GMCVO

Taking Charge Together

Final report on VCSE and Healthwatch organisations' Community Engagement Strand

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NHS in Greater Manchester

This report was produced in partnership with the following:

and the support of many voluntary, community and social enterprise organisations who kindly hosted conversations.

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1. Executive Summary

As part of the wider “Taking Charge Together” campaign GMCVO led a partnership project delivered by ten borough wide and five themed voluntary, community and social enterprise (VCSE) and Healthwatch partnerships in Greater Manchester. Our target participants were those people less likely to be reached by the general campaign.

The 15 partnerships conducted a total of 138 conversations with a highly diverse sample of 1,837 participants to raise awareness of health and social care devolution in Greater Manchester and explore what encourages and makes it difficult for people to take charge of their health and wellbeing.

In addition, partnerships generated a total of 1,746 responses to the standard online survey exceeding their minimum target by 39.6% and contributing roughly a third of the overall sample (29.9%, N=5,841). They also referred 393 people to the dedicated carers’ survey.

The evidence from conversations highlighted participants’ holistic understanding of health and wellbeing along with their appreciation for the wider determinants of health.

In particular the following key themes emerged from the data:

1) “It’s all environmental”: A range of factors commonly defined as wider health determinants were recognised as having either a direct impact on health or on people’s ability to adopt healthy behaviours such as healthy eating or exercise. Factors included income and costs, work and employment transport, housing, skills and education, town and city planning, crime and community safety, pollution, social and cultural norms, climate and weather.

2) “It’s all about people”: Participants highlighted the role of social and community support structures, the harmful effects of social isolation and the importance of people as positive role models and motivators. VCSE groups and organisations were seen as key in facilitating social support and providing opportunities for creating meaningful connections.

3) “It’s all in the mind”: Mental health was given equal if not more importance as physical health. Self-confidence, a sense of self-efficacy (especially in relation to perceptions of behaviour change as possible and likely to result in positive health impacts), and motivation all featured strongly in discussions.

4) “It’s all relative”: Participants emphasised the relative nature of health and wellbeing and referred to significant levels of diversity in relation to individual and sociocultural differences as well as transitions across the life course. The conclusion was reached that ‘one size does not fit all’, and a particular focus was put on the additional access and inclusion requirements of particular communities such as disabled, Deaf, LGBT, and young people, and people for whom English isn’t their first language.

5) “It’s all about equality”: Participants drew a direct connection between structural inequality and ill health, in line with mainstream theory on health inequalities. This suggests that addressing structural inequalities in society has to be at the centre of all health improvement work.

6) “It’s all about knowledge”: While participants generally reported good levels of knowledge about healthy living, they recognised an unmet need for accessible information for particular groups and communities, and for consistent messaging and education from a young age. Also, gaps in knowledge around particular issues and the needs of particular communities amongst professionals were highlighted.

Overall participants demonstrated willingness to take charge of their health and wellbeing while recognising that their ability to do so on an individual basis is limited by other factors. While improvements to health and social care services were seen to play a role in this, participants put more emphasis on improving personal and community support structures.

It follows that creating conditions in which people are enabled to take charge of their own health and wellbeing will require a truly holistic approach based on radical improvements of the physical and socio-economic environment and transformative grassroots community development.

It is recommended to:

1) Invest in individual and community empowerment through the creation of personal and community connections, as well as meaningful service user and resident involvement in the design and delivery of facilities, services and information.

2) Invest in community-based facilities and activities run by VCSE groups and peer networks, using methods like small grants, social prescribing and personal budgets.

3) Use the legislative powers of local government and target capital and revenue spending by all public sector agencies to effect environmental changes that enable healthy lifestyles.

4) Ensure health and social care services are accessible and inclusive by mainstreaming accessibility and inclusion to the highest possible level and offering additional targeted solutions to meet the needs of specific groups.

5) Invest in both neighbourhood and Greater Manchester level VCSE-led initiatives to reduce health inequalities by targeting specific marginalised communities, and making the most of existing relationships and the position of trust VCSE groups and organisations enjoy vis-à-vis those people and communities most affected.

6) Invest in improving the Greater Manchester and locality evidence base by funding further research into identified gaps in knowledge and understanding and issues that appear to warrant deeper exploration.

2. Introduction

Between 15 February and 31 March 2016 a public engagement campaign entitled “Taking Charge Together” was delivered by a group of organisations comprising Key 103, the Manchester Evening News, Clever Together and GMCVO to inform the implementation of health and social care devolution in Greater Manchester.

Under the banner of this wider campaign GMCVO led a partnership project delivered by local Healthwatch organisations and the voluntary, community and social enterprise (VCSE) sector in the ten boroughs.

This strand of the larger public engagement initiative was aimed at:

- informing the public and communities, especially those less likely to access mainstream information, about health and social care devolution,
- understanding to what extent people and communities are willing and able to be #takingcharge of their health and wellbeing and that of their families.
- gaining some initial indications about what the public sector could do to create the conditions for a shift in the balance of responsibilities between people, communities and public sector.

To this effect, GMCVO signed up 15 lead organisations – a combination of Healthwatch organisations and VCSE infrastructure – to co-ordinate ten local and five Greater Manchester-wide thematic partnerships. Each of these lead organisations assembled a partnership drawing on a variety of networks and contacts to maximise the potential for reaching those who would be unlikely to engage with the mainstream campaign.

The local partnerships coincided with Greater Manchester’s ten boroughs and the thematic partnerships were as follows:

- Black and minority ethnic (BME) people
- Disabled people
- Lesbian, gay, bisexual and trans (LGBT) people
- Refugees and asylum seekers
- Young people

3. Approach

Each of the 15 partnerships was asked to conduct a set number of conversations with demographic groups that the partners had chosen based on their knowledge of the local community or the community of interest or identity. Although the conversations were guided by a standard format, as set out below, the partners were encouraged to tailor the format and duration of conversation events to their target audience.

The standard content of conversations included:

1. Provision of basic information about what is happening with health and social care devolution (making use of the standard materials provided)
2. Q&A and/or discussion enabling participants to express their views and feelings with the following standard trigger questions to be asked:

   a. *Do you think you know what people should do for themselves and their families to stay fit and healthy?*
   b. *What do you think encourages people to do these things?*
   c. *What do you think makes it difficult for people to do these things?*
3. Facilitation to complete the standard survey (which could be done directly into a PC by participants or on paper and then transferred on-line by a facilitator)
4. Invitation to join a mailing list of individuals keen to be more involved

Partnerships were asked to produce records of individual conversations using the format provided in Appendix A. From these individual records they generated a short narrative executive summary covering:

1. any important themes emerging from the conversations
2. any enablers or barriers identified which were considered particularly significant
3. any examples of good practice highlighted
4. one or two case studies illustrating any or all of the above

Along with the short executive narrative summary, the partnerships' final reports submitted to GMCVO contained information about the number and nature of conversations held, participants, the number of people who had completed the survey and/or were referred to the carers' survey, a list of contact details for participants interested in becoming more involved, and a list of any communications initiatives undertaken to raise awareness.

3.1 Conversations

Originally tasked to organise 105 conversations with a minimum of 1,050 participants, the vast majority of partnerships exceeded their individual targets and in the end facilitated a total of 138 conversations involving 1,837 participants. This represents an average of 17 participants per conversation. For a full breakdown of conversation targets and actual conversations achieved by partnership see Appendix B.

The target audiences for conversations were groups and communities the partnerships considered to have a key stake in Health and Social Care Devolution, and to be more marginalised and less often heard in mainstream engagement initiatives. This included the broad groups outlined in the text box below as well as various specific subgroups and audiences with multiple intersecting identities. While local partnerships also targeted BME, disabled, LGBT and young people, as well as refugees and asylum seekers in their area, the five additional Greater Manchester-wide partnerships facilitated by leading equalities organisations enabled an in-depth exploration of views amongst those groups. For a full breakdown of conversation audiences by partnership see Appendix C.

Conversation Audiences:

Black and minority ethnic (BME) people
Blind and partially sighted people
Carers
Community activists/ volunteers/ residents interested in health and care/ key VCSE support workers
Deaf people and those who are hard of hearing
Ex-offenders
Homeless people
Lesbian, gay, bisexual and trans (LGBT) people
Older people
Parents

People living with
- physical disabilities
- learning disabilities
- long-term conditions (particularly cancer, multiple sclerosis and HIV)
- mental health issues
- alcohol or substance misuse/ in recovery

Refugees and asylum seekers
Social care customers
Stroke survivors
Survivors of domestic violence and abuse
Students
Unemployed people
Young people (particularly those "not in education, employment or training", i.e. NEET)

3.2 Participants

Demographic characteristics of conversation participants are reported in Table 1 with a narrative overview given below[1].

Table1: Demographic characteristics of conversation participants

Demographic Categories		Frequency	Percentage	Cumulative Percentage
Age (in years)	45-65	446	29.4	29.4
	35-44	280	18.5	47.9
	66-79	267	17.6	65.5
	20-34	250	16.5	82.0
	19 or less	137	9.0	91.0
	80+	91	6.0	97.0
	Rather not say	44	2.9	100
	Total	**1,515**	**100**	**n/a**
Gender	Female	884	57.3	57.3
	Male	614	39.8	97.1
	Rather not say	36	2.3	99.4
	Non-binary	8	0.5	100
	Total	**1,542**	**100**	**n/a**
Resident in	Manchester	262	16.2	16.2
	Bolton	205	12.7	28.9
	Stockport	195	12.1	41.0
	Salford	156	9.7	50.7
	Wigan	148	9.2	59.9
	Rochdale	143	8.8	68.7
	Trafford	137	8.5	77.2
	Tameside	117	7.2	84.4
	Oldham	100	6.2	90.6
	Bury	81	5.0	95.6
	Rather not say	39	2.4	98.0
	Outside GM	33	2.0	100

[1] NB: The variation in figures between categories is a result of some participants preferring not to answer particularly questions. Also, some participants preferred not to complete demographic monitoring forms at all leading to lower figures here compared to overall participation ones.

	Total	1,616	100	**n/a**
Demographic Categories		**Frequency**	**Percentage**	**Cumulative Percentage**
Ethnicity	White: British	990	61.8	61.8
	Asian British or Asian: Pakistani	110	6.9	68.7
	Black British or Black: African	102	6.4	75.1
	Rather not say	93	5.8	80.9
	Other	65	4.1	85.0
	Asian British or Asian: Bangladeshi	47	2.9	87.9
	White: Other	38	2.4	90.3
	Asian British or Asian: Indian	35	2.2	92.5
	Black British or Black: Caribbean	29	1.8	94.3
	White: Irish	22	1.4	95.7
	White: Gypsy or Irish Traveller	22	1.4	97.1
	Asian British or Asian: Chinese	20	1.2	98.3
	Asian British or Asian: Other	19	1.2	99.5
	Black British or Black: Other	11	0.7	100
	Total	**1,603**	**100**	**n/a**
Employment Status	Employed	402	25.7	25.7
	Not working - retired	350	22.4	48.1
	Unemployed	265	17	65.1
	Rather not say	186	11.9	77.0
	Student	156	10	87.0
	Not working - disability	127	8.1	95.1
	Not working - health	77	4.9	100
	Total	**1,563**	**100**	**n/a**

In terms of age Table 1 shows that almost half our sample (47.9%, N= 1,515) was between 35 and 65 years old. Another quarter of participants was between 20 and 35 (25.5%) and 9% were 19 years of age or younger. Older people over the age of 65 made up just short of another quarter (23.6%).

We also see a rough 60/40 gender split with women making up 58.7% (N=1,542). 8 participants identified as non-binary (0.5%) and a further 36 (2.3%) chose to not disclose. The latter is an unusually high number for questions on gender. This suggests that the way the question was phrased may not have been appropriate for some people who might not feel that any of the response options adequately expresses their gender identity .

To make sense of the locality information outlined in Table 1 responses from outside of Greater Manchester and "rather not say" responses have been excluded (N=1,544). This left us with 17% of participants living in Manchester, closely followed by Bolton (13.3%), Stockport (12.6%), Salford (10.1%) and Wigan (9.6%). Together these top five made up almost two thirds of the sample (62.6%). Fewer participants indicated residency in Bury (5.2%), Oldham (6.5%) and Tameside (7.6%). This distribution is roughly in line with the overall Greater Manchester population across boroughs as outlined in Table 2.

Table 2: Survey responses and Greater Manchester population breakdown by borough

Borough	Survey Responses		Population (ONS 2014)	
	Frequency	Percentage	Frequency	Percentage
Manchester	262	16.9	520,215	19.0
Bolton	205	13.3	320,975	11.7
Stockport	195	12.6	286,755	10.5
Salford	156	10.1	280,439	10.3
Wigan	148	9.6	242,040	8.9
Rochdale	143	9.3	232,458	8.5
Trafford	137	8.9	228,765	8.4
Tameside	117	7.6	220,771	8.1
Oldham	100	6.5	212,962	7.8
Bury	81	5.2	187,474	6.9
Total	**1,544**	**100.0**	**2,732,854**	**100.0**

Excluding "rather not say" responses for ethnicity from the analysis (N=1,510) Table 1 highlights an unusually diverse sample with only 71.1% of participants identifying as White (including 65.6% White British). Amongst BME participants the largest groupings were from Pakistani (7.3%), Black African (6.8%), Bangladeshi (3.1%), other White (2.5%) and Indian (2.3%) backgrounds. Altogether almost a sixth of participants (15.3%) identified as Asian British or Asian and almost one tenth (9.4%) identified as Black British or Black. Compared to the ethnic breakdown of the overall Greater Manchester population as reported in Table 3 (on page 11) this means that every single ethnic minority is overrepresented in our sample. This is especially impressive in relation to very small and seldom heard communities such as Gypsies (Roma) or Irish Travellers. While the 2011 Census only reported 0.1% of the Greater Manchester population to identify as such, 1.5% of conversation participants did[2].

