INSTITUTE of HEALTH EQUITY

BUILD BACK FAIRER IN GREATER MANCHESTER: HEALTH EQUITY AND DIGNIFIED LIVES

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CHAPTER 1
INTRODUCTION

The decade of 2010–20 was not good for health in England, or for health in Greater Manchester. Life expectancy stopped increasing; inequalities in health between groups widened; and for the poorest people in Greater Manchester, life expectancy declined. The 2020 report *Health Equity in England: The Marmot Review 10 Years On* provided an overview of these declines in health in England and assessed that it was likely that national policies of austerity played a part in this unwelcome situation.

Recognising persisting inequalities in health, the Greater Manchester Health and Social Care Partnership, including Greater Manchester Combined Authority (GMCA), considered if, as a devolved region, it could take the necessary steps to improve health and reduce health inequalities. To aid this process, in 2019 the UCL Institute of Health Equity (IHE) was invited to work with the Greater Manchester system to establish a Marmot City Region, focussed on reducing health inequalities and inequalities in the social determinants of health. Then, the COVID-19 pandemic arrived, exposing and amplifying inequalities in health and the social determinants of health in Greater Manchester, as in the rest of England. IHE's work with Greater Manchester was reoriented, the aim being to provide evidence of the health inequality challenges the City Region will face post-pandemic and to make recommendations to monitor and reduce them.

COVID-19 AND INEQUALITIES

Within Greater Manchester, as across the world, inequalities in COVID-19 mortality have been only too apparent and the long-term economic and social impacts of containment measures will widen inequalities in health for the foreseeable future. Analysis shows that rates of mortality from COVID-19 in Greater Manchester are 25 percent higher than in England as a whole. Life expectancy in the North West of England also declined more during 2020 than in England overall, according to provisional data (2).

Economic inequality, working and living conditions, types of employment and high levels of physical interconnectedness partly explain the circumstances that have led to high infection and mortality rates in Greater Manchester; and the timing of the containment measures implemented in England did not align well with the trajectory of the pandemic in the City Region. Greater Manchester has also experienced highly unequal mortality rates: the COVID-19 mortality ratio in the most deprived decile was 2.3 times greater than in the least deprived decile between March 2020 and January 2021. These socioeconomic inequalities in mortality from COVID-19 are wider than in the rest of England.

The City Region has also experienced particularly damaging longer-term economic, social and health effects from a combination of local and national throughout and through the first half of 2021. Impacts include deteriorating community and environmental conditions as the public purse is further strained, widening inequalities during children's early years and in educational engagement and attainment, increasing poverty and income inequality, rising unemployment, particularly for young people, and deteriorating mental health for all age groups but again particularly for young people. All of these negative impacts will damage health and widen health inequalities in Greater Manchester. This report assesses these unequal impacts and makes proposals about how to take urgent, remedial action.

CHAPTER 2

BUILDING BACK FAIRER IN GREATER MANCHESTER

This report provides a framework for how Greater Manchester can 'Build Back Fairer' in the aftermath of the pandemic. Fundamental to achieving a permanent reduction in health inequalities is a focus on the social determinants of health: those factors outside health care that affect health.

Some of our recommendations are new and some offer support for, and expansion of, existing approaches in Greater Manchester. The framework calls for health equity to be placed at the heart of governance, including resource allocation, in Greater Manchester and for all policies in the region to be geared towards achieving greater health equity.

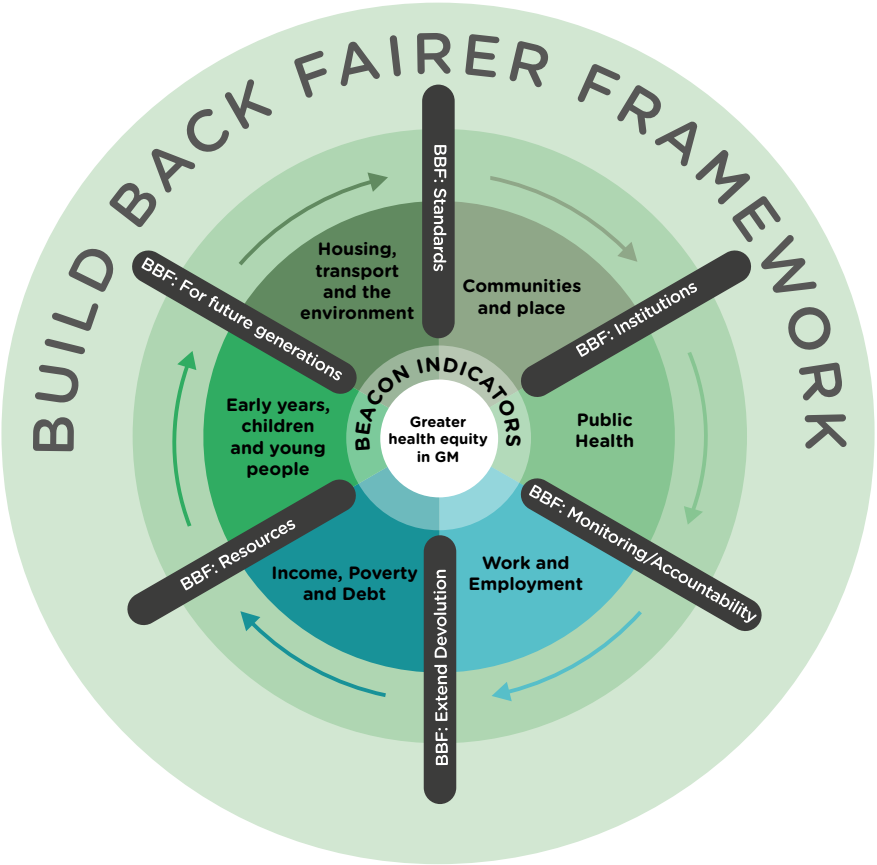
The Marmot City Region approach developed in Greater Manchester over the last two years has provided a good basis to place health equity at the centre of action in communities, local authorities and in the Combined Authority, and, we hope, with business, to focus on Building Back Fairer. Greater Manchester is well positioned to lead on this agenda. As a devolved region, it has the leadership, capacity, powers, partnerships and a strong identity that enable it to act on health inequalities in ways that are not available in other parts of England. Greater Manchester already has many investments, policies and strategies that are pro-equity in relation to economic inclusion, employment, housing, transport, the environment, education, early years, community support and public health. The Inequalities Commission has made further important recommendations to push forward the goal of greater equity in Greater Manchester and to prioritise wellbeing. This report challenges the whole of Greater Manchester to go further and faster on reducing health inequalities and inequalities in economic, social, environmental and cultural circumstances.

The time is appropriate for the actions we set out here. Due to the pandemic, health and equity have been at the forefront of the national consciousness, the whole of government and society have worked together in common endeavour, and there is greater recognition of the importance and efficacy of public systems; these are essential features of successful action on health inequalities. The unfairness of economic and social arrangements, ethnic disadvantage and racism and the extent of health inequalities have been exposed and public and political appetite to remedy these may have increased. There has been greatly heightened awareness of the vital role of key workers and the importance of local assets – clean air, green spaces and the role of the voluntary sector. Community resilience and social cohesion have been strengthened, at least in the short term.

A FRAMEWORK FOR BUILDING BACK FAIRER IN GREATER MANCHESTER

The framework we have developed for the Build Back Fairer approach is based on our assessment of priority areas for action and required approaches in order to strengthen implementation and governance for health equity in the region. Specific recommendations in each of the social determinants of health areas are set out in the rest of this report and relate to the social determinants in the Building Back Fairer framework in Figure 1.

Figure 1. Framework for Building Back Fairer in Greater Manchester



BUILD BACK FAIRER FOR FUTURE GENERATIONS

While children and young people have been at far less risk from COVID-19 disease than older adults, they have been disproportionately, and inequitably, harmed by the impacts of restrictions and lockdowns. Closure of early years services and schools and disruption to universities, further education and apprenticeships have led to widening inequalities in children and young people's development and education and in post-18 training and employment. Restrictions on socialising have been harmful for many young people. This group is also experiencing rapid increases in unemployment, with many of the sectors that especially employ young people – sport, leisure and hospitality – being most affected by COVID-19 restrictions.

There has been an increase in poor mental health among children and young people from already concerning levels before the pandemic. A significant acceleration is needed in the provision of mental health services for young people and in programmes to support mental health in schools, further education and workplaces.

Greater Manchester has an excellent record on reducing inequalities in early years development and educational attainment but given the impacts of the pandemic this work needs to be immediately strengthened, scaled up and while greater support is needed for all young people, it needs to be proportionately greater in more deprived areas, educational settings and workplaces.

BUILD BACK FAIRER RESOURCES

Cuts to public funding in the decade to 2020 damaged health and contributed to England's high and unequal toll from COVID-19 (1). The cuts to funding were regressive – poorer areas and those areas outside London and the South experienced proportionately larger cuts. The resulting damage to local authorities with greater deprivation have affected the course of the pandemic and, crucially, the resilience of areas to cope with the economic and social impacts of pandemic containment measures.

In order to achieve the Government's own agenda to 'level up' across regions in England, and to Build Back Fairer, these regressive cuts must be reversed and compensated for. Greater funding must be allocated to more deprived areas and those areas that have experienced higher rates of COVID-19 and endured longer lockdowns and restrictions. The case for increasing national funding allocations across Greater Manchester is powerful, the City Region having experienced significant cuts prior to the pandemic, high and unequal rates of COVID-19 infection and mortality, and longer lockdowns. Additional resources would enable Greater Manchester to begin to recover faster and more equitably. Several of our recommendations relate to national advocacy for increases in resource allocations from central government.

Proportionate universalism is an important principle. Funding should be proportionate to the scale of the problem, but universal in reach: more funding should be given to areas of greater deprivation and to communities experiencing high levels of poverty and exclusion. The mechanisms that Greater Manchester has already established to enable this need to be re-examined and extended, given the impacts from COVID-19 and containment measures.

In addition to advocating for higher levels of funding allocations from central government, it is important to generate more resources and action locally in support of the Building Back Fairer agenda. One way of achieving this is through contractual mechanisms where 'additional social value' is included in the tender requirements and contracts partly awarded on the basis of what additional social value they bring (4) (5). Business has a significant role to play here.

Despite increasing levels of demand for services, it is crucial that funding for interventions that reduce the likelihood of poor outcomes is increased. This applies to local government funding allocations as well as national allocations. Services must focus more on preventing problems such as homelessness, school exclusions and low educational attainment, food poverty, debt, poor health and unemployment before outcomes deteriorate further. Evidence shows that such prevention-based interventions are hugely beneficial and cost-effective. Across Greater Manchester there is evidence of successful action on prevention, and public service reforms have facilitated the necessary shared working to support such actions. but there is still a need to build capacity and knowledge and to significantly scale up these efforts. We also propose that the budget for prevention in the total health care budget in Greater Manchester should be doubled within five years and a system-wide prevention/health creation spending target for all of Greater Manchester is developed by the end of 2021, with incremental targeted increases over five years.

BUILD BACK FAIRER STANDARDS

In order to reduce health inequalities and Build Back Fairer, standards in several key drivers of health need to be improved in Greater Manchester, related to living and working conditions. We propose that Greater Manchester develops a set of minimum standards, a quality threshold that underpins a commitment to provide healthy living and working standards for all the City Region's residents. These standards should cover quality of employment, environment and housing, transport and clean air and have a high public profile and transparent accountability mechanisms that enable residents to challenge employers, businesses, service providers and local authorities that do not meet these standards. Guaranteeing access to a range of quality services in Greater Manchester will help ensure better equity of access and improvements to quality and form the basis of a Greater Manchester universal services guarantee. Services covered should include health care, education and training, police and fire, environmental and housing services and public health and go beyond what is currently available in terms of environment, housing, employment support services, training, for instance.

Alongside commitments to improved standards of living and employment and access to services, a baseline minimum income for healthy living needs to be developed for Greater Manchester. The minimum income standard, developed in 2008 by the Joseph Rowntree Foundation and Loughborough University, is a useful measure of the income needed to live a healthy life (6). It includes clothes, shelter and healthy food as well as social participation, travel and leisure. The minimum income for healthy living for Greater Manchester is likely to differ from England-wide minimum incomes enshrined in the living wage, which is often too low to support healthy living.

