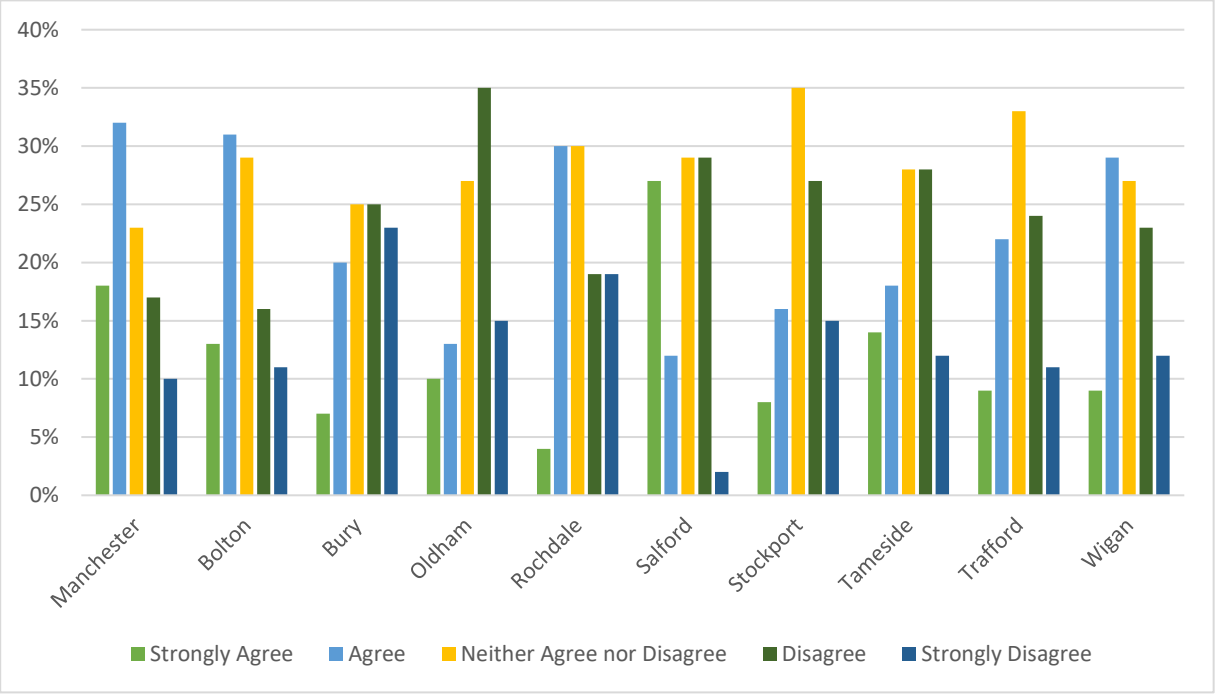


- **1.2 Gender**: Limited difference in results between men and women (max. 2%-point difference), with results almost identical to that of the total sample.

- **1.3 Age**: As age increases, the percentage that disagrees/strongly disagrees that their household income impacts their ability to access NHS health and social care increases, whilst the percentage that agrees/strongly agrees decreases. The highest percentage of those who strongly agree are 18–24-year-olds (19%) whilst those making 65+ category has the lowest percentage (2%). 25-34-year-olds make the highest percentage of those that agree (33%), whilst the 65+ category still makes the lowest percentage to do so (16%). The 65+ category has the greatest percentage of individuals that disagree (29%) and strongly disagree (26%), whilst the 25-34-year-olds make up the lowest percentages in those categories (15% and 65 respectively).

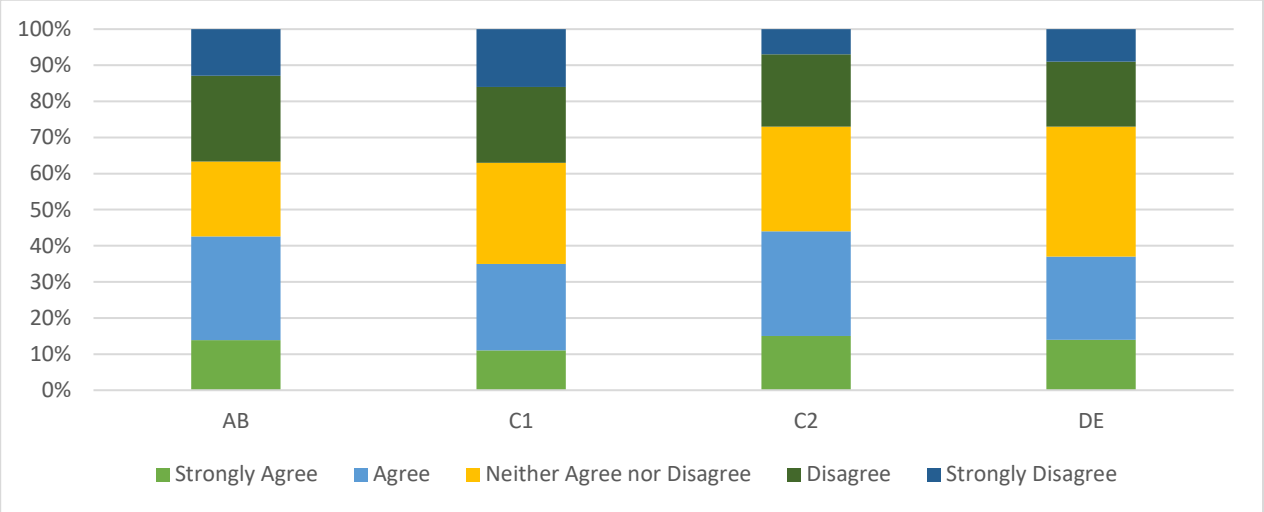


- **1.4 Local Authority Area:** Salford ranked the highest regarding those who strongly agree to their household income impacting their ability to access NHS health and social care services (27%) by a large margin amongst all the local authorities. Manchester ranks the highest in those that agree to the statement (32%) followed closely by Bolton, Rochdale, and Wigan (31%, 30%, and 29% respectively). Amongst those who disagree, Oldham has the highest percentage (35%). Bury has the highest percentage (23%) of individuals who strongly disagree.



- **1.5 SEG (Socio-Economic Grade):** The percentage of those who generally agree (i.e. both strongly agreed and agreed), generally disagree (i.e. both strongly disagreed and disagreed, and neither agree nor disagree are similar across all SEGs – averaging at 13% strongly agreeing,

26% agreeing, 29% neither agreeing nor disagreeing, 21% disagreeing, 11% strongly disagreeing. Greater distinguishment (socio-economically) between can be discerned through the household income categories (see 1.6).



- **1.6 Household Income:** In general, as household income increases, the percentage of those who disagree/strongly disagree that their household income impacted their accessibility to NHS health and social care services increases, whilst the percentage of those that agree/strongly disagree decreases. The income bracket of 'less than £15,000' has the highest percentage of those that strongly agreed to the statement (19%) amongst all income brackets, whilst the income bracket of £50,001-£80,000 has the highest percentage that agrees with the statement (31%), followed closely by the income bracket of £15,000-£30,000 (30%). The income bracket of '£100,001 or more' has the highest percentage of those that disagree (38%) and strongly disagree (23%) amongst the income brackets.

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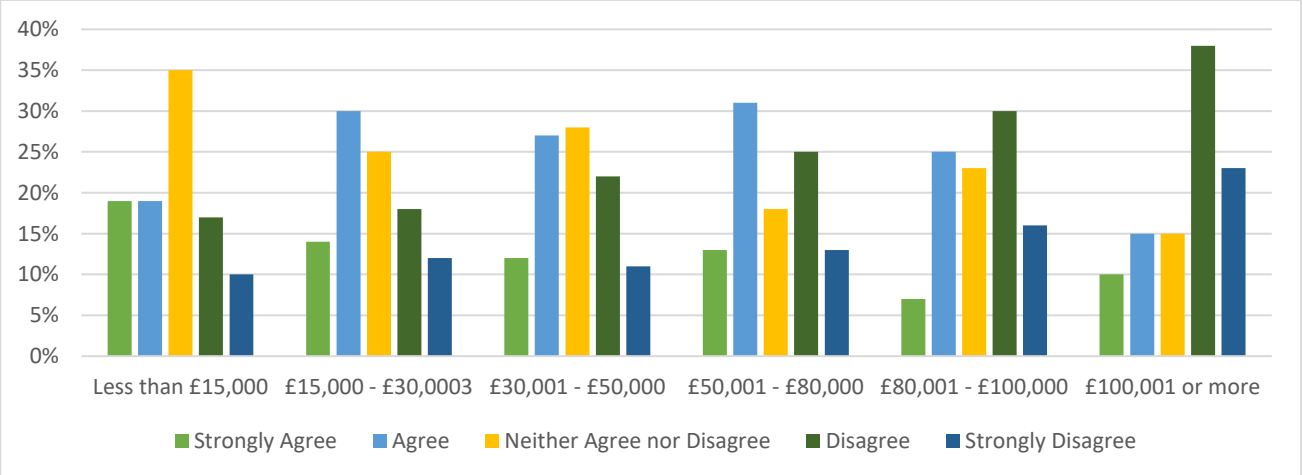
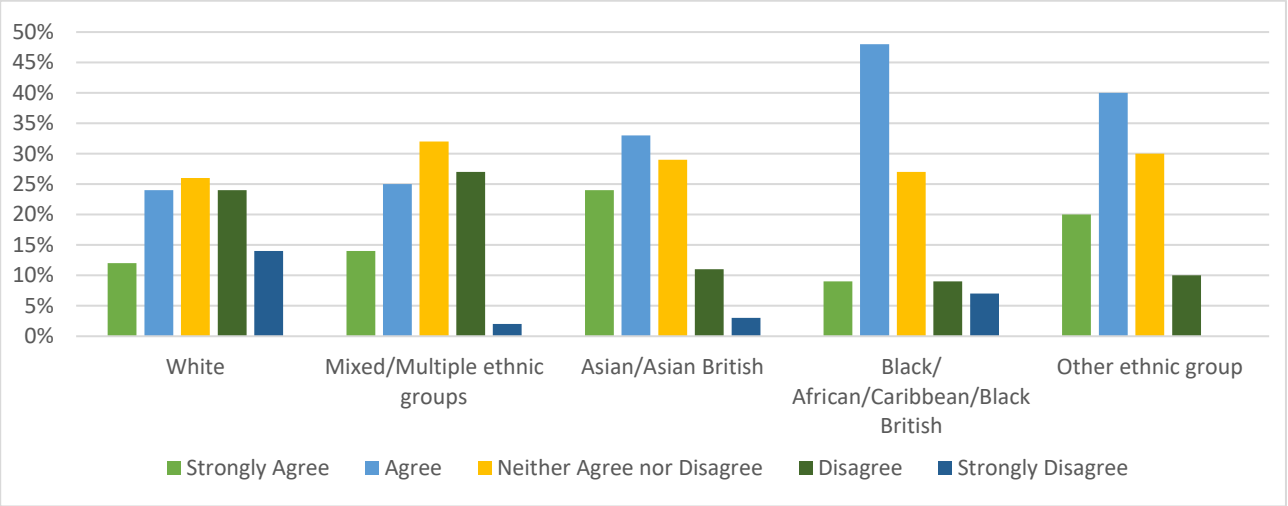
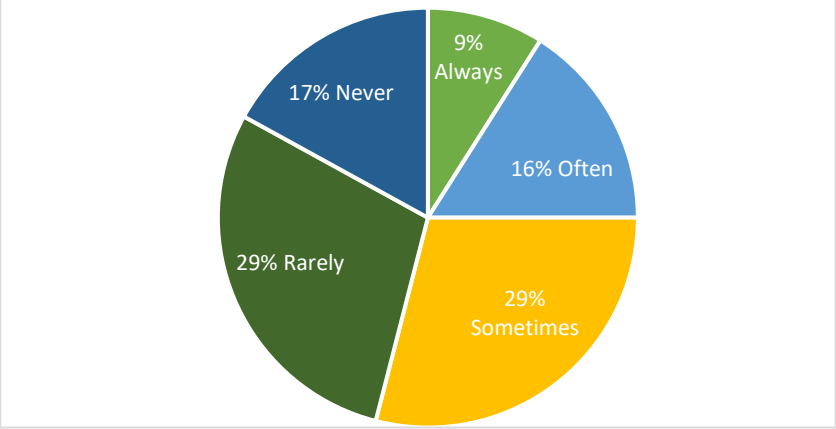


- **1.7 Ethnicity:** In general, individuals from a BAME background have a higher percentage agreeing/strongly agreeing to the fact that their household income their ability to access NHS health and social care services compared to their white counterparts, whilst those identifying as White have a higher percentage disagreeing/strongly disagreeing with the statement. Asian/Asian British make the highest percentage of those that strongly agree to the statement (24%) amongst the ethnicities, whilst Black African/Caribbean/Black British have the highest percentage agreeing (48%). On the other hand, those identifying as White have the second highest percentage amongst all ethnicities that disagree (24%) and the highest that strongly disagree (14%).



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

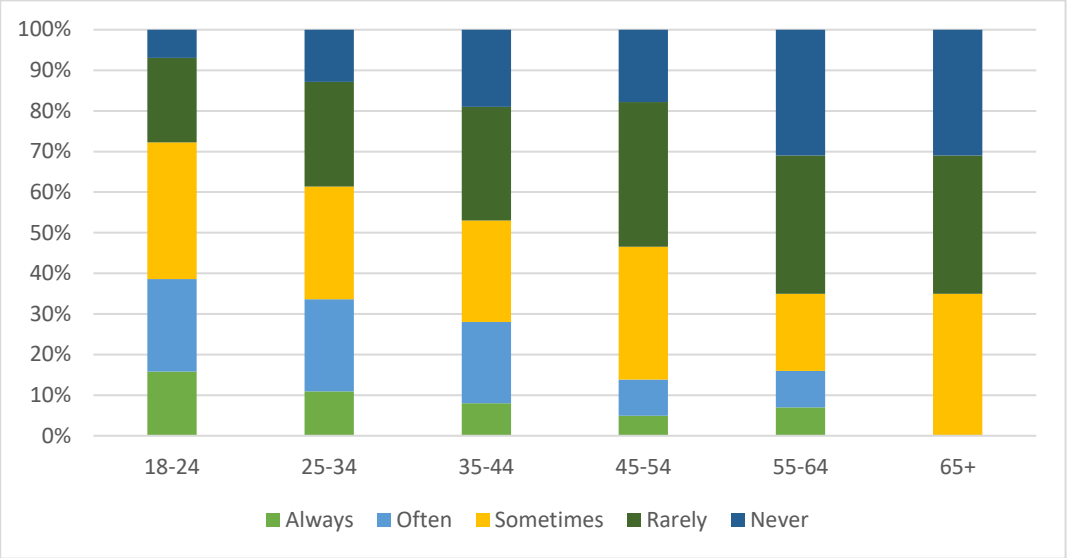
- **2.1 Total sample:** Majority allude to cost implications not often being taken into consideration by the NHS, with the highest percentage of individuals stating cost implication being taken either 'sometimes' (29%) or 'rarely' (29%). Almost half of the respondents answered 'rarely' and 'never' (29% and 17% respectively) and a quarter of respondents responded, 'always' or 'often' (9% and 16% respectively).



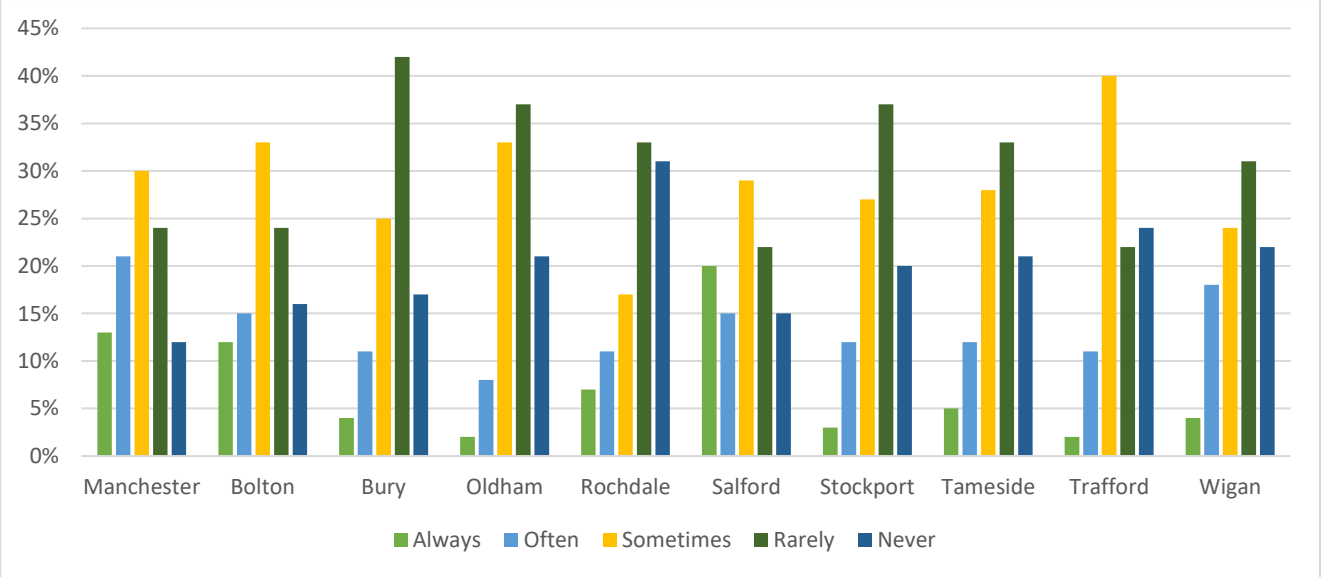
- **2.2 Gender**: Limited difference in results between men and women (max. 2%-point difference), with results almost identical to that of the total sample.