Table 1 also highlights that the sample is heavily skewed towards people not in employment with over a third (40.5%, N=1,377) of those choosing to provide a response indicating that they have a job (29.2%) or are studying (11.3%). A further quarter of participants (25.4%) were retired but this leaves a third (34.1%) who are unemployed (19.2%), or not working due to disability and ill health (14.8%)[3]. However, this is in line both with partnerships' attempts to

[2] NB: Census figures are based on a residential survey and hence might not capture travelling communities accurately.

[3] NB: Feedback from the Disabled People partnership suggests that many of their participants ticked "unemployed" rather than "not working for disability related reasons" even though the latter might be a more accurate description of their circumstances. Hence, these figures need to be interpreted with caution.

target those who are more marginalised on the basis of ill health, disability, unemployment and age, and the fact that most conversations took place during the working week making it harder for those in employment to attend.

Table 3: Ethnicity of conversation participants and Greater Manchester population

Ethnicity	Conversation Participants		Census 2011	
	Frequency	Percentage	Frequency	Percentage
Asian British or Asian: Indian	35	2.3	53,461	2.1
Asian British or Asian: Pakistani	110	7.3	130,012	5.0
Asian British or Asian: Bangladeshi	47	3.1	34,186	1.3
Asian British or Asian: Chinese	20	1.3	26,079	1.0
Asian British or Asian: Other	19	1.3	28,435	1.1
Black British or Black: Caribbean	29	1.9	17,767	0.7
Black British or Black: African	102	6.8	44,691	1.7
Black British or Black: Other	11	0.7	11,639	0.4
White: British	990	65.6	2,141,687	82.2
White: Irish	22	1.5	34,499	1.3
White: Gypsy or Irish Traveller	22	1.5	1,523	0.1
White: Other	38	2.5	70,414	2.7
Other	65	4.3	12,399	0.5
Total	**1,510**	**100.0**	**2,606,792**	**100.0**

For a full breakdown of participants' demographic characteristics by partnership see Appendix D.

3.3 Surveys

Aiming to meet a minimum target of 1,250 survey responses overall the partnerships have actually managed to generate a total of 1,746 thereby exceeding their target by 39.6%. For a full breakdown of survey response targets and actual survey responses achieved by borough and themed partnerships see Appendix E.

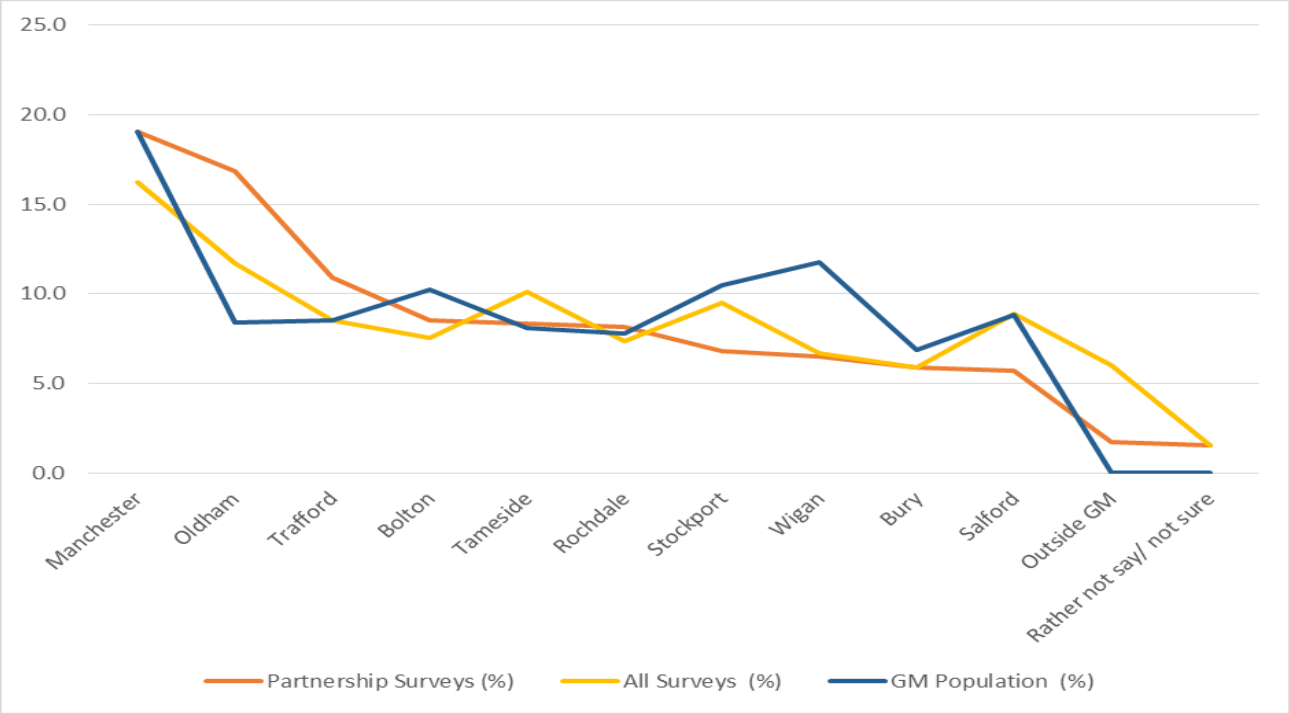
An analysis of the survey responses outlined in Table 4 shows how many surveys have been completed using one of the unique links assigned to each partnership. To maximise insight this has been presented in relation to where respondents said they lived, rather than in relation to which unique link they used. Please note that in some cases, conversations had taken place before the unique links were created. This means that the counts in the table below are lower than the number of survey responses actually generated by the partnerships.

Table 4: Survey responses generated via unique links by respondents' residency

	Partnership Surveys (PS)		All Surveys (AS)		PS Proportion of Whole Sample (AS)	GM Population (ONS 2014)	
	No.	%	No.	%		No.	%
Manchester	333	19.1	949	16.2	35.1	520,215	19.0
Oldham	294	16.8	682	11.7	43.1	228,765	8.4
Trafford	190	10.9	499	8.5	38.1	232,458	8.5
Bolton	149	8.5	441	7.6	33.8	280,439	10.3
Tameside	146	8.4	589	10.1	24.8	220,771	8.1
Rochdale	142	8.1	429	7.3	33.1	212,962	7.8
Stockport	119	6.8	556	9.5	21.4	286,755	10.5
Wigan	113	6.5	390	6.7	29.0	320,975	11.7
Bury	103	5.9	345	5.9	29.9	187,474	6.9
Salford	100	5.7	521	8.9	19.2	242,040	8.9
Outside GM	30	1.7	350	6.0	8.6	n/a	n/a
Rather not say/ not sure	27	1.5	90	1.5	30.0	n/a	n/a
Total	**1,746**	**100.0**	**5,841**	**100.0**	**29.9**	**2,732,854**	**100.0**

As Table 4 highlights, the partnerships collectively generated almost a third of all survey responses (29.9%, N=5,841) with some partnerships, namely Oldham, Manchester, Trafford, Bolton and Rochdale contributing in excess of this. With some minor variation the distribution of survey responses across the ten boroughs was in line with the overall population and survey responses as illustrated in Figure 1.

Figure 1: Distribution of survey responses across Greater Manchester



Oldham and Salford represent notable exceptions with the Oldham partnership generating a disproportionately high number of survey responses and Salford generating a disproportionately low number in relation to the overall population and overall survey responses. The response rate for Wigan was also low in comparison to the overall population but in line with the overall survey response rate.

It is also clear that the community-based communication and engagement methods employed by the partnerships were more successful at targeting residents in the ten boroughs, since only 1.5% (N=1,746) of the partnerships' surveys were completed by respondents living outside of Greater Manchester compared to 6% (5,841) in the overall sample.

The five themed partnerships have generated 454 of these survey responses, which represents over a quarter (26%, N=1,746). A full breakdown of survey responses generated by themed partnerships is presented in Table 5.

Table 5: Survey responses generated by themed partnerships

Partnership	Survey Responses
BME People	141
Disabled People	82
LGBT People	47
Refugees	107
Young People	77
Total	**454**

Finally, the 15 partnerships have referred a total of 393 people to the dedicated carers' survey. Please note that the project did not specifically target carers.

3.4 Communications initiatives

To generate the level of engagement outlined above, partnerships have taken extensive publicity efforts to raise awareness about the wider "Taking Charge Together" campaign, the local conversations taking place, the online survey and the Key 103 Bus roadshow.

Communication channels included:

- Partnership organisations'
  - websites (12 individual sites)
  - newsletters (3 individual newsletters)
  - e-bulletins (20 individual e-bulletins with direct recipients exceeding 10k[4])
  - Twitter (24 individual accounts with followers exceeding 50k)
  - Facebook (11 individual accounts)
  - dedicated distribution lists aimed at particular target audiences (8 individual lists/networks)
  - mail outs (to a minimum of 80 people)
  - direct emails
  - email footers (in 1 organisation)
- Key 103 bus: road show and radio interviews
- Other organisations' communication channels, including the organisations and groups hosting some of the conversations
- Posters displayed in partners' offices, local shops, community centres, etc.

Information was also disseminated and surveys distributed at community events and venues such as:

- Oldham Voluntary, Community and Faith Partnership
- Fatima Women's Health Event
- Ambition for Aging events (Failsworth and St Andrews Church)
- Oldham Locality Plan event
- Salford CVS Conference (200 delegates)
- Trafford Volunteer Managers Network meeting
- Trafford Victim Support
- Relate
- Trafford Libraries
- Trafford Youth Offending Service
- St John's Centre in Old Trafford
- Trafford VCSE Strategic Forum
- Wigan VCS Assembly

Wherever required and possible, partnerships made information available in alternative formats (e.g. in different languages, easy read, Braille) and piggybacked onto existing meetings, events, and communications channels to maximise reach. This approach of carefully targeting communications to the needs and preferences of particular audiences has

[4] NB: As this was not required, only a small number of partnerships have provided data on the reach of their communication channels. The figures given here are merely the sum of this very limited data. Hence, the actual reach is significantly higher.

been very successful in reaching exactly those people who are less likely to access mainstream information and get involved in generalised public engagement initiatives as demonstrated by the diverse demographic make-up of conversation participants (see Table 1).

3.5 Data analysis
The quantitative data the partnerships generated from the online surveys has been analysed by Clever Together as part of the overall sample and will be presented in a separate report.

The qualitative data generated from the conversations has been analysed in two stages. In stage one partnerships carried out a broad thematic analysis extracting key points from the individual conversation records for the narrative summaries they submitted to GMCVO. In stage two the data from the narrative summaries was analysed using a simplified framework approach[5]. This involves combining themes from the theoretical framework with themes from the data to develop a coding framework. Despite starting deductively from pre-set aims and objectives, the framework approach still reflects original accounts and observations through a process involving the five stages of familiarisation with the data: identification of a thematic framework, indexing, charting, mapping and interpretation[6].

In addition, Voyant Tools 2.0[7], a web-based reading and analysis environment for digital texts, was used to determine high frequency terms and their collocation within the narrative summaries. Essential terms for the conversations such as “people”, “health”, and “healthy” were excluded and simple data visualisations produced.

4. Findings

While a small number of participants indicated good knowledge of Greater Manchester health and social care devolution and how it might affect them, most seemed to have very little if any understanding. Partnerships reported many participants being aware that something was happening but not knowing any of the specifics. Importantly, responses did “not suggest that there is any sense of this being the ‘dawn of a new era’ or a historic sea-change in the relationship with public services”.[8]

As a result many participants directly expressed their gratitude for being invited to join the conversations and provided with information about health and social care devolution in ways they could easily digest. The short video and leaflet were found to be particularly useful.

Conversations focused mainly on what participants thought people should do for themselves and their families to stay fit and healthy, what encourages them to do these things and what makes it difficult.

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[5] Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman and R.G. Burgess (eds), *Analysing qualitative data*. London: Routledge.

[6] Pope, C., Ziebland, S. and Mays, N. (2000). Qualitative research in health care: analysing qualitative data. *BMJ*, 2000, 320, 114-116.