BUILD BACK FAIRER INSTITUTIONS

Across Greater Manchester there has been a welcome focus on developing anchor institutions. Anchor institutions are usually conceived in relation to large public sector organisations that are rooted in places and connected to their communities, such as universities and hospitals (7). These large institutions have significant assets and spending power and can use these resources to benefit communities, often

through their own employment practices and recruitment approaches, hiring from local populations and directing supply chains to support local economies. They can add social value by providing fair and good employment, recruiting from lower income areas and offer the living wage, investing locally and sharing use of land and property (4). In Greater Manchester it is estimated that health and care organisations employ 127,715 people and spend nearly £16 billion per year. If even a small part of their budgets were spent on local suppliers, this could help to generate local economic opportunities (4). While Greater Manchester does have an established programme of anchor institutions – particularly NHS anchor institutions – there is now a need to significantly extend these approaches and incorporate other public sector organisations and business.

In this report we highlight the potential greater role that business can play in action on health inequalities and the social determinants of health in Greater Manchester. Businesses have a significant and often underdeveloped contribution to make, summarised in Box 1. As the pandemic recedes, there are signs of renewed interest from business in reducing health inequalities, a response to the worsening conditions through the pandemic and a greater awareness of the injustice of health inequalities. The Combined Authority and local authorities in Greater Manchester can take a lead in supporting and advising businesses to contribute more to Building Back Fairer in terms of direct financial contributions and partnering with the public sector and the voluntary, community and social enterprise (VCSE) sector, but also through making shifts to their business operations, investments and services.

BOX 1. BUILDING BACK FAIRER BY BUSINESS

Employers: Good working conditions, fair progression, decent pay and security of work are vital to good health. Developing within-work training and extending apprenticeships and other training schemes are important ways to skill-up the workforce at all ages, to contribute to reducing the numbers of young people not in education, employment or training (NEET), and to reduce unemployment in Greater Manchester.

Service and products: Businesses procure and deliver services and products. These services and products and the related contracts offer potential routes to greater health equity. Healthier products are important, but supply chains also need to support healthy living and working conditions, and businesses have an important role in scrutinising suppliers and contracts to ensure they protect health and equity in the supply chain.

Social value: Businesses have a great potential to add social value through their usual business practices, including the addition of social value in tenders and in contract awards – contracting for social value.

Investments and assets: Businesses invest in, own and manage assets that can benefit or undermine good health and equity in the social determinants of health. Divesting from assets that undermine health and equity is a powerful lever for supporting change. Thriving businesses have an opportunity to fund and support essential services and assets for local communities. We suggest a regional investment fund to facilitate coordinated investment in Building Back Fairer.

Business anchor institutions: Anchor institution approaches have mainly been developed in the health care sector, with some additional developments in other public sector organisations such as universities. Businesses are also located in places and have an important place-shaping role. This includes but extends beyond their role as employers as they affect social, economic, cultural and environmental conditions within places and includes social value contracting and ensuring that assets and investments support, rather than undermine, health equity.

Wider partnerships: Businesses should be closely involved with other organisations working to improve local conditions and foster healthier local areas. Hitherto, these collaborations have been weak or one-offs, and greater more sustained collaborations between business, the VCSE sector, local authorities and public services would be highly beneficial to building back fairly.

Workforce contributions: Many businesses support their staff to volunteer their time and expertise to support local communities. We suggest these roles and support are extended so that all staff who wish to are able to support their local communities, including those employed in small and medium-sized enterprises (SMEs).

Advocacy: Businesses can also be powerful advocates for greater health equity and equity in the social determinants nationally and locally.

Embedding social value into commercial and public services operations is an important strategy to reduce health inequalities (5). The concept and provisions of the 2013 Social Value Act applies to all public sector commissioners and requires them to consider economic, social and environmental wellbeing in procurement of services. A great deal of effort has been made to encourage large public sector employers such as the NHS to adopt a social values approach and to maximise the social value of public procurement budgets. The approach should also be applied by businesses in order to maximise their contributions to improving the social determinants of health and reducing health inequalities. Manchester City Council increased the proportion of procurement spend with SMEs by 63 percent in the five years to 2019/20 (8).

The 2020 Greater Manchester Social Value Framework is structured around six priority goals: provide the best employment that you can; keep the air clean in Greater Manchester; create employment and skills opportunities; be part of a strong local community; make organisations greener; develop a local, Greater Manchester-based and resilient supply chain (9). Despite good support for the idea of social value, and while social value policies and frameworks are used by all local authorities in Greater Manchester, implementation has been limited and interviews with staff across the City Region found there was a lack of consistency in the use of social value in commissioning and procuring (4). However, there are examples of good practice (Box 2) (4). From 2016, Manchester City Council introduced a minimum 20 percent weighting for social value into its tender decision-making process and can show significant social value from the commissioning/procurement process (4) (10) (11).

BOX 2. AN ANCHOR INSTITUTION IN NORTH MANCHESTER: THE NORTH MANCHESTER GENERAL HOSPITAL

North Manchester is the most deprived area in England in health and disability-related deprivation, the second most deprived in income deprivation, and the fourth most deprived in employment deprivation (12). Both men and women in North Manchester can expect to live nine fewer years in good health than those living in England as a whole and there is a considerable burden of ill health and mental illness that causes significant demand for healthcare and other public services.

The most significant community asset in North Manchester is North Manchester General Hospital (NMGH). However, its facilities have suffered from underinvestment. Recently, investments have been made, including a £73m investment by Greater Manchester Mental Health NHS Foundation Trust into a new adult mental health inpatient unit, and £54m seed funding through the Department of Health and Social Care's Health Infrastructure Plan. The full redevelopment and construction of the NMGH is planned for 2025–30, subject to business case approval. GMCA's ambition is to work with and empower North Manchester's communities, to level-up health outcomes, productivity and sustainability in the area through the redevelopment of NMGH. This will be achieved through a healthcare-led approach to the civic regeneration of the hospital site, along with a new approach to public-service delivery and appropriate private-sector involvement, with the NMGH conceived of as an anchor institution and enabler for wider renewal.

The redevelopment of the hospital site is expected to be completed in 2026 with socioeconomic benefits including:

- Increasing the life expectancy of North Manchester residents by 1.3 years
- Gross Value Added impact of £350m over 10 years
- Additional social value of £144m for North Manchester residents
- Creating good quality, affordable homes for North Manchester residents.

Alongside NMGH, the Victoria North (previously Northern Gateway) initiative should deliver up to 15,000 new homes over 20 years through a Joint Venture Partnership between the City Council and Far East Consortium (FEC) and 6,000 of the 15,000 homes affordable homes. The NMGH and Victoria North teams are working together on a joint social value framework to improve social, economic and health outcomes.

Both projects intend to use procurement as a tool to drive social value through supply chains, working in partnership with Manchester City Council and local voluntary and community sector organisations to connect opportunities locally. Shared metrics are proposed to track the delivery of social value alongside monitoring of wider indicators of health, employment and environmental impact in the area.

BUILD BACK FAIRER MONITORING AND ACCOUNTABILITY

The Greater Manchester Marmot Beacon Indicators (see Chapter 5) were proposed specifically for monitoring equity in areas that are highly relevant to health equity, as set out in the framework diagram (Figure 1). The Indicators underpin the Build Back Fairer approach. Greater Manchester's Marmot Beacon Indicators are intended to help the City Region monitor the impact of, and recovery from, COVID-19, through an equity lens. The proposed regular monitoring of these indicators will enable greater understanding about likely health and health inequality trajectories, inform action and maintain a focus on the social determinants of health and will also enable greater accountability for progress, or otherwise, on reducing health inequalities.

BUILD BACK FAIRER THROUGH GREATER REGIONAL AND LOCAL POWER AND CONTROL

While Greater Manchester, as a devolved region, has more powers and flexibilities than other regions in England, there are still significant limitations in how far the Combined Authority can make decisions that affect health and equity. There are many areas where the Combined Authority has no leverage or power to make changes and where there is no flexibility about how to invest nationally distributed funds. We suggest some areas where national advocacy could be strengthened to devolve greater powers to the City Region to benefit greater health equity.

In the main, the City Region has made great strides in unifying public services and fostering collaborative work over geographic areas and sectors and this has been enhanced during the pandemic. This kind of collaborative working is essential for action on the social determinants of health and, even without further devolution of powers, can be extended. The Build Back Fairer framework emphasises the power and value of multi-agency and cross-sectoral partnerships. It provides a structure for greater collaboration between sectors and a coherent framework for the multiple approaches and strategies that are already being adopted across Greater Manchester. There is a tendency in the City Region for strategies to be siloed. Strategies for education, housing, employment and transport, for instance, focus mostly on their specific sector rather than supporting a coherent systemwide approach to reducing inequalities.

The response to the pandemic nationally and within Greater Manchester has led to new ways of working that are beneficial to actions on the social determinants and equity. These changes are important for work being carried out to reduce health inequalities and they need to be extended. They are based on better knowledge about and inclusion of local communities in the design and implementation of interventions. The public service workforce, VCSE sector, local authorities and the private sector have worked closely with communities to reduce levels of infection and to support people who are shielding and self-isolating. The rollout of the vaccination programme has further enhanced such collaborations.

Discussions we have had suggest that as a result of this response, collaborations with communities have been strengthened and trust between services and communities may have increased. A range of services and workforces physically went to where people were and worked hard to make sure approaches to offer support, control infection and increase access to vaccinations and uptake were attuned to the specific needs of different communities: there was more outreach by the NHS and local authorities with faith-based organisations, community groups, workplaces and schools, for example. Local data about small areas and communities were developed and drawn on extensively. These approaches must be reinforced after the pandemic has receded.

The recommendations we set out below include commitments that the public should expect in Greater Manchester in the post-pandemic period. Some of the recommendations are ambitious – for example, supporting all young people into education, work or training, and establishing and providing healthy standards for housing, air quality, conditions of employment and a living wage. But these ambitions are realisable with sustained focus and action, and increased support from central government and allocation of funding that is proportionate to need and increasingly focussed on prevention. We anticipate that securing the public's involvement and their awareness of these commitments will galvanise further action and support population health, wellbeing and greater equity in Greater Manchester. Additional recommendations made in this report, in each social determinant of health, fit within this approach.

BUILD BACK FAIRER – RECOMMENDATIONS

1 Build Back Fairer for future generations

Prioritise children and young people

- Provide further support for early years settings in more deprived areas, including additional support for parents
- Extend interventions to support young people's mental health and wellbeing at school and at work
- Ambition for all young people, 18–25 years old, to be offered in-work training, employment or post-18 education
- All policies assessed to consider impacts on health equity for future generations
- Implement all recommendations and commitments in Greater Manchester's Young Person's Guarantee

2 Build Back Fairer resources

Rebalance spending towards prevention

- Share expertise and evidence of prevention interventions across local authorities and public services, and continue to build capacity and partnerships
- Double the budget for prevention in the total health care budget in Greater Manchester within five years and a system-wide prevention/health spending target for all of Greater Manchester to be developed by end of 2021, with incremental targeted increases over five years
- Advocate for real terms percentage increase in the regional budget for public health

Build Back Fairer opportunities for all

- Ensure proportionate universal funding – increase funding in more deprived communities and particular areas of public services
- Advocate for increases in local government funding and public service allocations and other regional shares of national budgets
- Establish a Build Back Fairer Investment Fund in Greater Manchester to include contributions from businesses that support the Build Back Fairer agenda
- Increase funding and support for training and apprenticeships in more deprived communities
- Request that businesses invest in a regional Build Back Fairer Investment Fund or equivalent through social value approaches and corporate social responsibility

Build Back Fairer commissioning

- Extend social value commissioning to all public sector contracts and to businesses in Greater Manchester to enhance business contributions to Building Back Fairer

3 Build Back Fairer standards

Standards for healthy living

- Identify the minimum income for healthy living in Greater Manchester and advocate for national resources to meet this in public sector pay and support business to pay the minimum income for healthy living
- Guarantee offer of universal access to quality services including existing public services and public health services and universal access to training, support and employment for young people
- Develop Greater Manchester minimum standards for quality of employment, environment and housing, and transport and clean air and advocate for enforcement powers and resources

