

The Big Conversation Phase 2 findings

Executive summary

Phase 2 of the Big Conversation took place in October 2022 and involved a range of methods for engaging people across the length and breadth of Greater Manchester.

More than 2,000 individuals were involved, including men and women; older and younger people; carers; lesbian, gay, bisexual and transgender communities; disabled people; people and communities experiencing racial inequalities; asylum seekers; refugees and other underserved and inclusion health groups including sex workers and people experiencing street homelessness. We had over 10,000 comments.

What were the top five themes to occur?

Across Greater Manchester, there is:

- widespread concern with **funding and staffing levels** for the NHS, as well as for social care and the local voluntary, community and social enterprise (VCSE) sector
- widespread concern with the difficulties experienced in accessing **GP appointments**, as well as other access problems such as **waiting times for hospital care**
- a demand for more **personalised and person-centred care**, which takes account of the needs of different individuals and communities, and recognises that one size does not fit all
- a demand for **more and better partnership working with the VCSE** sector which is seen as ideally placed to help statutory services negotiate some of the above, and
- an expressed need for more action on **prevention and the wider determinants of health**, including help with the cost of living.

Throughout the engagement, the first two themes overshadowed all others.

The key themes to emerge from responses to the individual questions below were a variation on the above with a small number of additional, but linked themes.

Q1: What would make the biggest difference for you/the communities you serve in relation to being healthier, happier and better?

- Better access to the NHS, particularly GPs, and to mental health support
- Properly funded services
- Healthier lifestyles
- Action on cost of living and other determinants of health, for example housing, employment, environment, transport
- Equal opportunity to be listened to - personalised/person centred care

Q2: What is stopping this?

- Systematic problems with making GP appointments
- Underfunded services
- A range of barriers to achieving a healthy lifestyle
- Lack of money/cost of living crisis
- Communication problems
- Lack of support around mental health
- Lack of partnership with the VCSE sector

What is stopping this from the perspective of communities sharing a particular characteristic?

- Problems accessing services and communicating particularly for the digitally excluded, the d/Deaf, those with partial sight, low literacy levels, little or no English, or a learning disability
- Linked to this, a perceived lack of awareness and understanding amongst some staff of the different needs of different groups, such as the d/Deaf, blind/partially sighted or those with learning difficulties
- A perceived lack of cultural awareness amongst some staff of the different experiences of ethnic groups, or the LGBTQ+ community
- A general feeling of invisibility, being unimportant, and of wanting to be heard

Q3: What would help?

- More and longer-term funding for the VCSE sector
- Access problems to GPs being fixed; longer, face to face GP appointments; out of hours services, more NHS dentists.
- Support with the cost of living
- Help with achieving healthier lifestyles particularly food and activity
- Better partnership with VCSE sector
- A focus on early intervention and prevention

What would help from the perspective of communities sharing a particular characteristic?

- A workforce that was more representative and with lived experience
- Staff training, including cultural and disability awareness training, and improved communication skills
- Information and communication which is accessible to different groups facing the biggest barriers to communication
- Addressing language barriers
- Community involvement
- Being listened to and understood

Q4: What is the most important thing for health and social care?

- **Better communication** (between services as well as with the public)
- more **accessible** services including access to primary care and waiting times
- **partnership working** with the community and the community sector
- better **funding**, more training and better wages for NHS and care staff
- **personalisation/person centred care**

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1. Introduction and background

Greater Manchester Integrated Care Partnership (ICP)

In July 2022 Greater Manchester Integrated Care Partnership was established. The partnership brings together all the different organisations which support people's health and care.

Members of the partnership come from all ten parts of Greater Manchester (GM), including all NHS organisations, councils, GM Combined Authority, organisations from across the voluntary, community, faith and social enterprise sectors and others all working together to help achieve a shared vision.

The partnership will work with people and communities to create and oversee the region's overall integrated care strategy.

Greater Manchester ICP Strategy

The strategy aims to address the health and care needs of the population across Greater Manchester. It includes actions to improve health and healthcare and reduce inequalities in health outcomes, experience and access to services.

GM ICP wanted to understand what matters most to people and communities to make sure the strategy reflects the needs of Greater Manchester's people and communities.

Big Conversation

Phase 1 (vision and aims). Between March and May 2022, GM ICP carried out a Big Conversation across GM to ask about the vision and aims of the plan. 1332 gave their views and told us they agreed with these.

Phase 2 (priorities and actions). Following this the partnership wanted to understand what matters most to communities across all ten localities in GM to help shape the priorities and actions for the plan.

A Big Collaborative event took place in September to coproduce phase 2 engagement in partnership with the VCSE sector. Key lines of enquiry were agreed at the event to inform the questions for Big Conversation phase 2:

1. For community groups: What would make the biggest difference for communities you serve in relation to being healthier, happier and better?
For individuals: What would make the biggest difference to your life in relation to being healthier, happier and better?
2. What's stopping this?
3. What would help this?
4. What's the most important thing health and care services need to improve?

Engagement took place in October 2022 and was led by the VCSE sector including Healthwatch, GM Equality Alliance and local infrastructure organisations working in

partnership with GM ICP Engagement leads (table 1 below). This has enabled us to reach deep into communities and involve those who are less likely to take part in surveys or provide their views in traditional ways.

Table 1. Partnership engagement

Local VCSE infrastructure organisations x 10	Focus groups and one to one discussions with organisations representing underserved communities and communities of identity In neighbourhoods
Healthwatches x 10	Focus groups, outreach events and surveys capturing the views of people and communities In neighbourhoods
Greater Manchester Integrated Care Engagement leads x 10	Events, outreach, surveys and focus groups capturing the views of citizen panels, patient groups, people and communities In neighbourhoods
GM=EqAI	Focus groups and one to one interviews with groups and organisations representing protected characteristics, inclusion health groups and underserved communities At Greater Manchester level

This was a complex piece of work to analyse. More than 30 individuals from different organisations were required to draw together and input summary information regarding very different types and levels of engagement – from one-to-one conversations to large focus groups and survey responses, and there was variation in the way in which this was done. However, the responses given during these engagement events have now been analysed. **More than 2,000 individuals** were engaged in Phase 2 across Greater Manchester, producing a wealth of information at grassroots level and a rich insight into what the people of Greater Manchester - including many of our most vulnerable residents - feel about health, the barriers and enablers to good health, and what needs to change.

What follows is an attempt to draw out some of the key themes emerging from the overall engagement, as well as from different equalities groups, in a way which captures the breadth of issues which arose, as well as giving a flavour of some of the rich narrative to emerge from this phase of the consultation.

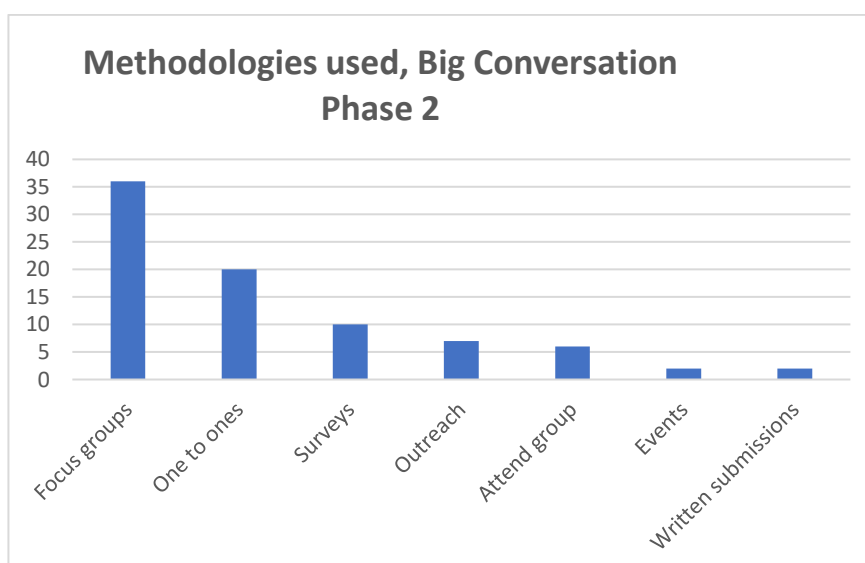
2. Methodology

The main methods of engagement are shown below. The most common approaches to engagement were via focus groups. Nine of these were at a Greater Manchester level as noted above, and involved the following groups: Awakening Minds, GM Older People Panel, Idaraya Life CIC, Manchester Action on Street Health, Manchester People First, TS4SE Cooperative, Pankhurst Trust (incorporating Women’s Aid and the GMCA Women and Girl’s Equality Panel), Wraparound Partnership, and the Zimbabwe Women’s Organisation.