[7] http://voyant-tools.org/ [accessed on 10 April 2016]

[8] Manchester

Frequency analysis of the responses to these questions indicates that participants' discussions centred on the key terms "support", "services" and "activities" as illustrated by Figure 2.[9]

Figure 2: High frequency terms in summary narratives

Other frequently used terms included the following:

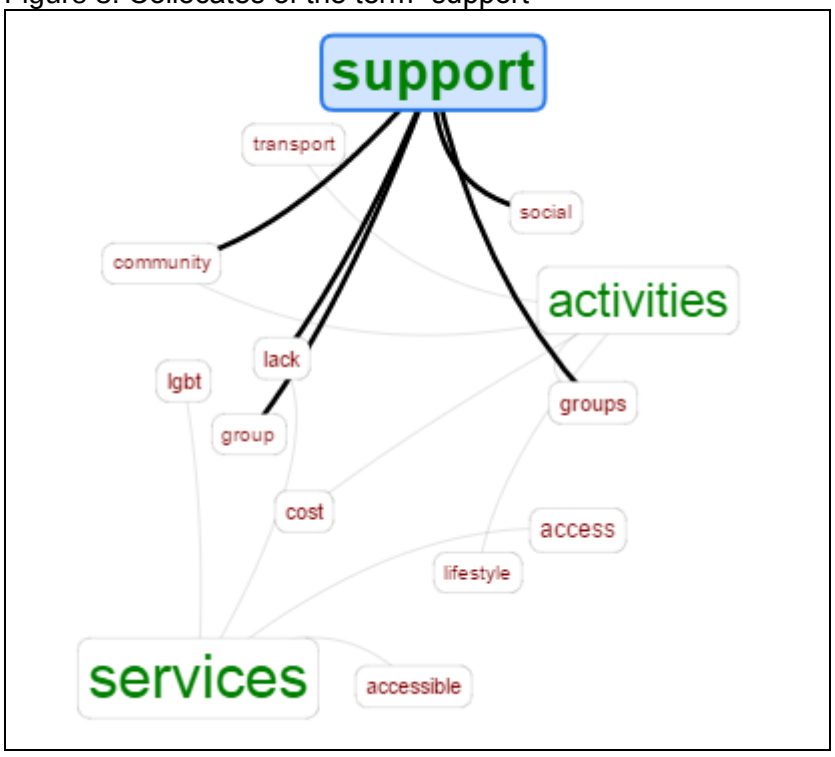
- Groups (52 mentions)
- Access (48 mentions
- Mental (39 mentions – as part of the term "mental health")
- LGBT (38 mentions)
- Information (39 mentions)

[9] NB: The frequency analysis was applied to the summary narratives rather than individual conversation records or indeed full transcripts. As such it is based entirely on the language used by partnership workers to describe key points in the conversations, rather than the actual language used by participants. While this still offers an insight into how participants framed the issues, our ability to accurately infer from this is limited.

- Exercise (37 mentions)
- Care (34 mentions)
- Community (33 mentions)
- Lack (31 mentions)
- Family (31 mentions)
- Barriers (29 mentions)
- Lifestyle (27 mentions)

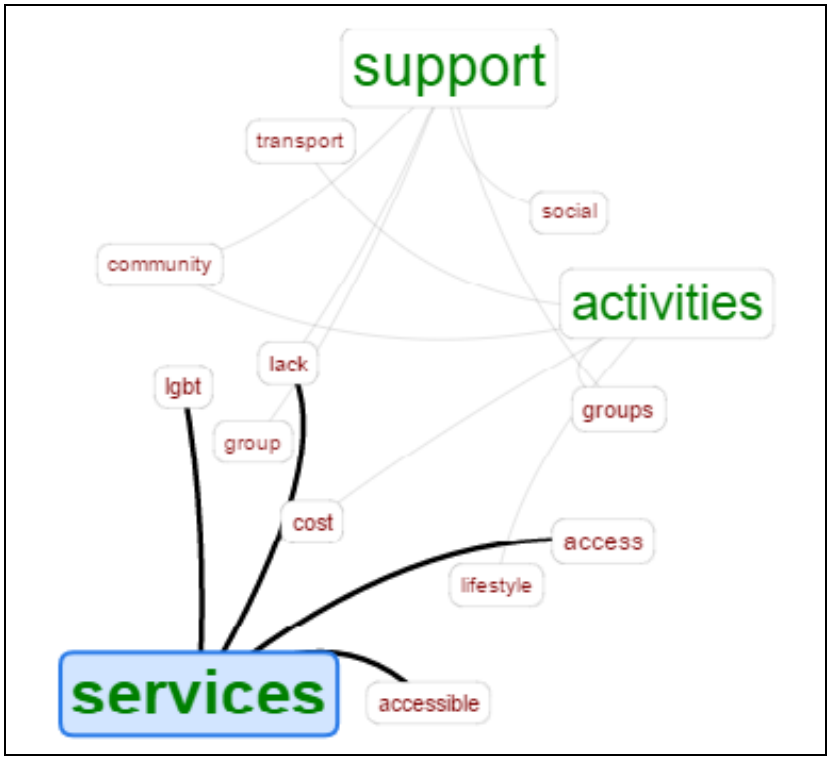
Figures 3 to 5 illustrate the relationship between these terms within the text by highlighting collocates, i.e. terms that most often appear together.

Figure 3: Collocates of the term “support”



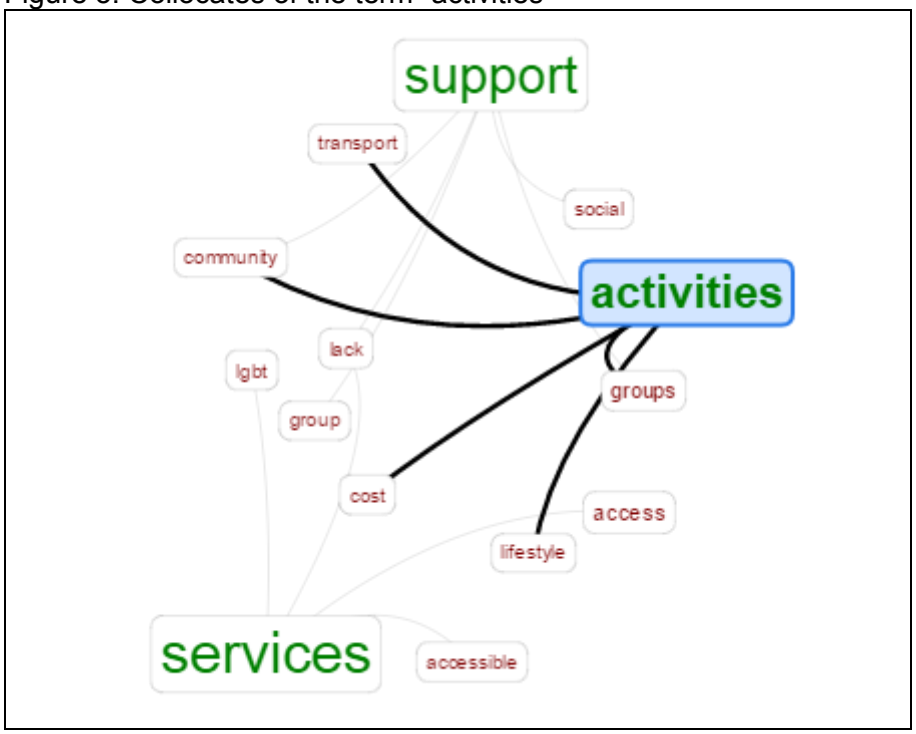
This shows that discussions of support most often included references to “groups”, “social” and “community” support, as well as a “lack” thereof (see Figure 3).

Figure 4: Collocates of the term “services”



Discussions of services most often referred to a “lack” as well as “access”, “accessible” and “LGBT” (see Figure 4).

Figure 5: Collocates of the term “activities”



Activities were spoken about most often in relation to “groups”, “community”, “transport”, “cost” and “lifestyle” (see Figure 5).

While this frequency and collocation analysis offers initial insight into how participants framed the issues, our ability to accurately infer from this is limited since it was applied to the summary narratives rather than individual conversation records or indeed full transcripts. As such it is based entirely on the language used by partnership workers to describe key points in the conversations, rather than the actual language used by participants.

For a deeper understanding of the data, let’s turn to the results of the simplified framework analysis. This suggests that responses to the key questions fall into two broad categories: on one hand participants highlight factors related to the wider environment and on the other factors related to people. Within these broad categories the following main themes emerged:

1) “It’s all environmental”
2) “It’s all about people”
3) “It’s all in the mind”
4) “It’s all relative”
5) “It’s all about equality”
6) “It’s all about knowledge”

Due to the highly diverse demographic make-up of the sample as a whole, the themes ran through the entire data set with no major differences being observed between data from local and themed partnerships. This suggests that participants honed in on universal factors and themes that are important to all people, and that additional considerations of relevance to the themed partnerships represent a difference in degree rather than a fundamental difference in experience or need.

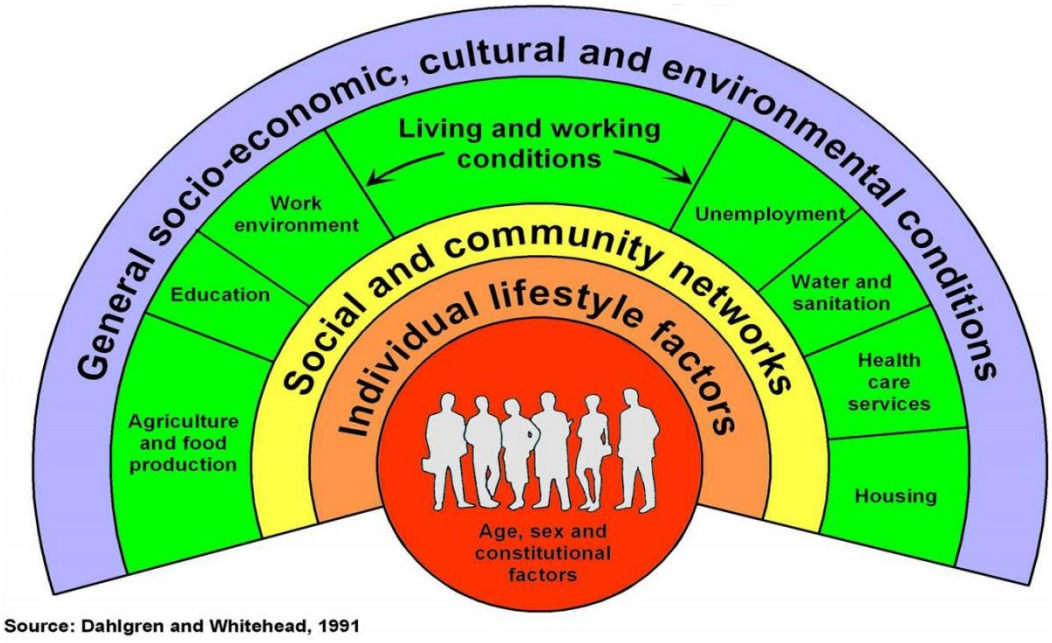
While it is acknowledged that the themes are interconnected, for reporting purposes they will be outlined individually in the following sections.

4.1 “It’s all environmental”

In line with dominant public health theories as represented by the Dahlgren and Whitehead[10] model featured in Figure 1 below, participants demonstrated a strong appreciation of the wider determinants of health.

Figure 6: Wider determinants of health

[10] Dahlgren, G. and Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health.* Stockholm: Institute of Futures Studies.



Source: Dahlgren and Whitehead, 1991

They described a range of environmental factors as having a significant impact on their health and wellbeing by creating conditions that enable or prevent individuals from taking charge of their health and wellbeing. Factors discussed most often included:

a) Income and costs
b) Work and employment
c) Transport
d) Housing
e) Skills and education
f) Town and city planning
g) Crime and community safety
h) Pollution
i) Social and cultural norms
j) Climate and weather

In some instances these factors were seen to affect health and wellbeing directly as highlighted by the following quotes:

> "Breathing problems caused by traffic and pollution" (Tameside)

> "Housing […] came out as a specific issue regarding wellbeing and the impact it had on individuals. Issues included having access to safe and appropriate accommodation (not damp but clean and warm), [and] the support from social housing providers (and case studies of individuals being left without adequate cooking and bathroom facilities)" (Salford)

> "There also seemed a common thread that the sunshine or longer days made people feel healthier even though they may not partake in activity or improved diet!" (Stockport)

> "Generally a lack of feeling safe was highlighted as 'depressing' due to the constant noise of sirens and police activity." (Salford)

In other instances factors were indirectly linked to health and wellbeing through people's ability to adopt healthy behaviours such as healthy eating or exercise. For example, the cost, availability and accessibility of healthy food, opportunities to exercise or take part in activities, and health and wellbeing services were seen as a barrier. This was directly linked to (un)employment, working conditions and key skills such as English language proficiency and literacy:

> "It is noticeable that in the conversations this is often linked to employment and money issues. There are several examples of people saying that the pressure of work (long hours / low pay / uncertainty) leaves them with little time, money, motivation or energy to make the changes required to adopt what they know would be a healthier lifestyle." (Manchester)

> "Skills for Employment – There were numerous discussions regarding wanting to improve personal literacy, key skills and improving their ability to speak English as a second language. This skills gap isn't just affecting their wellbeing through limiting employment but also their access to health and community services." (Salford)

> "Many of the people we spoke with are on benefits and/or low incomes and said the cost of healthy food and activities such as gyms was too much for them." (Disabled People)

Also, the particular neighbourhood people live in and broader sociocultural norms were highlighted as significant:

> "The location of an area was reflected as being an influence 'you get stuck in a bad area and around people that aren't good for you ……but you have to be mates with someone', lack of choice due to the crime in their area - 'Victim or inflictor, that's the choice'. " (Salford)

> "Clean and safe neighbourhoods (environment free from pollution, clean facilities, less crimes) [were seen as enablers]" (Refugees)

> "There was an underlying theme of breaking the culture of 'normal' social behaviour that impacts health i.e. going to the pub together, social substance abuse or "hobby", [smoking] for a break." (Salford)

Other examples of environmental factors such as transport influencing people's ability to live healthy lives included the following:

> "Cost and lack of transport, and difficulty in using transport (e.g. with walkers) makes it difficult to get to activities and appointments. Community transport as a solution was valued." (Tameside)

> "Transport was raised as a big barrier by many – in terms of cost, proximity, access, safety and reliability. Some people were relying on cars and taxis because of this, and said they were therefore losing out on an opportunity to do some walking. Some day centres make people pay for their own taxis, leaving them with little to spare for healthy food." (Disabled People)

> "Costs frequently arose as a barrier, both to eating healthily and participating in exercise." (Young People)
>
> "Every group talked about limiting the number of fast food outlets" (Stockport)
>
> "[The] preservation of parks and green spaces creates an environment more suited to activity, and encourages people to leave the house more" (Trafford)
>
> "Having vibrant towns, access to jobs and good quality housing were suggested as important enablers. A strong inward investment programme would support improved health and wellbeing." (Tameside)

On the level of local and national policy and legislation specific suggestions for actions that could be taken included outlawing advertising of unhealthy foods and drinks, improving food labelling so consumers understand nutritional content better, changing the national curriculum to make food technology/home economics compulsory, and introducing an explicit focus on mental health in PSHE).