4 Build Back Fairer institutions

Extend anchor institution approaches

- Implement Greater Manchester's social value framework and extend anchor institutions approaches to VCSE sector and businesses
- Extend the remit of anchor institutions to incorporate social value procurement and commissioning and contributions to the Build Back Fairer Investment Fund

Scale up social value contracting and extend business role

- Health and social care act as leaders in social value commissioning and work in partnership across local authorities to develop local supply chain across Greater Manchester
- Embed widescale social value requirements in the Local Industrial Strategy and Good Employment Charter
- Add provision of apprenticeships for all ages to the social value framework
- Link Innovation Greater Manchester with social value framework

5 Build Back Fairer monitoring and account-ability

Develop Build Back Fairer equity targets for Greater Manchester

- Based on the Marmot Beacon Indicators develop publicly accessible targets to monitor progress towards Building Back Fairer
- Report biannually on Marmot Beacon Indicators related to targets
- Invest in routine data collection to support monitoring of reductions in inequalities in wellbeing, opportunity and community cohesion within local authorities

6 Build Back Fairer through greater local power and control

Build Back Fairer devolution

- Advocate for increased local control of employment services, post-16 skills, labour market, social housing and early years policies and services
- Build on success of devolved services and advocate for further powers and resources to deliver local health and wellbeing needs
- Further involve communities in the design and delivery of interventions to support their health and wellbeing
- Enhance public visibility of the Build Back Fairer approach in Greater Manchester, including explicit commitments and offers to the public
- Develop publicly accessible data on equity in health, wellbeing and the social determinants of health

HEALTH EQUITY AT THE HEART OF GREATER MANCHESTER: GOVERNANCE FOR HEALTH EQUITY AND DIGNIFIED LIVES

At the core of the Build Back Fairer framework is the requirement that health equity is at the heart of policy and action in Greater Manchester. As well as specific actions, laid out in this report, prioritising health equity requires specific governance arrangements. The principles for governance for health equity, which were set out in IHE analysis of health inequalities in England from 2010–20, are highly relevant to Greater Manchester in the post-pandemic period (3).

BOX 3. PRINCIPLES FOR GOVERNANCE FOR HEALTH EQUITY – FROM *10 YEARS ON*

1. Health equity is an indicator of societal wellbeing.
2. The whole of government is responsible for prioritising health equity in all policies.
3. Development of strategies and interventions must involve a wide range of stakeholders.
4. Accountability must be transparent with effective mechanisms.
5. Communities must be involved in decisions about programmes and policies for achieving health equity (3).

Greater Manchester has already made considerable progress on the five governance principles outlined in Box 3. But while progress has been made, Greater Manchester must go further, particularly in the context of widening health, social and economic inequalities that have resulted from the pandemic. Health equity, rather than economic equity, must be at the centre of all decisions.

The powers that have been devolved to the Combined Authority provide it with levers to improve the social determinants of health and facilitate the coordinated action needed for effective action on the social determinants. Since 2016 Greater Manchester has been in charge of its entire budget spent on health and social care in its 10 boroughs. In 2019 the Greater Manchester Model white paper was launched, placing people at the centre of the region's single integrated public services.

In the Greater Manchester model, devolution and cross sector working is central to achieving "a preventative, truly place-based and person-centred approach" (13). Greater Manchester's model of place-based integration of services aims to identify early those people at risk of developing more complex issues that, over time, could place significant pressure on services and lead to poorer outcomes for individuals or families. In each of the 10 local authorities the NHS, social services, community groups and the voluntary sector have formed a single organisation providing joined-up health and social care services, known as the Integrated Care System (ICS). These joined up services share a budget, set of standards and a mission: to provide care centred on the individual's needs (14). Population health and health equity need to be central to the ambition for Integrated Care Systems, with approaches based on acting on the social determinants of health through direct action by the NHS and social care and through partnerships with other sectors.

The pursuit of population health was a founding principle of the Greater Manchester Heath and Social Care Partnership and continues to be as the City Region plans its future health and care strategies. Greater Manchester has ambitious population health programmes, including the following, implemented in the past five years as part of its population health approach:

- Significant investment (approximately £30m) in developing the first ever Greater Manchester Population Health Plan and delivering a portfolio of programmes to enable improved health outcomes across the City Region (15). In 2019 the plan was refreshed and sought to go further in its whole-system approach, and aimed to put health at the centre of every policy and strategy across all of Greater Manchester's public services (16).
- A dedicated Population Health Board, operating with delegated authority on behalf of the Greater Manchester system, to coordinate activity and ensure a focus on health outcomes and reducing inequalities.
- The recognition of the population health potential of being the only Marmot City Region within a Mayoral Combined Authority, including the development of a single set of outcome measures at a locality and Greater Manchester level to track progress against key Marmot priority areas.
- Alignment to the Greater Manchester strategy and commitments relating to the wider determinants of health, and the shaping of other key strategies including the Greater Manchester Independent Inequalities Commission, Local Industrial Strategy and the Prosperity Review (11) (17) (18).

While there is much in place for action on the social determinants of health in Greater Manchester, particularly in the Health and Social Care Partnership, health equity must be further prioritised and become central to all activity within the Combined Authority and in relation to its advocacy at the national level. The Build Back Fairer approach outlined here sets out what to do. It does require enhanced focus on the governance arrangements for health equity and for health equity to be at the heart of the City Region.

Given much higher awareness there is now of inequalities in health and associated living and working conditions, there is a great opportunity to enact measures to reduce inequalities in health and to Build Back Fairer. The interest is from national, local government, the public, civil society and particularly a new interest and appetite from business to support and be involved in action to recover from the pandemic and reduce inequalities. In illustration, this report contains case studies and examples of positive policies and programmes from across Greater Manchester.

CHAPTER 3

HEALTH INEQUALITIES IN THE PANDEMIC – THE NEED TO BUILD BACK FAIRER

In *10 Years On* we documented three worrying features of health in England over the decade from 2010, pre-pandemic:

- A slowdown in improvement in life expectancy that was more marked than in any other rich country except Iceland and the United States
- Increased health inequalities
- Declines in life expectancy for the poorest people, outside London.

This poor state of health, we suggested, was a result of governance that failed to make equity of health and wellbeing a priority, and damaging and highly inequitable policies and programmes in the previous 10 years.

The findings from IHE's assessment of health inequalities in England over the decade from 2010 are summarised in Box 4. Notably for Greater Manchester, the analysis showed widening regional inequalities in health over the period, with areas outside London and the South East faring worst.

BOX 4. INEQUALITIES IN HEALTH IN THE DECADE FROM 2010 – SUMMARY FROM *10 YEARS ON*

LIFE EXPECTANCY SINCE 2010

- Since 2010 life expectancy in England has stalled, with the slowdown greatest in more deprived areas of the country.
- The UK has seen small increases in life expectancy compared with most European and other high-income countries.
- Inequalities in life expectancy in England have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18.
- Female life expectancy declined in the most deprived 10 percent of neighbourhoods between 2010–12 and 2016–18 and there were only negligible increases in male life expectancy in these areas.
- There are growing regional inequalities in life expectancy. Life expectancy is lower in the North and higher in the South. It is now lowest in the North East and highest in London.
- Within regions, life expectancy for men in the most deprived 10 percent of neighbourhoods decreased in the North East, Yorkshire and the Humber, and the East of England.
- Life expectancy for women in the most deprived 10 percent of neighbourhoods decreased in every region except London, the West Midlands and the North West.
- For both men and women, the largest decreases were seen in the most deprived 10 percent of neighbourhoods in the North East and the largest increases in the least deprived 10 percent of neighbourhoods in London.
- In every region men and women in the least deprived 10 percent of neighbourhoods have seen increases in life expectancy and differences between regions for these neighbourhoods are much smaller than for more deprived neighbourhoods.

HEALTH SINCE 2010

- There is a strong relationship between deprivation measured at the small area level and healthy life expectancy at birth. The poorer the area, the worse the health.
- There is a social gradient in the proportion of life spent in ill health, with those in poorer areas spending more of their shorter lives in ill health.
- Healthy life expectancy has declined for women since 2010 and the percentage of life spent in ill health has increased for men and women.

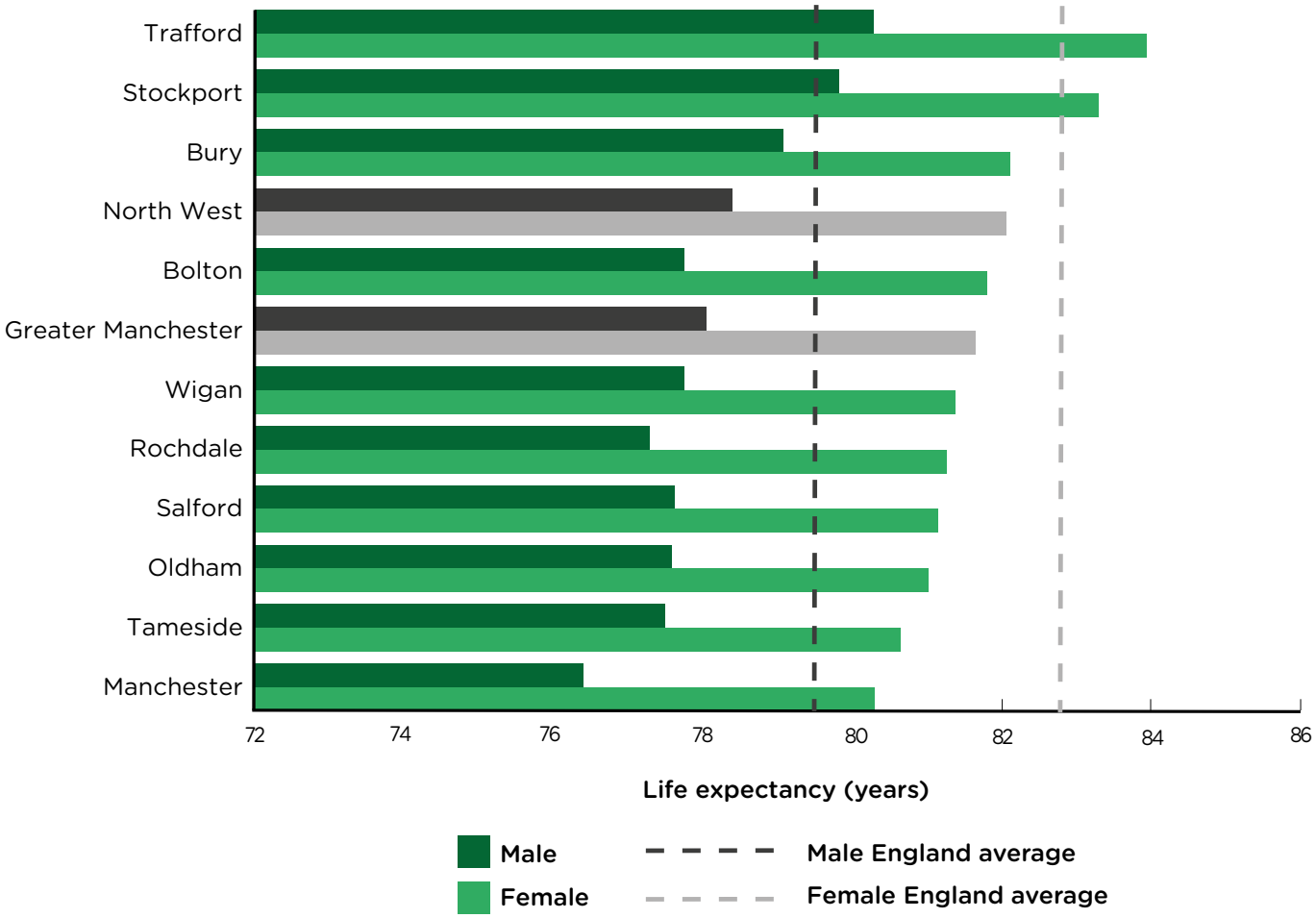
MORTALITY RATES SINCE 2010

- There has been no sign of a decrease in mortality for people under 50. Mortality rates have increased for people aged 45–49. It is likely that social and economic conditions have undermined health for this age group.
- For people in their seventies mortality rates are continuing to decrease, but this is not so for those at older ages.
- The slowdown in mortality improvement cannot, for the most part, be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, resulted from influences other than winter-associated mortality.
- There are clear socioeconomic gradients in preventable mortality. The poorest areas have the highest preventable mortality rates and the richest areas have the lowest (3).