Some organisations also chose to supplement focus group discussions with one-to-one conversations. These ranged from structured conversations with representatives from organisations working with those who were perhaps least likely to engage, such as those experiencing street homelessness, to more opportunistic conversations (for example with South Asian men dropping off wives and daughters to a Zumba class.)

In addition, ten different surveys were carried out, and organisations used a range of additional methods to reach different parts of the community, such as outreach, attendance at events and at existing group meetings, such as a ‘knit and natter’ group and an LGBTQ+ action group, both in Wigan, and an evening meeting with the Jain Samaj community in Manchester. A small number also invited written submissions.

It should be noted that the above reflects the numbers of different approaches adopted in each category, rather than the numbers of people engaged by each, which was extremely difficult to ascertain from the information provided. It is recommended that for any future events of this kind, methods for recording information be simplified, with clear guidance given on what it is important to record and report.



Some of those providing information regarding the engagement work provided detailed demographic information on those engaging, particularly those using surveys. Others did not collect or report this in a quantifiable way, making it impossible to obtain accurate numbers. However, the different methods of engagement reached many different communities, including a mix of ages (younger and older people and people of working age), carers, disabled people, women, South Asian women and some men, black African men and women, members of the LGBT community, asylum seekers and refugees and other excluded groups including sex workers and people who are experiencing street homelessness.

Overall, the engagement reached more than 2,000 people in Greater Manchester.

3. Results

3.1 What would make the biggest difference?

Participants were asked what would make the biggest difference in relation to being healthier, happier and better. Most respondents used this first question as an opportunity to list a wide range of factors (commonly around 15-20) which they felt needed to change, making this an extremely challenging question to analyse. Despite this, two extremely dominant common themes emerged, with a small number of common but relatively more minor themes.

Theme 1: Better access to the NHS

The biggest theme to emerge was around the need for better access to the NHS, principally primary care, and in particular GPs, although access to dentists and waiting times for hospital appointments were also common. Problems getting through to a GP surgery on the telephone and not being able to get a GP appointment when needed was a common concern, raised by large numbers throughout each of the questions. Having to telephone a surgery at a certain time to book an appointment and join a queue of people waiting for their calls to be answered was raised as a specific issue for those who have work commitments, may be trying to get children to school, or who are otherwise excluded, for example by having insufficient credit on their phone. The implications were that some people were unable to seek medical advice when needed, 'stayed ill', or went to A and E.

"Getting through to doctors and GPs is difficult. It is not normal."

"It has been really challenging with the on-call/phone appointments because people work zero contract hours and are unable to take the day off for their GP appointments."

"People with no credit will end up in A and E."

A related theme was around reliance on access to the internet to book appointments and the impact on specific groups. Many highlighted that digital access was not possible for some people, including some (and by no means all) older people, those lacking digital skills and those with no or limited access to the internet or smart phones.

“Recognise that not all people can be connected to the internet or use mobile phones when sending out information and booking appointments.”

“Digital exclusion, can’t afford it and don’t like it.”

“The technological barriers in place to negotiate to speak to a GP or health professional – not everyone has a smart phone or access to the internet at home.”

Problems accessing GPs was felt to have become much worse since the pandemic, although there was disagreement as to why. Some felt that Covid was effectively ‘being used as an excuse’ to restrict care, others were more sympathetic and noted that staff were looking stressed and exhausted, and that it was the system at fault. Related subthemes were demands by some for longer, and face to face appointments.

“To be able to sit down with your GP and have a proper conversation about your condition not just a three-minute consultation.”

“GPs only have five minutes with a patient, it’s just not enough time to understand someone as a person, about wider issues they may be experiencing.”

“Actual face to face appointments with the GP, rather than a promise of a call back or being referred to 111 or A&E unnecessarily.”

This was often cited in the context of providing an opportunity to be listened to and understood, to build a relationship with a named GP, or avoiding saying the same thing over and over.

“GPs don’t have time to get to know you and advise beyond giving out prescriptions.”

“Don’t want to be telling same story to so many different people.”

“People just want a person-centred service with one person so they can build up a relationship with these health professionals and don’t have to keep explaining their needs and how best to support them at every single appointment they attend.”

The demand for face-to-face services was also expressed for mental health services:

“Moving counselling/mental health services to all being back to face to face instead of online/telephone appointments.”

Other less dominant but common access issues to emerge were long waiting times to hospital appointments, difficulties accessing NHS dentists and difficulties accessing mental health support.

Theme 2: Properly funded and resourced services

The second, linked and extremely strong theme to occur in relation to this question was the need for properly funded services. Participants expressed concern about what was described as the underfunding of services, principally the NHS:

“There is no money in health care, the saying that prevention is better than cure is a big one... but there’s not even the money in a cure either.”

“The NHS is woefully understaffed, as such the health needs of community members are not met, and the few staff available are overwhelmed with the high number of cases they have to deal with in recent times.”

The concern with underfunding also extended to social care, mental health services, and the VCSE sector, and was inextricably linked to a concern about staff shortages. Again, this tended to focus on the NHS and primary care, which was criticised for an over reliance on locums and part time staff and having a high staff turnover, but also extended to the care system as well as to the VCSE sector.

“There simply aren’t enough staff to cope.”

“Staff move on and that knowledge is lost.”

“There are no funds for backfilling roles e.g. staff off with mental health issues and maternity leave etc., this causes problems for the patients.”

Theme 3: Healthier lifestyles

The above two themes predominated in the responses to this first question. A slightly less common theme to arise in terms of what participants thought would make the biggest difference to health was a healthier lifestyle, particularly diet, activity and weight loss. The link between healthy lifestyles and achieving better health seemed to be strongly established, however an additional aspect of this theme was the way in which group activities connect people with others:

“What is really clear is that people need connections with other people to become healthier and happier. It is that personal support and networks from people you know that makes a difference to people’s lives.”

Theme 4: Action on the cost of living and other determinants of health

Having enough money to afford the basics, let alone live healthily was a common theme, often cited in the context of the cost of living.

“With two adults working we still cannot afford things, particularly healthy food and clothing.”

*“To be able to afford healthy food and activities for example sports and clubs.”
“Just having enough money to live on.”*

One participant provided a reminder that those who were struggling financially extended beyond those on benefits:

“Just because you’re working doesn’t mean you’ve got enough money for food.”

Wider determinants of health such as housing, transport, employment and the wider environment were also commonly included in the long list of factors given by respondents in terms of what would make the most difference to their health.

*“Affordable public transport and better public transport to local hospitals.”
“Outside green space - places to walk, to see and to ‘escape’.”*

“Access to good quality and safe affordable housing and holding private landlords to account.”

Theme 5: Equal opportunity to be listened to and understood

One of the factors making it hard to pull out common themes from this question, apart from the first two which emerged so strongly, was that there was enormous variation on what would make a difference to people, depending on personal situations. For one participant with arthritis, a wheelchair would make the biggest difference, as this would enable them to interact more socially. For an asylum seeker it was bringing their case to a conclusion. For a parent of a child with autism, it was getting an assessment and some support quickly. Factors such as age, ethnicity, language, sexuality, disability, parental and caring status (in other words, the equalities groups) all had a major impact on what would make the most difference. For many people generally, and for many equalities groups, there were comments about not being heard or listened to, being invisible, or being ignored.