- **2.3 Age**: In general, as age increases, the percentage of individuals that have 'always' or 'often' felt that cost implications are taken into consideration by NHS health and social care professionals (when appointments are scheduled) decreases, whilst the percentage of those that have 'rarely' or 'never' experienced costs being taken into account by NHS professionals increases. The age bracket with the highest percentage of those who believe that cost implications are 'always' taken into consideration by NHS professionals are 18–24-year-olds (16%) and the age brackets with the highest percentage of 'often' experiencing this are 18-24- and 25–34-year-olds (23%), with the inverse being true, with the 18-24 year-old age bracket having the lowest percentage of individuals that felt that cost implications was rarely considered (7%). On the other hand, 0% of individuals 65+ believe that cost implications are 'always' or 'often' taken into consideration by NHS professionals, whilst the group holds the highest percentage

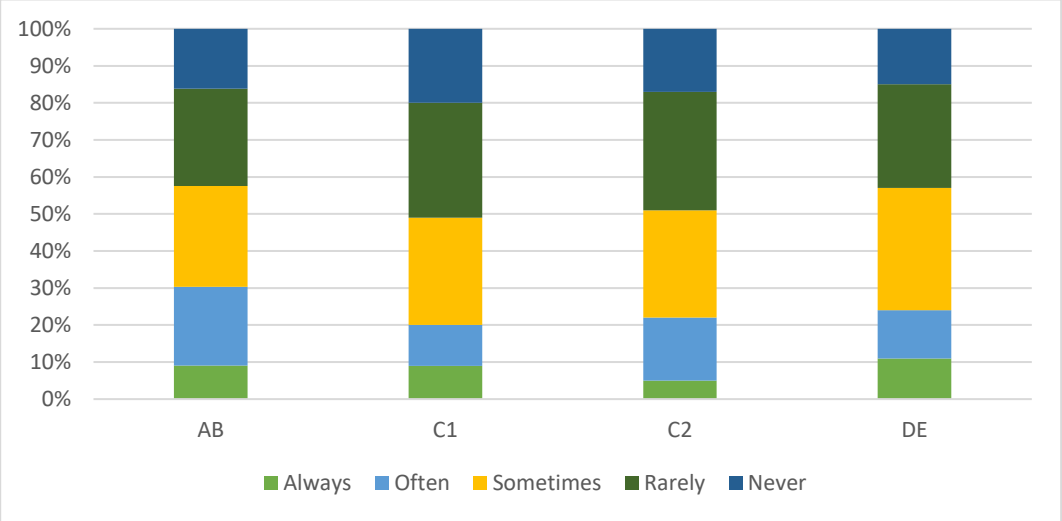
of those that have ‘never’ felt that cost implications are taken in consideration (in conjunction with the 55–64 age group, at 31%).



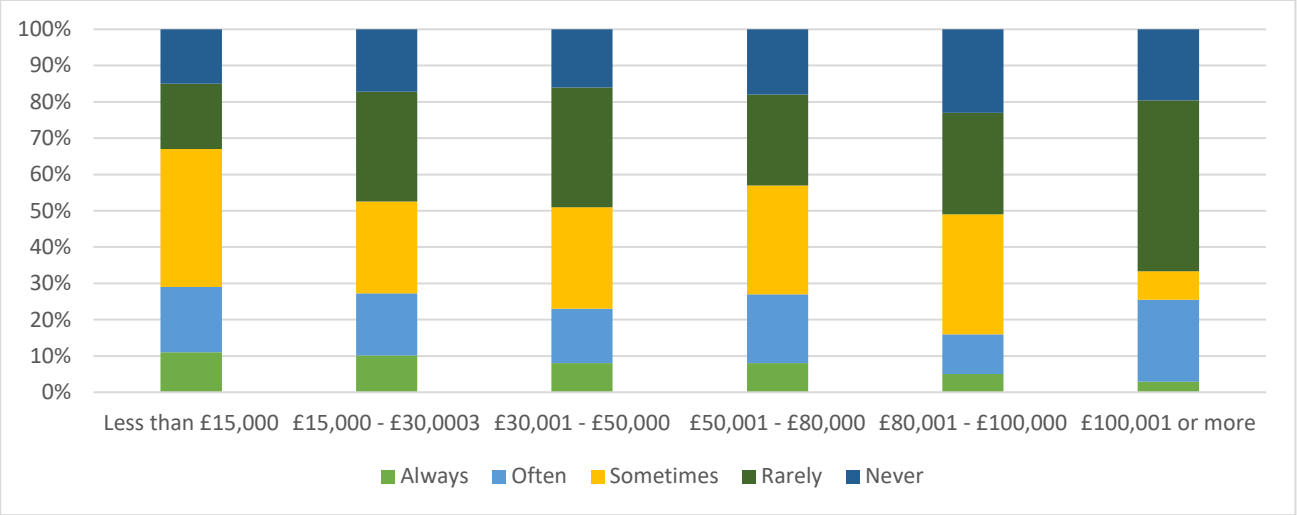
2.4 Local Authority Area: The local authority with the highest percentage of individuals that felt that cost implications are ‘always’ considered by NHS professionals when appointments were scheduled is Salford (20%), whilst the local authority with the highest percentage that felt that they are ‘often’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



- **2.5 SEG (Socio-Economic Grade):** The majority of individuals identify cost implications to be either ‘sometimes’ or ‘rarely’ considered by NHS professional across the SEGs (following the general trend seen in the question across the whole sample). The difference in responses due to socio-economic reasons can be seen more clearly via the household income than SEGs (see 2.6).



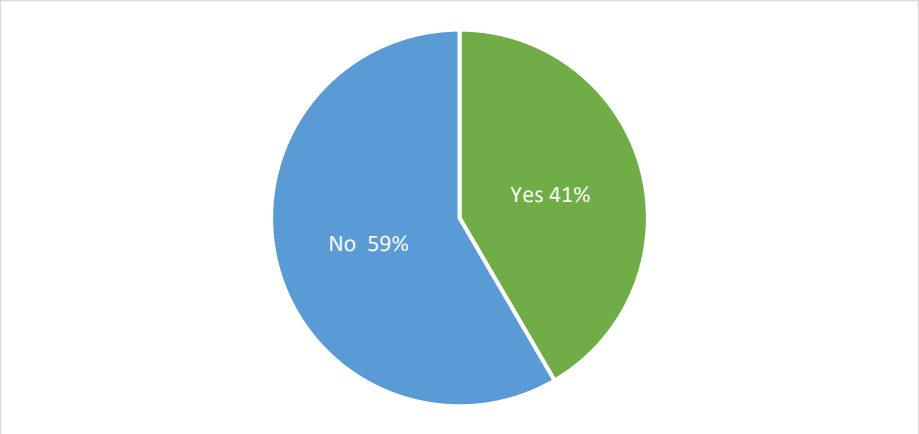
- **2.6 Household Income:** Whilst the key trend across income brackets follow that seen across SEGs – with the responses ‘sometimes’ and ‘rarely’ being dominant – the income brackets help highlight that those having an income of ‘£100,001 or more’ have the highest percentage of those that felt that cost implications were ‘rarely’ considered (48%) across the income brackets, whilst also having the second highest percentage of those that thought cost implications were ‘never’ considered by NHS professionals (20% - second only to the £80,001-£100,000 income bracket at 23%). On the other hand, the ‘£100,001 or more’ income bracket has the lowest percentage of those that believed that cost implications were ‘always’ considered (3%), whilst the income brackets of ‘less than £15,000’ and £15,001-£30,000 have the highest percentage of individuals that believed that cost implications were ‘always’ considered (11% and 10% respectively).



- **2.7 Ethnicity:** Those that identified to be from mixed/multiple ethnic groups or other ethnic groups have the highest percentage of individuals that felt cost implications are 'always' considered by NHS professionals (18% and 20% respectively). Those identifying as Black African/Caribbean/Black British have the highest percentage of individuals that felt that cost implications were 'never' considered (23%) across the ethnic groups, whilst those identifying as White have the highest percentage of individuals that felt that cost implications were 'rarely' considered (32%).

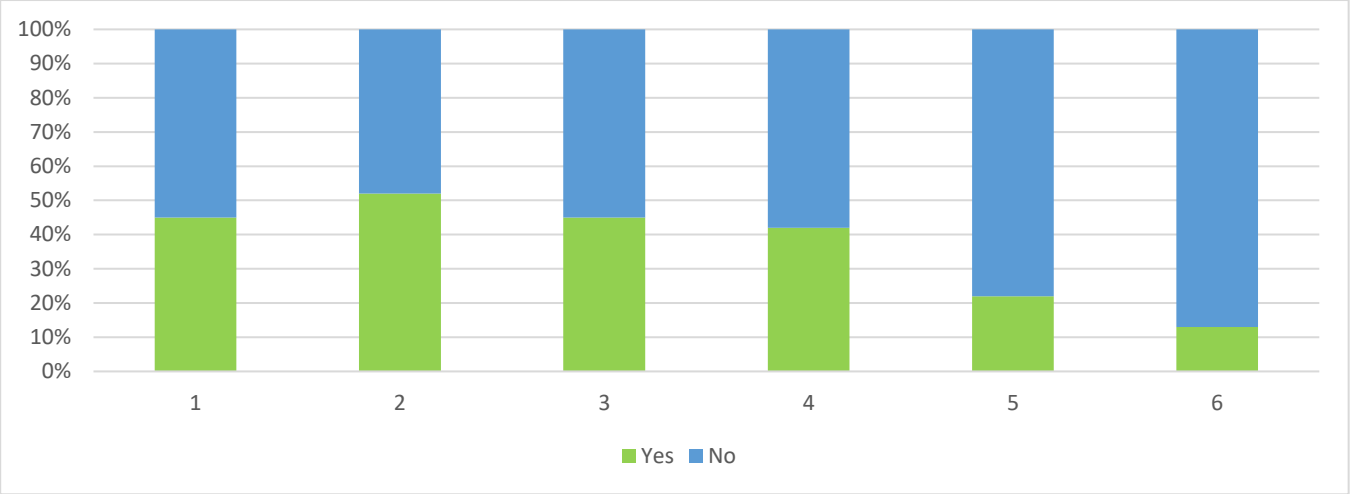
Q3. Have you ever not accessed an NHS health and social care service or amenity due to cost implications (such as time away from work, distance from your house, childcare responsibilities, parking etc.)?

- **3.1 Total sample:** Whilst the majority disagreed with not having accessed an NHS service or amenity due to cost implications, a huge percentage (41%) agreed with the statement, identifying cost implication to be a significant barrier in NHS GM.

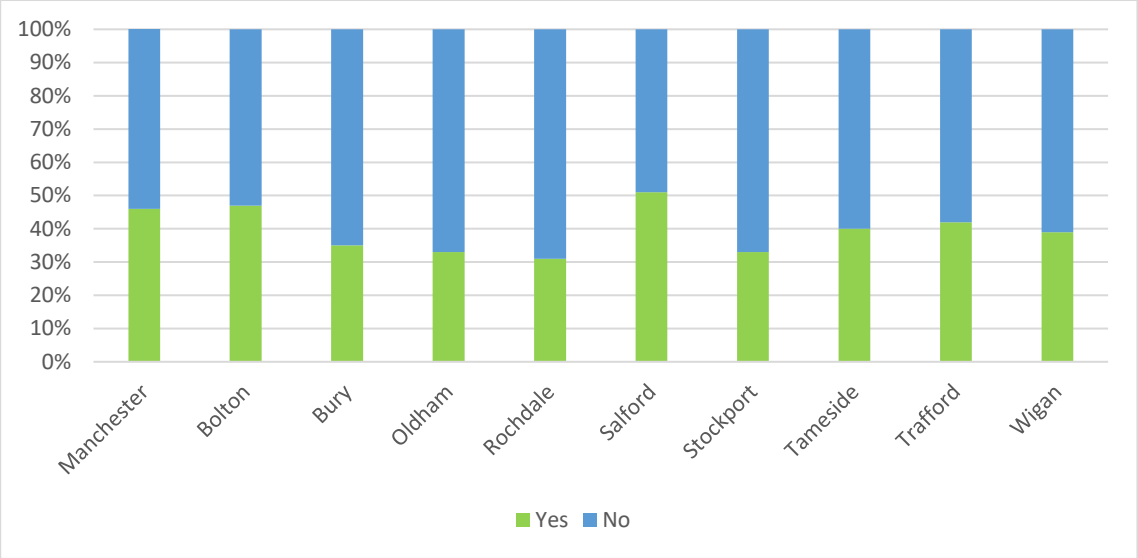


- **3.2 Gender**: Limited difference in results between men and women (max. 1%-point difference), with results almost identical to that of the total sample.

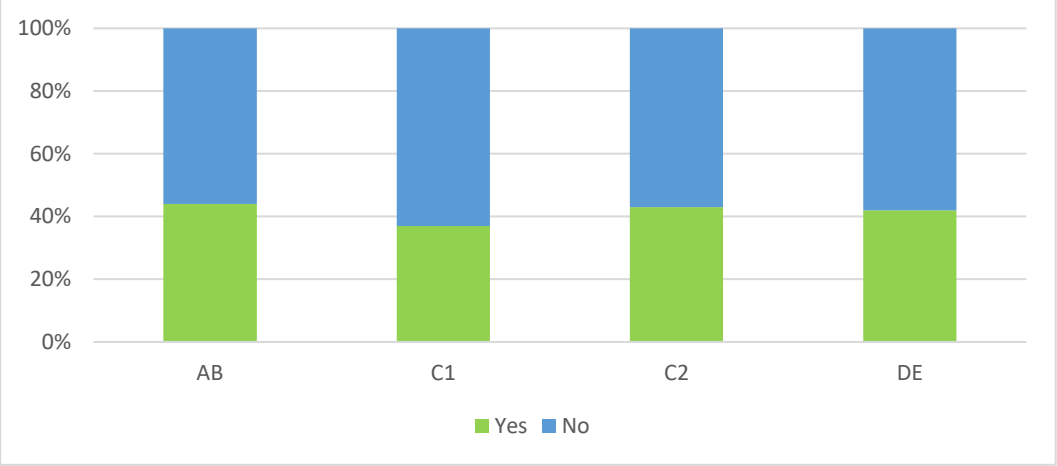
- **3.3 Age**: Overall, as the age increases, the percentage of individuals that have not accessed an NHS service or amenity due to cost implications decreases – the 25-34 age group has the highest percentage of individuals identifying to having not accessed a service/amenity due to cost implications (52%), whilst the 65+ age group has the lowest percentage of individuals facing such circumstance (13%).