Prior to the pandemic Greater Manchester had relatively poor overall health and, as nationally, increasing health inequalities. It had also experienced some deteriorations in social and economic conditions in the decade to 2020. Greater Manchester is slightly more ethnically diverse than England and Wales as a whole, household incomes are lower than the national average, and there are higher levels of deprivation (19) (20) (21). All of this has contributed to the City Region's high and unequal mortality rates from COVID-19.

Figure 2 shows life expectancy in Greater Manchester for 2017–19. The average life expectancy for women in Greater Manchester at 81.7 was lower than the average for England, 83.4 years. For men in Greater Manchester, the average life expectancy of 78.1 years was lower than the England average of 79.8 years. Only Trafford and Stockport had higher life expectancy than the average for England for both men and women.

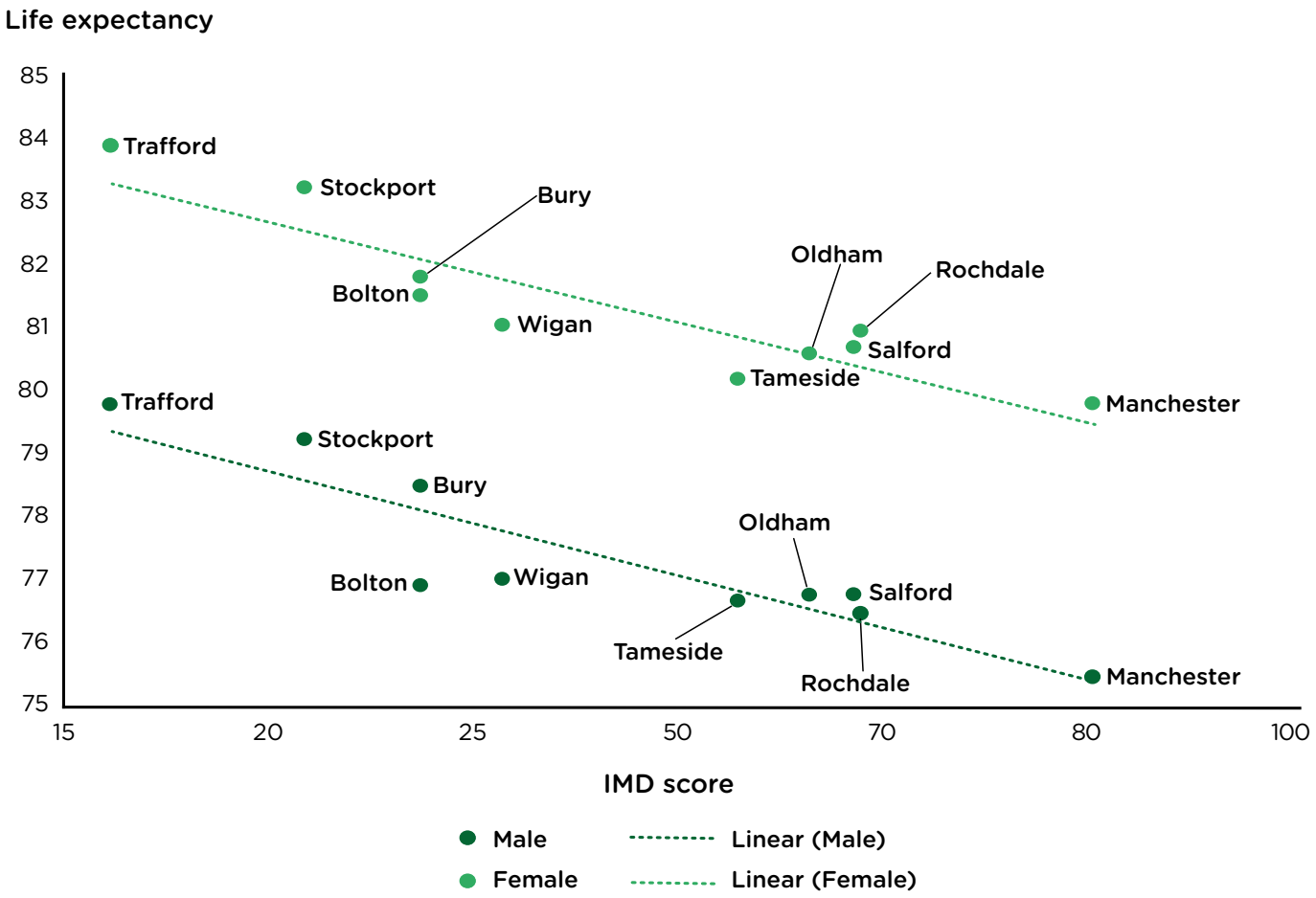
Figure 2. Estimated male and female life expectancy at birth for Greater Manchester, its local authorities, the North West region and England, 2017–2019



Source: *Office for National Statistics (ONS). Life expectancy estimates by sex, age and area, 2017-19 (22).*

In Greater Manchester life expectancy is related to level of deprivation, as shown in Figure 3 for each local authority. The graded relationship with deprivation is remarkably similar to that seen in England as a whole, although, as noted above, life expectancy is generally lower in Greater Manchester.

Figure 3. Male and female life expectancy at birth (2017–19) and average score in the Index for Multiple Deprivation (IMD) (2019)



Source: *ONS. Life expectancy estimates by sex, age and area, 2017-19 (22).*

In the 2020 *Build Back Fairer* report for England we asked the question of why, pre-pandemic, the UK should have had near to the slowest improvement in life expectancy of any rich country, bar the US and Iceland, and among the highest excess mortality during the pandemic. We set out four possible explanations. These also apply to Greater Manchester.

1. **The governance and political culture** such that equity of health and wellbeing were not at the heart of government policies.
2. **Widening inequities in power, money and resources** between individuals, communities and regions.
3. **Policies of austerity** regressive in nature, which widened social and economic inequalities and damaged public services and civil society.
4. **Health and gains in life expectancy had stopped improving** and there was a high prevalence of the health conditions that increase case fatality ratios of COVID-19 (1).

ETHNICITY AND INEQUALITIES

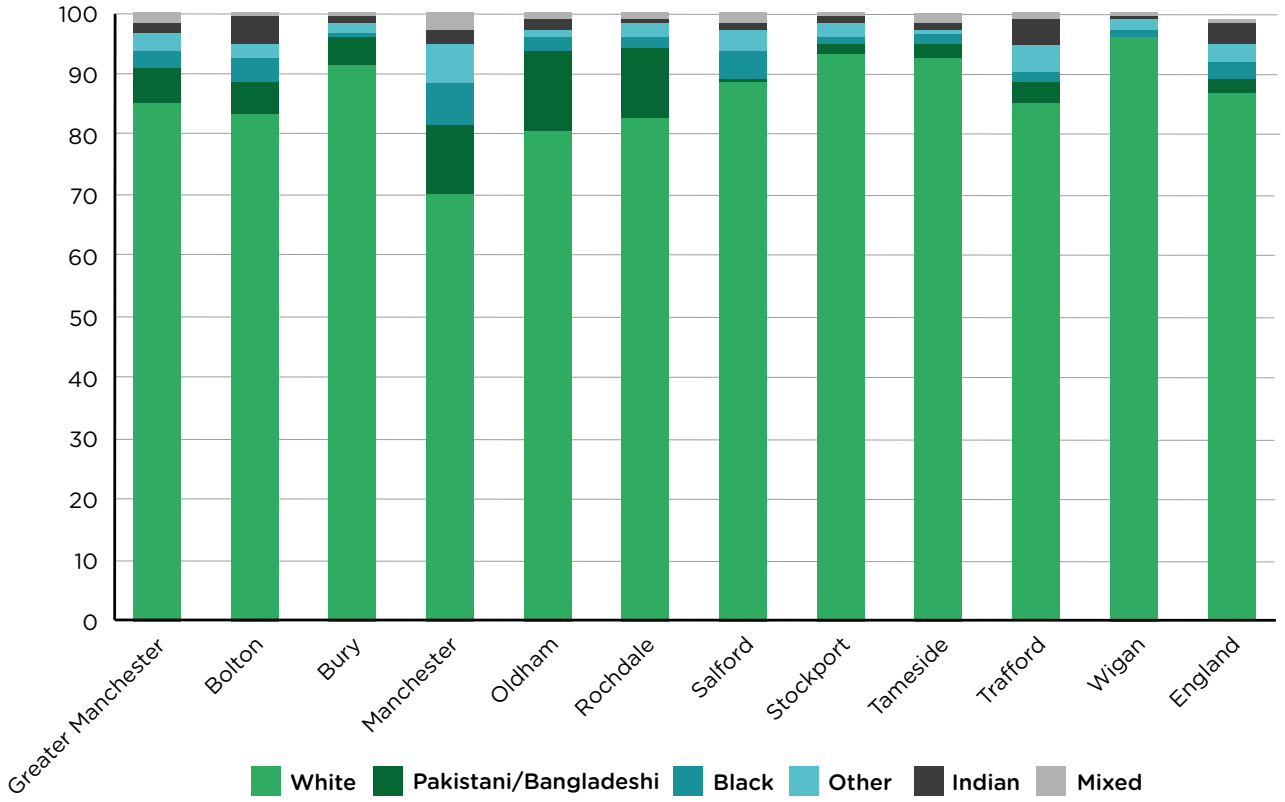
Some ethnic communities have faced a disproportionately high toll from COVID-19, including higher infection and mortality rates. There are also signs of disproportionate social and economic harm to some ethnic minority communities as a result of containment measures. In this report we set out ethnic inequalities in key social determinants of health in Greater Manchester, where data are available, and also refer to the 2021 Independent Inequalities Commission. Our *Build Back Fairer* report of 2020 for England was clear: there are higher mortality rates from COVID-19 among Black British people and those of South Asian descent. While much of this can be attributed to where people live and work and socioeconomic disadvantage, structural racism is also a cause of these disadvantages (1) (23).

The Greater Manchester Independent Inequalities Commission stated structural racism must be a top priority as a part of the agenda to tackle inequality in Greater Manchester. Research for the Commission's report showed that for people from ethnic minorities, the working-age employment rate is over 10 percentage points below the overall rate for Greater Manchester and 6 percentage points below the national average, and that the highest proportions of workers receiving low pay are Black/Black British workers, and the second highest proportion Asian/Asian British workers, followed by White workers (11).

The recommendations from the Inequalities Commission include: establishing an independent Anti-Discrimination body in Greater Manchester to tackle breaches of the Equality Act; a joint commitment across the Combined Authority, districts and statutory partners to tackle inequality faced by ethnic minorities with a clear plan for rollout; a Race Equality Strategy in Greater Manchester, backed by a plan to increase representation of Black and Asian minorities in senior positions in the GMCA and to tackle race inequality in health, education, policing, work and housing; and giving Equality Panels a stronger mandate and sufficient resources to constructively challenge public bodies (11).

In 2020 Greater Manchester had a slightly greater proportion of its population identifying as not White than England as a whole: 15 percent compared with 13 percent (Figure 4) (24).