“Our African communities do not feel listened to.”

“Being listened to by the health professional you are dealing with.”

“Listen and understand what communities are telling services about how to make improvements.”

“People with learning disabilities are a group without a voice.”

“Maternity staff need to listen more to the women in their care.”

Therefore, the final theme that has been included here is that there should be no ‘one size fits all’ approach. Although only a few participants framed it in this way, this was essentially about care which is **personalised and person centred**, and which is **equitable** to all groups. This will be addressed more fully in the next section with a focus on the barriers and enablers from the perspective of equalities groups.

3.2 What is stopping the above, and what would help?

Participants were asked what was stopping the above (i.e. them being healthy, happy and better – the barriers) and what would help (the enablers.) The responses to these two questions have been combined to avoid repetition.

There was some repetition with the first question, in that the same issues recurred, namely lack of funding, access to primary care, problems achieving healthy lifestyles, the cost of living crisis and other determinants of health, and the opportunity to be listened to, alongside three additional themes: communication, lack of support around mental health problems, and lack of engagement with the community and voluntary sector. These will be considered in turn, before turning to those themes which were specific to or more common in the equalities groups (i.e. those with protected characteristics) alongside other groups who tend to be excluded and who were included in this consultation.

Lack of funding as a major barrier - what would help?

The way in which underfunding was perceived as a key barrier has been described above. Respondents wanted to see more funding and resources for the NHS, social care and mental health in particular, including better pay for staff. A small number of respondents went beyond the need for more funding and wanted funded that was better targeted (ie towards communities) or accompanied by other changes:

“It’s not just about ‘chucking money’ at it...we need a thorough review of the whole system.”

“A review of services to focus funding on areas where it can do most good.”

“We know resources are stretched, it is not always about money, it’s about culture and attitude.”

“Don’t just put in more staff e.g. social prescribers without investing in information management systems as well.”

Participants wanted more and longer-term funding to the community and voluntary sector. This was linked to more recruitment and retention of key staff, and to enabling the voluntary and community sector to be in a position to work better with the wider system:

“Long term flexible funding- ensure the VCSE sector can work collaboratively with the health system, not competing for small, short term funding pots.”

“An organisation is only funded for six or 12 months, so managing that workforce and managing that capacity and capability is really difficult.”

“The VCSE sector is continually bidding for small amounts of short-term investment that are proven to make a huge difference but are not sustained. It is hard not to feel disheartened and undervalued.”

“It is about recognising the whole system as a round. And that means ensuring the voluntary sector has enough long term funding to offer reliable capacity to give the best support and the best journey of support for that individual.”

For one respondent, there was a perception that funding to the VCSE sector was based on ‘whether your face fits’ rather than evidence or a track record of a service working and meeting the needs of service users. For another, it was felt that funding often went directly to large top-down charities because it was simply ‘easier’ to do this.

One focused on how extra funding could be used to meet immediate client needs:

“It would also be great to have discretionary pots of money we could tap into. We get carers coming to us for all sorts of things that would make their lives a little bit easier. We would love to be able to say, you don’t have to wait six months for a carers assessment before we can give you £250 so that you can go and get a break away or buy a laptop.”

There was less focus on social care, however the themes were the similar:

“Make jobs within social care more attractive to increase provision.”

“Recruitment of staff from abroad. Better pay... Improved funding for care homes.”

A less common subtheme was the need to properly resource schools to support young people, particularly with mental health.

Access to primary care as a major barrier - what would improve this?

Again, the way in which problems accessing primary care and particularly GP appointments was covered above. A range of suggestions were made for addressing this, including:

- Increased appointment slots during the day for all GP surgeries; drop in/walk in slots; evening slots; out of hours services
- A range of options for making appointments e.g. phone, online, in person
- Prioritisation for particular groups to get appointments e.g. older people, the vulnerable, those with long term conditions
- A return to face-to-face appointments
- More NHS dentists

In terms of access to hospitals, one person suggested the allocation of very early hospital appointments to those who work and/or drive, giving later appointments to older people.

Overreliance on digital was a particularly strong theme to occur. A small number of respondents wanted to see more support with digital skills, and more online appointments:

“Just done a course to get 70 online and we helped them to use the NHS app. Much more for this direct support is needed.”

“Allow consultants to offer more telephone/online appointments where they professionally deem more appropriate to cut waiting times for the more priority cases.”

“Better IT – free connectivity. Open schools at weekends.”

However, it was far more common for digitisation to be mentioned in a negative light, with barriers regarding digital exclusion of particular groups. Overwhelmingly, respondents wanted more efficient ways of making appointments, face to face appointments, and person-centred consultations that allowed their needs to be expressed and heard.

“Stop making appointments without asking if we are available. Make appointments with agreement not by default.”

“GP surgeries need to return to face to face appointments as the telephone appointments are rushed and don’t allow the health care providers to provide detailed diagnosis and treatment.”

“A move away from ‘one size fits all’ mentality in which there is not the time to really consult and explore options for treatment, more follow ups and true holistic support.”

Lack of healthy lifestyles as a main barrier – what would help?

Cost was probably the most commonly cited barrier to achieving a healthy lifestyle. Eating well and exercising were seen by many as costly, and the cost of living (see below section) preventing people from thinking about healthy living.

“Am constantly worried about cost of living crisis - so no time to think about other things that cost money.”

“Everyone is struggling with the cost of living and times are hard and I can’t run my classes as much as I would like to as people can’t afford the prices

Food banks were seen as important however it was noted that there was not enough choice, there were few non-food essential items available, and they were not open in the evenings, making it difficult for those that work to access them.

Other barriers including childcare, work, lack of activities in the evenings, lack of affordable options, transport, weight, disability, tiredness, and laziness.

On top of help with the cost of living, help with food and diet was the most common theme to emerge. There were calls for

- cheaper, healthier food
- more information on the benefits of a good diet and consequences of bad diet
- clearer food labels and an understanding of what food labels mean.
- support with how to cook healthy meals; online videos/training sessions
- food banks open in the evenings for those that work
- recipe boxes and ideas/‘food essential’ kits for families living in poverty
- food projects to farm unused land to grow fresh food
- better access to affordable healthy foods and supermarkets, recognising that not everyone has access to a supermarket
- better diverse and cultural food options

In terms of exercise and activity, there were calls for more free and affordable activities, for example, subsidised or cheaper gym memberships, improved access for those with children such as free creches in gyms, tailored activities for the less mobile, greater use of community spaces, and more activities in the evenings.

“Invest in community led prevention work such as active lives, walking and outdoors groups.”

“Exercise and wellbeing programmes that are affordable and accessible.”

“Use local churches and schools and charities to spread out sports and activities across the borough.”

“More outdoor walking activities etc to get more people out of the house/feel less isolated.”

Many linked the above to more social prescribing and wanted more information to be provided on what was available locally.

Cost of living and other determinants of health as main barriers – what would help?

Rising costs were felt to be a key barrier, not just in the context of living healthily, as outlined above, but for example, in preventing people accessing the fuel or transport needed to attend appointments, and by causing constant worry. It was also noted that there was an expectation that the VCSE sector would be able to respond to the growing crisis - including amongst the sector itself.

In terms of what could be done, a starting point was for there to be recognition of the impact of money on health:

“Recognise that people need money and the material conditions of their lives changed before they get support with anything else.”

“Less money equals an unhealthier lifestyle.”

A range of macro level measures were suggested in relation to the cost of living crisis, including increasing wages, increasing benefit levels, changing the threshold for free school meals and lowering energy bills.

“Ensure wages people get enable them to live with pride and not rely on benefits to top up low wages – need to be able to buy food, pay bills and have the basics in life.”