Finally, while most participants did not focus closely on health and social care services, some groups, particularly people with additional needs, emphasised the negative impact of provision being cut:

> "The conversations that took place […] highlighted that people want to be more active and healthier but due to cuts in their personal budgets, carers were only being used to do the bare minimum which left people dropping from 60 hours a week of care to 16 hours. This has a massive impact on individuals' health and wellbeing." (Rochdale)
>
> "Cuts to services, benefits and, in particular, social care support packages, are leaving people with little scope to pay for more than the basic minimum in their lives. Support packages used to include an amount for support with leisure activities but this is now very rare. This puts the onus on leisure services to provide assistance in-house to disabled people who might need it. Additionally, more than one person said the fear of further cuts was impacting on their mental health." (Disabled People)
>
> "General cutbacks in councils affect […] older people's ability to get out more e.g. pavements and street lighting less well maintained and the rundown nature of parks and green spaces. Cutbacks in council services such as libraries, Sure Start, care homes, youth centres and lack of maintenance of cycle paths impact […] on wellbeing. Withdrawal of funding impact[s…] on community groups' ability to improve wellbeing e.g. older people's gentle exercise groups." (Trafford)

4.2 "It's all about people"

Alongside the wider environment, people were seen as a crucial factor in health and wellbeing with discussions highlighting many different examples.

Participants particularly emphasised the role of social support structures and the harmful effects of social isolation:

> "Many participants took a holistic approach and view to their own health and wellbeing, citing that eating well and participating in activity is important but having a healthier lifestyle to them means also being supported by family, friends and other factors such as church, owning a pet, being part of a social group (could be a craft group, football match, singing group), getting out and about particularly outside in the fresh air." (Stockport)

> "Most people we spoke with were very aware of what is needed to stay fit and healthy and saw this quite holistically – not just diet, weight, smoking, drinking, exercise, but also staying socially connected and informed. This is extremely important as mainstream, accessible opportunities for social connection are now more limited for a lot of disabled people." (Disabled People)

> "The importance of neighbours and having people who talk to their neighbours. Having that initial contact or key person who checks up on you and helps provide continuity. Generally 'looking after each other'. Peer support came out more strongly than family support in the majority of cases." (Rochdale)

> "Tackling isolation and loneliness was an important theme for most of the groups we engaged with. Many people stated that it can have a really negative effect on an individual's health and wellbeing." (Bury)

> "Social isolation leading to stress and depression." (Disabled People)

VCSE groups and organisations were seen as key in providing such support and opportunities for creating meaningful personal and community connections[11]:

> "It was highlighted that there should be more importance placed on community links, networks and places for socialising [and] that this can reduce isolation and provide better locally accessed points of support. […] The attendees also highlighted that BME community organisations play an important role in helping people from their communities access these services." (BME People)

> "LGBT [Foundation] run a men's only Asian group, which welcomes all gay men from across greater Manchester and gives them the chance to come to socialise and be educated on varies topics. The service users of this group sang its praises, explaining they felt they had a safe place to come to discuss personal matters with people who can relate to their circumstances. The irony here is LGBT [Foundation] in the Rochdale Borough has been decommissioned so where will these services users now go, what support will they receive?" (Rochdale)

> "For some, organisations such as Disability Stockport and Manchester People First were the only way that they got to take part in health/fitness related activities and to meet other people because they wouldn't feel they could access mainstream services on their own." (Disabled People)

> "Clubs and community activity important to young people – use of these to promote healthy living essential" (Stockport)

[11] For countless more examples see Appendix F: Examples of good practice and case stories.

> "[Participants from a men's group] said they were more likely to [access healthy eating, mindfulness and other support] in a community space that didn't feel like a health centre. This had led them to link in with other activities that improve their health outcomes like courses, smoking cessation and counselling." (Salford)

Participants also detailed the importance of people as positive role models and motivators:

> "Adults in families set examples for their children – need to make sure they're positive ones." (Oldham)
>
> "Having good role models (also "HIV positive" ones) (LGBT People)
>
> "Enablers could include […] good BME role models" (BME People)
>
> "Many older people quoted their grandchildren as motivators for being active; they want to keep up with them!" (Stockport)
>
> "Develop good relationships; having friends who are fit and healthy and encourage you to do so." (Refugees)
>
> "When part of a group or team, you are expected to turn up." (Stockport)
>
> "Doing activities as a family: 'Running with my dad every morning. It helps me keep doing it, because I have the company, but also keeps me safe, especially in the winter when it's dark'." (Trafford)
>
> "One person described how a family member being diagnosed with a smoking related illness had motivated them to take the first steps to giving up smoking themselves." (Oldham)

4.3 "It's all in the mind"

As some of the above quotes (and indeed the frequency analysis) have already highlighted participants tended to view health and wellbeing holistically focusing not just on physical but also on mental health and how these are connected:

> "A group of people in recovery emphasised the need to get mental health right as well as physical health and to recognise that they are inter-related. For people in recovery from substance misuse this included the need to 'fill up the day' to reduce temptation to go back to substance use. Low intensity exercise activities that lasted a long time and could be done with other people was suggested as a solution in this situation." (Oldham)

Here how participants felt about themselves, their health and their ability to make changes came out strongly:

> "People talked a lot about feelings: they want to feel fitter and healthier. Feelings of positivity, open mindedness and the outlook on life generally had a lot more to do with how people viewed their personal health." (Stockport)
>
> "Have a strong mind and positive attitude" (Bury)

> "Keeping myself happy" (Rochdale)

In terms of psychological factors, confidence was a common topic for discussion both in terms of people's self-confidence and confidence in the potential benefits of behaviour change:

> "[Confidence] was mentioned several times and from two main perspectives. One was [around] confidence regarding the fear of others' perception (e.g. when using the gym or doing public activity) with the other being around an individual's personal confidence and a belief that it's 'too late or difficult to change'." (Salford)

> "Being confident that activities/lifestyle changes will help. Self-awareness. Understanding that there is a bad consequence for not taking action. Fear of failing so deferring because [people] feel it is "too difficult". Fear of medical tests/diagnosis […] Overcoming 'fatalism' e.g. re cancer treatment" (Tameside)

Linked to confidence in the potential benefits of behaviour change participants also put a strong emphasis on the role of motivation in enabling or preventing healthy behaviours:

> "Motivation is important not just at the beginning but throughout the process of achieving healthier lifestyles" (Bolton)

> "There is an underlying theme of wanting support with motivation." (Manchester)

> "Lack of motivation or shyness to go to the gym due to mixed sessions" (Refugees)

> "Lack of motivation e.g. exercise but what causes that? (NB: mental health can affect motivation and willpower)" (Tameside)

Here some pointed to the necessity of "setting realistic goals" (Oldham) to reduce the risk of failure and its demoralising and demotivating effects.

It is worth noting that perceptions were also identified as guiding people's choices in relation to credibility, trust and personal fit (i.e. whether participants identified as the target audience):

> "Some people said that if NHS staff look unhealthy this gives a negative message to the public in terms of healthy lifestyles." (Tameside)

> "Homeless people reported a distrust of agencies such as the NHS and local councils." (Wigan)

> "The perception of gyms and public exercise put […] people off participating." (Trafford)

4.4 "It's all relative"

Another significant theme running through participants' discussions was that of variation, diversity and relativity. This took a number of different forms.

On the level of perception, participants concluded that "fit' means different things to different people in different circumstances" (Oldham). Also, it was recognised that health and

wellbeing was not necessarily a top priority for people, especially those in need of basic necessities such as housing, heating, clothing and food:

> "Many [homeless people] in this group did not prioritise healthy living, stating that issues such as accommodation were of utmost importance." (Wigan)

Most frequently, however, participants highlighted significant levels of diversity in terms of people's experiences, needs and preferences. This was expressed in relation to both individual and sociocultural differences:

> "Different people will need different approaches to motivate them – it's not 'one size fits all'." (Tameside)

> "Solutions that were culturally appropriate were seen as important – recognising that people of different ages, ethnicities, levels of fitness and in different towns will all need different things." (Tameside)

> "Multiple marginalisation (for example, older people from BME communities, refugee, asylum seeker, gypsy/traveller communities, BME LGBT people, mental health service users) can have significant negative outcomes on health which are not always picked up by mainstream service provision." (BME People)

> "Policies that assume everyone prefers to take part in mainstream social activities will potentially disadvantage people who have limited spoken fluency in English, LGBT people who feel unsafe in public settings, or those who have strong religious or cultural preferences that influence how and where they want to socialise." (BME People)

> "Issues of immigration may lead to ill health" (Refugees)

> "Reluctance among some BME groups to ask for a health check or an assessment, because of pride or fear of stigma, especially in relation to mental health." (BME People)

> "The [young people's] group also discussed the health implications of the digital age, some were worried about what health problems might emerge from using digital devices (comparing this unknown to that of smoking 50 or 60 years ago). They were also concerned that they had too many gadgets and spent too much time being 'plugged in'." (Bolton)

A particular focus was put on the additional access and inclusion requirements of particular groups and communities such as disabled, Deaf, LGBT, and young people, and people for whom English isn't their first language:

> "There is a staggering lack of information in accessible formats. The assumption that if you need something in an accessible format you will ask for it assumes you can find, read and understand the info in the first place. NHS and similar accessibility standards don't solve this." (Disabled People)

> "Members of the Deaf community who use BSL felt particularly excluded from getting information and support around their health, and from other activities such as job-

seeking. They gave numerous examples where they had been prevented from communicating effectively with health professionals like GPs because qualified interpreters had not been provided. Budget cuts are often given as a reason for the lack of interpreters. Their access needs had not been taken into account in other ways – e.g. in many GPs' surgeries, appointments are only announced verbally and they have telephone-only booking systems. Many reported that the resultant stress has a very negative impact upon their mental health." (Disabled People)

"A strong feature in conversations with groups for whom English is not the first language is that not only is the inability of most services to cope with language other than English a barrier to access, it's a cause of depression, isolation and stress in terms of daily living." (Manchester)

"Importance of LGBT visibility when accessing health and social care services. Avoid presumption of heterosexuality. Understanding of importance of trans and non-binary recognition. Demonstrable understanding of diverse health and care needs and ability to evidence and signpost." (LGBT People)

"Young people involved in the Princes Trust, often referred to as being NEET […] have experienced difficulties in accessing health services including delays in getting gym membership, cuts to services and activities being unaffordable." (Wigan)

"Some people said that the equipment at gyms and leisure centres was not accessible to them and that staff there were not trained to support them appropriately. Some people wanted to attend more than they did, but were constrained by the availability of support." (Disabled People)

The following case story illustrates the interplay between being faced with additional barriers and motivation[12]:

"My local swimming baths have made a commitment to fixing the hoist into the pool, but last time I spoke to them still hadn't progressed this. I am aware of my rights, and know how to challenge services to get them to fulfil their legal obligations. However, like many people I struggle with motivation to exercise, so challenging the delivery of services that I would then have to push myself to access, ends up a low priority on my list." (Disabled People)

It is also worth noting that participants recognised the importance of transitions and of how individual circumstances change across the life course:

"One person said they had started to misuse alcohol when their children had grown up and left home. They said they didn't know what to do with themselves. They also said that they eat less healthily now as they found it difficult to transfer the skills they had in cooking for several people to cooking for just themselves. They said they couldn't be bothered to cook nice meals just for themselves and they weren't sure how to cook well for just one person." (Oldham)

"Younger people rather than older people focused on not drinking excessively, not taking drugs and not smoking as main contributors to leading a healthy lifestyle." (Stockport)

[12] A full record of good practice examples and case stories is included in Appendix F.

> "LGBT [people were] concerned about failure of services dealing with young people at the time of transition to adulthood. Lack of appropriate places where health services are delivered for 15 – 17 year olds with mental health problems. Links between children's and adult services 'messed up'. Especially in relation to gender and mental health clinics"

> "A stroke survivor said that the six week reablement support she had received after leaving hospital had been really good. It helped her to get some confidence back and learn how she could still exercise and maintain some physical fitness even though her medical condition meant she couldn't exercise in the ways she had done before." (Tameside)

In relation to this, but also generally, participants highlighted that "people need input when they're most vulnerable – when they have tried to change and got to a certain point and then hit a stumbling block. Help needed at the right point" (Wigan).