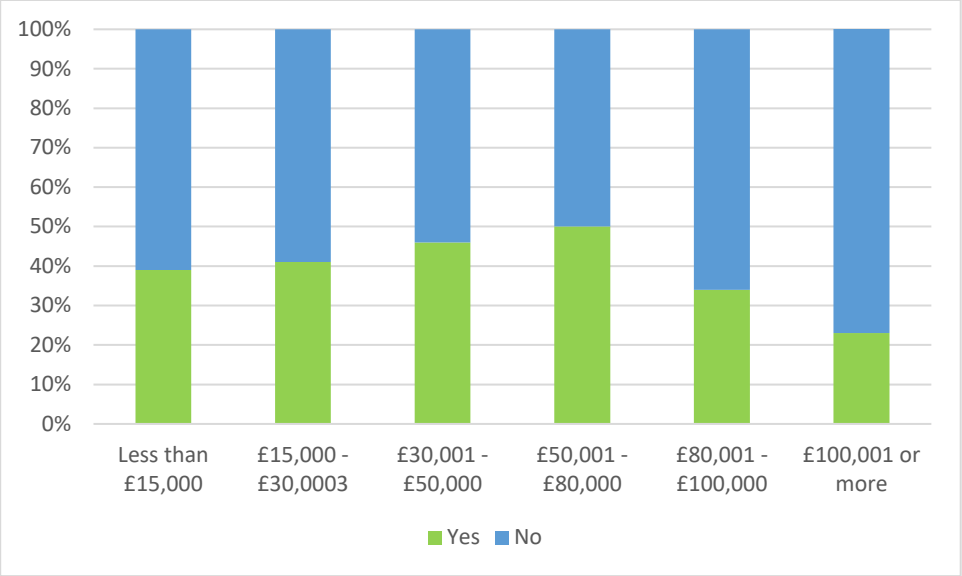
- **3.4 Local Authority Area:** The trend across local authorities follows closely the general trend seen across the whole sample. Salford has the highest percentage of individuals that have not accessed an NHS service or amenity due to cost implications (51%), being the only local authority with the majority having their accessibility impacted by cost implications. Rochdale, on the other hand, has the lowest percentage of individuals having been impacted by such accessibility issues (31%).



- **3.5 SEG (Socio-Economic Grade):** The trend across local authorities follows closely the general trend seen across the whole sample – with only a (maximum) percentage point difference between the values of 3% across the grades for the percentage of individuals having their accessibility to NHS services/amenities being impacted by cost implications. Greater difference can be seen through analysing the household income as a socio-economic indicator instead (see 3.6).



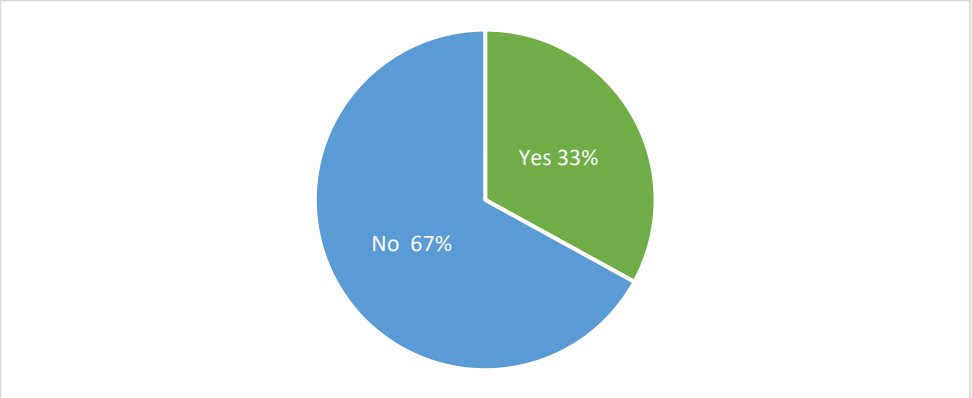
- **3.6 Household Income:** The £50,001-£80,000 household income bracket has the highest percentage of individuals which identified having their accessibility to NHS services/amenities being impacted by cost implications (50%), whilst the '£100,001 or more' income bracket has the lowest percentage facing such circumstance (23%).



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

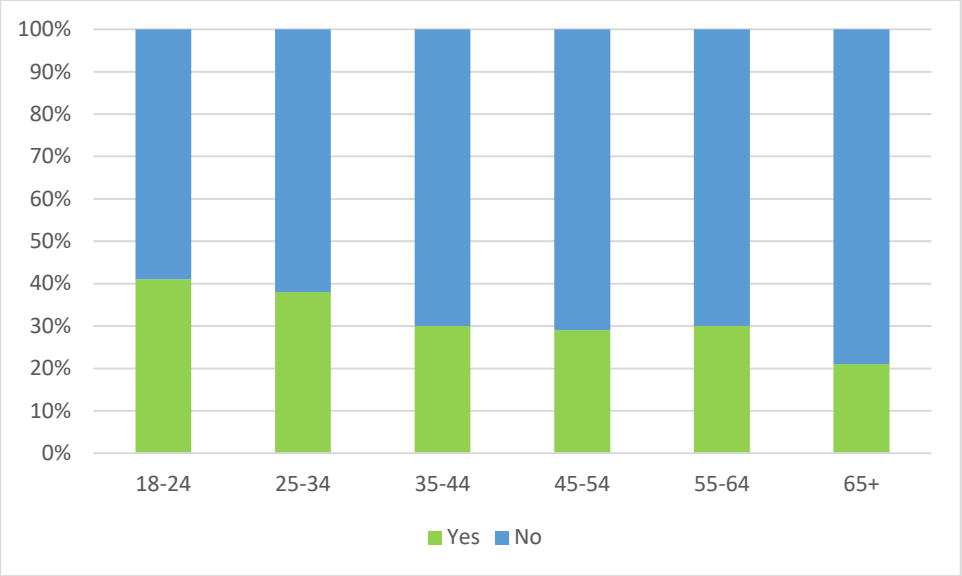
Q4. Are you aware of any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs?

- **4.1 Total sample:** Two-thirds of all respondents could not identify any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs.

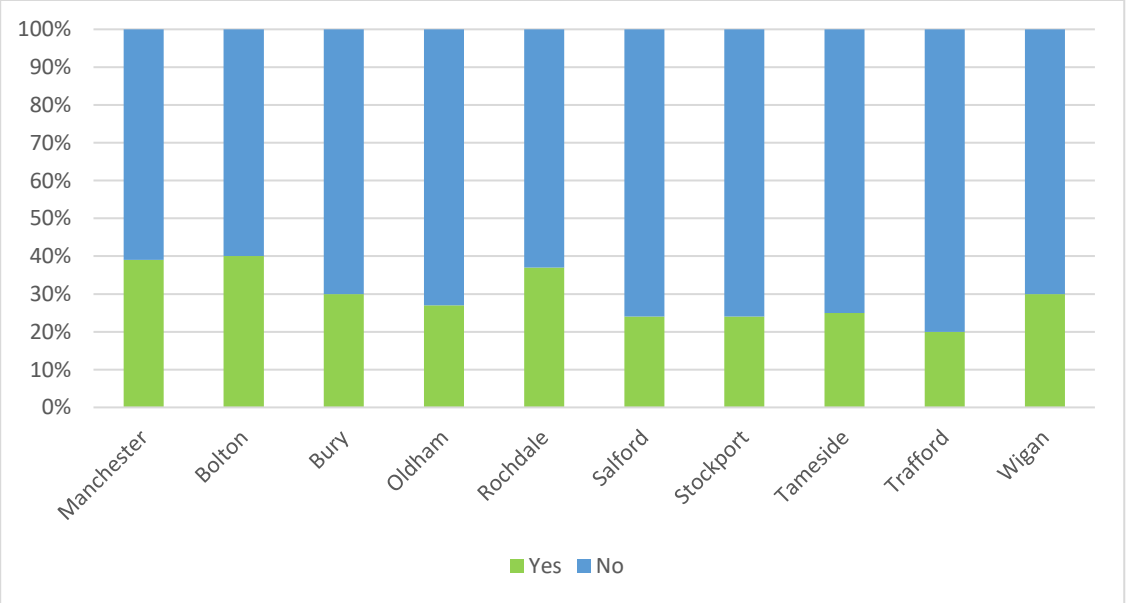


- **4.2 Gender**: Limited difference in results between men and women (max. 2%-point difference), with results almost identical to that of the total sample.

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



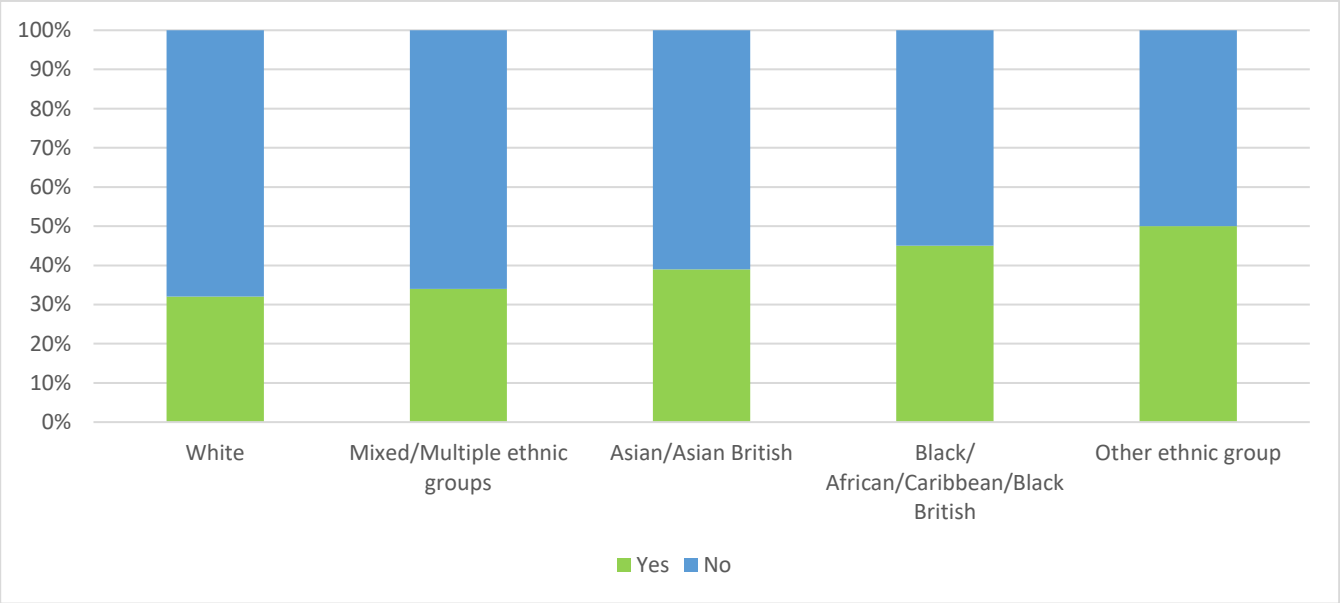
- **4.4 Local Authority Area:** Bolton and Manchester have the highest percentage of individuals that are aware of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs (40% and 39% respectively), whilst Trafford has the lowest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



- **4.5 SEG (Socio-Economic Grade):** The trend across SEGs follows closely the general trend seen across the whole sample – only a (maximum) percentage point difference of 3% across the grades – with an average of 33% of individuals being aware of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs across the SEGs.

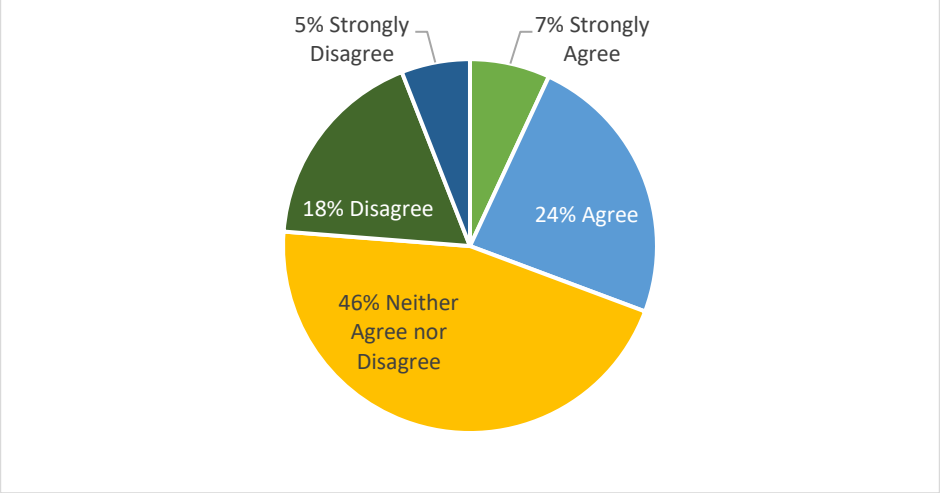
- **4.6 Household Income:** The trend across household incomes follows closely the general trend seen across all the sample, with an average of around a third (34%) of individuals being aware of NHS schemes or assistance across the income brackets.

- **4.7 Ethnicity:** In general, those who identified as White being the least aware of any NHS schemes or assistance (32%) compared to other ethnicities, with those identifying with other ethnic groups category having the greatest awareness (50%), followed by those in Black African/Caribbean/Black British (45%), Asian/Asian British (39%), and then mixed/multiple ethnic groups (34%).

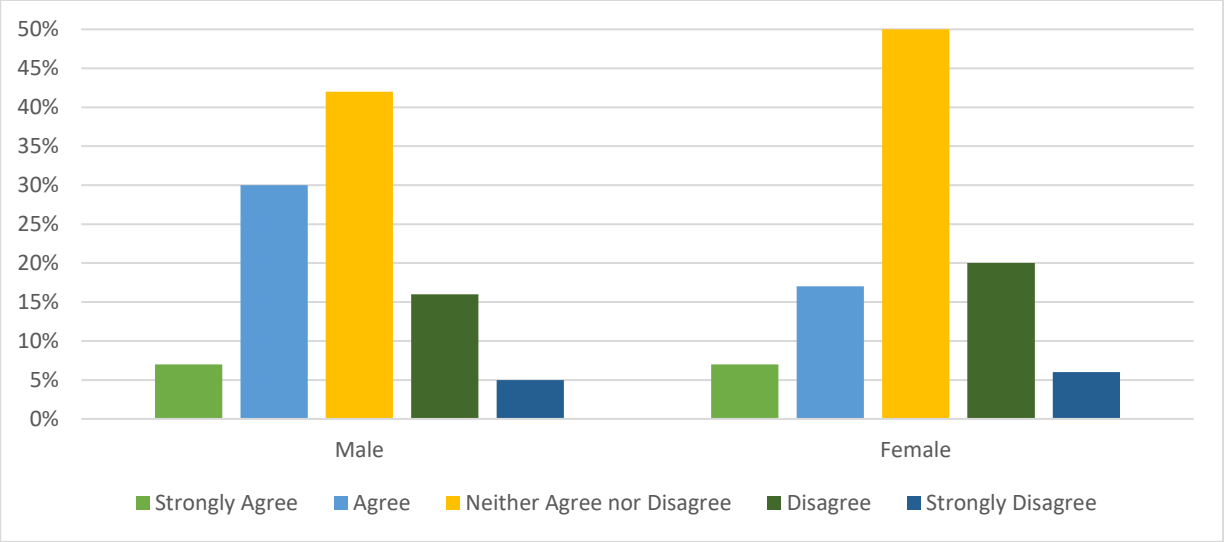


Q5. To what extent do you agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years?

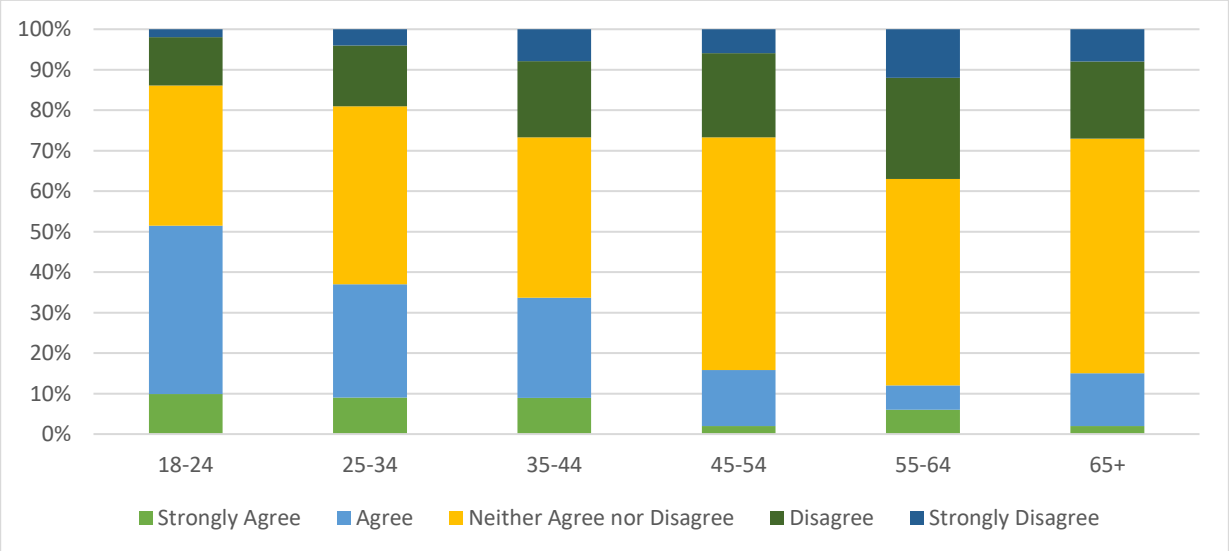
- **5.1 Total sample:** Overall, regarding the statement that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years, 31% generally agree (i.e. 7% strongly agree and 24% agree), 46% neither agree nor disagree, and 23% generally disagree (i.e. 5% strongly disagree and 18% disagree).