Figure 4. Ethnicity by local authority in Greater Manchester and in England, 2020



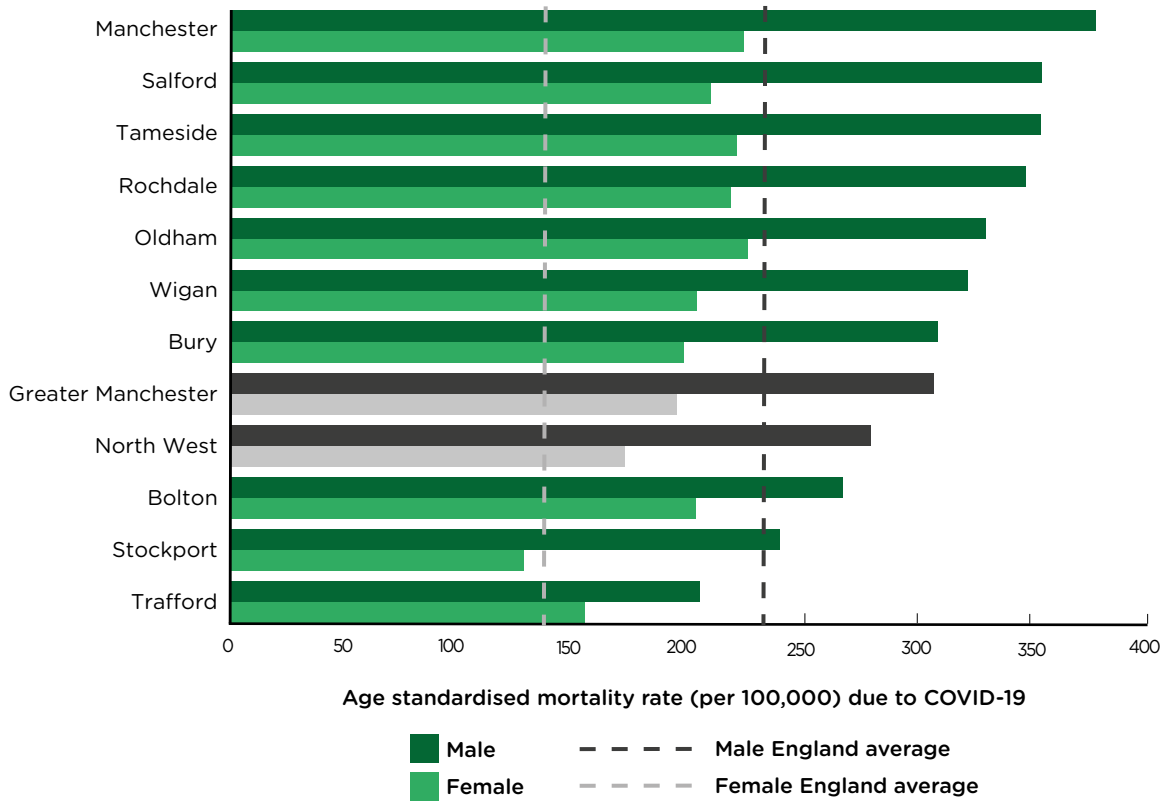
Source: *Office for National Statistics (24).*

Research shows that ethnic minority populations experience more barriers when accessing health and care services and as a result, have greater unmet needs (25). A study of the older ethnic minority population in Greater Manchester found a lack of trust in healthcare providers, including local GPs and hospitals, and showed levels of satisfaction and confidence in services were lower and that many older people from ethnic minorities in Greater Manchester did not feel they were treated with dignity in health and social care settings (26).

COVID-19 MORTALITY IN GREATER MANCHESTER

While England has experienced high COVID-19 mortality rates compared with other countries, the rate in Greater Manchester has been even higher than the average in England. The COVID-19 mortality rate between March 2020 and April 2021 in Greater Manchester was 307.1 per 100,000 population for men and 195.2 for women compared with England averages of 233.1 per 100,000 for men and 142.0 for women (14). Figure 4 shows that Greater Manchester as a whole, and all but one of its local authorities (Trafford for men, Stockport for women), had higher mortality rates from COVID-19 than England over the same period (28).

Figure 5. Age-standardised COVID-19 mortality per 100,000 for England, the North West, Greater Manchester and its local authorities, 13 month total (March 2020 to March 2021)



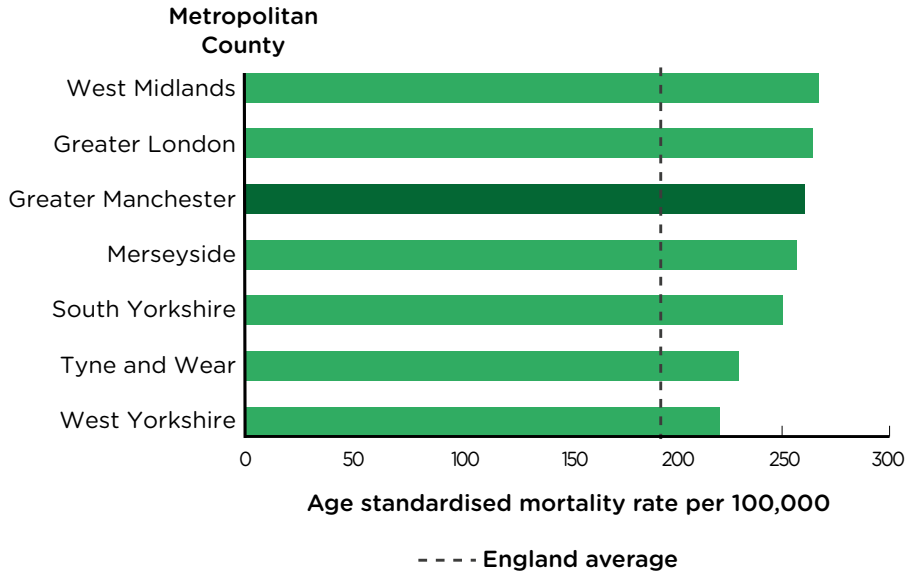
Note: *Deaths 'due to COVID-19' only include deaths where COVID-19 was the underlying (main) cause.*

Source: *ONS. Age-standardised rates from COVID-19, People, Local Authorities and Regions in England and Wales, deaths registered between March 2020 and March 2021 (28).*

Overall, according to provisional figures, life expectancy in the North West declined more during 2020 than it did in England overall: for females in the North West by 1.2 years, compared with 0.9 for females in England as a whole, and for males in the North West by 1.6 years, compared with 1.3 for males in England as a whole (29).

Comparing with similar metropolitan counties and with Greater London (Figure 6), Greater Manchester had the third highest COVID-19-related mortality rates per 100,000 population (261 per 100,000 population), after Greater London (265.1) and the West Midlands (266.5). The age-standardised mortality rate for England was 193.9 per 100,000 population for the period running from March 2020 to March 2021 (28).

Figure 6. Age-standardised COVID-19 mortality rate per 100,000, metropolitan counties in England and Greater London, 13 month total (March 2020 to March 2021)



Note: *Deaths 'due to COVID-19' only include deaths where COVID-19 was the underlying (main) cause.*

Source: *ONS. Age-standardised rates from COVID-19, People, Local Authorities and Regions in England and Wales, deaths registered between March 2020 and March 2021 (28).*

The IHE's report of December 2020, *Build Back Fairer*, which covered England, showed a disproportionately high burden from COVID-19 and consistently higher mortality rates from COVID-19 among Black British people and those of South Asian descent across England compared with other ethnic groups (1). There are also signs of disproportionate social and economic harm on some ethnic minority communities as a result of containment measures.

The reported rate of infection from COVID-19 is an inaccurate measure of actual prevalence of infection as it depends on the rate of testing. Rates of testing in turn relate to availability, which was low at the start of the pandemic, willingness to be tested and levels of symptomatic infection. Nonetheless, it is worth noting that according to the available data, infection rates were higher during the pandemic in all local authorities in Greater Manchester and the North West than in England as a whole.

COVID-19 MORTALITY AND INEQUALITIES IN ENGLAND

Assessments of inequalities in COVID-19 infection and mortality in England show clear relationships with deprivation, prior health status, ethnicity, age and gender (1). Our analysis on inequalities in infection and mortality from COVID-19 for England in 2020 is summarised in Box 5.

BOX 5. INEQUALITIES IN INFECTION AND MORTALITY FROM COVID-19

HEALTH CONDITIONS

Some underlying health conditions significantly raise the risk of mortality from COVID-19. These include dementia and Alzheimer's disease, diabetes, hypertension, cardiovascular disease and other chronic diseases such as chronic obstructive pulmonary disease (COPD) and chronic kidney disease (30) (31).

DEPRIVATION AND INEQUALITY

The more deprived a local authority is, the higher the COVID-19 mortality rate has been during the pandemic. This social gradient in mortality is similar to that from all causes, suggesting the causes of inequalities in COVID-19 mortality are similar to the causes of health inequalities more generally. There was some further relative excess for COVID-19 mortality rates in the bottom three income deciles, possibly linked to a higher likelihood of being employed in frontline occupations and in living in overcrowded households (1).

REGIONAL INEQUALITIES

While different regions in England have been affected differently at various points during the pandemic, the close association between underlying health, deprivation, occupation and ethnicity and COVID-19 make living in more deprived areas in some regions particularly hazardous. Given the widening health and social determinants inequalities between regions prior to the pandemic, it is expected that mortality rates in deprived areas will be higher in regions outside London – particularly the North West and the North East, and that has been the case since the end of the first wave (1).

LIVING CONDITIONS

Overcrowded living conditions and poor quality housing are associated with higher risks of mortality from COVID-19 and this kind of accommodation is more likely to be found in deprived areas and inhabited by people with lower incomes. Evidence from our analysis in *10 Years On* showed that housing conditions had deteriorated for many in the previous decade (1) (3).

OCCUPATION

There are clear differences in risks of mortality related to occupation. Being in a key worker role, unable to work from home and being in close proximity to others put people at higher risk.

Occupations at particularly high risk include those in the health and social care, food processing, leisure and transport sectors. In men aged 20 to 64, the largest numbers of deaths in 2020 were among security guards and taxi drivers, while the highest rates were seen in occupations with fewer workers than these – bakers, publicans, police officers. Among women, the largest numbers of deaths were seen in care workers and home carers and the highest death rates were seen in sewing machinists.

While mortality risks are closely linked to occupation, area of residence has an important bearing on the extent of occupational risk. Managers living in deprived areas have above average risk for their occupation and workers in the elementary occupational group living in the least deprived areas have a lower risk of COVID-19 mortality (32).

Ethnic minorities

Mortality risks from COVID-19 are much higher among many ethnic minority groups than among White groups in England. Ethnic minority groups are disproportionately represented in more deprived areas and high risk occupations; these, and other risks, are the result of longstanding inequalities and structural racism. There is evidence that ethnic minority groups working in highly exposed occupations are not always being sufficiently protected with PPE or safety measures (23) (1).

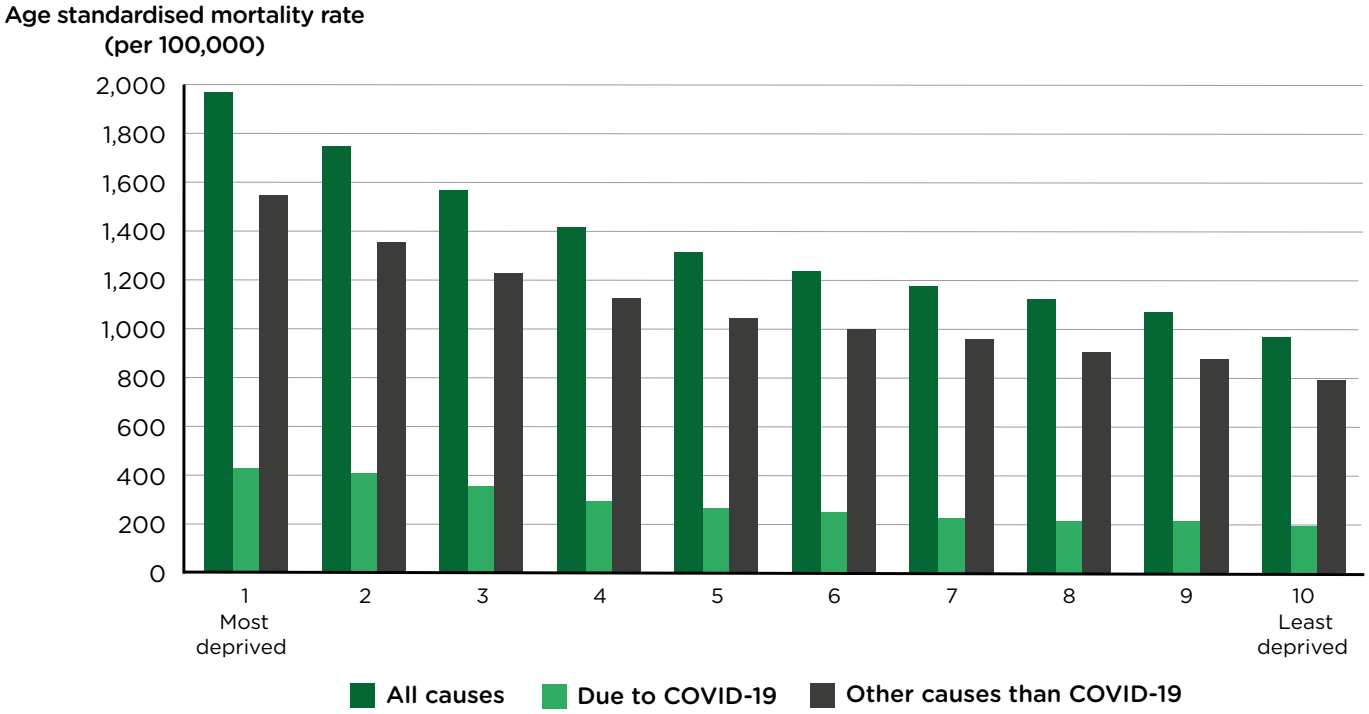
CUMULATIVE RISKS

Risks of mortality are cumulative – being male, older, and from an ethnic minority group, with an underlying health condition, working in a higher risk occupation and living in deprived area in overcrowded housing have led to much higher rates of mortality from COVID-19 and reflect lifetime experience (1).