Participants also wanted to see low level, localised interventions to provide financial help, for example:

- focused anti-poverty work to provide debt and money skills advice,
- packages of support focused on patients after diagnosis including welfare benefits checks and support with form filling and appeals,
- financial help to people to enable people to attend appointments,
- a low cost transport system to drive older people to appointments
- support with practical things that were now difficult such as getting clothes dry or accessing clothing (ie via clothing exchanges.)

The topic of loan sharks arose with respondents wanting more awareness of this issue amongst NHS staff. Other less common themes were the need for investment in housing, better transport particularly for disabled people and to parks and open spaces, improved air quality/clean air zones, and a healthier environment ie with more and better access to green space, and allotments to enable people to grow their own food.

“More greenspace and places to be able to walk be active in the community.”

“Improved access to green spaces and more of them to support health and wellbeing.”

Alongside the repetition of the main themes to emerge from question 1, three new themes emerged: communication, the lack of mental health support, and the need for better partnership working. These shall now be explored in more depth.

Communication as a major barrier

Poor communication between health professional and patients was a key theme to emerge in the responses to this question. Use of medical terms and jargon was a common barrier, with one describing the presumption of understanding by doctors as intimidating. There was also thought to be poor communication about the health system itself and how it worked,

“We need to improve the language of health and care systems so that everyone can understand it and know how to engage with it.”

“Doctors speak too fast for me to understand.”

“Instead of saying carbohydrates, say rice!”

“Don’t trust the use of vernacular when speaking e.g., ‘have your bowels opened?’ Be more explicit in consultations to be understood.”

Failure of health professionals to realise low levels of literacy levels was seen as a barrier, and some felt that those patients who could communicate ‘properly’ got better outcomes:

“If you can articulate yourself then you get a better service.”

“A significant number of adults in Manchester cannot read. If you cannot read, you are totally excluded from employment, benefits and social activities...There is no easy read option, you might not have access to the internet or often people cannot travel to the library.”

Concerns with communication also arose in the context of poor communication between health professionals and service users with carers in particular. Poor communication was a particularly strong theme for vulnerable groups:

*“The jargonistic terms used in health and social care don’t translate into BSL.”
“Information in different languages so we can understand how we’re being looked after.”*

“Communication - There's a lot of information, but if it's in the wrong format and wrong language, then nothing is going to make a change.”

“There needs to be... more focus given to communication styles that work for people who can’t read, who don’t speak English, have autism or a learning disability. If people get letters (and don’t understand them so don’t respond or miss a phone call they get taken off the list as did not attend – no follow up.”

Some made the connection between poor communication and lack of trust.

“Building trust to get people to go (to health appointments) is hard and then when the support is a letter or just a telephone conversation that they can’t read or can’t communicate properly in they don’t go again. This story spreads in their community and exacerbates the lack of trust”.

What can be done to improve communication?

Participants focused on the need to personalise communication, clearly explaining, for example, in multiple languages and formats, the access routes to get help. The need not to make assumptions about literacy levels or that people could read the information that was being sent was also highlighted.

“Forms need to be easy read or sent via text or voice note.”

“Information needs to be delivered in plain English, less jargon, acronyms or complicated language so more people will be aware of it and take up the support.”

Lack of mental health support as a major barrier

Access to mental health support was also a common, if not completely dominant theme to emerge. It should be noted here that mental health was a cross cutting theme across the questions, never quite emerging as a dominant one, partly due to the questions themselves, partly because the vast majority of respondents focused on primary care. However, many noted that mental health has worsened since the pandemic, particularly for young people, and services were now seen to be in crisis. As one person put it, there were now new people dealing with mental health problems, as well as those with previously managed mental health problems not coping. Access to appropriate services was felt to be a big problem, particularly

during the transition period for young people as they entered adult services and were no longer prioritised. In addition, understanding of mental health was not thought to be strong within general practice, with overreliance on medications and referrals to other overstretched services. One participant highlighted the links between mental health, trauma and substance misuse, with services often treating these separately, and the need for this to change. Another raised the issue for addicts with poor mental health who could not get support until they stopped using substances, but couldn't because of their trauma and mental health.

What can be done to address issues with mental health support?

There were calls for parity between mental health and physical health services, with more funding, more services, and a redesign of mental health services to stop people falling through gaps or ending up in A and E. There was felt to be a specific gap that needed bridging for those who may have already had psychological therapies but who were waiting for more intensive support. Investment in prevention, training and awareness for professionals around mental health was also thought to be important. One participant suggested a key mental health connector, within the health sector, to support the VCSE sector to get the right help for the people they supported, alongside facilitated VCSE forums and action learning sets to share and encourage knowledge. Another called for local links between community mental health services, GP link workers, and local social enterprises and charities to ensure stronger and more interlinked ways of working together.

Lack of engagement with communities and with VCSE as a major barrier

Perceptions of a lack of partnership working with communities themselves, or with the VCSE, or the need to improve this, was another common theme to arise.

“We need to feel true parity alongside other partners and sometimes that is not always the case.”

“Nobody will ever be as expert as that individual about that individual's own experiences. So it's about having trust in the person to understand what it is that would help them at that particular time. It's about us as a system respecting that and then helping them to navigate the right element of support.”

“Our organisation has only ever met up with individuals from health and care services when THEY have looked for OUR support to help THEM with one of THEIR initiatives; to ensure positive outcomes with their commissioned projects. Surely it should be the other way round?”

What can be done to improve partnership working with VCSE?

Participants highlighted the need for changes in the relationships between the VCSE and the NHS and other statutory partners, ranging from better relationships to more

systemic changes, with the inclusion of VCSE in decision making, commissioning and co-designing of services at all levels:

“More consultation with grassroots groups – an ongoing Big Conversation would be a good idea.”

“More interaction with commissioners so that we could flex our contract and receive more referrals to support older isolated people.”

“VCSE to be seen as part of the ‘pathway’ including proactive prevention, treatment and funding opportunities.”

“The opportunity to plan with primary care or other experts that can share what priorities there are and what outcomes are expected from projects so that impact can be monitored and measured.”

“Listen, engage and co-design services with the community.”

“Working from the community up (people needs) rather than developing services from a system level.”

“I genuinely think if communities had more influence in decision making on how cash was spent, they would be more engaged in creating long lasting solutions.”

Although one facilitator noted that one focus group was particularly negative and angry, there was a general positivity about the engagement process, particularly in such challenging times:

“The focus groups felt it was really positive that the ICS is engaging with the VCSE sector and is recognising our expertise, the knowledge and insight we have about communities.”

“There’s just too many people trying to access the same services and nothing is getting through, things are getting worse and there are other organisations that can help so we need to come together.”

The VCSE was felt to be ideally placed to support health, in particular in engaging those groups and individuals which health traditionally finds harder to engage.

“The voluntary sector should be seen as an expert by their own experiences, because we are so closely connected to the communities that other services often feel removed from.”

“We need to make sure we are connecting with people and when we connect with people then they will buy into the idea and then they’ll listen and

participate. Community organisations are the ones who can lead this, we have the trust of communities.”

Some felt that there was very little recognition of this, with the statutory sector being very inward focused

“More understanding from statutory partners of the impact and benefits of what the community can provide to help compliment more clinical/ traditional health and care offers so that they actively encourage the use and engagement with the community.”

“The health system needs to understand the language of the voluntary sector. We need a shared understanding of the social value that we bring and that impact and be taken seriously.”

“Some health staff seem unaware of the good work being done out there by the Voluntary sector and how working together we can offer a better more wholesome service to our most vulnerable in society.”

Some felt there was a lack of leadership in Greater Manchester, with disjointed health services, and initiative after initiative being launched without much learning being gleaned and carried forward. Systems were felt to be complex and too bureaucratic for people to understand

“We need a system mature enough to build trust. Relationships and the behaviours are there at senior system level to say look, we're stronger together, we have to do this in collaboration. - Committed leadership willing to take a risk.”

“Needs to be someone publicly visible within the GM structure whose job it is to own this agenda and drive it forward. A centre of excellence/specialist service at GM level is needed.”