- **5.2 Gender**: A greater percentage of men (30%) agree to NHS health and social care services in Greater Manchester becoming more accessible to those facing financial hardships over the past two years than the percentage of women that agree to the statement (17%). Inversely, a greater percentage of women did not agree with the statement (20%) compared to men (16%). A greater percentage of women neither agreed nor disagreed to the statement (50%) compared to men (42%) – yet this response makes up the majority for both categories.

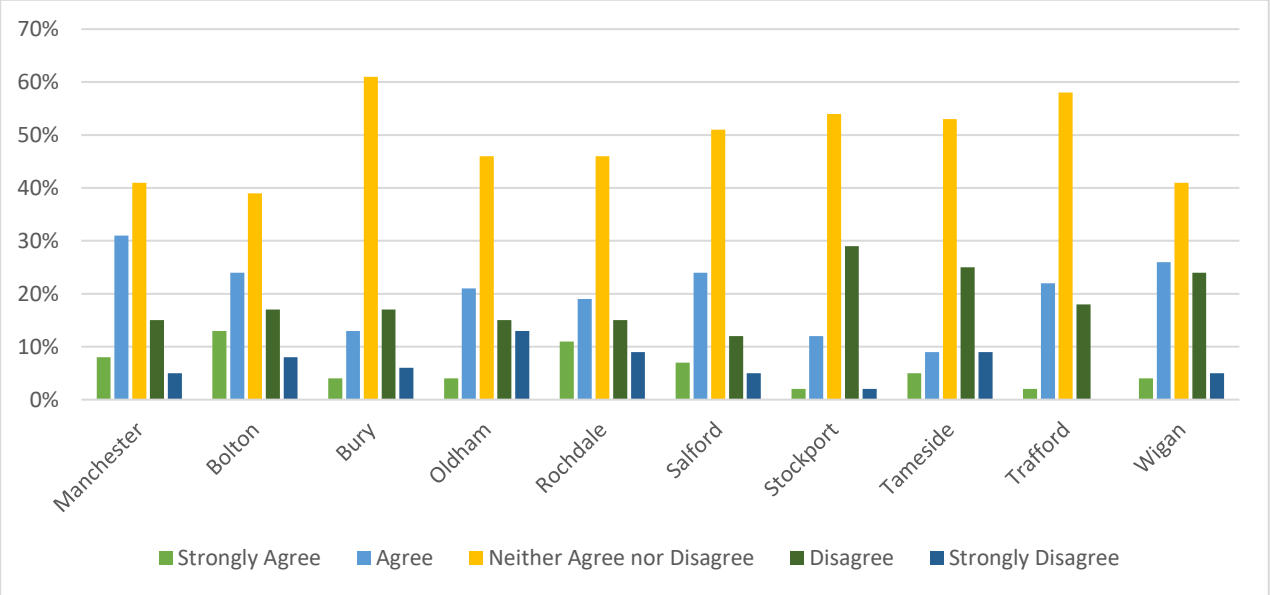


- **5.3 Age**: The 18-24 age group has the highest percentage of individuals that 'strongly agree' and 'agree' that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years (10% and 42% respectively) amongst the age brackets. On the other hand, the age group of 55-64 has the highest percentage of individuals that both 'disagree' and 'strongly disagree' (25% and 12% respectively) amongst all the age groups. However, the 'neither agree nor disagree' make the majority of all age groups (bar 18–24-year-olds group).

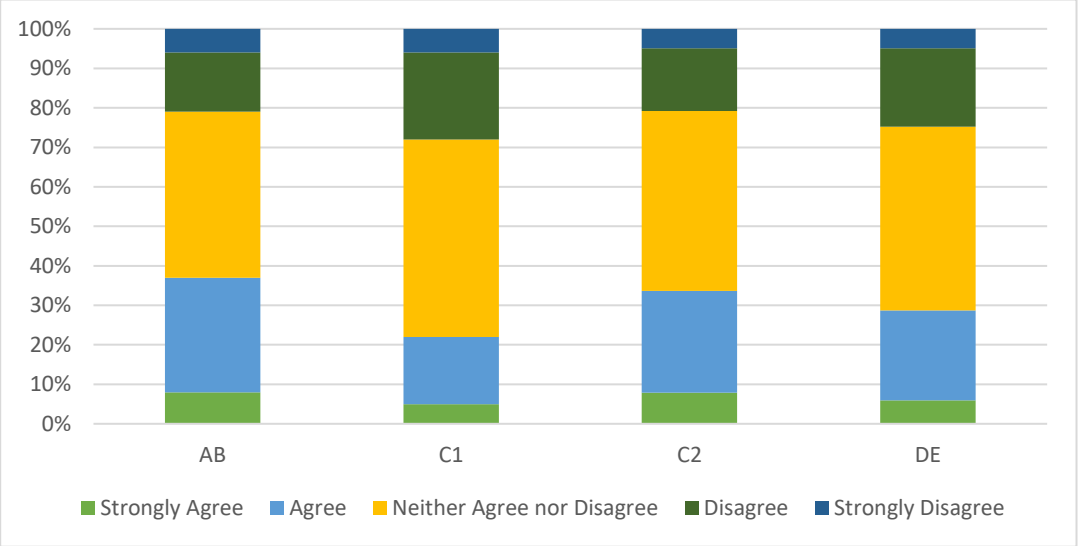


- **5.4 Local Authority Area:** The local authorities with the highest percentage of individuals that strongly agree and agree with the statement are Bolton (13%) and Manchester (31%) respectively. Stockport and Oldham have the highest percentage of those that disagree (29%) and strongly disagree (13%) respectively. However, as is the

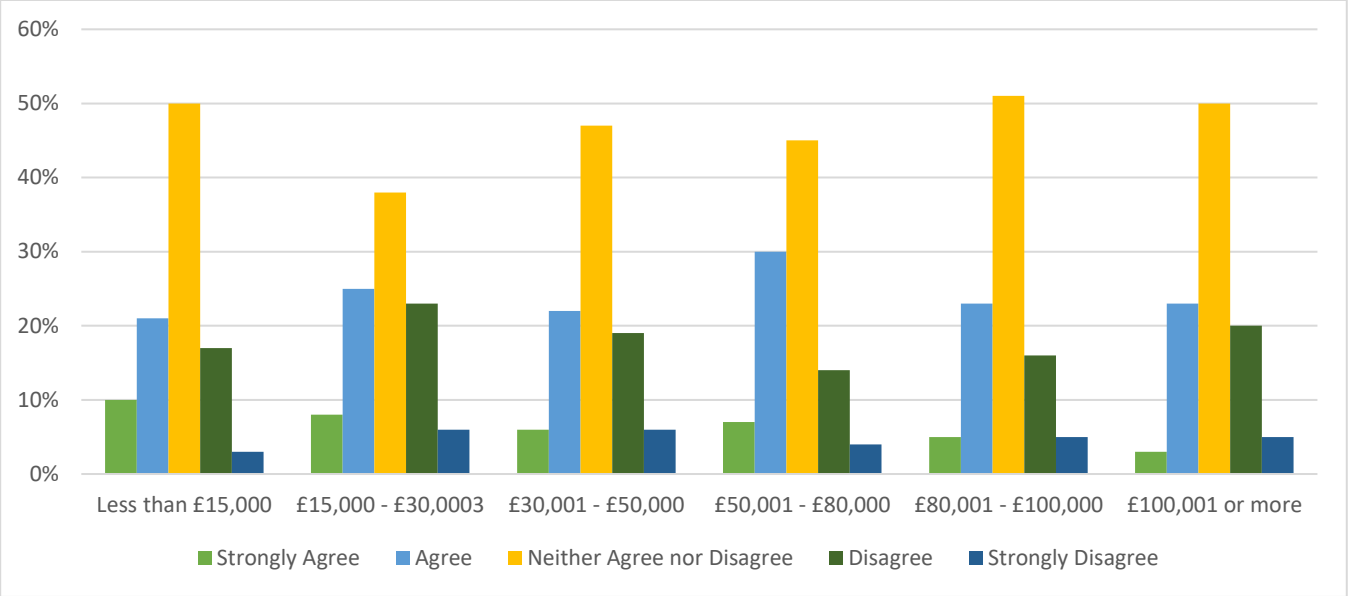
trend in the whole sample, the majority within each local authority stated that they neither agreed nor disagreed that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years.



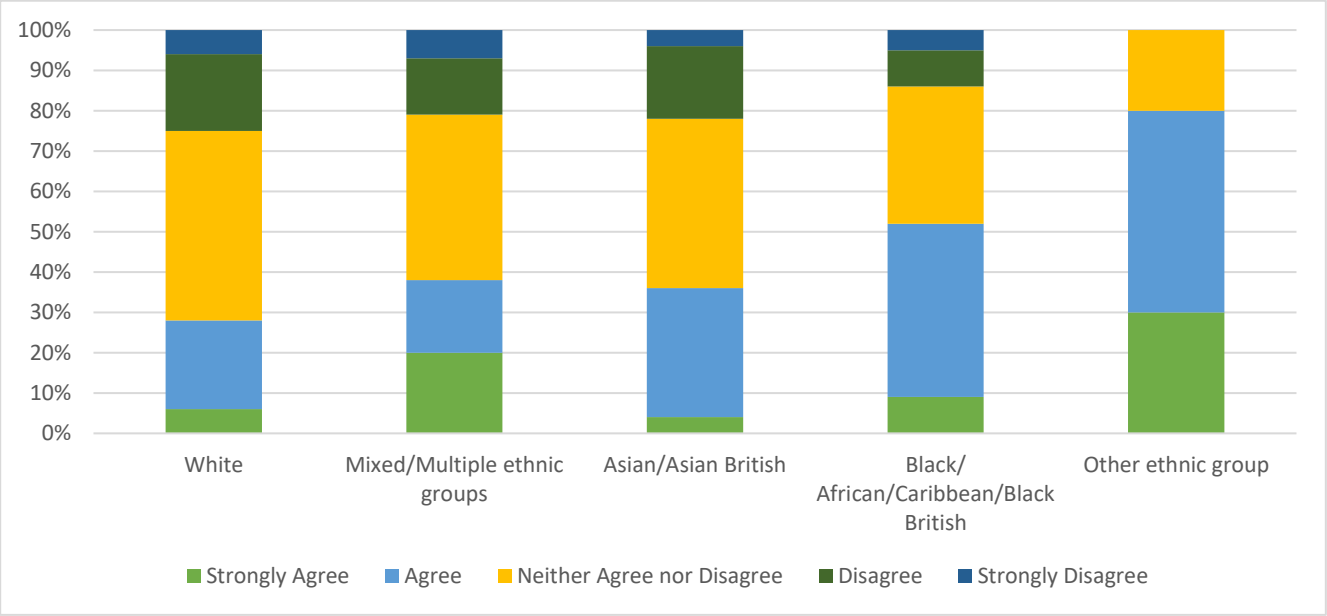
- **5.5 SEG (Socio-Economic Grade):** The trend across SEGs (i.e. average percentages) follows closely the general trend seen across the whole sample (see 5.1).



- **5.6 Household Income:** The trend across income brackets follows closely the general trend (i.e. average percentages) seen across the whole sample (see 5.1).

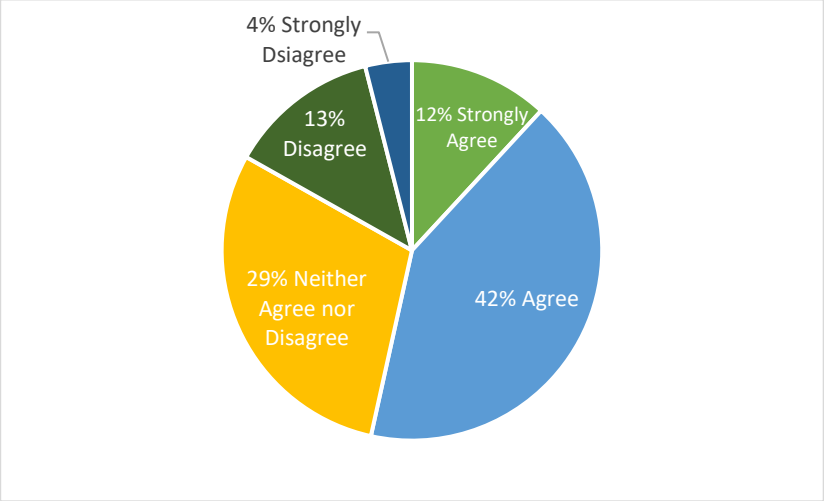


- **5.7 Ethnicity:** In general, those who identified as White are least likely to agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years compared to other ethnicities. 28% of those that identified as White agree to the statement to some extent (i.e. agreed and strongly agreed) compared to those of mixed/multiple ethnic groups (38%), Asian/Asian British (36%), Black African/Caribbean/Black British (52%), and other ethnic groups (80%).



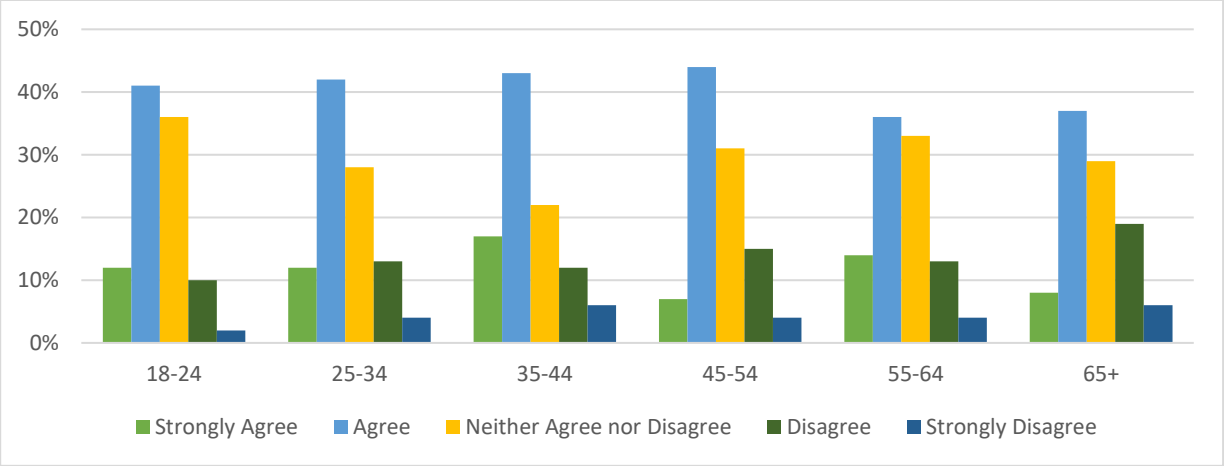
Q6. To what extent do you agree that NHS health and social care professionals have some responsibility to assist patients regarding their financial hardships?

- **6.1 Total sample:** Over half of all respondents (54%) agree to some extent (i.e. either agree or strongly agree) that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships, whilst only 17% disagree to some extent (i.e. disagree or strongly disagree). Almost a third neither agree nor disagree.

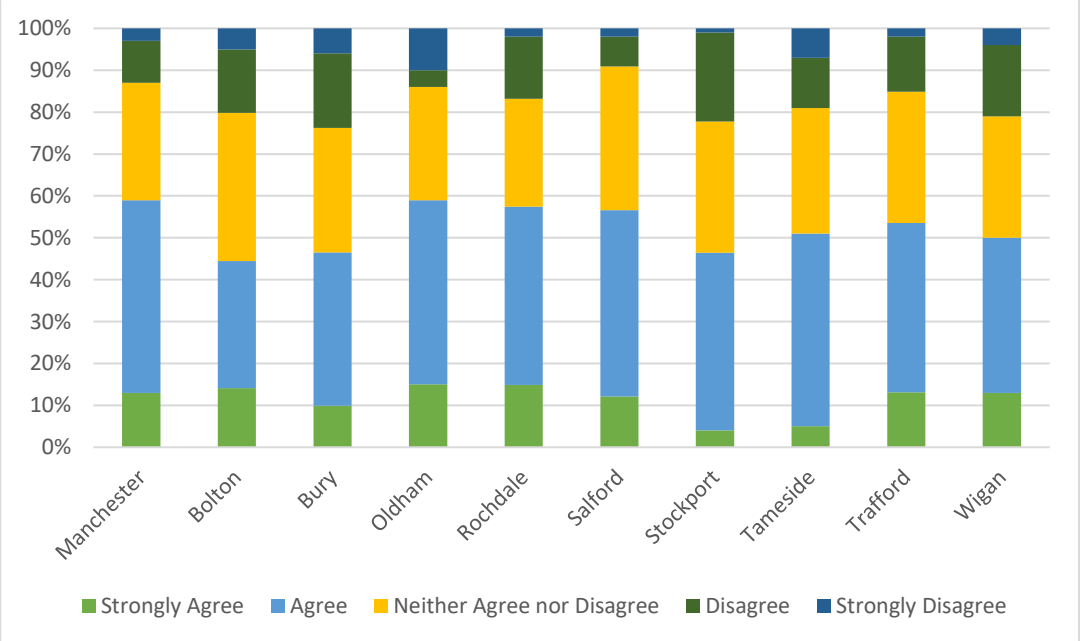


- **6.2 Gender**: Men were more likely to agree to some extent (i.e. strongly agree or agree – at 13% and 43% respectively) that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships than women (who strongly agree or agree at 11% and 40% respectively). Inversely, the pattern continues, with men being less likely to disagree with the statement (11%) than women (15%).