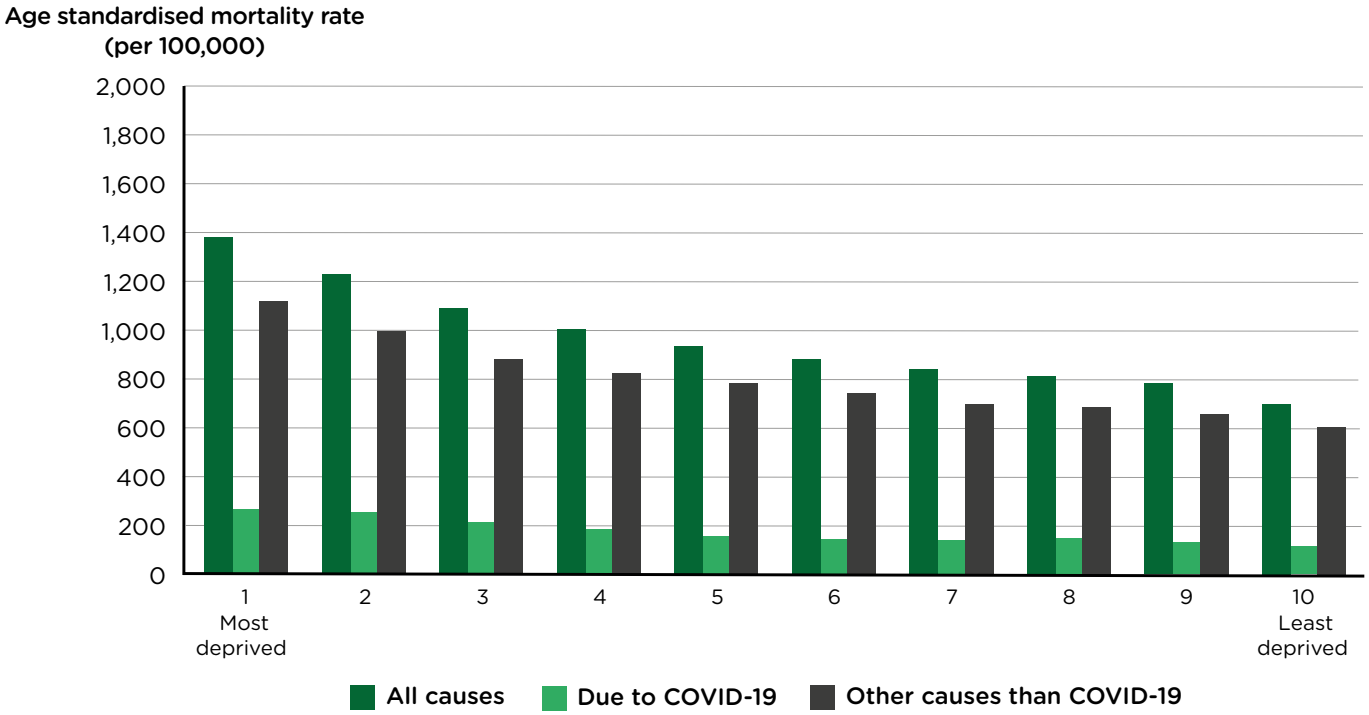
The relationship between all causes of mortality and deprivation in England is similar to the relationship between deprivation and mortality from COVID-19 (Figure 7). The more deprived the area of residence, the greater the mortality rate from COVID-19. The gradient was slightly steeper for COVID-19, than for all-cause mortality.

Figure 7. Age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000), by sex and deprivation deciles in England, March 2020 to February 2021

a) Men



b) Women



Source: *ONS. Deaths involving COVID-19 by local area and socioeconomic deprivation, 2021 (33).*

COVID-19 MORTALITY AND DEPRIVATION IN GREATER MANCHESTER

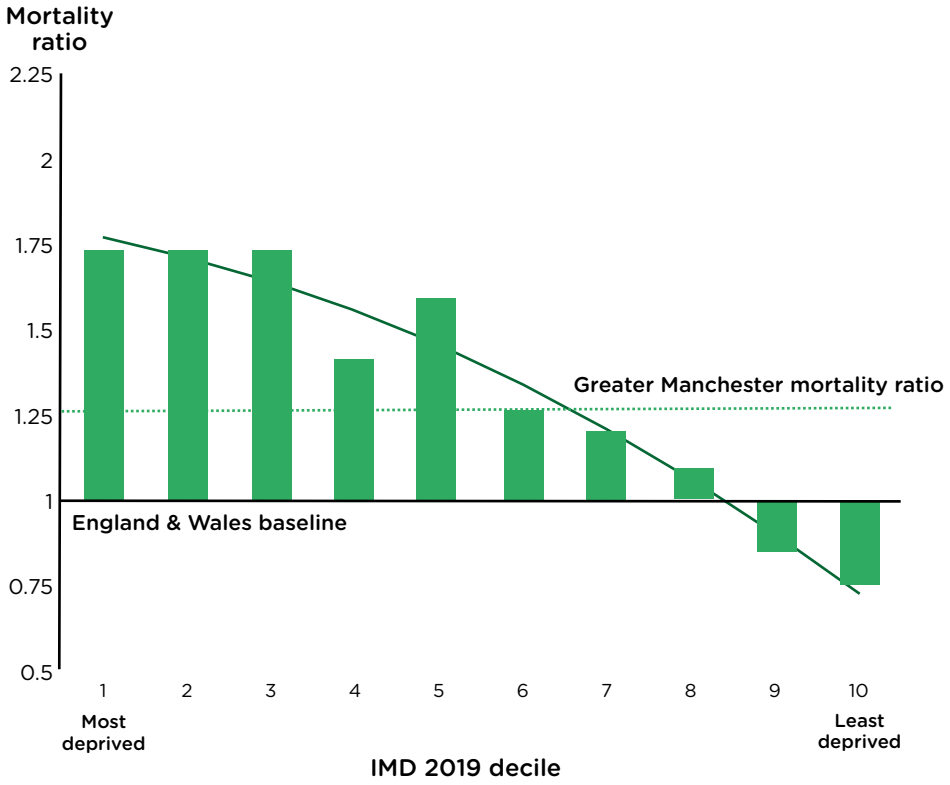
Understanding the close associations between deprivation and mortality rates from all causes of death and COVID-19 is important for understanding how COVID-19 has affected inequalities in mortality in Greater Manchester and in developing appropriate and effective remedial interventions.

Figure 8 shows the ratio of COVID-19 mortality by deprivation using deciles in the Index for Multiple Deprivation (IMD) within Greater Manchester compared with the number expected on the basis of COVID-19 mortality rates (age- and sex-specific) in England and Wales. Overall, COVID-19 mortality in Greater Manchester was 25 percent higher than the England and Wales average between March 2020 and January 2021, with wide inequalities in mortality across deprivation deciles. Mortality ratios in Greater Manchester were equally high in the three most deprived deciles and then decreased as the level of deprivation decreases. In the two least deprived areas, mortality from COVID-19 was lower than the England and Wales average over the same period, but in all other deciles COVID-19 mortality in Greater Manchester was greater than the England and Wales average.

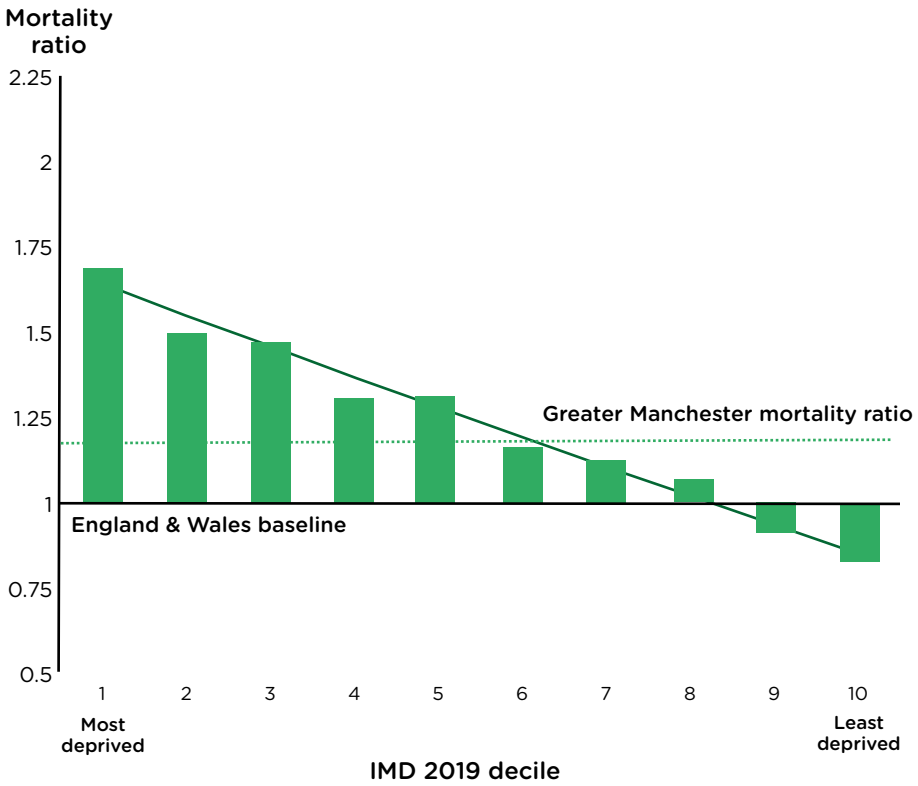
In Greater Manchester the COVID-19 mortality ratio in the most deprived decile was 2.3 times greater than in the least deprived decile, and the corresponding figure for all causes of death in Greater Manchester was 2.1, shown in Figure 8. In the City Region as for England as a whole, inequalities in COVID-19 mortality are slightly wider than for all-cause mortality (Figure 8b).