Here, and later in the engagement, participants emphasised how important it was to get feedback from their involvement in meetings and events such as the Big Consultation, and to see that they had made a difference.

“When we attend these meetings seeing the actions being delivered no matter how small tells us what difference we have made.”

Additional theme – more focus on early intervention and prevention

Although the lack of early intervention and prevention work didn't particularly emerge in the form of a 'barrier', a focus on these was often given by individuals and groups in their wider responses to what was needed, going forward.

“Early intervention, prevention. NHS taking a more proactive service to prevent illnesses or worsening of conditions, for example check-ups on medication and appointments. Bring frontline healthcare workers into community spaces to deliver low level prevention support.”

3.3 Community groups and inequalities – what are the specific barriers and enablers?

The following section of the report considers the themes to emerge for different groups who share a specific protected characteristics including age, sex, ethnicity and disability, as well as for inclusion health groups, i.e. those specific groups included in the engagement who do not necessarily share a protected characteristic but are known to experience inequalities, such as carers, homelessness and sex workers.

Barriers for older people

Access to the NHS was a particularly strong theme in relation to digital exclusion and wanting face to face appointments.

“Older people often find it difficult to book an appointment as they want to speak with someone on the phone but only option is to book online.”

The additional barriers for this group, particularly those with a number of different health conditions was lack of joined up or holistic approaches, and poor administration of their health and social care appointments, with these being sent late or clashing with other appointments. Several older people also described having had bad experiences of hospital discharge with delays causing worsening health problems.

What would help address the barriers facing older people?

The ‘solutions’ for this group would include addressing the barriers accessing GP appointments as highlighted above, more joined up care and better discharge information. The suggestion of over 75s physical health checks, incorporating mental health checks, was also made.

Barriers for carers

Carers raised a lack of respite care, which was sometimes seen as due to lack of coordination between local authorities and the NHS, lack of joined up care as above, poor communication from the NHS, and the pressure and time spent caring for others leading to lack of sleep, low energy, and poor mental health, and the problems this posed with thinking about their own health:

“Trying to fit in different appointments at different hospitals (husband under 8 different hospital services) with loads of consultants, chasing up queries re

medication contraindications, telling story to so many different people as often don't see the same person is extremely stressful for a carer of someone on an end of life pathway."

"I don't have time for myself as too busy sorting out my loved one's care."

What would help address the barriers facing carers?

There was a demand for

- recognition that carers are a marginalised group in need of extra support and communication
- better respite and support
- more investment, and less reliance on unpaid carers
- better communication from GPs to carers to stop them having to constantly chase information
- carer's champions to raise awareness across health and social care
- systems to identify carers in case they fall ill themselves.

One person flagged as good practice the example of a GP surgery in Rochdale GP which rang carers each month to ask "how are they doing, do they need anything, are they struggling to get an appointment?"

Barriers for disabled people

Within the engagement process, the way in which the information from groups was recorded (i.e. from the group as a whole) meant that it was not always possible to distinguish the views of specific individuals, such as disabled people and those with long term health conditions, unless their specific situations were mentioned in the responses. (This was less the case for those who were D/deaf or had a visual impairment, two groups that will be considered directly below.) Many of the groups involved disabled people and people with long term health conditions, and as such, their concerns will be very similar to the key themes to emerge from the engagement. Specific issues which did arise were problems accessing primary care, lack of continuity of care, and waiting times for secondary care.

What would help address the barriers facing disabled people?

Some felt that those with long term health conditions should be given priority for GP appointments and that continuity of care was even more important for this group of people, to avoid them repeating their problems over and over again to different people. Transport concerns were also flagged as a particular issue for those with mobility problems, with the knock on effect of preventing many people from accessing preventative activities in the community.

Barriers for d/Deaf people

Poor access to services due to barriers making appointments and communication problems during appointments were common, with adjustments not being made, and resultant health messages being missed. Variations in levels of literacy in the d/Deaf communities were also highlighted, with one citing the average reading age of a Deaf adult at nine years.

What would help address the barriers facing the d/Deaf community?

Being d/Deaf was seen as a hidden disability, with a key first step being that staff are aware of someone's deafness in advance of appointments to ensure preparations could be made to remove communication barriers. One participant suggested an alert/records flagging system to make someone's deafness more visible to professionals. There was felt to be a need for staff training and awareness raising around what was required to support the d/Deaf community and ways of communicating with d/Deaf people, as well as specific support for d/Deaf people to help navigate the systems.

“Deaf awareness training should be mandatory in the NHS.”

“Embed Deaf awareness in doctors, nurses and medical professional training, as this is a gap in the medical curriculum.”

It was noted that Bury Hearing Hub were developing a d/Deaf awareness course which could be more widely commissioned, and that the d/Deaf community were working with Healthwatch on access to services including access issues with audiology services.

Funding for advocacy services, potentially d/Deaf specific services, and health and social activities for d/Deaf people to bring them together were also common themes

“Having Deaf specific service – for example having a deaf front door for the NHS to help deaf people navigate the services. There are already learning disability nurses in the system.”

“Deaf (people) need other deaf people to get ideas and support.”

One participant made the practical suggestion of supporting the d/Deaf community to access yoga and other activities by using a large screen, with subtitles and images of what was going on for them to follow. Another reinforced the need for codesign of communications.

Ultimately, it was felt that there was a need for a culture change in the NHS.

“There is a need to bridge the gap between the health care service and patients, that would help walk deaf people through the diagnostic process. There is an issue of “conceptual understanding” to help explain what is happening to deaf people.”

Barriers for blind and visually impaired people

Accessibility was again the main issue that emerged in relation to blind and visually impaired people, including the problems associated with appointments sent by letter, or assumptions that things could be done online.

What would help address the barriers facing blind and visually impaired people?

As with the d/Deaf community, participants advocated for greater training and awareness of the barriers to services experienced by visually impaired people, alongside alternative ways of reaching blind and visually impaired people such as Alexa or You Tube, and the simple adjustment of addressing font sizes.

“Just change everyone’s letters to 16 font for ease.”

“Increased training to ensure people are able to work with blind and partially sighted people.”

The need for addressing social isolation also emerged.

“Somebody to take people out more so that people with blind and partially sighted people would feel less lonely and isolated - Increased awareness on activities and places which you are able to go to.”

Finally, increased support to help with day to day activities, to reduce reliance on friends and family, ie with food shopping, and gardening, or with form filling, was also seen as an enabler.

Barriers for young people

Children and young people as a whole were underrepresented in this exercise. As one parent put it

“There needs to be a big conversation with our children and young people, an effort made to find out what they think, we (as parents) can only offer our thoughts... what they think will differ from what we think.”

Issues for children and young people emerged mainly from the events and groups including parents of children with an SEN and therefore this report focuses on this issue. Additional issues in relation to children and young people generally revolved around the lack of resources and capacity within education to support young people’s mental health, waiting times for CAMHS, with services only acting at crisis point, and specific barriers to healthy lifestyles for 16 to 18 year olds being charged the same gym prices as adults.

Barriers for children and young people with special educational needs (SEN)

The key barrier to emerge for parents of children with special educational needs was waiting times for SEN support, which were described as "...off the scale...children can have left school before appointments come through and diagnoses are given." There were also thought to be cultural problems

"Children and young people with SEN are seen by services and professionals as a cost/a nuisance/ a referral/ a case number, not as a person, an individual in their own right, even those who do not communicate and have profound needs have aspirations, opinions and views."

What would help address the barriers facing children and young people with special educational needs?

There were a wide range of views from this group in terms of how care for children with SEN could be improved. Some of the 'solutions' mirrored those of the wider groups in terms of more resources and funding. Parents groups also wanted to see more person centred care, alongside more outcome focused care

"All professionals working with a child/young person should have at the top of each of the forms the 3 or 4 outcomes that the child/young person wants to achieve so that each professionals mind is focussed on that."