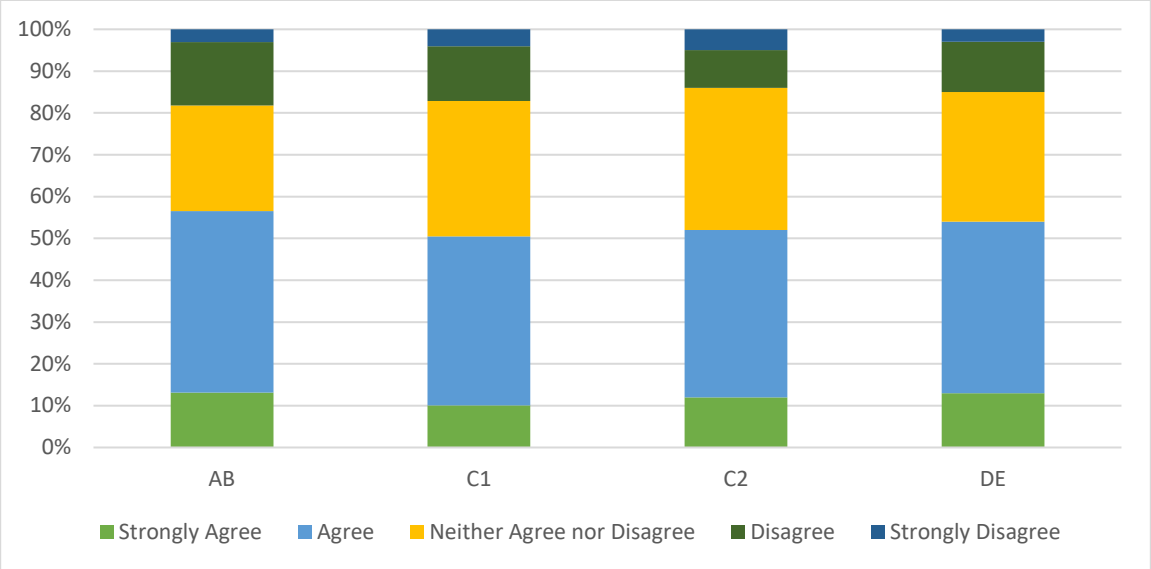
- **6.3 Age**: Overall, the predominant response across all age-groups consisted of agreeing to the sentiment that NHS health and social care professionals have some responsibility to assist patients regarding their financial hardships. The 35–44 age group had the highest percentage of individuals that strongly agree (17%) and agree (43%) to the statement amongst all age categories (second only to the 45–54-year-old age group at 44%). On the other hand, the 65+ age group has the highest percentage of individuals that generally disagree (19% disagreeing and 6% strongly disagreeing) across the age groups.



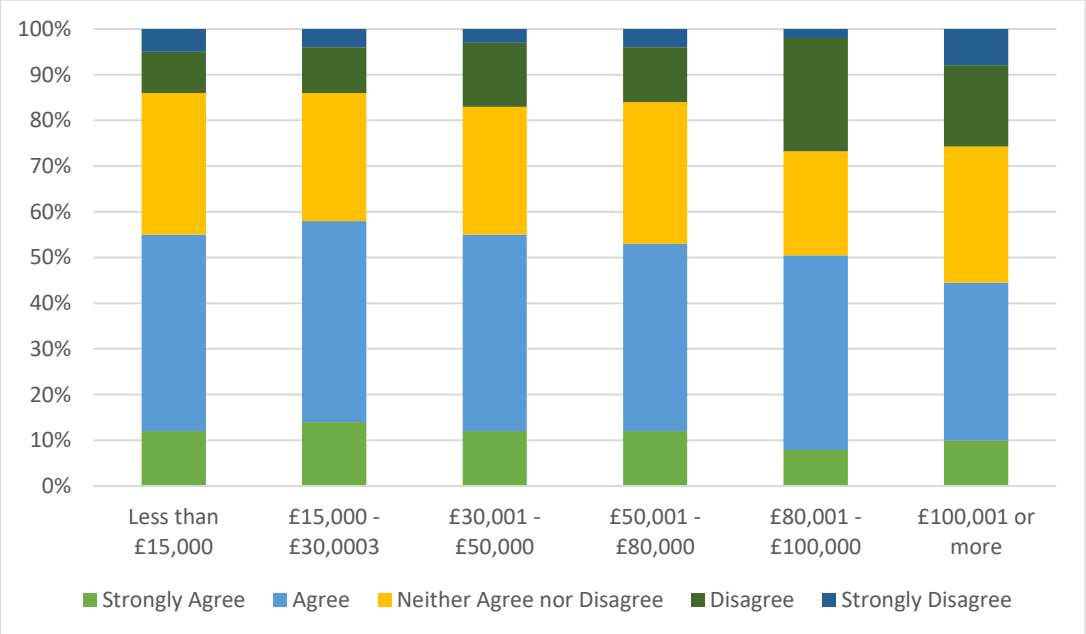
- **6.4 Local Authority Area:** Across all local authorities (bar Bolton), the most popular response, amongst all responses, to the statement is that of 'agree'. Oldham and Rochdale have the highest percentages of individuals agreeing (both strongly agreeing – both 15% - and agreeing – 44% and 43% respectively) to the need of NHS professionals have some responsibility to assist patients regarding their financial hardships. On the other hand, Stockport has the highest percentage of individuals that disagree with the statement (21%).



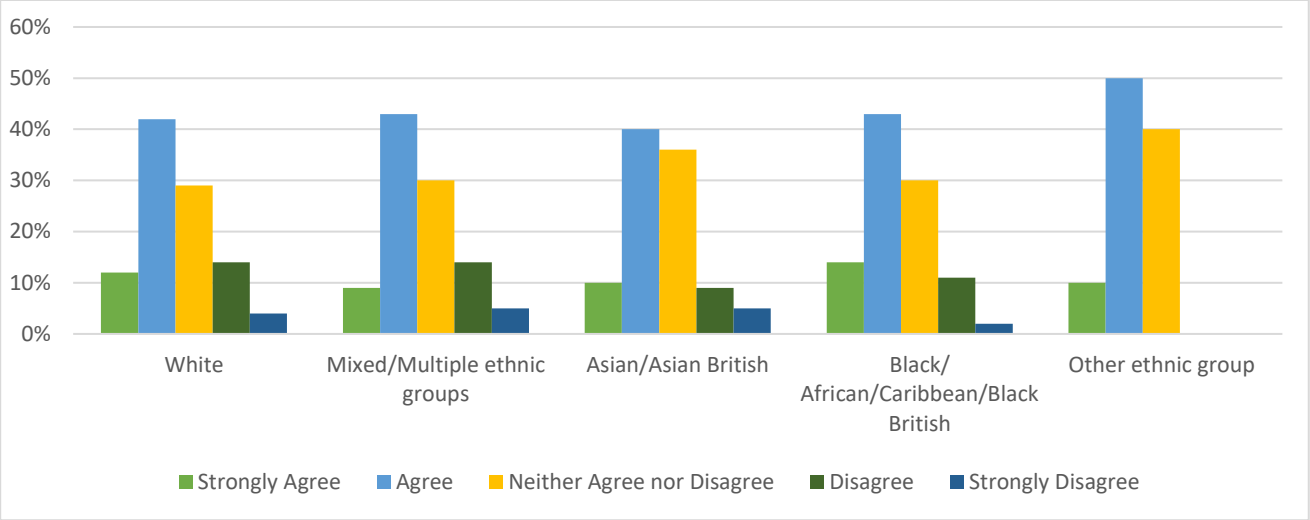
- **6.5 SEG (Socio-Economic Grade):** The trend across SEGs (i.e. average percentages) follows closely the general trend seen across the whole sample (see 6.1).



- **6.6 Household Income:** The trend across income brackets (i.e. average percentages) follows closely the general trend seen across the whole sample (see 6.1).

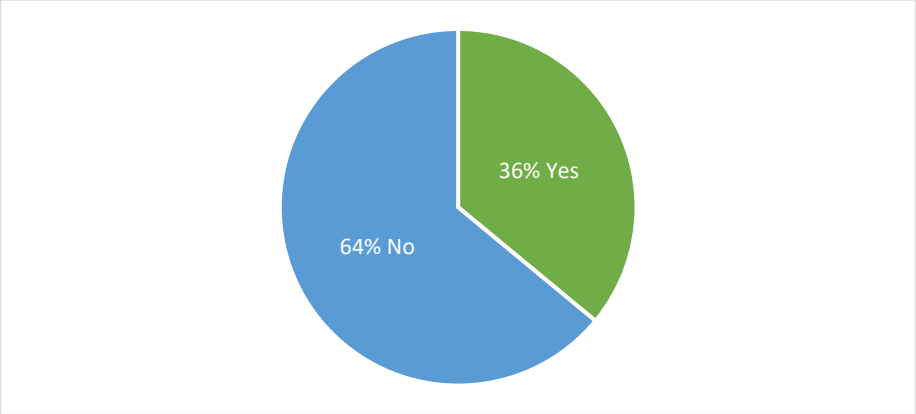


- **6.7 Ethnicity:** Across all ethnicities, the most popular response to the statement is that of 'agree' amongst all responses, with at least 40% of respondents from each ethnicity agreeing with the statement. Those from a White or mixed/multiple ethnic groups have the highest percentage of those who disagree (both 14%), whilst those categorised in other ethnic group have no respondents that identify to disagree with the statement.

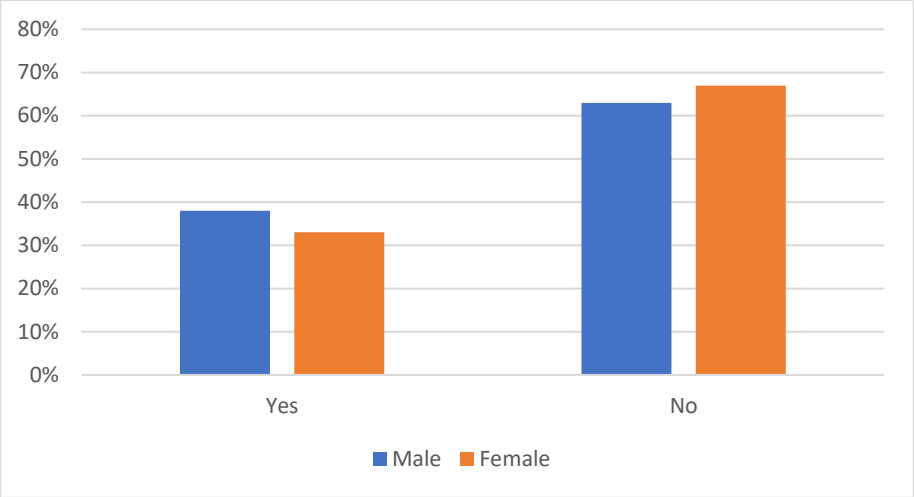


Q7. If you had concerns about your household's financial situation, would you raise these with NHS health and social care professionals?

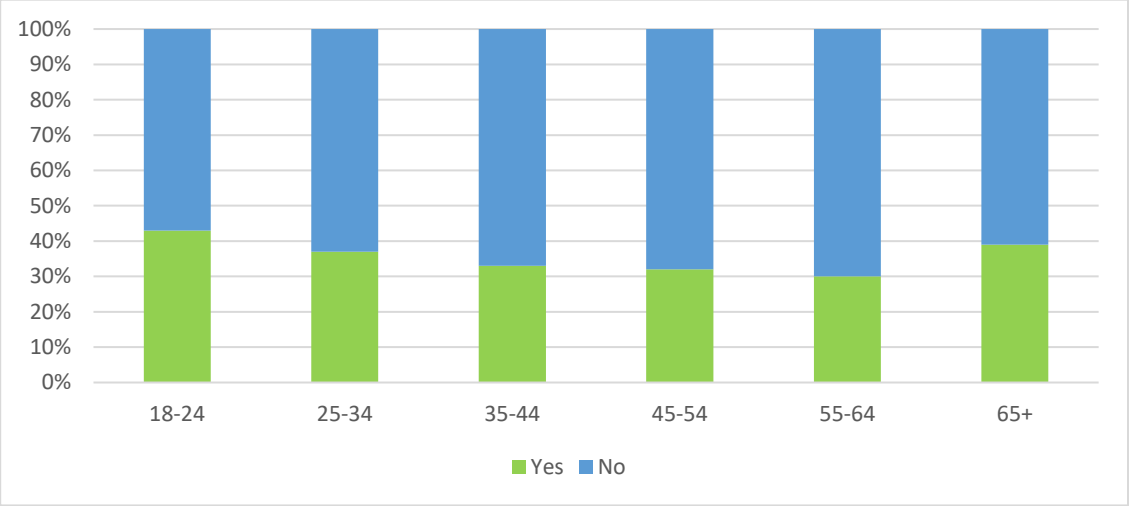
- **7.1 Total sample:** Almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals.



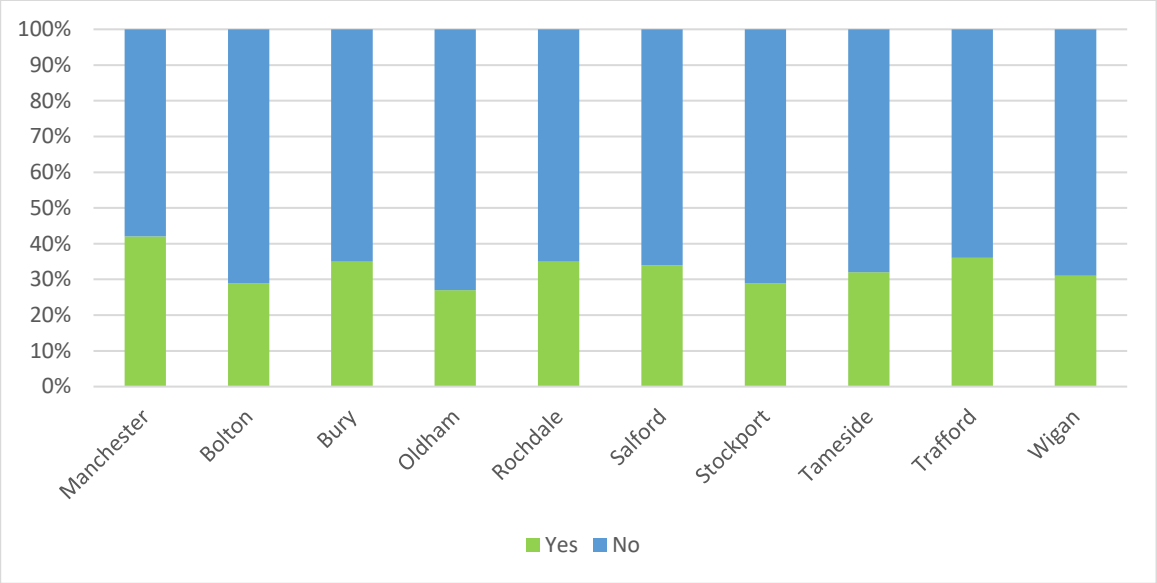
- **7.2 Gender**: The overall trend across the genders followed that of the total sample (as seen in 7.1), however, a greater percentage of men (38%) would share their financial concerns with NHS professionals than women (33%).