This suggests there is a need for a much more specific evidence base to make sense of diversity, target interventions appropriately and remove access barriers, as recommended, for instance, in relation to BME people in the following quote:

> "The term BME is widely and generically used to cover a significant and growing range of communities. Policies and services should be reflective of this issue and base developments on actual facts and evidence so that services are better targeted." (BME People)

4.5 "It's all about equality"

Linked to but distinct from the theme of variation, diversity and relativity described above, participants drew a direct connection between structural inequality and ill health, in line with mainstream theory on health inequalities[13] :

> "Deaf people at Leigh Deaf Club feel excluded generally in society. They can't access activities that would aid them in being or becoming healthy such as keep fit classes or slimming clubs. Interpreters and communication barriers have the biggest impact on their health. Reports such as Sign Health's 'Sick of it' report show that Deaf people are as active as hearing people, eat a similar amount of vegetables, drink less alcohol and smoke far fewer cigarettes yet suffer far worse health outcomes." (Wigan)

> "Multiple marginalisation (e.g. older people from BME, refugee, asylum seeker, gypsy/traveller communities, BME LGBT people, mental health service users) can have significant negative outcomes on health which are not always picked up by mainstream service provision. " (BME People)

> "Previous experiences of discrimination and poor treatment will influence their opinions [of provision]" (BME People)

[13] See e.g. Black, D. (1980). *Inequalities in health: Report of a research working group*. London: DHSS.

> "As an LGBT person, the most important thing when using a health or social care service is that the organisation is working towards reducing health inequalities." (LGBT People)

In particular, participants identified "acceptance of and respect for diversity (culture, race, religion, disabilities)" (Refugees) and "being treated as an individual with dignity, respect and kindness" (LGBT People) as important enablers of health and wellbeing:

> "It's noticeable in the conversations with migrant groups that the value of groups and individuals who provide support, advocacy and interpretation/translation is much more than simply opening the door to the right treatment or healthcare. The message is strongly that this is part of feeling valued as a person who has a social identity in the wider community outside their community of identity." (Manchester)

> "Enablers [included] being treated as an individual with dignity, respect and kindness; recognition of same sex partner; having LGBT quality assurance mark at GPs and other primary care services. Barriers [included] having to bring up subject of LGBT identity and issues related to this (prefer professional to be confident, knowledgeable enough to do this); lack of discretion and respect around LGBT identity in health and social care services" (LGBT People)

> "Services/promotion/information that acknowledges my LGBT identity (without thinking it defines me)" (LGBT People)

This suggests that addressing structural inequalities in society has to be at the centre of all health improvement work. One way to start the ball rolling on this would be to fund "dedicated outreach workers who can build up connections with local communities and groups" (BME People).

In addition, meaningful community engagement was seen as crucial:

> "Engagement came through strongly in a couple of groups. Both from the perspective of service users being involved in decision making and development and services (in particular integrated care) but also from a need to ensure that a diverse group of individuals are engaged and not simply those who are already involved in the process and 'know what's going on. We all are very busy but we need more people to get a better idea of what people need'. The consensus was that it needed to be meaningful engagement and that individuals are not just consulted once that plans have already been made." (Salford)

4.6 "It's all about knowledge"

Despite (or possibly as a consequence of) a general emphasis within health promotion work on the provision of information as a vehicle for behaviour change, lack of information was not identified as a significant issue in most conversations. Indeed, participants generally reported good levels of knowledge about healthy living:

> "Healthy eating and exercise came up in every conversation, participants had a good understanding and awareness of what it is to be healthy and the actions needed for a person to be healthy and lead a healthy lifestyle." (Stockport)

> "Generally there was a feeling amongst most of the groups that they knew what they had to do but that they didn't always know how best to do it or needed support." (Salford)

Notable exceptions related to information not being accessible for or inclusive of particular groups and communities (see section 4.4 above), and there being a greater need for consistent messaging and education from a young age:

> "Often family and professionals aren't aware of all the services, activities and groups available. Finding information particularly surrounding specific topics and support groups can be seen as difficult and challenging. Similarly other groups were unaware of support they could access including re-referrals, their rights to benefits as well as when accessing health services and their rights under the Carers Act." (Salford)

> "Childhood interventions – you are more likely to be healthy and active if you have been taught that lifestyle from the early age." (Bury)

> "Education for Young People – A mixture of groups mentioned effective school education to get a better start in life as well as the need for schools to educate beyond the core curriculum and into broader awareness (healthy eating, substance abuse, sexual health, mental health)." (Salford)

> "The [Youth Council] group spoke a lot about the inconsistency of school attitudes to healthy lifestyles. Some parts are good, like a free salad bar at one school, free fruit at break time at a primary school, good PE facilities equipment at a former sports college. Other parts are less good. Several people reported that school sport stops in year 11 and sports time used for revision, sports teaching was seen to be sexist with girls and boys options quite fixed." (Bolton)

> "Primary schools were generally praised for their work around healthy eating and the meals available. It was felt that this was not carried forward into secondary schools where there was easier access to unhealthy eating options." (Tameside)

Finally, it is worth noting that participants emphasised a need for education and awareness-raising amongst professionals around particular issues and the needs and experiences of particular communities:

> "Another common theme included the lack of education and knowledge both for professions and the general public 'Everyone knows the signs of a heart attack or stroke but not mental health" (Salford)

> "Stereotyped ideas among professionals about the extent of family support available within families of people from black and minority ethnic groups [were seen as a barrier]" (BME People)

> "Greater awareness among professionals of the LGBT community and what needs are present." (LGBT People)

> "Training of staff is important. Training should cover the content (able to provide specific advice to disabled people), and delivery (understanding of the social model of disability, understanding of providing support in a non-patronising and non-

> invasive manner etc, appropriate use of language, understanding of individual's personal boundaries etc). Staff with these skills are more likely to feel confident at supporting and where appropriate pushing people to achieve more." (Disabled People)
>
> "They (social housing provider) should flag up where people are vulnerable and help them. Staff don't have any understanding of issues and need training." (Salford)

This highlights the need for services, professionals and communities to learn from one another.

A useful case story illustrating one possible approach comes from the BME People's partnership:

> "Improving Awareness and better understanding through engagement" (a commissioned project by Public Health with MBMEN): Working with the community to better understand sexual health and BME women as a way of informing the future commissioning of sexual health services for women. Commissioners were prepared to invest and work with the Manchester Black and Minority Ethnic Network (MBMEN) in exploring needs and perspectives through a community champions approach. Taking a collaborative and co-design approach, the MBMEN recruited (from within its relevant network members) female volunteers and trained them in sexual health issues and research methods. Working as a team and supported by MBMEN they undertook the research which involved interviewing women in the community and organising and holding focus groups, talking and having conversations about sexual health issues and needs. The findings provided intelligence about the sexual health needs of BME women, their views and use of contraception and their views on termination of pregnancy. This information was given to commissioners to be used to inform and influence future commissioning of sexual health services for women and having more appropriate approaches that meet the needs of BME women. This also left essential learning in the community, built knowledge, connection and skills. It provided commissioners with the knowledge of cultural needs and a greater connection to community support and services leading to more intelligent commissioning and provision of services.

5. Conclusion

Considering the significant need for greater public involvement in health and social care devolution and awareness-raising of its likely impact, the VCSE sector/Healthwatch led approach adopted here has proven very successful in starting community conversations, particularly with those who are less likely to access mainstream information and tend to be more seldom heard.

As a consequence the conversations contain many suggestions for actions that could be taken to enable specific groups and communities to take charge of their health and wellbeing. The project has also thrown up a number of areas worth further investigation as outlined in Appendix G.

Findings from these conversations suggest that people are surprisingly well informed about healthy lifestyle measures and are indeed willing to take charge. This is very encouraging and bodes well for plans outlined in "Taking Charge of our Health and Social Care in Greater

Manchester"[14], although participants also recognised that their ability to take charge on an individual basis is limited due to the wider determinants of health, especially social and environmental factors, which will need to be addressed. While improvements to health and social care services were seen to play a role in this, it is notable that participants put more emphasis on improving personal and community support structures and the provision of accessible activities.

It follows that creating conditions in which people are enabled to take charge of their own health and wellbeing will require a truly holistic approach based on radical improvements of the physical and socio-economic environment (e.g. public transport, local economy and jobs market, housing, education) and transformative grassroots community development (to reduce crime, eradicate inequality and discrimination, forge strong, cohesive communities based on celebrating diversity by bringing people together).

Crucially, along with greater responsibilities, communities also need to be given greater powers. Therefore the devolution of powers to shape health and social care must not stop at the level of Greater Manchester but continue into local neighbourhoods and the hands of residents themselves.

In addition, there is a need to continue lobbying central and local government for changes to policy and legislation. Specific suggestions included outlawing advertising of unhealthy foods and drinks, improving food labelling so consumers understand nutritional content better, changing the national curriculum to make food technology/home economics compulsory, introducing an explicit focus on mental health in PSHE).

6. Recommendations

On the basis of findings presented above we recommend the following:

1) **Invest in individual and community empowerment** through the creation of personal and community connections, as well as meaningful service user and resident involvement in the design and delivery of facilities, services and information. There were numerous comments about the value of social connections and peer support. It was also clear that the degree to which people feel they have control of factors that affect their health and/or influence over public service provision both directly and indirectly affect their mental wellbeing.

2) **Invest in community-based facilities and activities run by VCSE groups and peer networks**, using methods like small grants, social prescribing and personal budgets. For maximum impact target neighbourhoods, specific communities of identity and high-risk life transition points, and widely promote what is already available in more accessible and inclusive ways.

3) Use the legislative powers of local government and target capital and revenue spending by all public sector agencies to **effect environmental changes that enable healthy lifestyles**. Evaluate major commissions in advance, and educate private business, to make no-cost changes to projects that enhance the environment

[14] GMCA and NHS in Greater Manchester (2015). *Taking Charge of Our Health in Greater Manchester (Final Draft v11.3)*. Manchester: GMCA and NHS in Greater Manchester.

and to ensure the enablers of healthy lifestyles are not accidentally destroyed. It is important that transport, environmental health work, housing, and education and training are planned and delivered in such a way as to support healthy living. The availability of safe and welcoming parks and green spaces, and other community hubs and assets is also crucial. More use could be made of existing facilities, although additional provision is also needed in many areas. City and town planning could also be a real enabler of "healthy environments", alongside local government legislation (e.g. to restrict fast food outlets; to provide better protection for tenants in private renting).

4) **Ensure health and social care services are accessible and inclusive** by mainstreaming accessibility and inclusion to the highest possible level and offering additional targeted solutions to meet the needs of specific groups. Along with many examples of good practice by public sector staff, participants also offered many examples of poor and occasionally outright discriminatory practice. However, in many cases the driver for bad or discriminatory practice was a lack of awareness and education or a failure to actively remove barriers, rather than deliberate exclusion or prejudice. There is a need for comprehensive diversity-accommodation policies, consistently monitored and enforced, improved training for public sector staff, and ongoing dialogue between public sector staff and the representatives of communities of identity.

5) **Invest in both neighbourhood and Greater Manchester level VCSE-led initiatives to reduce health inequalities** by targeting specific marginalised communities, and making the most of existing relationships and the position of trust VCSE groups and organisations enjoy vis-à-vis those people and communities most affected. This is essential because previous negative experiences of public sector provision has led to high levels of mistrust within particular communities.

6) **Invest in improving the Greater Manchester and locality evidence base** by funding further research into identified gaps in knowledge and understanding and issues that appear to warrant deeper exploration. The findings here have thrown up a number of areas which seem worth understanding in more depth. For a full list of suggestions see Appendix G.

Appendices

Appendix A: Format for reporting individual conversations

a. Date of conversation

b. Venue

c. Name and website address of the organisation hosting the conversation

d. Description of target audience (e.g."Asian elders")

e. Number of people included in the conversation

f. Demographic breakdown of people included in the conversation as follows:-

AGE	
19 or less	
20 – 34	
35 – 44	
45 – 65	
66 – 79	
80 or more	
Rather not say	
GENDER	
Female	
Male	
Non-binary	
Rather not say	
WHERE DO YOU LIVE	
City of Manchester	
Stockport	
Tameside	
Oldham	
Rochdale	
Bury	
Bolton	
Wigan	
City of Salford	
Trafford	
Outside of Greater Manchester	
Rather not say	
ETHNIC GROUP	
Asian British or Asian: Indian	
Asian British or Asian: Pakistani	
Asian British or Asian: Bangladeshi	
Asian British or Asian: Chinese	
Asian British or Asian: Other	
Black British or Black: Caribbean	
Black British or Black: African	
Black British or Black: Other	
White: British	
White: Irish	

White: Gypsy or Irish Traveller	
White: Other	
Other	
Rather not say	
CURRENT EMPLOYMENT STATUS	
Employed	
Unemployed	
Not working – due to ill health	
Not working – due to disability	
Not working - retired	
Student	
Rather not say	

g. A short narrative summary (no more than two pages) of:
   1. the responses made during the conversation to the following questions:
      - *Do you think you know what people should do for themselves and their families to stay fit and healthy?*
      - *What do you think encourages people to do these things?*
      - *What do you think makes it difficult for people to do these things?*
   2. any examples given of good practice with regard to encouraging or making it easy for people to stay fit and healthy
   3. any case stories told by individuals which illustrate the enablers and barriers they have experienced to staying fit and healthy, or which demonstrate how they have "taken charge" of their own health

h. Number of people completing the survey during the session (this can be done electronically during the session, or done on paper and uploaded subsequently by a third party such as the conversation host or the lead or partner organisation)

i. Number of people also referred to the carers' survey

j. The names and contact details of anyone interested in becoming more involved (these details will be shared with NHS GM/c)

Appendix B: Conversations and participant targets and actual conversations and participation achieved

Partnership		Population (ONS 2014)	Conversations		Participants		Participation Average for Conversations
			Target	Actual	Target	Actual	
Bolton		280,439	10	12	100	183	15
Bury		187,474	7	7	70	96	14
Manchester		520,215	19	20	190	245	12
Oldham		228,765	8	9	80	90	10
Rochdale		212,962	8	10	80	133	13
Salford		242,040	9	13	90	133	10
Stockport		286,755	10	17	100	218	13
Tameside		220,771	8	10	80	129	13
Trafford		232,458	9	11	90	153	14
Wigan		320,975	12	12	120	202	17
GM/c	BME People	2,732,854	5	2	50	73	37
	Disabled People			9		90	10
	LGBT People			1		18	18
	Refugees			1		52	52
	Young People			4		22	6
Total		**n/a**	**105**	**138**	**1,050**	**1,837**	**17**

Appendix C: Target audiences for conversations[15]

Partnership	Conversation Audience
Bolton	Parents of disabled children People with mental health issues Representatives of VCS health and social care organisations Volunteers with interest in health and care People affected by cancer Asian women Parents of under 5s Young people Women involved with Probation Service Blind people People who are hard of hearing
Bury	Children and young people Deaf and hard of hearing people Homeless people Blind and partially sighted people Older people People with mental health issues South Asian women
Manchester	General public with interest in health and care Refugees and asylum seekers (including but not limited to people from Syria, Iraq, Kuwait and Eritrea) European migrants People with learning disabilities Students People living with multiple sclerosis Roma people Black African people Churches and religious groups People with mental health issues and carers Chinese older people People living with HIV Young BME people Spanish speaking migrants
Oldham	People in recovery from drug and alcohol addiction BME women People with learning disabilities LGBT people Unemployed people General public with interest in health and care
Rochdale	People with mental health issues Older people

[15] NB: The audiences were defined by participants' key shared features. This necessarily obscures the internal diversity and participants' multiple intersection identities. For instance, groups of BME people will have included older and disabled people, carers, etc.