Figure 8. Age- and sex-standardised mortality ratios by deprivation deciles of MSOAs* in Greater Manchester against the England and Wales baseline, March 2020 to January 2021

a) COVID-19 mortality ratios



b) All-cause mortality ratios



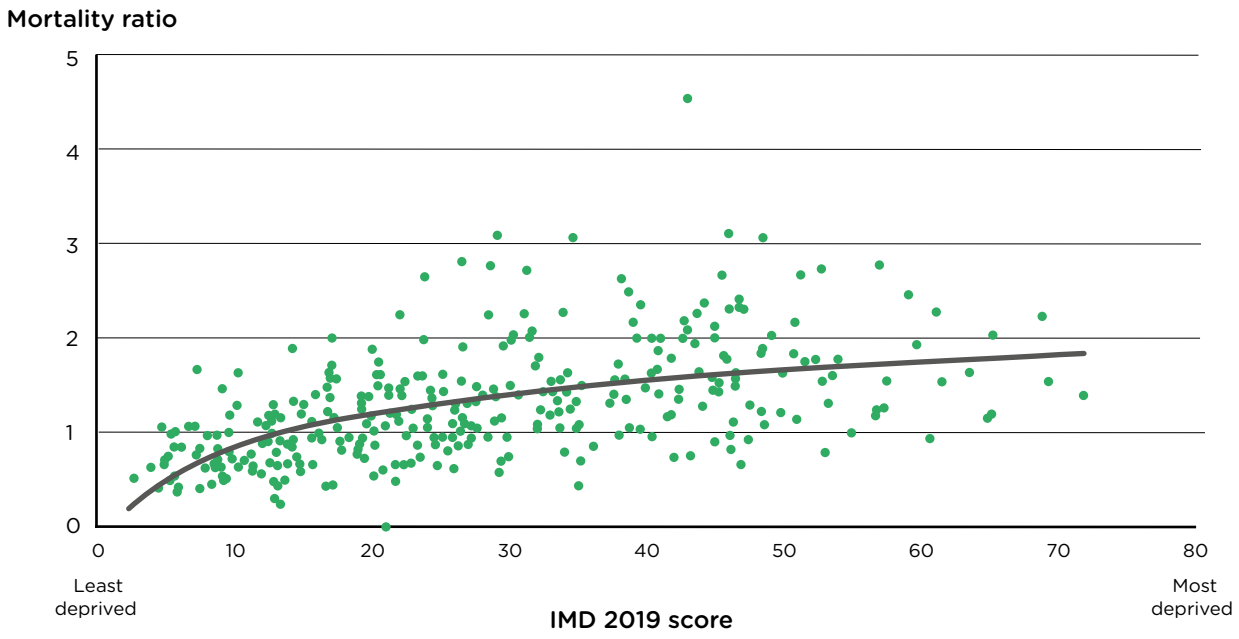
Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Greater Manchester by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these domains for each MSOA, as set out in the Technical Report on The English Indices of Deprivation 2019 (34). Deciles were obtained by ranking each MSOA within Greater Manchester and then population weighting these ranks to split all MSOAs into 10 groups with equal sized populations, ordered according to the IMD scores of the MSOAs in each group. Mortality ratios were obtained by applying England and Wales COVID-19 mortality rates to the age and sex specific populations of each decile to obtain an expected number of deaths and then dividing the observed number in each decile by this figure. The horizontal black line shows a ratio equal to one, representing the England and Wales average. Deciles above this line have more deaths than expected based on this average, those below the line fewer deaths. The ratio of COVID-19 mortality for Greater Manchester as a whole is shown by the horizontal green dotted line.*

Source: *ONS. Deaths due to COVID-19 by local area and deprivation, March 2020 to January 2021 (35)*

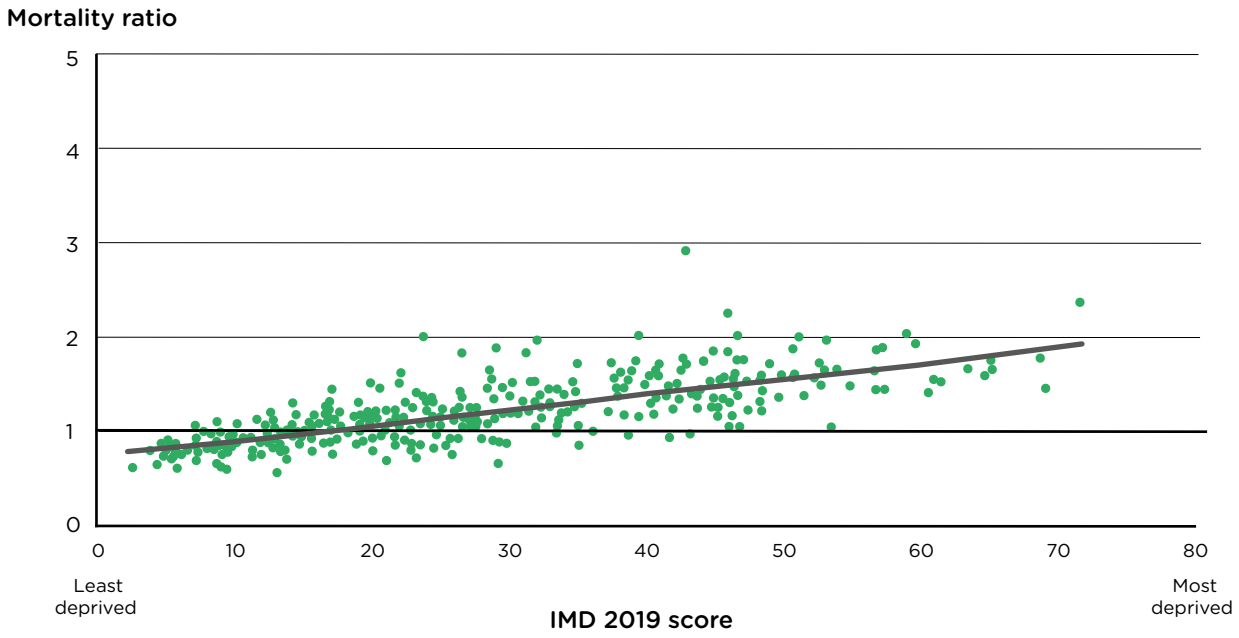
To explore how mortality from COVID-19 varied between neighbourhoods in Greater Manchester, we calculated neighbourhood mortality ratios for each middle layer super output area (MSOA). Neighbourhood-level mortality ratios for COVID-19 and all-cause mortality broadly follow the same trend lines, associated with deprivation as illustrated in Figure 9 in which each dot represents the mortality of a neighbourhood. However, for COVID-19 it is evident that there is considerably more variation around the trendline than for all-cause mortality. This is in part due to the smaller number of deaths represented by each dot in Figure 9(a) resulting in greater statistical variability. However, it also suggests that factors other than deprivation (as measured by the IMD) may have influenced the size and effect of local disease outbreaks during 2020. These include the outbreaks in care homes, particularly in the period March to July 2020.

Figure 9. Age-adjusted mortality ratio of observed to expected deaths by level of deprivation, March 2020 to January 2021, neighbourhoods (MSOAs) in Greater Manchester

a) COVID-19 mortality ratios



b) All causes

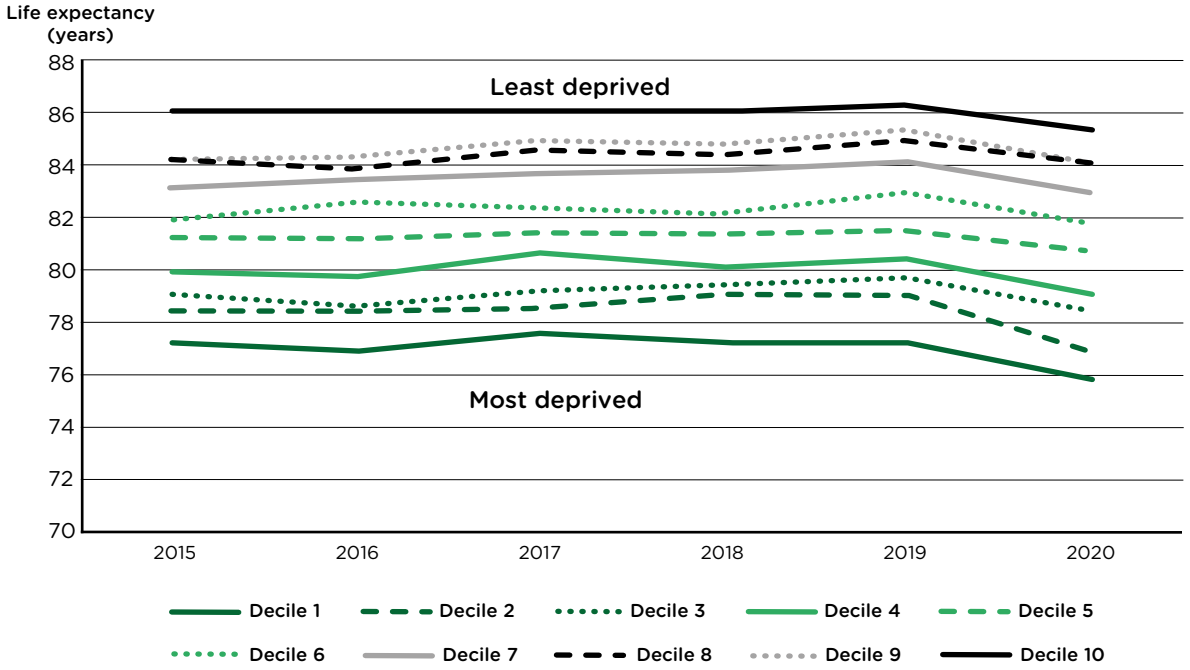


Source: *ONS. Number of deaths by Middle Layer Super Output Area, England and Wales, deaths registered between March 2020 and January 2021 (35); ONS. Mid-2019 Population Estimates for Middle Layer Super Output Areas in England and Wales by single year (36).*

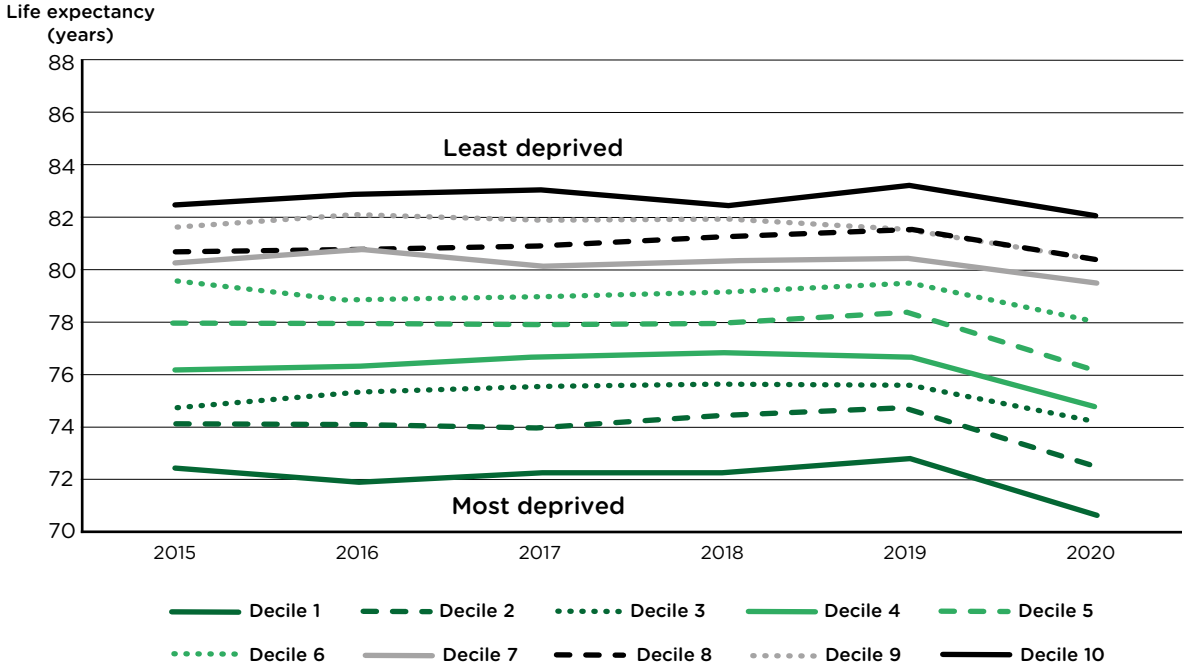
The high and unequal impact of COVID-19 mortality on life expectancy in the North West region is shown in Figure 10, based on provisional data for January to December 2020, by deprivation decile (29). Mortality data by deprivation are not yet available for Greater Manchester or for local authorities. In the least deprived half of areas in the North West, changes in life expectancy were in line with trends since 2018 but in the two most deprived deciles the reduction in life expectancy in the North West was much greater, leading to increasing inequalities in life expectancy – from 9.8 years difference between the highest and lowest deciles for men in the same period in 2019 to an 11.3 year difference in 2020. For women, the difference in life expectancy between the highest and lowest decile grew from 9 years in 2019 to 9.5 years in 2020.

Figure 10. Life expectancy at birth by national deprivation deciles (IMD 2019) 2015–2020, North West region of England (provisional data)

a) Females



b) Males



Source: *Public Health England (PHE). Wider impacts of COVID-19 on health monitoring tool (29).*

COMPONENTS OF AREA DEPRIVATION DRIVING COVID-19 MORTALITY

The high mortality rates in Greater Manchester relate to its socio-demographic characteristics, previous health status, living and working conditions and occupations, ethnicity, levels of deprivation and physical inter-connectedness.