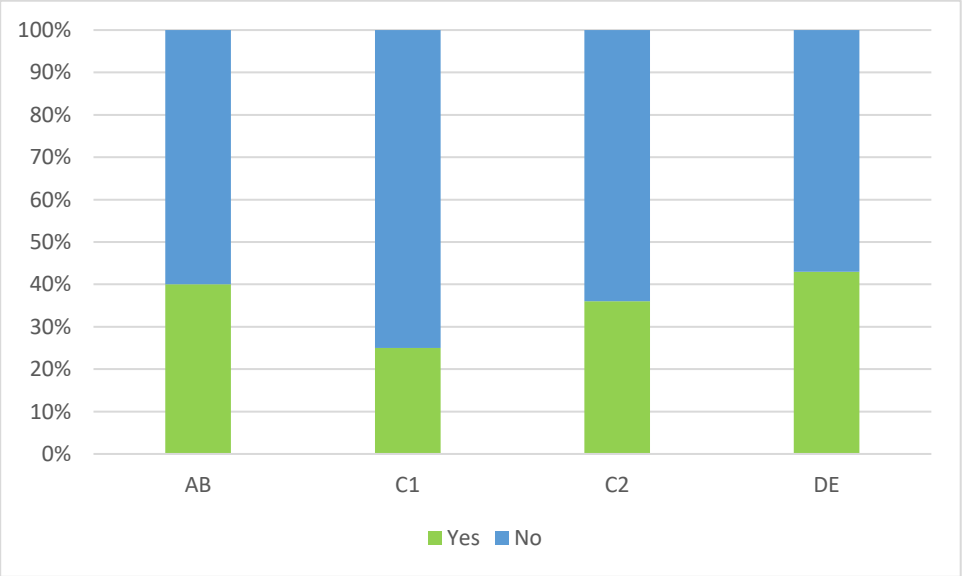
- **7.3 Age**: From the age group of 18-24 till 55-64, as the age increases, the percentage of individuals willing to share concerns about their household's financial situation with an NHS professional decreases; with 43% of individuals in the 18–24-year-old age group willing to share, compared to 30%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



- **7.4 Local Authority Area:** Across all local authorities, a greater percentage of individuals said 'no' to sharing their financial struggles with NHS professionals (like the trend seen in the whole sample for the question); Oldam having the highest percentage not willing to share (73%) and Manchester having the lowest percentage (58% - yet still maintaining a majority in those that responded 'no' to the statement).

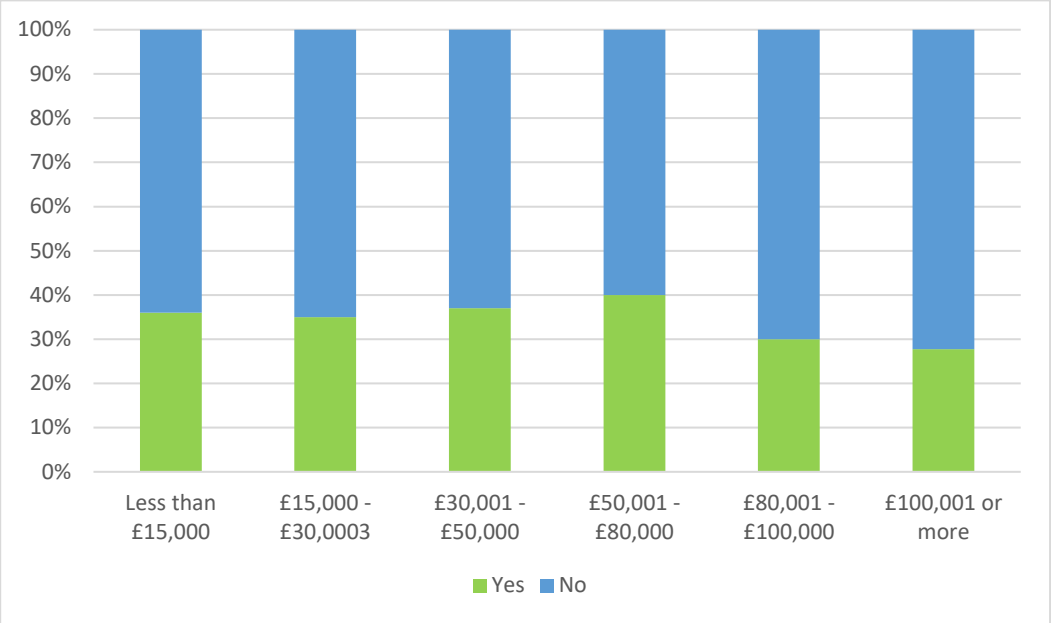


- **7.5 SEG (Socio-Economic Grade):** Across all SEGs, a greater percentage of individuals said 'no' to sharing their financial struggles with NHS professionals (like the trend seen in the whole sample for this question). Those in C1 have the highest percentage of individuals unwilling to share their financial struggles with NHS professionals (75%), whilst those in DE having the lowest percentage of individuals unwilling to do so (57% - yet still maintaining a majority in those that responded 'no' to the statement).

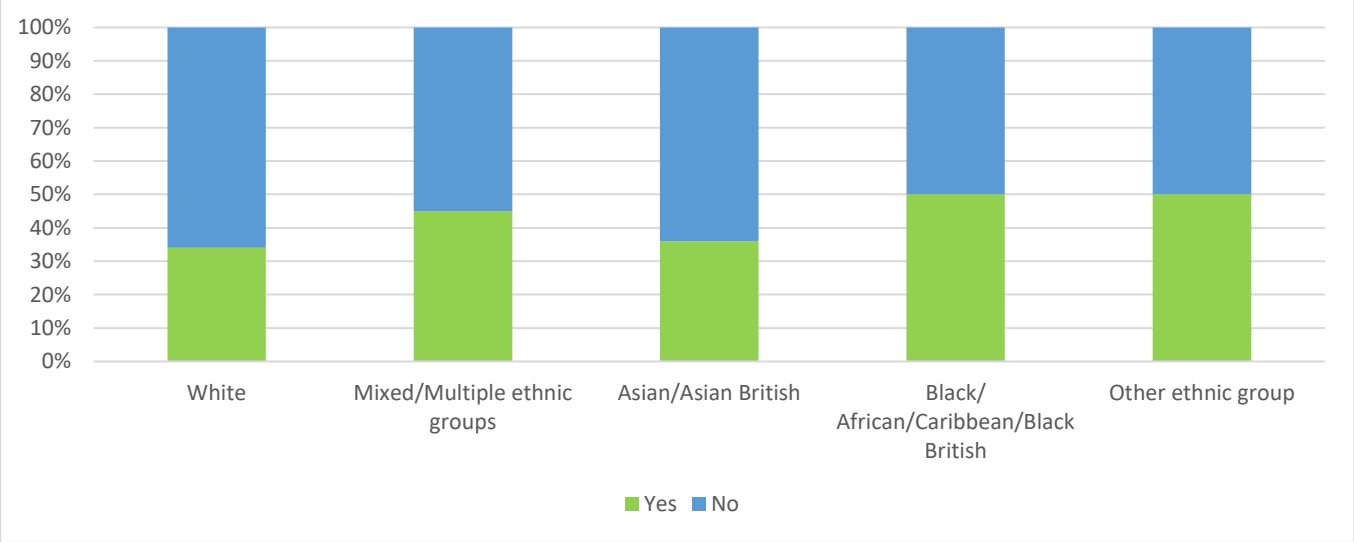


- **7.6 Household Income:** Similar to the trend seen in SEGs (and across the whole sample for this question), a greater percentage of individuals said 'no' to sharing their financial struggles with NHS professionals across all income brackets, with at least

60% saying ‘no’ to the statement – in the £50,001-£80,000 income bracket – to up to 73% saying so – in the ‘£100,001 or more’ income bracket.



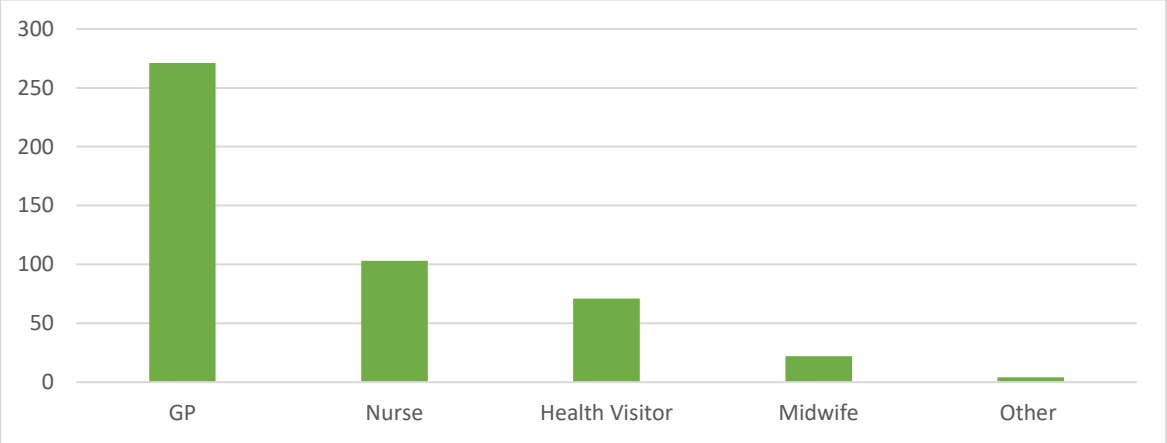
- **7.7 Ethnicity:** The majority of individuals who identified as either White, Mixed/multiple ethnic backgrounds, or Asian/Asian British stated that they would not raise their household financial concerns with NHS professionals – with those identifying White having the highest percentage (66%) amongst the three groups – whilst those that who identified as Black African/Caribbean/Black British and Other ethnic group had an equal percentage of individuals willing to share their financial concerns with NHS professionals to those not willing to share (i.e. 50%).



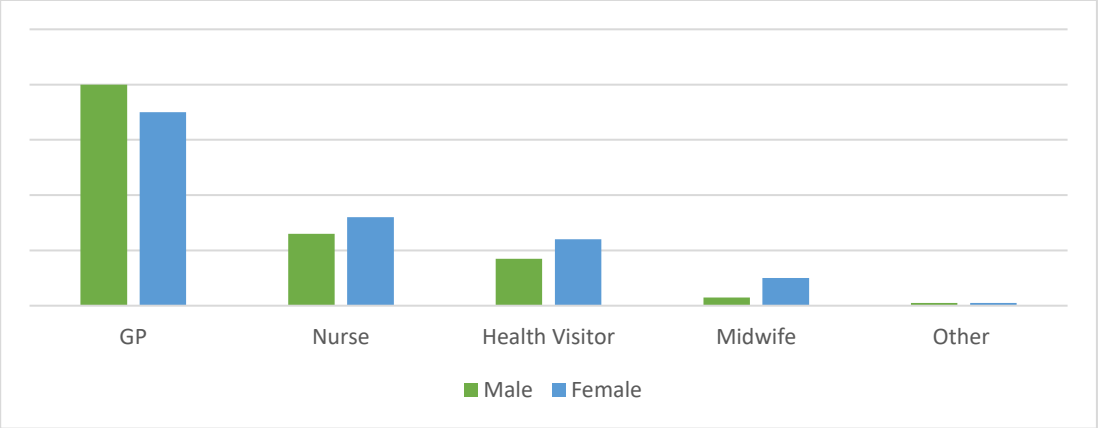
Q8. You said if you had concerns about your household's financial situation, you would raise these with NHS health and social care professionals (based on the previous question). Who would you feel most comfortable discussing your financial concerns with?

Number of respondents (for this question): 357. It should be noted that this question (unlike any other question in this survey) allowed respondents to choose multiple answers.

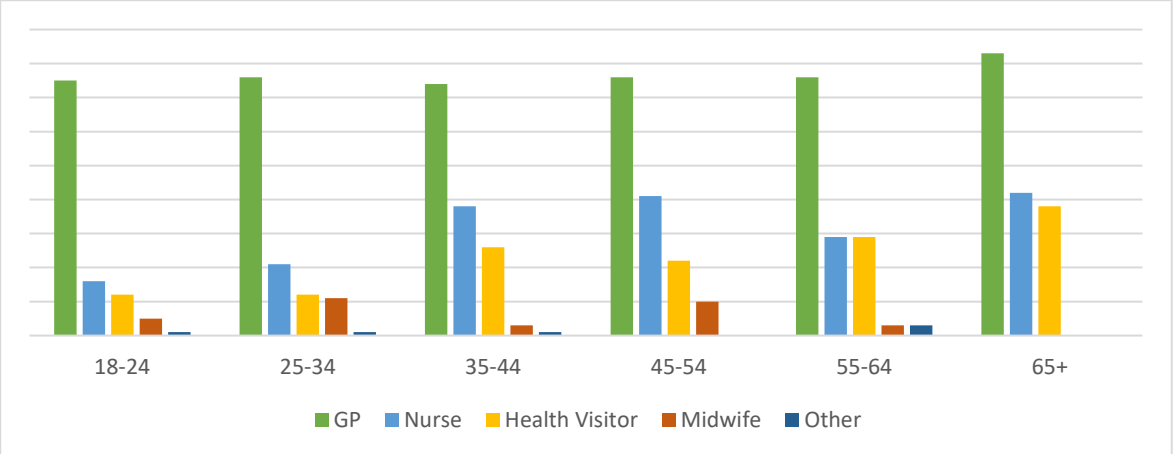
- **8.1 Total sample:** In this question, where respondents could select multiple options, the most popular answer – regarding which health and social care professional they would feel most comfortable with raising their household concerns – was GP, with 271 respondents (76% of the sample), followed by Nurse with 103 respondents (29%), health visitor (71 respondents – 20%), then midwife (22 respondents – 6%).



- **8.2 Gender**: The general trend regarding the preference of the type of NHS healthcare professional that both genders feel comfortable in confiding their financial struggles with matches that of the general population – with GP being in lead, followed by nurse, health visitor, then midwife. However, the level of popularity for each option varies amongst the genders, with GP being the more popular amongst men (with 80% of men choosing the option) compared to women (with 70% of women choosing the option). On the other hand, the choices of nurse, health visitor, and midwife were more popular amongst women in comparison to men (given the respective percentage of individuals that selected the option in their gender).

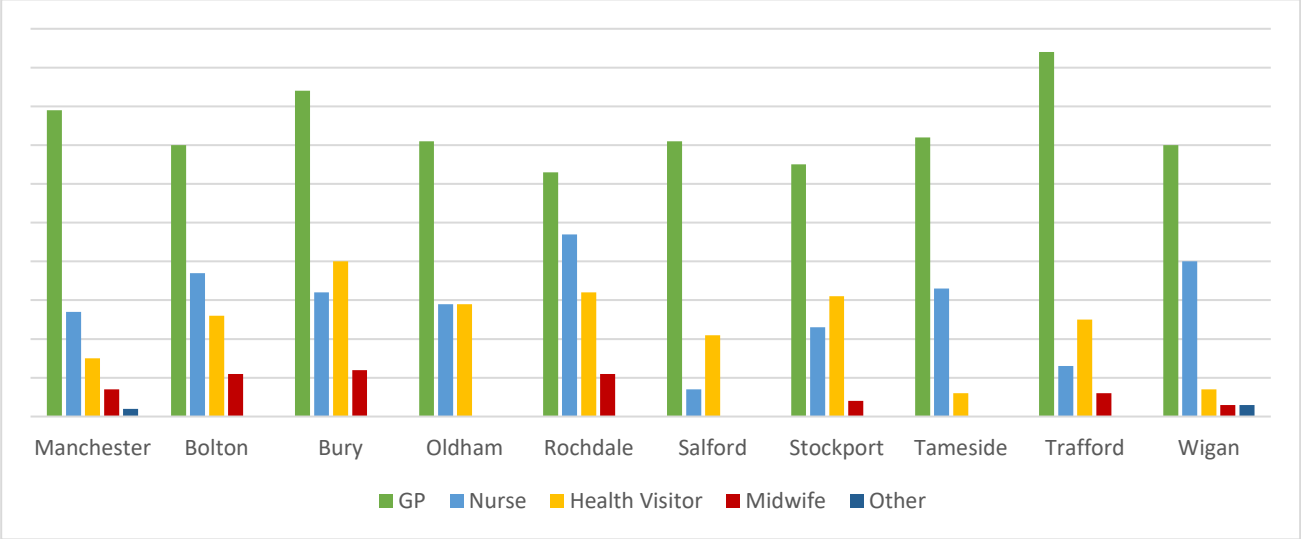


- **8.3 Age**: The general trend regarding the preference of the type of NHS healthcare professional amongst all age groups matches that of the general population – with GP being in lead, followed by nurse, health visitor, then midwife. However, the level of popularity for each option varies amongst the age brackets. An average of 75% of individuals choosing a GP as the healthcare professional they would be most comfortable confiding their financial struggles across each age group bar the 65+ age group (where a higher percentage of 83% choosing a GP as a healthcare professional they would feel comfortable discussing their household financial worries with). The 45–54-year-old age group had the highest percentage of individuals choosing a nurse (41%) amongst all age groups; the 25-34 year-old age group having the highest percentage of individuals choosing a mid-wife (11%); the 65+ age group having the highest percentage choosing a health visitor (38%).