	Asian LGBT men Disabled people Homeless people Young people Asian people (including older Asian people) Carers
Salford	People with learning disabilities Carers Young carers Military veterans and people with mental health issues Homeless refugees Older people Children in care and “not in education, employment or training” (NEET) Homeless people or people with history of substance misuse LGBT people People with mental health issues People living in Langworthy, Weaste and Claremont Mental health service users
Stockport	Older people People with mental health issues People with acquired brain injuries Young people General public with interest in health and care People on the autistic spectrum Homeless people Social care service users Unemployed women Dementia and Targeted Prevention support workers Families affected by pre/post-natal depression Carers Parents Disabled people People living with multiple sclerosis Patients Sick children and their families People with special educational needs
Tameside	Stroke survivors Survivors of domestic abuse People with mental health issues BME women Prostate cancer survivors Older people People who are socially isolated Community activists who regularly engage with general public around health and wellbeing

	General public with interest in health and care
Trafford	People from a disadvantaged area Older people Refugees and asylum seekers (including people from Ethiopia) Disabled people Young people BME people Deaf people People with mental health issues Young people “not in education, employment or training” (NEET) Carers
Wigan	Disabled people and people with long-term conditions Older people (particularly those socially isolated) GP patients Stroke survivors Deaf and hard of hearing people Carers Young LGBT people Young people (particularly NEET) Homeless people Volunteers with interest in health and care
BME People	BME people with particular focus on: Carers Young people Asian women
Disabled People	Disabled people with particular focus on: Unemployed people Deaf and hard of hearing people Older people
LGBT People	LGBT people with particular focus on: Minority LGBT people
Refugees	Refugees and asylum seeker accessing advice drop-in
Young People	Young people with particular focus on: Those “not in employment, education or training” (NEET) Disabled people People with long-term health conditions

Appendix D: Participants' demographic characteristics by partnership

Demographic Categories		Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	BME	Disabled	LGBT	Refugees	YP	Total	
																	No.	%
Age (in years)	19 or less	7	11	19	0	6	14	44	1	16	19	0	0	0	3	4	137	9.0
	20-34	28	21	44	21	12	22	23	11	20	17	12	19	18	12	18	250	16.5
	35-44	11	18	49	33	26	27	6	23	18	14	16	14	7	18	0	280	18.5
	45-65	57	22	25	30	34	49	30	28	45	35	22	44	8	17	0	446	29.4
	66-79	25	10	1	6	35	17	41	38	27	57	2	6	0	2	0	267	17.6
	80+	0	5	0	0	13	3	15	27	12	16	0	0	0	0	0	91	6.0
	Rather not say	3	1	0	0	7	0	20	1	6	5	0	1	0	0	0	44	2.9
	Total	**131**	**88**	**138**	**90**	**133**	**132**	**179**	**129**	**144**	**163**	**52**	**84**	**33**	**52**	**22**	**1,515**	**100.0**
Gender	Female	135	55	75	60	72	2	84	91	92	96	40	42	18	19	3	884	57.3
	Male	46	30	63	30	60	69	70	28	44	59	11	42	14	33	15	614	39.8
	Non-binary	0	1	0	0	1	2	0	0	2	2	0	0	0	0		8	0.5
	Rather not say	2	2	0	0	0	0	13	7	6	6	0	0	0	0		36	2.3
	Total	**183**	**88**	**138**	**90**	**133**	**73**	**167**	**126**	**144**	**163**	**51**	**84**	**32**	**52**	**18**	**1,542**	**100.0**
Resident in…	Bolton	183	3	2	0	1	0	0	0	0	3	0	0	3	1	9	205	12.7
	Bury	0	75	0	0	0	0	0	0	0	0	1	1	2	2	0	81	5.0
	Manchester	0	3	125	1	0	1	0	0	15	2	21	59	14	18	3	262	16.2
	Oldham	0	0	0	86	0	0	0	1	0	0	8	2	0	3	0	100	6.2
	Rochdale	0	1	0	1	128	0	0	0	0	0	5	2	0	1	5	143	8.8
	Salford	0	2	1	0	0	130	0	0	0	2	4	3	4	10	0	156	9.7
	Stockport	0	1	2	0	0	0	170	1	0	0	3	12	1	5	0	195	12.1
	Tameside	0	0	1	1	0	0	0	104	0	0	2	3	2	4	0	117	7.2
	Trafford	0	0	0	0	0	0	0	0	121	0	7	0	3	6	0	137	8.5
	Wigan	0	0	0	0	0	0	0	0	1	145	0	0	0	2	0	148	9.2
	Outside GM	0	0	0	0	0	2	0	19	1	4	1	2	4	0	0	33	2.0
	Rather not say	0	2	0	1	4	0	18	1	6	7	0	0	0	0	0	39	2.4
	Total	**183**	**87**	**131**	**90**	**133**	**133**	**188**	**126**	**144**	**163**	**52**	**84**	**33**	**52**	**17**	**1,616**	**100.0**

Demographic Categories		Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	BME	Disabled	LGBT	Refugees	YP	Total	
																	No.	40 %
Ethnicity	Asian British or Asian: Indian	15	0	0	0	0	1	5	2	8	0	1	0	1	1	1	35	2.2
	Asian British or Asian: Pakistani	8	19	11	16	24	3	0	1	9	0	4	4	0	9	2	110	6.9
	Asian British or Asian: Bangladeshi	1	0	0	9	18	0	0	15	1	0	2	0	0	1	0	47	2.9
	Asian British or Asian: Chinese	3	0	14	0	0	0	2	0	0	0	0	0	1	0	0	20	1.2
	Asian British or Asian: Other	0	0	0	0	5	0	0	0	6	0	0	2	0	6	0	19	1.2
	Black British or Black: Caribbean	0	1	1	1	0	1	0	2	4	0	10	5	0	4	0	29	1.8
	Black British or Black: African	3	0	41	1	0	4	3	0	18	0	9	1	1	21	0	102	6.4
	Black British or Black: Other	0	0	2	0	0	0	4	0	2	0	1	1	1	0	0	11	0.7
	White: British	107	61	3	56	85	117	136	82	80	149	14	54	27	0	19	990	61.8
	White: Irish	1	2	0	2	0	0	4	3	3	2	0	4	1	0	0	22	1.4
	White: Gypsy or Irish Traveller	0	0	18	1	0	3	0	0	0	0	0	0	0	0	0	22	1.4
	White: Other	1	1	22	2	1	1	2	0	2	2	2	2	0	0	0	38	2.4
	Other	3	1	30		0	2	5	0	4	2	8	0	1	9	0	65	4.1
	Rather not say	41	4	1	2	0	1	27	2	7	6	0	1	0	1	0	93	5.8
	Total	**183**	**89**	**143**	**90**	**133**	**133**	**188**	**107**	**144**	**161**	**51**	**74**	**33**	**52**	**22**	**1,603**	**100.0**
Employment Status	Employed	52	16	68	28	4	34	12	15	39	28	31	32	28	15	0	402	25.7
	Unemployed	20	23	30	26	21	25	8	26	19	15	9	15	2	16	10	265	17.0
	Not working - health	4	6	5	8	12	2	1	6	10	5	1	11	0	6	0	77	4.9
	Not working - disability	8	8	0	7	8	32	n/a	5	18	8	0	19	0	2	12	127	8.1
	Retired	18	17	8	11	40	23	47	65	35	74	2	7	1	2	0	350	22.4
	Student	8	12	25	0	4	14	47	1	14	19	1	0	2	9	0	156	10.0
	Rather not say	73	5	7	10	44	2	9	7	9	14	1	3	0	2	0	186	11.9
	Total	**183**	**87**	**143**	**90**	**133**	**132**	**124**	**125**	**144**	**163**	**45**	**87**	**33**	**52**	**22**	**1,563**	**100.0**

Appendix E: Minimum survey response targets and actual survey responses achieved

Partnership		Population (ONS 2014)	Min. No. of Survey Responses	Actual Survey Responses
Bolton		280,439	100	149
Bury		187,474	70	103
Manchester		520,215	190	333
Oldham		228,765	80	294
Rochdale		212,962	80	142
Salford		242,040	90	100
Stockport		286,755	100	119
Tameside		220,771	80	146
Trafford		232,458	90	190
Wigan		320,975	120	113
GM/c	BME People	2,732,854	250	141
	Disabled People			82
	LGBT People			47
	Refugees			107
	Young People			77
Total		**n/a**	**1,250**	**2,143**

Appendix F: Examples of good practice and case stories

Bolton

Case stories:

- Youth Council - Barriers: Several members were in year 11 one young man spoke specifically of the fact that school PE no longer happens in the pre-exam phase and that PE sessions are redesignated as revision sessions. The group concurred that this was the case. They felt PE should continue as they need not just to maintain some levels of physical activity but also to help them distress. Enablers: Several members of the group used Health apps especially step counters, the discussion suggested they found step counting and BMI measures more intuitive than other ways of monitoring the health of the their lifestyles. Other: One young woman stated that she worried about the long term public health effects of using electronic devices all the time. The group acknowledged they used a lot of gadgets but wondered if perhaps in years to come, terrible health effects might come to light – they compared this to how people felt and behaved in relation to smoking in previous generations.
- Impact of Health Checks - Bolton has a system of over 50's health checks. Some people noted this check. Enabler: an older gentleman stated that at his health check his GP had said he was pre-diabetic. This had kicked him into action and despite mobility problems he had set himself up with a thorough exercise regime involving swimming twice a week and going cycling with Bolton's Active Lifestyle Group once a week. Barrier: Another gentleman, in middle age said that at his Health Check the GP had said there was nothing wrong with him. Obviously he was pleased with this but he said that it had not motivated him to change any habits or do anything differently – though he said himself he didn't think he had the healthiest lifestyle.
- Impact of Caring for others - Enabler: one woman who cared for a disabled child went running every morning after dropping her child off at school. She described the 'military operation' character of her life in terms of looking after her family and had used the discipline implied in this approach to make sure she got her run in every day. She also said that she really enjoyed the running as it was her time and hers alone. Barrier: One lady was struggling to get a Personal health budget for her disabled child. She described how the complexities, bureaucracy and un-joined-up-ness of systems seriously impacted on her time. This, on top of the demands of looking after her daughter and the rest of her family meant she had very little time for herself in any capacity. 'Trying to get help for your child takes over your life'.
- Parents - One parent described how she thought of her family as quite sporty, however in fact she was just watching the sport and not actually participating in any of it herself. Taking the kids everywhere and looking after their healthy lifestyle things was important to her but she recognised that it took up a lot of time and didn't support her own healthy lifestyle aspirations. A group of parents of older children and teens talked about concerns about unhealthy body image and expressed particular concerns that a lot of body image issues perhaps normally associated with teenage girls seem to be increasingly affecting girls as young as 6 and 7 and boys (especially worried about steroid use).

Bury

Examples of good practice:

- Streetwise 2000: many young people stated that the organisation has significantly improved their life by providing them with one to one support and peer support.