Again, there were calls for more training and awareness of staff on this issue:

"Parents and carers of young people with learning disabilities have different expectations than in previous generations – the medical profession needs to keep up with these different expectations - disability awareness training for doctors in training."

"Learning disability health training has made a massive difference where it is used, but not enough people being trained and using the tools that are there."

"Better training for Personal Assistants and community healthcare professionals in how to support children and young people with special educational needs."

"Specialists training for CAMHS nursing staff to be able to differentiate nursing approaches for children and young people with neurodiverse conditions such as ADHD, Tourettes, and Autism."

There was also a call for more training for parent and carers in deescalating challenging behaviours and safe restraint training to keep families safe. Parents wanted more transparency and accountability, potentially with a Greater Manchester scrutiny committee or people's panel specifically for children and young

people with Special Education Needs. Many spoke strongly of the simple need for organisations to do what they were legally obliged to without parents having to fight for this:

“The biggest difference would be if health, social care and local authority services and professionals followed the law, the children and families act, the care act, the chronically sick and disabled persons act, and schools actually had the resources to make their ‘best endeavour’ to meet children’s needs.”

“Too often we parents have to fight, go to tribunal, complain to get basic support in place, wheelchairs, speech therapy, physio, these are not the ‘nice to have’ these are essential support to ensure our children and young people maintain (and improve) the abilities they have.”

“Just follow the law and the NICE Guideline on integrating services for CYP with complex and severe needs. The guidance is out there it’s just not being followed.”

Other suggestions included designated key support workers as a first point of call to the right services and more local activities for children and young people with Special Education Needs.

Barriers for adults with learning disabilities (LD)

As with the parents of children and young people with Special Education Needs, there was a sense of frustration in this group.

“There has been report after report after report about health inequalities for people with a learning disability. The evidence is very clear, but it is not acted on.”

Equitable access to services was again a main theme to emerge. Lack of time within services to account for the needs of those with learning disabilities was an issue.

“Dental treatment can be scary for anyone, but with a person with LD they often don’t quite understand what is going to happen. Time is needed to support that person, but that’s not always available.”

Problems receiving communications from services was another barrier cited here. An example that was given was that people with learning disabilities were not being informed that their contribution to care has increased until the year has ended, leaving them in debt and needing to negotiate a payment plan. Achieving healthy lifestyles was another.

“With obesity and getting healthy, not all people with LD can access all types of physical activity. Swimming for some people with LD – they struggle with sensory issues this brings.”

What would help address the barriers facing adults with learning disabilities?

Improving access and ensuring equitable access to services was a key theme, alongside person centred care which took account of the needs of the individual.

“Ordinary services being accessible to people with LD.”

“Accessible hospitals and appointments that take into consideration the diversity of needs of their patients.”

“Need to extend GP appointments beyond 5 minutes with a person with learning disabilities, as some people can be non-verbal.”

The relationship with the health professional was felt to be even more important with this group:

“Professionals who can build a relationship with the individuals they are assigned to.”

More information was thought to be important.

“Part of the problem is not knowing what services are available.”

“For people with learning disability, you don't always know what you don't know, so you don't know what you might be and entitled to.”

The need for more training and awareness for professionals arose again, as did the need for families and community groups to understand more, for example, about autism and strategies which can support the family.

Again, there was felt to be a need for a culture change and for some of the assumptions of professionals to change:

“(With LD) some professional think “Why would you need to do cervical smears on women you know don't have sex? That that is a massive assumption. There is a particular problem with assumptions around sex and learning disability. Sex and relationship education is important, but often shied away from by professionals, families and carers.”

Barriers for lesbians, bisexual people and gay men

For LGB young people, key barriers to emerge were variation in the quality of services and a lack of understanding and awareness amongst professionals of

issues such as same sex violence. Young people with mental health problems did not want a referral to CAMHS to be seen as the immediate ‘quick fix’, neither did they want their identity to be a pre-requisite for a mental health condition since sometimes it was not a factor.

“I want to be seen as a person with mental health needs rather than a gay person with mental health needs.”

Barriers for trans young people

For trans young people engaged in the Big Conversation, the following barriers were flagged:

- access to appropriate health care,
- access to appropriate clothing (eg chest binders),
- access to and waiting times for Gender Identify Development Services
- actual misinformation on the part of health professionals, for example, about the relevance of screening programmes to trans people.

What would help address the barriers facing the LGBTQ+ community?

A key theme was the need to listen to people, rather than prejudice.

“I want to be seen a person with needs before things being assumed.”

There was a call for prioritising mental health and improving mental health services for young people more generally, providing them in places like school/colleges and ensuring anonymity where appropriate.

Again, the need for training and education of staff emerged, with a call for more awareness of the needs of LGBTQ+ people and communities.

“Educating medical staff on the same level of care for all and being aware of LGBT medical history especially trans, black medical history and the prolonged period of neglect.”

In relation to healthy lifestyles, some advocated specialised LGBT support groups around issues such as smoking cessation or drug and alcohol usage. In relation to sexual violence, others suggested more awareness that there is a Greater Manchester LGBT Independent Domestic Violence Advocate (IDVA). One person advocated more GP practices taking part in Pride in Practice. An example was given of a GP practice having received the Pride in Practice Award which made individuals feel much more comfortable.

Barriers for men

Although the demographic information we have on those engaged is not completely accurate, where sex was recorded (i.e. in the survey responses, and in some focus groups) the respondents tended to be overwhelmingly female, as is often the case with community engagement.

Given that facilitators were not asked to distinguish the views of men from women in their summary of responses from focus groups and surveys, it was also almost impossible to separate out any differences in the views of men and women.

One of the largest male only focus groups that was carried out with sixteen men, via a mental health support group called Talk About It Mate, highlighted that many of the main themes to emerge were the same as those highlighted in the report as a whole, in terms of problems accessing the GP for face to face appointments, long waiting times, being unable to access basic things like prescriptions and lack of coordinated care across systems.

In another men only peer support group carried out in Wigan, the main issues raised were again the same as the main themes to emerge from this engagement – concern with funding, staff shortages, waiting lists, lack of continuity of care. This group also mentioned the need for more modern technology. In another male only group in Wigan, consisting of unemployed men, there was a focus on the lack of accessible work and its impact on motivation and the ‘revolving door’ of poor mental health and confidence and anxiety.

What would help address the barriers facing men?

There was very little in this engagement to distinguish the views of men from women and it may be that more engagement work with men is required. The men involved in the focus groups wanted to see access to healthier food, more opportunity to be active, including free activities, and improved access to mental health services and counselling, as did those engaged as a whole. Some of the ‘enablers’ mentioned by the men’s groups that were not dominant in the survey as a whole were men’s groups, and peer support for illness. Further insight from South Asian men follows the section on South Asian women below.

Barriers for women

A wide range of issues facing women were flagged in the consultation the women’s groups that were represented, including

- a lack of training around women’s needs
- lack of support to breastfeed
- women’s roles as unpaid carers
- the impact of women’s roles on their employment
- women’s views e.g. around childbirth not being listened to
- lack of understanding around sexual violence
- fragmentation of reproductive health services

One group placed the above in the wider context of a healthcare system which has been designed around the male experience, with women’s health not being prioritised in medical curricula despite them being overrepresented in health services.

Another group focused on the needs of women who are disproportionately experiencing the impact of the cost of living crisis:

“The intense poverty women are experiencing is stopping them being able to plan for any kind of future. Having to hold so many responsibilities for others (caring, parenting), and living in such constant financial stress makes it very difficult for women to engage with change making. They’re too busy just surviving.”

What would help address the barriers facing women?