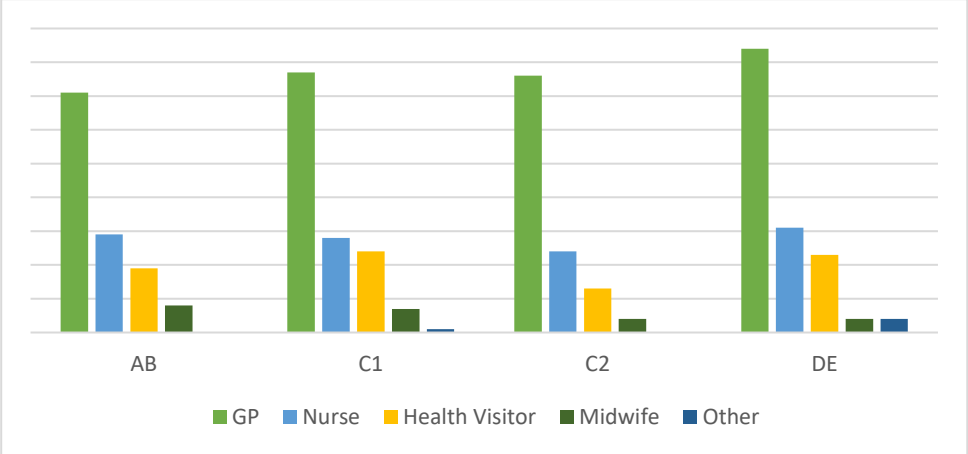


- **8.4 Local Authority Area:** Across all local authorities, the most popular answer was that of a GP, with Trafford having the highest percentage of individuals choosing that option (94%) across the local authorities and Rochdale having the lowest percentage (63%) (whilst still being the most popular answer within the local authority). The local

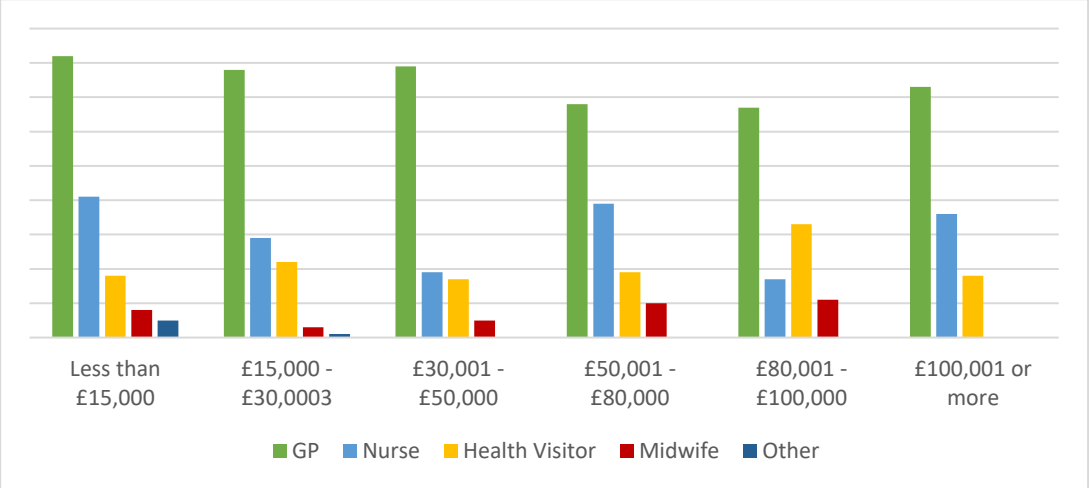
authority with the highest percentage of individuals that chose a nurse as an option was Rochdale (47%), whilst the local authority with the lowest percentage was Salford (7%). For the option of a health visitor, Bury had the highest percentage choosing the option (40%) whilst Tameside had the lowest percentage (6%). Oldham, Salford, and Tameside had no individuals (0%) that chose midwife as an option for comfortably discussing their financial situation with, whilst Bury had the highest percentage of individuals choosing that profession as an option (12%).



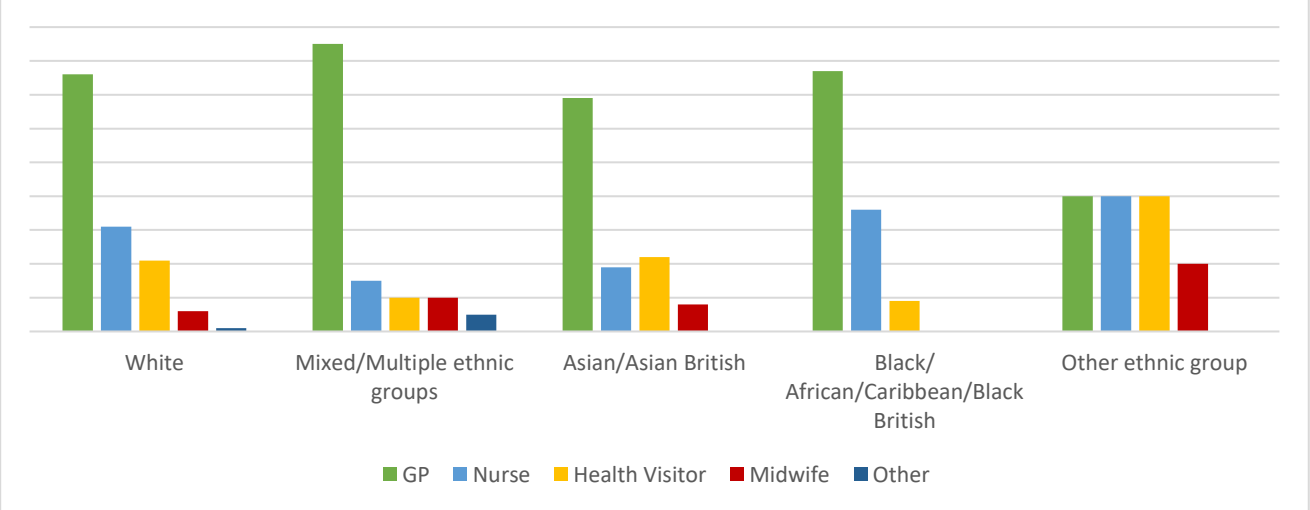
- **8.5 SEG (Socio-Economic Grade):** The general trend regarding the preference of the type of NHS healthcare professional amongst all SEGs matches that of the general population – with GP being in lead, followed by nurse, health visitor, then midwife. However, the level of popularity for each option varies amongst the SEGs. The options for GP and nurse have the highest percentages (amongst the SEGs) in DE (at 84% and 31% respectively), whilst health visitors are most popular in C1 (24%) and midwifes are most popular in AB (8%).



- **8.6 Household Income:** Across all income brackets, the most popular answer was that of a GP, with the 'less than £15,000' income bracket having the highest percentage (at 82%) amongst all income brackets. The second most popular answer amongst all income brackets – bar £80,001-£100,000 – for an NHS professional to share financial concerns with was a nurse, the 'less than £15,000' income bracket having the highest percentage of individuals choosing the option (41%). The options for health visitor and midwife are the most popular in the £80,001-£100,000 income bracket (at 33% and 11% respectively).

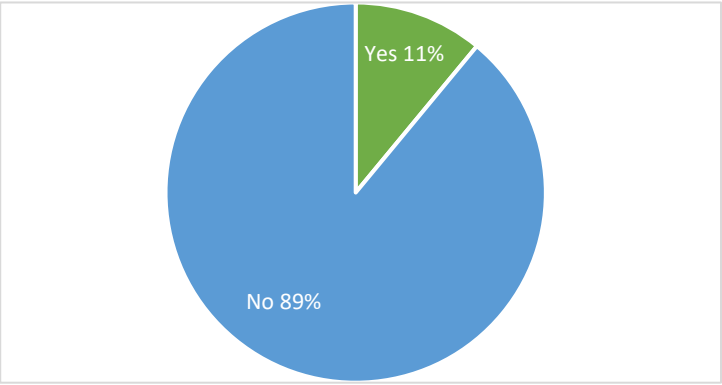


- **8.7 Ethnicity:** Across all ethnicities, the most popular answer is that of a GP, with mixed/multiple ethnic groups having the highest percentage of individuals choosing the option (85%). Other ethnic groups have the highest percentage of those choosing nurse, health visitor, and midwife (40%, 40%, and 20% respectively); on the other hand, the mixed/multiple ethnic groups have the lowest percentage of individuals that chose nurse as an option (15%), Black African/Caribbean/Black British have the lowest percentage of individuals that chose health visitor and midwife as options (9% and 0% respectively).



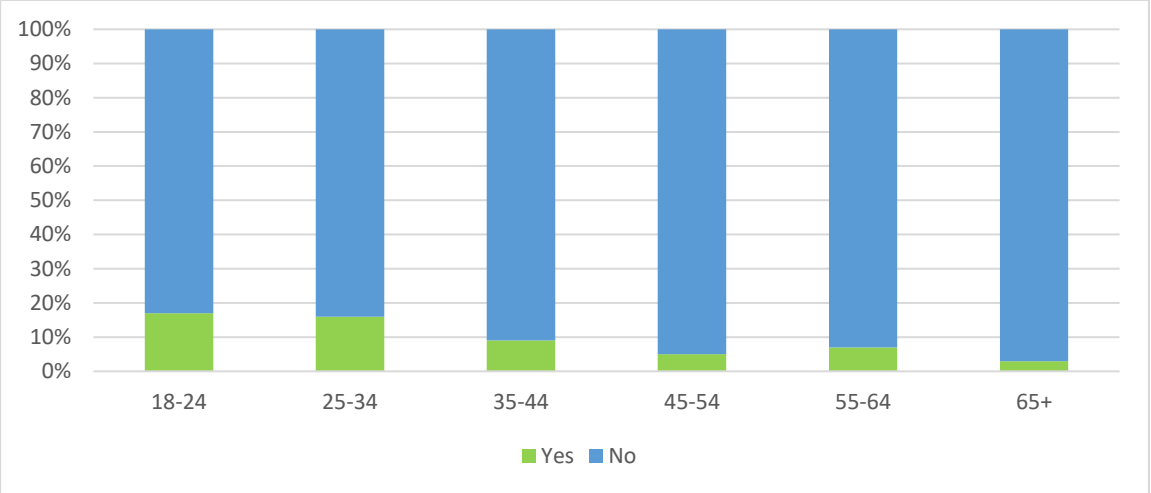
Q9. Have you ever raised concerns about your household's financial situation with an NHS health and social care professional?

- **9.1 Total sample:** A vast majority (89%) state they have never raised concerns about their household's financial situation with an NHS health and social care professional.

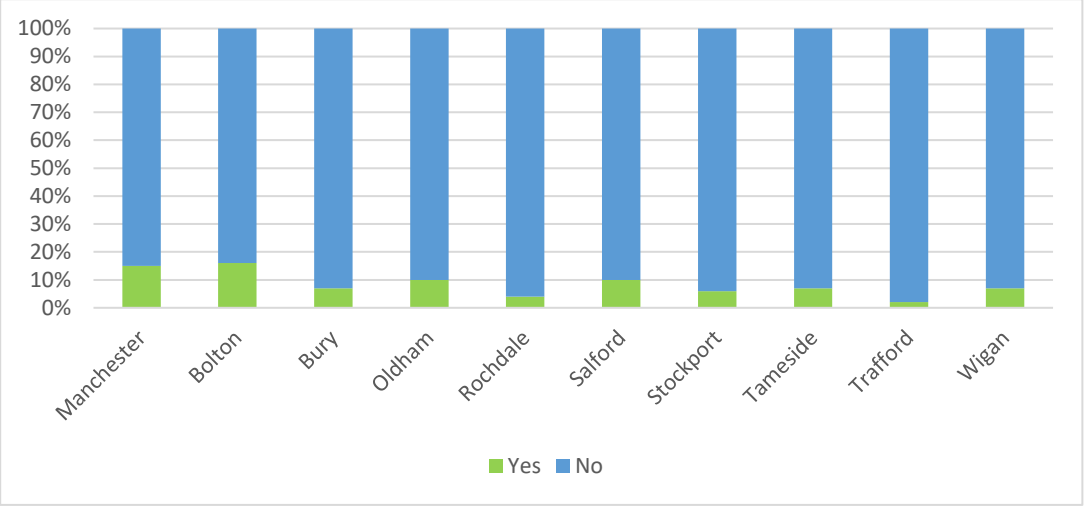


- **9.2 Gender**: The overall trend across the genders followed that of the total sample (as seen in 9.1), however, more men have raised concerns about their household's financial situation with an NHS professional than women have (by 3%).

- **9.3 Age**: Across all age groups, a vast majority of individuals said 'no' to having expressed their financial struggles with NHS professionals, with this percentage incrementally increasing as the age increases. The 18-24 year-old age group has the highest percentage of those who raised concerns about their household's financial situation with an NHS professional (17%) (and inversely having the lowest percentage amongst all age groups regarding voicing their concerns), whilst the 65+ age group has the lowest percentage (3%)of individuals that who raised concerns about their household's financial situation with an NHS professional (with the inverse of having the highest percentage (97%) of not expressing their concerns).



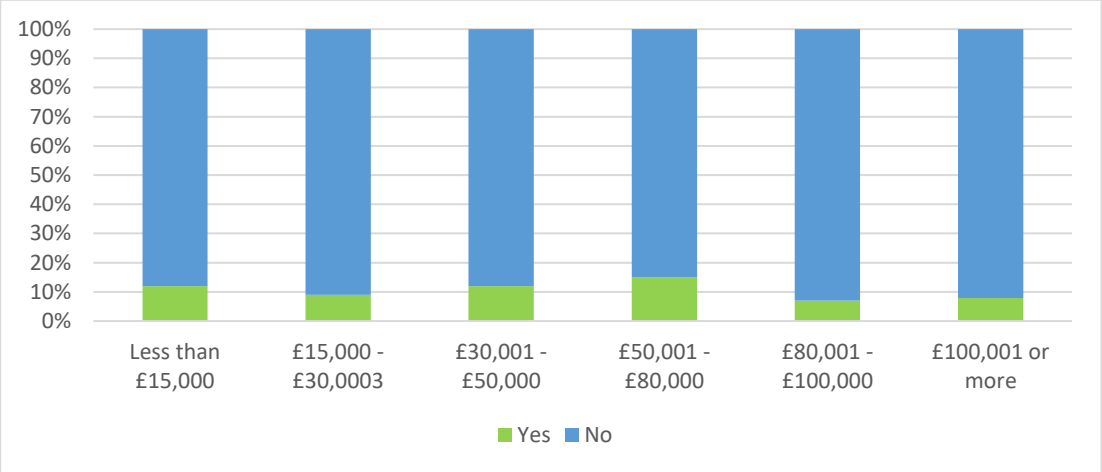
- **9.4 Local Authority Area:** A vast majority of individuals (over 80%) across all local authorities said 'no' to having expressed their financial struggles with NHS professionals. The local authorities with the highest percentage of individuals that expressed their financial concerns to NHS professional are Bolton (16%) and Manchester (15%), whereas the local authority with the lowest percentage of individuals expressing their financial concerns is Trafford (2%).



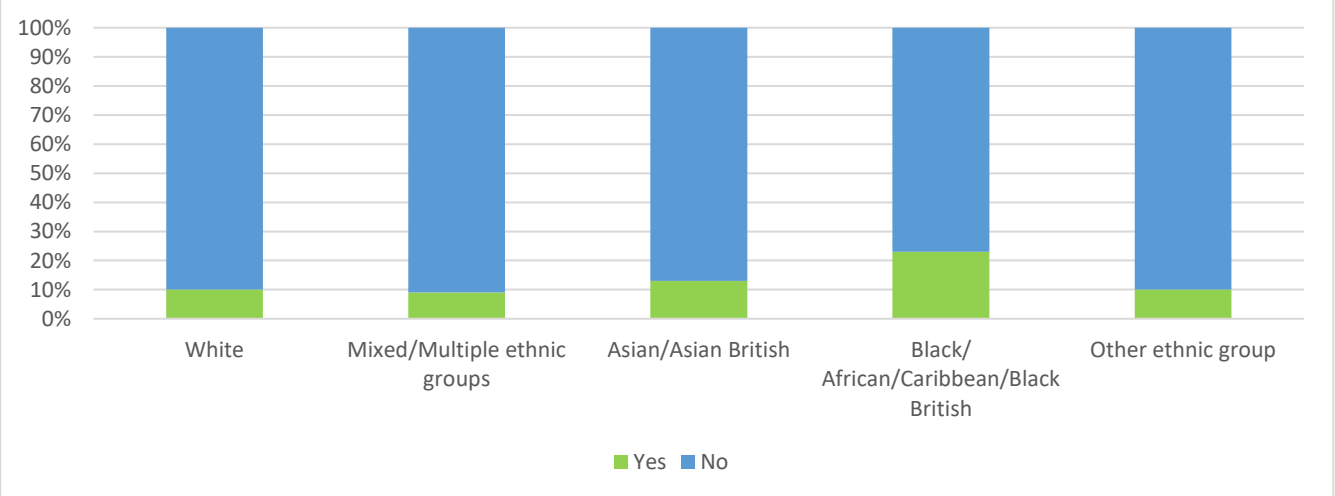
- **9.5 SEG (Socio-Economic Grade):** A vast majority of individuals (over 85%) across all SEGs said 'no' to having expressed their financial struggles with NHS professionals, with the highest percentage of individuals being in C2 (93%) – followed closely by C1 (92%) and DE (10%) – and the lowest percentage in AB (86%).