- I Will If You Will Programme in Bury: exercise programme targeting women to become more active. The programme was highlighted as a good example in various 'conversations'.
- BIG in Mental Health: the group members all stated that they have received more help from BIG in Mental Health than their GP. Everyone felt very strongly about the positive support they receive from the organisations and how that has helped them with their illness and recovery. Many suggested that GPs could signpost patients to this group while waiting for their appointment with the mental health professional.
- Age UK Bury Jubilee Centre: participants stated that the centre was their lifeline and has helped them to make friends and participate in various activities. Many of the group members are regular visitors to the centre.
- ADAB: Many participants said how they enjoy attending ADAB for different classes or activities.
- Bury Society for Blind and Partially Sighted People: Group members highlighted the importance of the difference that the organisation has made to their lives. One person stated: 'I have made more friends since I became visually impaired than I have ever done before.'
- Communic8te: all the participants stated that it is a great place for them to meet like-minded people. The organisation holds different activities for the people who attend the centre e.g. Social evening and self-defense classes.
- The Housing Link: the group members stated that they did not know how they would manage without the Housing Link support workers.
- Fairbridge programme in Bury
- Bury Exercise and Therapy Scheme (BEATS)
- Creative Living
- Healthy Cooking classes
- Jigsaw Link Bury
- Manchester United Deaf Football Club

In conclusion it emerged from these conversations that voluntary sector organisations provide enormous support to individuals in the community. Although this impact on individual's lives cannot always be measured these organisations are often a lifeline for people who are isolated or have a disability.

Case stories:

- Lack of communication was one of the key issues for people. One service user missed her mental health appointment and despite having attended all the previous appointments was discharged at a time when she was at her most vulnerable. The situation was desperate, one of the community organisations in Bury found some funding to pay for the client to receive therapy privately. Following therapy, she fell through the gap as there was no follow up service available.

- A further key issue to have emerged from these conversations is, undoubtedly, isolation and loneliness. There was an elderly man at Age UK Bury 'conversation' who explained that he was feeling very isolated and lonely after his wife died and he decided to start visiting Age UK Bury Centre to meet new people and make friends. He met a lady who had lost her husband and since then they have remarried and they feel very lucky to have met each other. They were both present at the session.

Manchester

Case stories:

- Support for people with long-term conditions: During our conversations there was a marked contrast between the general public – who barely talked about health services - and people with long term conditions who gave examples of where the NHS in particular is geared towards acute care rather than supporting people to manage long term ongoing conditions. The example was given of a young woman with progressive MS. She had developed bad bed sores and was admitted to hospital. When she was discharged, she was given a special mattress at home, to support her weight better and reduce the risk of bed sores. Her condition improved, so the mattress was taken away. Inevitably, she started getting bed sores again. Through this process there was no co-ordination with other care services. The young woman was seeing an MS Specialist Nurse but this nurse was not involved. Because the response was provided by a service which is based on a rapid response to a crisis, the system could not respond with a long term care plan. Not only is this not cost-effective, the outcomes for the patient are poor – actually disrupting rather than supporting condition management.
- Work and Wellbeing: A frequent theme of our conversations was the impact of other factors on wellbeing – in particular the quality of employment. One person told us he worked in a restaurant for four months. Some days he had worked up to 13 hours a day. This meant a lot of stress, a poor diet because of always eating the same thing in the restaurant. After a time he noticed that he felt physically weaker as a result of the situation. In turn this started to affect his mental wellbeing. He spoke of “a stressful life” with “very low morale”. It also meant that he could not do what he really wanted which was to learn English - the reason he had moved to the UK in the first place. To change the situation he decided to change jobs. This means he now works fewer hours but combines this with study and spending time with friends. “I go to the gym and take care of my diet. Now I feel physically very well.” It is worth noting that he has had to accept a reduction to his income in order to make health gains.

Oldham

Examples of good practice:

- Lung Foundation provide excellent support.
- Fatima women’s group had a women and daughters breakaway weekend where they cooked together, socialized together and shared knowledge between each other.
- Oldham Council’s green dividend scheme to help grow your own veg.
- Smoking cessation classes in Rochdale and Oldham were given as examples of help that people thought were good. The Rochdale one included gym access.

Case stories:

- One person found a women’s only swimming group that she wanted to join. Unfortunately the swimming pool couldn’t guarantee a female life guard. As a result she chose not to join the activity.
- One person said they had started to misuse alcohol when their children had grown up and left home. They said they didn’t know what to do with themselves. They also said that they eat less healthily now as they found it difficult to transfer the skills they had in cooking for several people to cooking for just themselves. They said they couldn’t be bothered to cook nice meals just for themselves and they weren’t sure how to cook well for just one person.
- One person described how a family member being diagnosed with a smoking related illness had motivated them to take the first steps to giving up smoking themselves.

Rochdale
Examples of good practice:

- BACP runs a gym which is culturally suited to the community.
- Free, easy access drop–in centres in every community where members of the public can go for activities, information, advice and leisure pursuits and which are age/culture friendly would help to improve public health.

Case stories/anecdotes:

- "Talking to people makes you feel better. At home children speak English, we can't communicate with them. Age groups within different cultures have different expectations. If we can socialise in a friendly environment where we understand each other, it would be so much better for our individual wellbeing."
- "People become isolated because they don't have support and can't get out."
- LGBT [Foundation] run a men's only Asian group, which welcomes all gay men from across Greater Manchester and gives them the chance to come to socialise and be educated on varies topics. The service users of this group sang its praises, explaining they felt they had a safe place to come to discuss personal matters with people who can relate to their circumstances. The irony here is LGBT [Foundation] in the Rochdale Borough has been decommissioned so where will these service users now go, what support will they receive? It is important for residents across not just Rochdale but Greater Manchester to feel safe within the service groups they are using. This group is a prime example of this. The meeting that was attended was the second meeting of its kind and the only one across Greater Manchester. At the first meeting 3 people attended. This went up to 7 after just one meeting. This group felt safe, educated and stress free at this meeting, this is what we want for service users.

Salford
Examples of good practice:

- Men's Health Event: Lots of the men at the event talked about accessing healthy eating, mindfulness and other support through the community centre. They said that it had reduced stress and anxiety. They said they were more likely to do it in a community space that didn't feel like a health centre. This had led them to link in with other activities that improves their health outcomes like courses, smoking cessation and counselling.
- GPs Making Adjustments: One carer said that the GP and nurses come to the house to do reviews and blood tests to reduce the anxiety caused to her son during these appointments. "They're wonderful and it means that we have less psychotic episodes and it's easier to maintain X's wellbeing."
- Managing Long Term Conditions: A couple of people talked about the help they had received to manage additional physical health conditions being useful (particularly diabetes). There were regular reviews and easy access to services that would help. Lots of information was given and some people had been taught how to monitor their own symptoms (like blood pressure). It was felt that this is a good way of helping people stay healthy.
- Housing and Adaptations: One woman talked about her experience of attempting to have her social housing adapted to meet her needs. Her bathroom took over a year whilst she struggled with her mental health and to access washing facilities due to

her physical disability. This was made worse by her gas cooker and oven being condemned due to problems with the pipes. “The workman who came in just turned it off, stuck a sticker saying not to use it and left without any explanation. It was like that for three months. I couldn’t eat properly. I have a liaison officer but they didn’t seem interested in helping since it was my cooker. In the end my brother rang someone out of the yellow pages and I paid £40 to have it fixed.” “They (social housing provider) should flag up where people are vulnerable and help them. Staff don’t have any understanding of issues and need training.”

- Mental Health Weekend and evening services: these can be the most difficult times for service users as there is a period where they may be unsupported. The introduction of the Weekend Workers within the GMW Community Services was meant to help staff refer known to them service users for weekend contact with the service where it was deemed to be a risk of crisis. This was introduced two years ago and people who have accessed the service have responded positively but there is currently a review happening to assess its impact in improving mental health, reducing A+E frequent flyers and reduce crisis and periods of illness amongst service users.
- Empowerment / Running their own group: The group members (Time out for carers) said that they prefer running their own group because they can have things the way they want and it links them into other things that help them manage their wellbeing.

Stockport

Examples of good practice:

- 1 mile run at school
- Park activities
- Social groups
- Slimming world
- U3A
- Food diaries/journals/planners
- A lot of groups talked about the growing number of local park run events, that were free/cheap and included all the family, plus it takes place outdoors – a factor also important for a lot of people (getting fresh air). However, these appear to be happening in some areas and not across the board. Assuming they are mostly run by volunteers and friends of the parks initiatives. Something which could be put forward to be supported?

Tameside

Examples of good practice:

- A group of older people talked about a session about healthy cooking using a slow cooker, including a reminder that they can freeze portions to reheat later helped some of their members to eat more healthily.
- A stroke survivor said that the six week reablement support she had received after leaving hospital had been really good. It helped her to get some confidence back and learn how she could still exercise and maintain some physical fitness even though her medical condition meant she couldn’t exercise in the ways she had done before.
- Primary schools were generally praised for their work around healthy eating and the meals available. It was felt that this was not carried forward into secondary schools where there was easier access to unhealthy eating options.

Case stories:

- Several stroke survivors spoke about how their strokes had led not only to them wanting to be healthier but also how it had been a 'wake up call' for other family members.
- One diabetic woman from a Bangladeshi group said how attending that group had improved her physical health and emotional wellbeing. She said that attending the group helped her to manage her health better.
- One member of the 'Making a Difference' support group spoke about how it had helped both him and his father to feel more involved with a range of activities and people. They now both support each other and have both given up the alcohol consumption that was having a negative influence on their own lives and the lives of those around them.
- Several people in a mental health support group mentioned that some courses offered to address mental ill health are run in partnership with the Job Centre. They said some people are too frightened to go on them in case they are sanctioned for (non)attending, even though it could be something like meditation (e.g. the Recovery College).

Trafford

Examples of good practice:

- Value of community groups: community groups able to distribute information in appropriate languages, deaf friendly groups able to disseminate information to their community; community groups such as EngAGE, able to offer a range of health activities and reduce social isolation in older people.
- Argentina – 'Exercise Sunday'. Government and local authorities promote Sunday as a day to do something healthy. This encourages families to exercise together. It was suggested that GM should do the same.

Case stories:

Self-help and peer-to-peer support groups: great impact on both physical and mental health; group walking and gardening:

- "Our [Carers] support group do a lot of physical and sports activities and this has been extremely helpful, the group has practically saved our lives"
- "Being part of groups (for example National Autistics) has given access to courses and training, helping to understand laws/policies, rights, even children's disabilities, which has helped a lot in reducing our stress – "can't imagine what our lives would be without it"

Wigan

Examples of good practice and suggestions:

- Jobcentres have a system that automatically flashes up when an interpreter is needed for a client and so any appointments and communication accommodates this. Appointments won't go ahead without an interpreter in place. Can this be replicated in Health and Social Care?
- Offering groups like the slimming ones for smoking and drinking.
- Give e-cigs out to people who want to stop smoking as an alternative (lesser of two evils).

- Train volunteers to lead health session for free – walking, running, yoga, Zumba, etc. Health Champions to come into The Brick to give information – take services out to people.
- Graduated retirement to ease people into now not working 40+ hours.
- Educate or re-educate older people, e.g. cooking for one. Many older people are living on ready meals rather than cooking.
- Active Living need to target activities earlier to prevent problems, rather than when the problem is already identified.
- Teach children about health in schools. Re-introduce Home Economics which teaches about home/ life skills.

Case stories:

- One person reported that they had to go private due to their negative experience at a local hospital when the medical staff turned their backs to the patient but carried on talking. They felt there was no awareness at all of staff to her needs as a deaf patient.
- One person lost weight (3st) to stop having knee replacement and also because husband took ill. This person feels healthier – although they have asthma and angina. She used Slimming World (a scheme supported by Wigan Council Public Health). She went with daughter-in-law as support.
- One participant reported that she had avoided a major operation by changing her diet and lifestyle and managing her medication. She was determined not to have an operation if she could do this with her GP.
- One participant reported being referred by her GP for cycling but there were problems with Wigan Leisure Culture Trust.
- One young person stated it took him 6 months to get a gym pass as he had to wait for his social worker to complete the form. He said there were only two ways that he knew of to get a free pass – one was through his social worker as he was leaving care, the other was through his GP if he had mental health problems.

BME People

Examples of good practice:

- Examples of good practice in improving awareness and uptake of services exist but attendees did not know how widespread they are
- Dedicated outreach workers who can build up connections with local communities and groups.
- Peer mentors (Champions) who can tell other people in their community about their experiences.
- Community gardening projects.
- Culturally appropriate swimming and other leisure services.
- Prescriptive exercise (and wider social prescribing)
- Pregnant women campaign for fruit & vegetables (£150 grant).
- In-work schemes, lunchtime walks, use stairs not lifts.
- Attaching childcare provision to fitness classes
- Good Mood Food which helps to develop cookery skills, based at Zion Centre, Hulme.
- African Befriending Group, mental health services.
- Provision of Tai Chi
- Use of new technology to overcome some barriers to access and information, particularly impacting on multiple marginalisation groups.