Approximately 40-50 different specific suggestions were made. Some of the overriding themes were:

- Training for healthcare professionals on women’s health; the disadvantages faced by girls and young women; women’s needs during pregnancy and birth; the impact of sexual violence; intersectional discrimination, menopause etc
- Manager training to retain women in senior roles; investment in the leadership of women in the social, charity, faith and third sector; training for young women from lower social economic backgrounds in health and care leadership
- Coaching, mentoring, and role modelling
- Empowering women and girls know their rights
- Trauma informed approaches in maternity services
- Women’s Health Hubs and other models of one-stop clinics
- Inclusion: giving women a voice in local decisions
- Using the lived experience of girls and women to consciously design spaces
- Services to be more flexible around the needs of carers (school times/term times)
- Specialist trauma support
- Awareness campaigns for girls and young women about Sexual Offences / Online abuse / Low Self-esteem / Misogyny / Domestic Abuse
- Systems leadership around reproductive health
- Becoming a city of excellence for women’s health
- A Northern Women’s Health Task Force
- Invest in the smaller more localized groups and services that know their communities of girls and women and where girls and young women trust in them.
- Forward thinking approaches to breastfeeding, menopause etc as well as maternity
- Using Equality Impact Assessments in every policy and practice decision
- Wider determinants: better access to accommodation /refuges for women and girls; increased pay and better conditions for carers
- A recognition of the proportion of women coming into pregnancy having experienced trauma, often of a sexual nature. Currently the way women are

treated within maternity care either retraumatizes or causes trauma for the first time

- Raising awareness with women as to how the maternity care process work

Barriers for South Asian women

Focus groups attended by the South Asian community highlighted culture as one of the main barriers for their communities. The traditional view of South Asian women as being judged for doing anything other than being the primary caregiver was felt to predominate, with South Asian women feeling guilty for not thinking of their families first, and always putting themselves last. Many South Asian women expressed a wish to do more exercise, this was seen as a male activity in South Asian culture.

“Movement, exercise and sports came up immediately, with the South Asian women complaining that there just wasn’t enough focus on movement for women, by women, shown through women. They wanted to be able to swim, to go cycling, to go to the gym and to play team sports.”

Other barriers included Islamophobia and lack of access to knowledge and education, partly due to the culture issues outlined above. South Asian women expressed that they did not know the true importance of a healthy lifestyle, and what it entails.

In addition, Older South Asian women reported not feeling safe going to classes etc in the evening, alongside some discomfort with not knowing if classes contained people of their age, as many older South Asian women feel less educated than the younger generation. Similarly, younger Asian women felt uncomfortable with some older South Asian women due to language barriers.

Older women were also noted to be less comfortable talking about cost barriers than younger women, reflecting the stigma about being seen to be struggling financially.

Barriers were revealed in accessing activities for healthy living, even if they were advertised as being for women only, since, these were never truly female only (eg male lifeguards) which prevented women from attending.

What would help address the barriers facing South Asian women?

South Asian women wanted a greater level of understanding regarding what it means to be a South Asian woman. They felt that few knew just how many hoops they had to jump through to get anywhere and do anything. One woman described it as ‘having to do ten thousand things for others’ before she even had a minute for herself, and that when she leaves the house, she has to think ‘how would this look to someone who didn’t know me?’

Because of this, the women agreed that it is infinitely easier for them if healthy living initiatives were single-sexed so that they could be assured that no male would

see them, and were either led by women of colour (since white women not only had so many opportunities available, but lacked the knowledge required of the South Asian lifestyle, for example, that South Asian women were often low in iron and needed specific minerals and vitamins) or aligned with South Asian culture.

Some South Asian women felt that holding healthy living activities during school/work hours would provide women caring for families and therefore expected to be in the home with a safe time to leave the house without facing judgement. For young women, they would not be able to attend events or activities in the evenings due to safety concerns from parents.

Young South Asian women also requested that better attention be given to the language used i.e. when communication with the South Asian community to advertise healthy activities. For example, the word 'exercise' should not be used, given that exercise was not seen as relevant to females. One group explained how the words 'dance' and 'dance night' were changed to 'movement' and 'movement therapy', which helped to eradicate the stigma attached to South Asian women dancing, even in the presence of only females. Another group highlighted the importance of using Islamic perspectives or quotes in written communications i.e. including what Prophets say regarding healthy eating as more likely to get a response.

The young women also expressed that if they were to go and exercise, they would have issues in more commercial gyms due to their clothing (many gyms are 'strict' on clothing that can be worn in the gym, especially college and university gyms), which prevents them from being as modest as they need to be when attending a gym with mixed-sex patrons.

Barriers for South Asian men

Male South Asian participants also reported that they had avoided community activities such as sport because of the presence of women – often leading the sessions.

Younger South Asian males mentioned 'toxic masculinity' and how this affected them in everyday life. They explained that there was a lot of pressure on their shoulders to earn and to perform to the best of their potential at all times, and not be 'weak.'

What would help address the barriers facing South Asian men?

Some expressed a demand for male only activities. Many were unsure what could be done to address the toxic masculinity issue, stating that they would love to be able to talk openly about things without being seen as weak.

Barriers for Black African communities

Members of Black African communities raised language barriers as a major issue. Participants reported being treated badly if their English was not good

“Doctors or Receptionist at these GP or Hospital are just not welcoming to ethnic minorities - my English is not good and they make sure that I know it and that everyone else sitting in the waiting area knows it. I had to walk away from my appointment once because it was just too embarrassing.”

There were thought to be specific problems with translation services, with translations that were not always accurate.

“Language line doesn’t really work and people can’t take their family member to help interpret anymore.”

“Mistakes are made – misunderstanding.”

“A lot of the time the translation isn’t up to standard.”

One person pointed out that interpretation was different to translation and this wasn’t available. Swahili was given as an example of a major language locally where there was never a translation option.

There was felt to be little cultural understanding of African communities. Examples cited were that in some African countries and cultures, being big was seen as a good thing (i.e. as a sign of wealth), that people did not tend to think about their health, and certainly not their mental health, or go to the hospital when ill. The perception that black women have a high pain threshold also arose. Some were disappointed when trying to address the need for cultural appropriateness:

“When you ask for a culturally sensitive approach, this can be met with judgement as it you are inconveniencing them”.

Less common themes included lack of information (from the Zimbabwean community) and access to maternity care: for reasons which are not clear from the notes, it was noted that the African community did not feel they could access maternity care.

What would help address the barriers facing Black African communities?

Achieving communication was felt to be a basic requirement, particularly when dealing with matters that could be complex, such as health conditions.

“People should expect to be understood and to be able to understand.”

A range of solutions were provided, including

- Improving access to interpreters and translators at health appointments
- Training for the people providing language services
- Health champions from the community groups

- funding and access to ESOL
- general practices to collect and use data on dominant languages
- IT solutions: NHS and GP websites to have a function for being translated into different languages, virtual assistants that speak multiple languages
- resource information videos in community languages;

It was felt that there was a need for a better understanding of the diseases and illnesses prevalent in people of African descent amongst health professionals to help them diagnose and treat many of these issues, as well as on cultural differences, in order to “treat them all with dignity and respect.”

“Professionals should recognise the main cultural barriers.”

“Listen and believe women when they say they feel pain.”

Several separate minority ethnic groups raised the need to pay attention to achieving workforces that were representative of a diverse community, rather than focusing only on training the existing workforce.

“Representation really matters: Seeing therapist, psychologist, specialists medical doctors, councillors that look like our community in the services that we need and engage with is essential to receiving adequate care. It is not enough to train the white community in cultural awareness.”

“More African psychiatrists.”

“More diverse doctors and healthworkers in the NHS (and more opportunities for young people from BAME communities to study medicine).”

This call for more diversity in the workforce was common across many ethnic groups.

“Roma people working as part of the NHS – target some recruitment to make the workforce more diverse and representative.”

It also extended to social class background:

“(We need) people in leadership positions within the NHS who are more representative of the communities they’re trying to reach (in terms of race and class), and who take a much more proactive approach. Who see things at the sharp end, rather than ‘from their ivory towers’. ‘It’s no good putting a building in a deprived area if you never go out of it, into the community.’”

“Working class folks in the medical space.”