- **9.6 Household Income:** Similar to the trend seen across SEGs, a vast majority of individuals (over 85%) across all income brackets said 'no' to having expressed their

financial struggles with NHS professionals, with the highest percentage of those that did not raise their concerns being in the £80,001-£100,000 income bracket (93%), whilst the lowest percentage of such individuals being in the £50,001-£80,000 income bracket (85%), followed closely by '£100,001 or more' (8%).

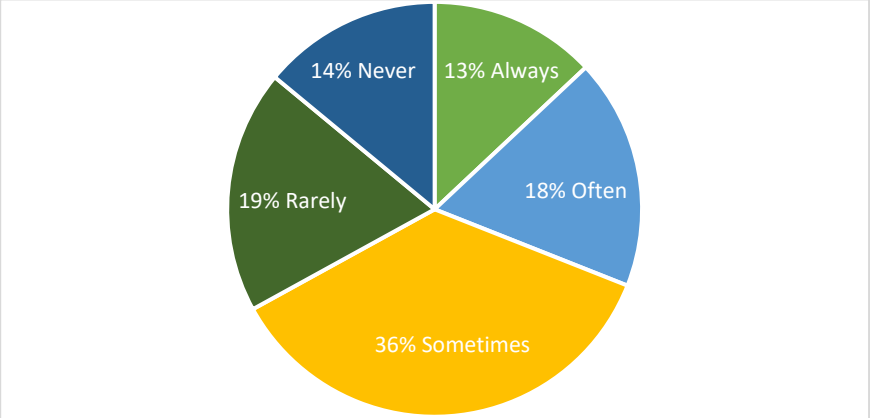


- **9.7 Ethnicity:** Similar to the trend seen across other demographics, the majority of individuals across all ethnicities said 'no' to having expressed their financial struggles with NHS professionals. The ethnic group with highest percentage of individuals that raised their financial struggles with NHS professionals are those that identified as Black African/Caribbean/Black British (23%). The ethnicity that has the lowest percentage of those that shared their financial situation with NHS health and social care professionals are mixed/multiple ethnic groups (9%), followed closely by White (10%) and other ethnic group (10%).



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

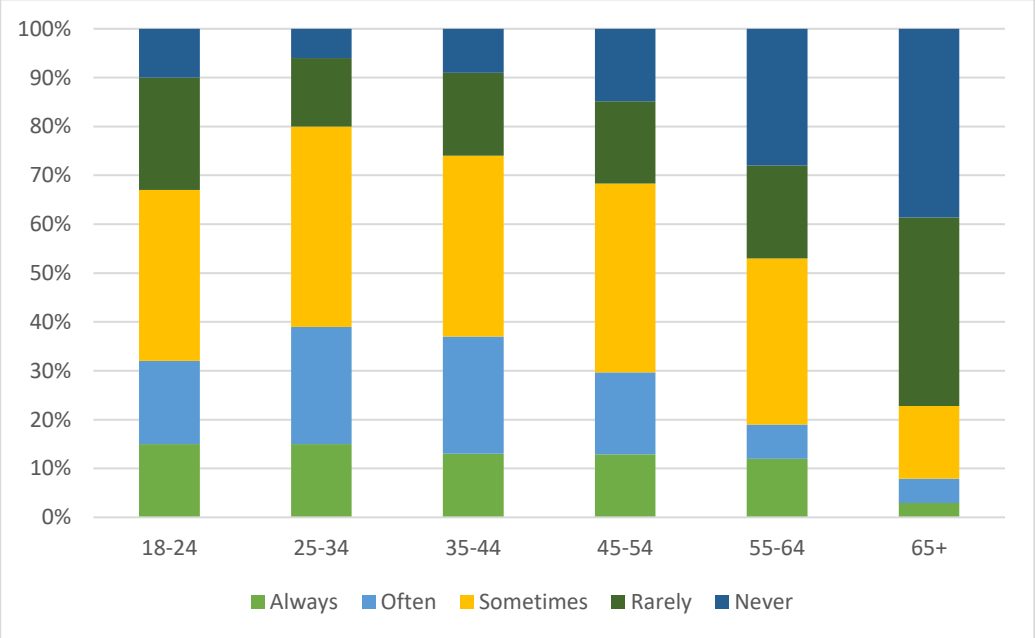
- **10.1 Total sample:** Almost a third (31%) of all individuals state that concerns and/or difficulties with household finances 'always' or 'often' impacts their physical and/or mental health. Over a third (36%) of individuals state that concerns about and/or difficulties with household finances 'sometimes' impacts their physical and/or mental health. A third (33%) state that concerns and/or difficulties with household finances 'rarely' or 'never' impacts their physical and/or mental health.



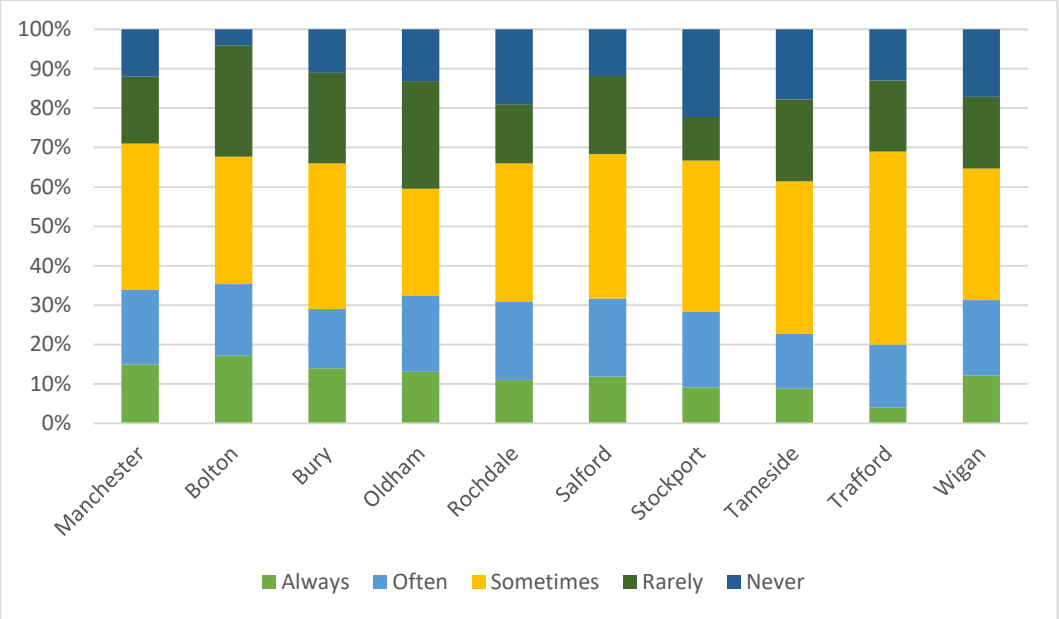
- **10.2 Gender**: The overall trend across the genders follows that of the total sample (as seen in 10.1), however, a greater percentage of women state that concerns and/or difficulties with household finances 'always' or 'sometimes' impacts their physical and/or mental health (4% and 5% more than men, respectively), whilst a greater percentage of men state that concerns and/or difficulties with household finances 'often' or 'rarely' impacts their physical and/or mental health (4% and 3% more than women, respectively).

- **10.3 Age**: In general, as the age increases, the percentage of individuals that believe that concerns and/or difficulties with household finances impacts their physical and/or mental health decreases. The age groups 18-24- and 25–34 age groups have the highest percentage of individuals that believe that concerns and/or difficulties with household finances 'always' impacts their physical and/or mental health (15%). Similarly, 25–34 age group has the highest percentage that believe that concerns

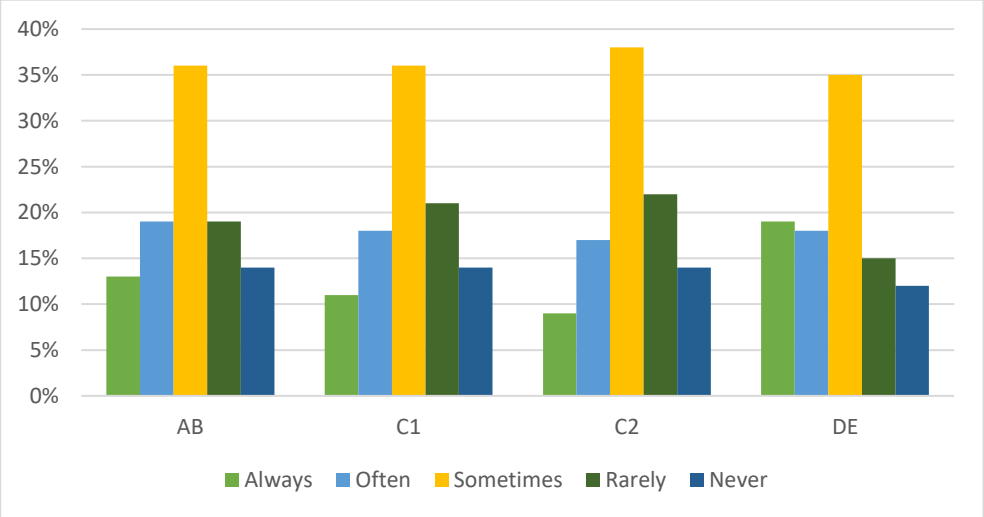
and/or difficulties with household finances ‘often’ or ‘sometimes’ impacts their physical and/or mental health (24% and 41% respectively), whilst having the lowest percentage of individuals that believe such concerns ‘rarely’ or ‘never’ impact their physical and/or mental health (14% and 6% respectively). On the other hand, the 65+ age group has the lowest percentage of individuals that ‘always’, ‘often’, and ‘sometime’ relate with the statement (3%, 5%, and 15% respectively), whilst having the highest percentage that ‘rarely’ or ‘never’ does (39%).



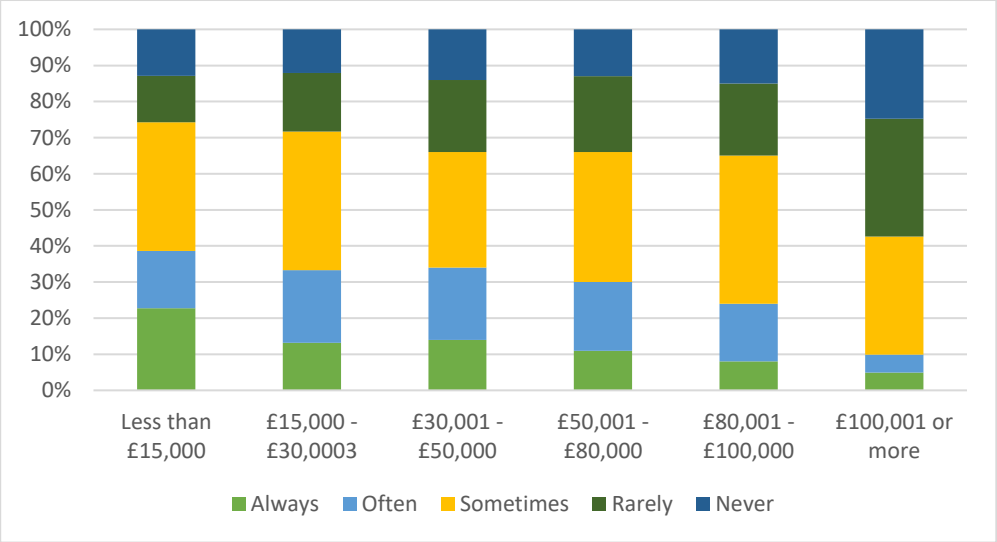
- **10.4 Local Authority Area:** The general trend across the local authorities follows that seen across the total sample (see 10.1), with only a few deviations across some local authorities. Trafford has the lowest – and a significantly lower – percentage of individuals (compared to all local authorities) that ‘always’ relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (4%). On the other hand, Bolton has the lowest – and a significantly lower – percentage of individuals that ‘never’ relate with the statement (4%), whilst having the highest percentage that ‘always’ relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (17%). Bolton has a much higher than average percentage of individuals that ‘rarely’ related with the statement (28%), where Stockport comparatively has a much lower percentage as such (11%).



- **10.5 SEG (Socio-Economic Grade):** The overall trend across the SEGs follows that of the total sample (as seen in 10.1), with the only deviation being C2 having a significantly lower percentage of individuals that 'always' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (9%), whilst DE having a significantly higher percentage of individuals that 'always' relate to the statement (19%).



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



- **10.7 Ethnicity:** Similar to the trend seen across the whole sample (see 10.1), the majority of individuals across all ethnicities – bar 'other ethnic groups' – stated that they 'sometimes' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (an average of 39%). Individuals identifying from mixed/multiple ethnic groups have the highest percentage of individuals that 'always' related to the statement (23%). Black African/Caribbean/Black British individuals have the highest percentage of those who 'often' related to the statement (20%). On the other hand, those identifying as 'other ethnic group' have the highest percentage of those who 'rarely' and 'never' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (50% and 30% respectively).

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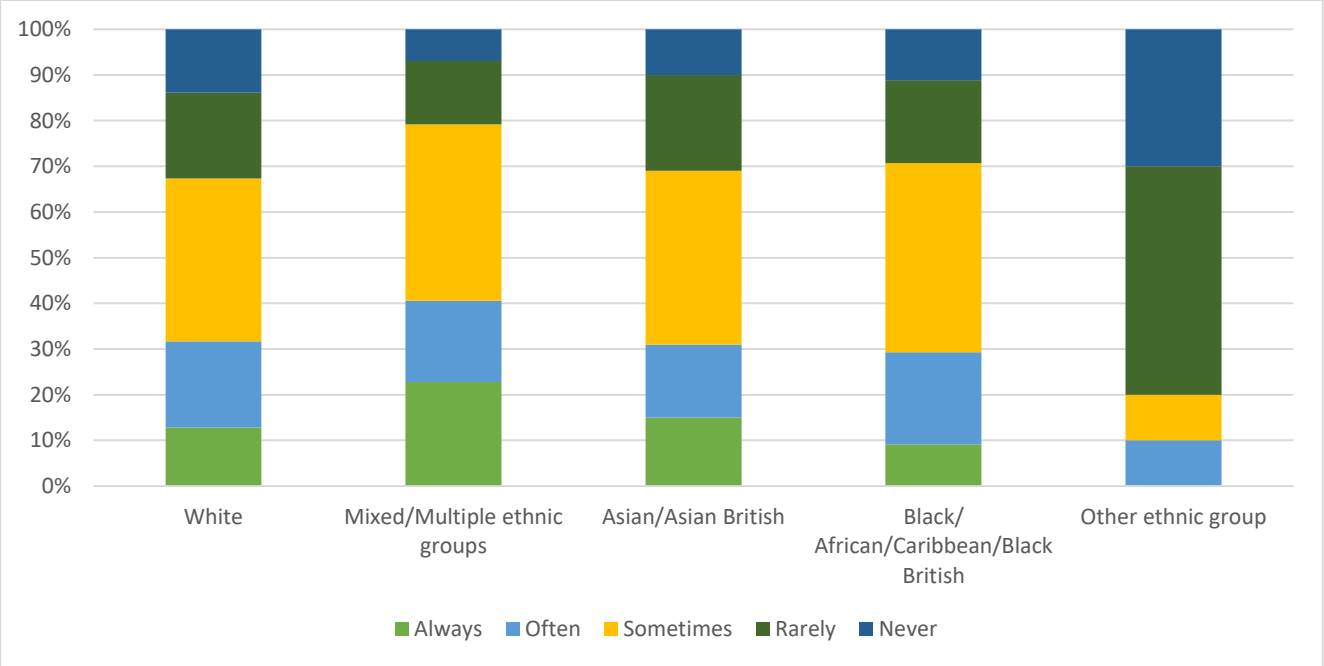
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
White
Mixed/Multiple ethnic groups
Asian/Asian British
Black/ African/Caribbean/Black British
Other ethnic group
Always
Often
Sometimes
Rarely
Never