Case stories:

- “Improving Awareness and better understanding through engagement” (a commissioned project by Public Health with MBMEN): Working with the community to better understand sexual health and BME women as a way of informing the future commissioning of sexual health services for women. Commissioners were prepared to invest and work with the Manchester Black and Minority Ethnic Network (MBMEN) in exploring needs and perspectives through a community champions approach. Taking a collaborative and co-design approach, the MBMEN recruited (from within its relevant network members) female volunteers and trained them in sexual health issues and research methods. Working as a team and supported by MBMEN they undertook the research which involved interviewing women in the community and organising and holding focus groups, talking and having conversations about sexual health issues and needs. The findings provided intelligence about the Sexual health needs of BME women, their views and use of contraception and their views on termination of pregnancy. This information was given to commissioners to be used to inform and influence future commissioning of sexual health services for women and having more appropriate approaches that meet the needs of BME women. This also left essential learning in the community, built knowledge, connection and skills. It provided commissioners with the knowledge of cultural needs and a greater connection to community support and services leading to more intelligent commissioning and provision of services.
- “Investing in Communities: resourcing communities and working with residents”: FCHO (First Choice Homes) is a housing provider in Oldham. They have invested in the BGreen programme which has several components including initiatives to address health and wellbeing. These are targeted at local residents in local estates. They have also invested in having one of their outreach staff trained in the ABCD (Asset Based Community Development) approach. They commissioned CLES (Centre for Local Economic Strategies) to undertake an evaluation of the B Green programme. The approach CLES took was to recruit local residents (as community researchers), train them to undertake surveys and support them to work with CLES in the research (doing local community /resident surveys). The level of engagement was greater because of this approach. The BME residents actively engaged with this approach (as did other local residents but more BME residents became involved and sustained their engagement). Several BME residents have engaged and developed their skills as community researchers and helped undertake this project survey. For this Health and Social Care Community engagement activity we were able to ask the “community researchers“ at FCHO to help us with the Healthchat surveys and we found that they were most effective in having these conversations because they had had previous training and were confident. It also meant that they were able to engage further in meaningful community work and more skilled and knowledgeable. We also found that because they had already been involved with the BGreen programme they were more knowledgeable about Health and Wellbeing as well as keen to be more active champions in this area. They and wider residents have also engaged actively in the local programmes targeted at the local community and some of its key issues, e.g. community garden projects developed to engage residents in outdoor activity and growing, healthy cooking classes have been held and had positive participation, community growing initiatives, exercise classes .The lesson here is that it is beneficial working with local people at a local neighbourhood level where access is easiest.

- "Working in partnership with local schools – creating community activities": Working in partnership with the local school the community members have set up a weekly fitness class that takes place at the school and encourages mums to participate. It has been really successful. This has been possible because a small level of funding was available for local activities. The class is very successful and attracts BME women making it easy for them to access as they come to drop off and pick up their children at the school and the class is FREE.

Disabled People

Examples of good practice:

- Accessible exercise and healthy eating classes at disabled people's organisations.
- Deaf Health Champions (www.signhealth.org.uk/deaf-health-champions-3) was given as an excellent example of work that must be supported and continued to ensure that health information is accessible to Deaf people.
- Physical Activity Referral in Stockport (PARiS) is the GP Exercise Referral scheme in Stockport, "designed to help patients with moderate medical conditions become and stay more physically active, whilst benefiting and or improving their health.": www.lifeleisure.net/enterprise/lifeleisurestockportgpreferral
- "Training of staff is important. Training should cover the content (able to provide specific advice to disabled people), and delivery (understanding of the social model of disability, understanding of providing support in a non patronising and non-invasive manner etc, appropriate use of language, understanding of individual's personal boundaries etc). Staff with these skills are more likely to feel confident at supporting and where appropriate pushing people to achieve more."
- One person mentioned a local volunteer-led running track which costs £2 a week for a child to attend twice.

Case study:
Inaccessibility of local provision: "My local swimming baths have made a commitment to fixing the hoist into the pool, but last time I spoke to them still hadn't progressed this. I am aware of my rights, and know how to challenge services to get them to fulfil their legal obligations. However, like many people I struggle with motivation to exercise, so challenging the delivery of services that I would then have to push myself to access, ends up a low priority on my list."

LGBT People

Examples of good practice and anecdotes:

- "My GP always includes my wife."
- "My wife has received health care in recent years and I have had positive experiences from these services when it has not been assumed that I am anything other than her partner"
- "My partner and I went for STI testing together –we were treated with dignity and respect and critically as a couple"
- "Sexual health services –didn't blink an eye about discussing gay sex"
- "We deliver talks and workshops to a whole range of older people's groups, I'm really keen to see the project engage with the LGBT community as there is potential to have such a positive impact."
- "your health pages; an impressive detailed section on anal cancer. It is undoubtedly a very helpful source for its readers.

- ‘ LGBT attitudes to smoking conference opened doors and dispelled myths about just being LGBT ‘friendly’. Lots of different aspects around LGBT smoking issues, young people, cancer treatments, attitudes etc .raised my awareness of LGBT community and prejudices still suffered and also barriers faced in accessing support services.’
- “Having an LGBT person speak at E&D events telling their stories in a human and inspirational way. For me it critically hits the point about how people from LGBT community are treated differently in NHS and impact this has on them.”
- ‘We have a new LGBT focus group to help influence policy and support our community’
- ‘Having heterosexual allies play an important role in educating staff on the importance of sexual orientation monitoring.’’
- LGBT case studies and research that is relevant really helps to get across LGBT health issues’
- “Seeing LGBT Foundation on this site (gay men’s social media site via netreach) is great because it gives us an opportunity to ask questions that we wouldn’t normally ask face to face and to discuss issues that for many may seem ‘controversial’ or ‘taboo’ about sex and sexual behavior.”
- "Brilliant to finally see some safe sex information and advice here (at gay men’s club night ‘Alert’). "Safe sex is always such a difficult topic to discuss, especially in places like this, by you being here you kind of make it ok to use protection, hope to see more of you"
- “Working in the local community (Rochdale Heywood & Middleton LGBT locality worker) really helps not only to support service providers but in actually having an impact on improving people’s lives, raising awareness and creating opportunities for LGBT support and inclusion.”

Case studies:

- “My records were not complete on my GP’s screen so GP went to reception and said ‘I have a man here and his records haven’t been updated.’ I am a trans woman and I was sat next to him. I had to walk past reception to leave the practice and felt that my dignity had been severely breached.”
- “When my wife received hospital care I lost count of the times I had to explain I was her partner and not a friend or relative. This made it difficult for me to feel confident to ask questions about her care.”
- Rosie Adamson Clark is one of LGBT Foundation’s volunteer Community Leaders in Bolton and has been heavily involved in ensuring LGBT people are included in EDS 2. Rosie is now 60 but has needed the input of medical services due to life threatening conditions from an early age. She has been with her female partner for 22 years, and is happily married. Rosie worked for the NHS for 15 years before early retirement due to ill health. During her time as a clinician in psychology and mental health services she was aware of the unmet needs of the LGBT community. “*Practitioners would say they treated everyone the same, and I would explain this approach is not person centred and for those who feel alienated or unsafe, the one size fits all, will only further alienate them. We needed and still need specialist services staffed by well-trained people who understand the pressures and strains of life lived under a heteronormative lens.”* Rosie feels passionately about challenging and eradicating health inequalities. Over the years she herself has experienced prejudice in Health services, being treated as the problem, purely because of her identity, and ‘non-heterosexuality’. Through volunteering with LGBT Foundation Rosie has managed, as a health champion, to visit more than 2/3rds of the 40 GP

practices in Bolton to ask if she could leave LGBT resources and information about Pride in Practice (GP programme). In most instances Rosie never got past the Receptionist window. Rosie recalled asking one practice if she could leave posters to be displayed and resources for LGBT Fdn; "*The Manager said* '*what's the LGBT?' I explained what it was and she replied 'we have no lesbians or homosexuals in our practice' I said well none that you are aware of, it might help if I left the information.* With the population of 270,000 in Bolton, and Stonewall figures stating the LGBT population is around 6% of the overall population... this translates to around 7,500 LGBT people in Bolton, and between 75 to 200 LGBT people in each GP practice, dependent on their practice population. Rosie adds: *"I was gobsmacked, saddened, surprised in equal measures to keep hearing the same rebuttals in the GP practices. I continued my work, and left many resources at many practices, which I heard later were useful and used by patients' I became a board member of Healthwatch, attended CCG meetings, visited the Hospital and RAID team with resources and helped with a stall to spread awareness of LGBT issues. I also visited Dental surgeries and physiotherapy practices. When the CCG decided to cut the budget for specialist LGBT mental health services, I attended many meetings to argue the case for its special status and need of funding. It took a long time and great deal of effort but in the end we won through and the CCG reversed their decision".* Rosie was also an early member of the 'Sexual Orientation Monitoring Task Group' in London, travelling down to be part of the group, and offering input along with the CEO of LGBT Foundation Paul Martin OBE. She worked on the new EDS2 framework with the Equalities commission group in London. Rosie says: *''Provision is at best patchy and often does not treat people with dignity and respect and with equal regard. I am very proud of the work we did on the ESD2 framework which is now due to be launched''…."Dignity, respect and appropriate responses from medical & social care providers has to become a reality. Persistence is a good thing, we have to be a voice for those in our community who continue to be marginalised and badly served. Testimony and story giving of our experiences, good and bad, are the key to changing and reducing barriers. There is still much work to be done Nationally, regionally and in our own home towns...certainly in my adopted home town of Bolton much needs to be done to create a level playing field and the equal access to services we deserve."* Rosie Adamson-Clark. March 18th 2016)

Refugees

Examples of good practice:

- Local NHS and social care services to establish links with refugee community organisations (RCOs) through which ongoing health training/awareness raising programmes can be achieved with increased participation and language provision.
- NHS GM/c to support health projects that are run within these RCOs through the provision of qualified facilitators, training for frontline project workers (community health educators), grants to cover some expenses and resources wherever possible; while facilitating accountability by the RCOs in the delivery of the outcomes.
- Keeping this kind of conversations ongoing throughout the devolution as a form of empowerment to local people hence to allow prompt feedback on the health priorities of Greater Manchester population as well as addressing concerns.

Case study:

There was a case story of a woman in her late thirty's who became obese, lacked self-esteem, suffered from anxiety and didn't know neither how to start a healthy routine nor maintain it. After she was given advice on health risks at a community health training in a

language she could easily understand; and she realised she could suffer from type 2 diabetes, she quickly made adjustments in her lifestyle. Although she enjoys swimming activities, she still found it difficult to use a local swimming pool due to cultural context. Her little use of English language made it difficult too as she couldn't do this compared to how swimming in her home country was essentially a group activity amongst friends. Therefore, she relied on her family support for healthy choices of food and walks to work to increase her physical activity. She desires more support on how to start healthy habits and maintain them.

Young People

Example of good practice:

One young woman talked about an event held in her community in Hattersley. The local housing provider held a day-long event open to the public, hosting stalls from different organisations. The stalls had different themes including healthy eating. She found this to be an accessible way to get information about health. She felt that there needed to be more community-based events.

Case study:

One person felt motivated to exercise due to putting on weight. She had not participated in exercise since she left school. She felt her weight was becoming a problem. She doesn't work so her lifestyle is fairly inactive. She wants to join a gym but felt the cost was off-putting, and she didn't really know what to do there. She felt that there wasn't any opportunities for her to participate in exercise, and wanted more community-based activities.

Appendix G: Suggestions for further data analysis, research and engagement

1) For the purposes of this report we have restricted our qualitative analysis to the summary narratives[16] all partnerships submitted. As many of the local partnerships also facilitated conversations targeting BME, disabled, LGBT and young people, and refugees a better insight into factors pertaining to those groups in particular might be gleaned by an analysis of relevant individual conversation records.

2) A few other marginalised and seldom heard groups were also targeted by a number of local partnerships (e.g. homeless people) so a more in-depth analysis of individual conversation records could be extended to those.

3) The data suggests that what enables or prevents healthy lifestyles changes throughout the life course along with personal circumstances. For instance, healthy eating will require different supports for school age children, students at university, single people, couples, people whose children have grown up and left the home, retired people, people affected by illness or disability etc. This means that even people who adopt healthy lifestyles are at risk of falling out of those and losing required support as they move through transitions. Considering the wider literature on the cumulative negative effects of badly managed or supported transitions (NB: this could be the transition from being single to starting a family, or the transition from being healthy to living with the effects of a stroke) it seems reasonable to assume that the benefits of public health initiatives re diet, exercise, smoking and alcohol consumption could be maximised if they were better targeted at those transition points. Further research into this would be highly recommended.

4) While knowledge about healthy lifestyles did get a few mentions, most partnerships reported that motivation and a sense of self-efficacy was seen as far more decisive factors. We are aware of the substantial academic literature in this regard but think it would be worth exploring further how this plays out in relation to particularly local seldom heard and marginalised communities, for instance, those with multiple intersecting identities most affected by health inequalities.

5) Considering that conversations took place in community settings and were facilitated by VCSE groups and organisations it's not surprising that participants emphasised the role of the VCSE sector in supporting people to take charge of their health and wellbeing. However, from the data collected here it wasn't always clear how groups and organisations went about this, and which approaches were particularly successful for which target groups in which circumstances. Considering the relatively sparse existing evidence base in this area, I think we need a programme of systematic evaluation to shed light on this and enable us to upscale the most useful interventions. This might involve a combination of primary process evaluation (e.g. embedded as requirement of funding for new projects, as part of pilot interventions), and secondary analysis of already available evaluation data (i.e. we could collect past project evaluations undertaken for funders or commissioners from VCSE orgs).

6) Again, it is clear from the data that a "one size fits all" approach to health promotion does not work and that the needs of different individuals and communities

[16] NB: Summary narratives consisted of the main points from individual conversation records.

are incredibly specific. For instance, the BME partnership strongly made the point that the term "BME" encompasses a large range of vastly different and diverse communities and hence it is too simplistic to explore issues on that level. Instead we require research into specific BME groups to plug gaps in the evidence base (e.g. recognise the Kashmiri community in Oldham as distinct from the Pakistani community).

7) Young people have raised issues relating to living in an increasingly digital world and how their use of various gadgets and social media platforms impacts on their health and wellbeing. While these wider sociological trends are already a focus of emerging research and will require longitudinal investigation, it would be useful to look into local, digital solutions to health promotion.