There was a big focus by black African respondents on the need for more community approaches. There was support for community champions and for community hubs to be developed as a central place for support and information to ethnic minorities.

“Fund Community Champions based in the community to speak the key messages and cascade this, if it’s in a similar language and authentic this can help build trust.”

“In our black African communities there needs to be a community-centered approach - what’s happening in the community, who is accountable, how do we know things are getting done, views need to be taken into consideration regarding our African communities.”

“We do not feel listened to, we need to have our voices heard.”

“More outreach and door knocking.”

“Develop more outreach work, bringing healthcare to people come out to visit and hold drop-in sessions, do proper engagement to connect with people.”

There was also a call for more and better information on health and particularly on how to navigate the system.

“Produce a signposting resource, with flowchart to help people navigate the ways in for support (including out of hours), develop something similar to the money referral tools. All this was done in COVID but no funding to continue this and build on it.”

Barriers for asylum seekers and refugees

For asylum seekers and refugees, the barriers were seen to be particularly large due to their unique and often traumatic experiences and complex health needs. GP registration was a big hurdle, alongside a migrant charging system which created ‘fear, avoidance and late presentation.’

“Navigating complex processes to register with GPs, book appointments, understand referrals and engage with the NHS in general - things that are inconvenient for most patients can be practically impossible for this cohort.”

“Complex presentations including pain and PTSD are common, compounded by difficulty navigating an alien healthcare system in a foreign language, while living in extreme poverty with minimal support and almost no control over any aspect of your life.”

Huge problems were faced by those asylum seekers and refugees who could not read or speak English, leading to many missing appointments.

What would help address the barriers facing asylum seekers and refugees?

There were calls for a better understanding of the asylum system and its effects on the people in it within the NHS, alongside equitable access, with support and information about how to navigate the NHS.

Barriers for people experiencing street homelessness

For the people experiencing street homeless, access to services was felt to be particularly difficult as they were often digitally excluded from booking appointments, often not registered with a GP, unable to physically attend appointments due to lack of funds, and often had a lack of knowledge about the services that were available.

Discharge from hospital was felt to be problematic: an example was given of a person with stage 3 cancer being discharged onto the streets.

What would help address the barriers facing people experiencing street homelessness?

A specialist homeless health service was felt to be one way of addressing the specific problems facing the homeless:

“A one stop shop for health services for the homeless (maybe a mobile service.)”

“One service to be dedicated to supporting rough sleepers where they could go and get a wide range of treatment without having to be registered with a GP.”

Other comments included better access to mental health and drug and alcohol services, places for people in crisis to stay, and for accommodation to be provided “every day, not just in cold weather.”

Barriers for sex workers

The main issues for sex workers included the partial criminalisation of sex work in the UK, the stigma and fear of being judged and labelled by professionals, and “dodgy punters.”

“Our current legal system plays a part. Encourages risky working practices. Forces women to behave differently. Punters emboldened to hurt us because fairly confident it won’t be reported.”

“Some people don’t want to connect with places because they don’t want to label themselves, like mental health or addiction.”

“Being a street-based sex worker, I didn’t feel welcome and didn’t feel those service were for me. On top of that, having a load of bad experiences in the past. My trust that I wouldn’t be treated badly or judged, was just gone.”

One person mentioned that she stopped talking about her traumatic experiences for fear of making staff uncomfortable:

“A lot of staff and services are not comfortable talking about sex workers. After assaults and stuff, I stopped talking about it because it made them feel uncomfortable.”

What would help address the barriers facing sex workers?

As well as legalisation of sex work, sex workers/those working with them wanted to see an awareness campaign around testing for clients, putting responsibility on clients rather than sex workers themselves.

In addition, they wanted to see more staff and volunteers with lived experience of sex work, and better staff awareness and training, with the suggestion of compulsory training for those coming across people in sex work.

3.4 Common themes amongst underserved groups

Having considered the specific additional barriers facing different communities and inclusion health groups, it is clear that there are some common themes to emerge in the form of

- Problems accessing services
- Communication barriers (especially for those who are d/Deaf or blind, had low literacy levels, little or no English, or were digitally excluded)
- A potential lack of awareness and understanding amongst some staff of the different needs of different groups, such as d/Deaf, blind or partially sighted
- A general lack of awareness amongst some staff of lived experience e.g. in relation to culture or sexual orientation
- Feeling invisible, excluded, unimportant, and wanting to be heard

In terms of what would help, the additional themes to emerge from these groups were:

- A workforce that was more representative in terms of ethnicity and class; more staff and volunteers with lived experience of the area in which they are working, such as sex work or homelessness.
- Staff awareness training eg to understand variations in health literacy within the d/Deaf community, to understand culture and communicate effectively
- Information and communications which is accessible to different groups e.g. blind people, d/Deaf community, older people, people for whom English is not their primary or first language people with different cultures.
- Language barriers being addressed
- Community involvement. This was particularly strong in black African groups

- Being listened to and understood

Questions : what are the plans to engage with communities you have identified as not represented in this exercise (e.g. men, black Caribbean community, neurodiversity, older LGB people)?

Will you be following up on areas for further study (e.g. terms used to talk about exercise within South Asian communities)?

How will you monitor which communities you are engaging with?

Where is this information going, who will be using it, and how will they use it?

How will you know that the Big Conversation has made a difference?

3.5 What is the most important thing health and social care need to improve?

Responses to the third question - the most important thing health and social care could improve - could be partly summarised in this response:

“Better access, more dentists, better access to GPs, more funding, more mental health support, better wages for health and care staff, shorter waiting times for referrals and shorter waiting lists.”

Again, it was not possible for groups or individuals to narrow down a single most important thing, reinforcing one of the key themes to emerge from this consultation, that one size does not fit all, since everyone’s perspective of the key issues is dependent on their circumstances or the circumstances of those they work with, for example whether you have children, speak English as first language, have a disability etc. Many gave long lists of around 15 to 20 priorities, summarising their previous points. One Healthwatch reported receiving 42 different responses to this question.

The most common themes to emerge here were

- **communication** (between services and with public), in general and particularly with vulnerable groups such as the deaf and ethnic minorities
- more **accessible** services including access to primary care and waiting times
- **partnership working** with the community and the community sector. There was a recognition that for health and care services to improve they need to utilise and invest in the third sector.
- better **funding**, more training and better wages for NHS and care staff
- **Personalisation**. Even if not expressed in this way, what people want is for their individual and personal circumstances to be heard and taken account of.

3.6 Top five themes to emerge

There are clearly some key themes to have emerged in this phase of the consultation, with much repetition in the responses to the different questions. By way of summary, the top five themes to emerge from the consultation are the following:

- Widespread demand for properly funded and staffed NHS and other services
- Widespread concern about the problems accessing GP services in particular
- Demand for more person-centred care which takes account of the specific needs of vulnerable individuals and communities
- Need for more action on prevention, early intervention including healthy lifestyles and the wider determinants of health including the cost of living, and
- There is a desire for more and better partnership working with VCSE.

4. Conclusions

One of the challenges with engagement work of this kind is in the balance of national and local concerns which inevitably emerge when broad brush questions regarding the need for change are asked. Here, macro issues dominated to a large extent, as participants took the opportunity to articulate their concerns with national policy issues. However, this report also provides some valuable insight into the myriad of different issues which face residents and communities and which they wish to see addressed, along with some potential solutions, including new ways of working.

One of these is much closer working between statutory agencies and the VCSE sector.

This phase of the Big Consultation has not only provided some detailed insight into the particular barriers facing underserved communities, but uncovered a deep desire on the part of communities and individuals to be listened to, to be seen, and to be heard.

In these challenging times, the desire of the VCSE sector to work together with the statutory sector and use their expertise and knowledge – particularly around working with underserved communities highlighted in this report - comes across loud and clear and should be seen as one of the report's key messages.

With thanks to Ideas Alliance for preparing this report on behalf of Greater Manchester Integrated Care Partnership.