Characteristics that contribute to the relationship between COVID-19 mortality and deprivation shown in Figure 9 above include: living in multi-generational housing or crowded conditions; having to continue working at a place of employment (outside the home) through lockdowns; type of employment, especially jobs in health and social care, other frontline occupations such as security occupations, process plant occupations – e.g. cleaners and workers that pack/bottle and can, and food, drink and tobacco process workers – chefs and taxi drivers (32). not feeling secure enough financially to self-isolate; being in poor health prior to infection; and being from an ethnic minority group.

These characteristics are often experienced simultaneously by lower income groups and lead to much higher risks of mortality. For example, being in poor health, older, male, from an ethnic minority group, a key worker and living in a deprived area is associated with a much higher risk of mortality from COVID-19. Furthermore, ethnic minority groups are disproportionately represented among key workers and are more likely to live in more deprived neighbourhoods (1).

It is tempting to try to disentangle all the different factors associated with deprivation and poor health that relate to COVID-19, so that interventions can be tailored to areas and groups where risk is highest. Because the variables that make up the deprivation index are themselves correlated, and have different measurement precision, it is difficult to isolate which are the most important elements. The analysis that follows should therefore be seen as a guide, rather than definitive.

Our analysis for Greater Manchester presented in Table 1 shows that levels of income and education and skills, type of employment and health are more strongly related to inequalities in COVID-19 mortality, (and all-cause mortality) than other factors associated with neighbourhoods and deprivation (crime, housing, living environment). If, as we propose, effective action is taken in those domains associated with both COVID-19 mortality and non-COVID-19 mortality, then inequalities in health will be reduced.

Table 1. Relationship between each of the domains of the Index of Multiple Deprivation (IMD 2019) and COVID-19 and non-COVID-19 mortality for neighbourhoods (MSOAs) in Greater Manchester, March 2020 to January 2021

IMD 2019 deprivation domain	Percentage of variance in COVID-19 mortality
COVID-19 mortality	
Income	27
Employment	26
Education, skills and training	26
Health and disability	25
Crime	17
Barriers to housing and services	6
Living environment deprivation	4
Non-COVID-19 mortality	
Income	49
Employment	49
Education, skills and training	44
Health and disability	51
Crime	33
Barriers to housing and services	10
Living environment deprivation	7

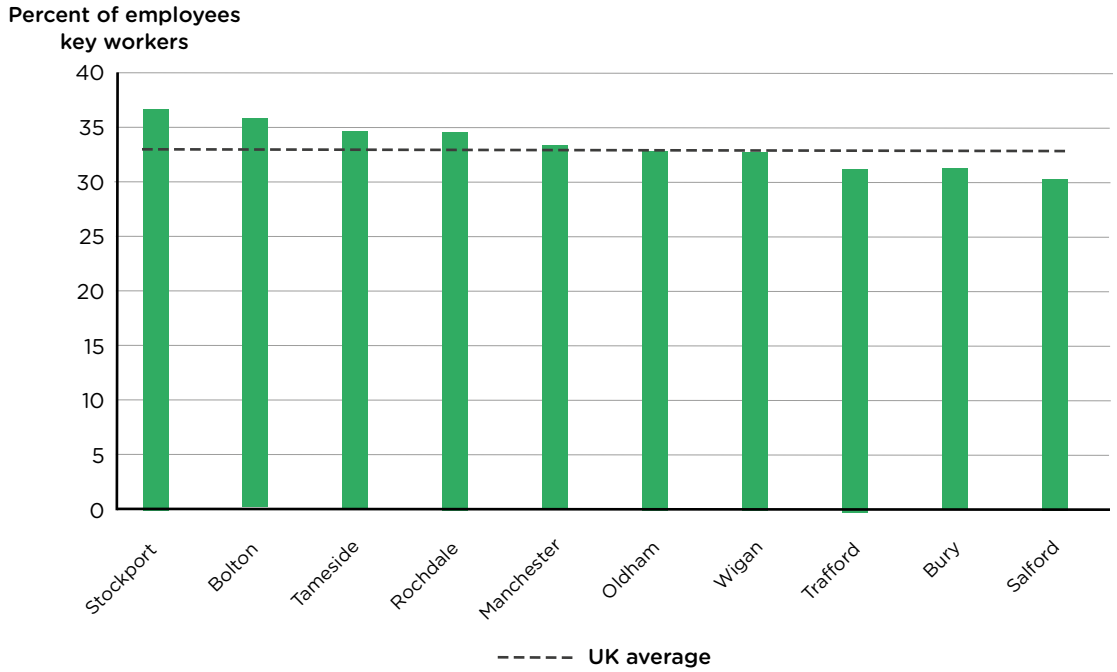
Source: *ONS. Number of deaths by Middle Layer Super Output Area, England and Wales, deaths registered between March 2020 and January 2021 (35); ONS. Mid-2019 Population Estimates for Middle Layer Super Output Areas in England and Wales by single year (36).*

KEY WORKERS AND COVID-19 MORTALITY

During the COVID-19 pandemic there have been clear differences in risks of mortality related to occupation. Being in a key worker role, unable to work from home and working in close physical proximity to others have placed people at higher risk.

Keyworkers have experienced greater exposure to COVID-19 because they have continued to work during lockdowns. 10.9 percent of Greater Manchester's keyworkers work in health and social care, the largest group of key workers, followed by education and childcare (7.4 percent) (37). Within the City Region's local authorities, the percentage of employees who were keyworkers in 2019 was greatest in Stockport at 36.5 percent and smallest in Salford at 30.2 percent (Figure 11).

Figure 11. Percentage of employees who are key workers by Greater Manchester local authority, January to December 2019

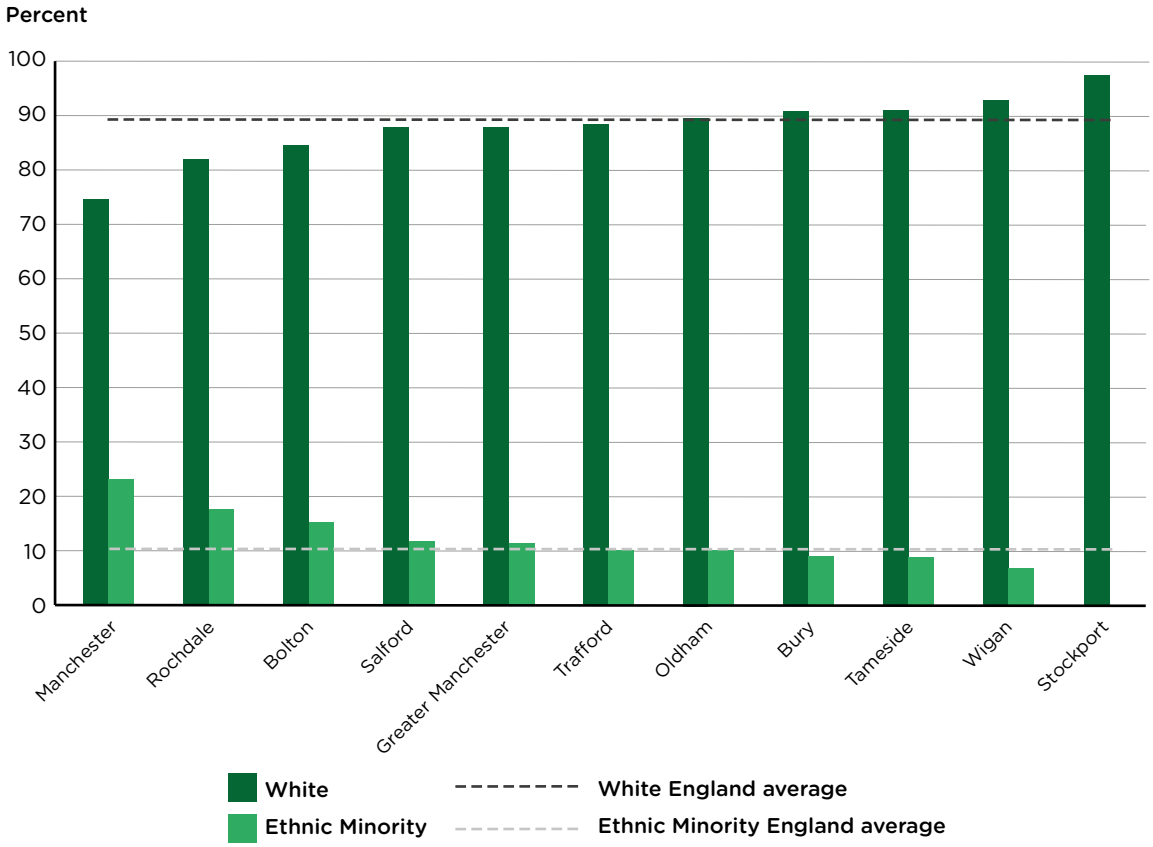


Source: *ONS (38).*

WORKING FROM HOME

Nationally, a higher proportion of individuals in occupations requiring higher qualifications reported to be working from home during the pandemic compared with those in elementary and manual occupations (39). Similarly, those working as managers, directors and senior officials were much more likely to be able to work from home, leading to clear socioeconomic inequalities in risk of exposure and mortality from COVID-19. There is also a clear ethnic inequality related to this and Figure 12 shows that in England, and across Greater Manchester, the overwhelming majority of those who are managers, directors and senior officials are White (38).

Figure 12. Percent aged 16 and over in employment who were managers, directors & senior officials by whether White or Minority Ethnic, local authorities in Greater Manchester



Note: *Stockport ethnic minority data is not included due to incomplete data.*
Source: *ONS. Annual Population Survey, 2020 (38).*

The disproportionate representation of workers from ethnic minorities in elementary and manual occupations partly explains higher rates of COVID-19 infection and mortality from COVID-19. Managers, directors and senior officials, mostly from White backgrounds, are most likely to continue to work remotely, to continue working their normal number of hours and to maintain the same level of earnings as during pre-COVID times.

INEQUALITIES AND SELF-ISOLATION

One of the key components of the Government's strategy to control the spread of COVID-19 is the Test, Trace and Isolate system, launched in May 2020. People are asked to self-isolate for a minimum of 10 days upon receiving a positive test result. For those on zero-hour contracts, self-employed or on low pay, taking 10 days off to self-isolate is difficult or impossible and self-reported ability to self-isolate or quarantine is three times lower for those with incomes less than £20,000 or savings less than £100 (40). In Israel a survey indicated that intentions to self-isolate increased from 57 percent to 94 percent when lost wages were compensated (41). In a UK poll only 17 percent of people showing COVID-19 symptoms said they had tested themselves, the rest reluctant to do so for fear that a positive result and the ensuing self-isolation will lose them money (42). The Greater Manchester population survey in February 2021 (1,003 respondents) found 14 percent of respondents stated their pay was reduced when they took time off to self-isolate and 5 percent stated they were not allowed to take time off to self-isolate (43).

The UK government introduced two policies to reduce the risks of loss of income due to self-isolation for those on low incomes but they have had limited success, and sick pay in the UK remains the lowest among OECD countries (44). In September 2020 the Government introduced a payment of £500 to enable people "to self-isolate without worry about their finances" (45). To be eligible people must prove that they: have been asked to self-isolate; have a job; are unable to work from home and will lose income from self-isolating; or that they are in receipt of certain means-tested benefits (45). The numbers supported by this have been low: in England an estimated 1.5 percent of people told to isolate between 1 October 2020 and 15 January 2021 received the £500 payment (46). Between 28 September 2020 and 15 January 2021, only 35 percent of people who applied were successful; 62 percent of applicants who were turned down either did not meet the criteria or were found not to be in 'financial hardship' and councils reported the strict eligibility criteria did not allow those who needed the emergency funding to receive it (46). In a survey carried out in Greater Manchester in February 2021 only 16 percent on average of those needing to self-isolate claimed this financial support (13 percent in January 2021 and 20 percent in December 2020). There were also high levels of unawareness: 26 percent of those surveyed were unaware of the £500 support offer; and 4 percent were unable to complete the application (43). The scheme is set to run until June 2021.

Provision of adequate and accessible financial support would have a large effect in achieving high levels of self-isolation and testing that benefits lower income groups (47).

Emerging research from the UK to understand residents' thoughts and experiences of the Test, Trace and Isolate system, found that:

- 76 percent said that a guarantee that they would not lose their job would make them more likely to isolate
- 73 percent said they needed help with shopping
- 44 percent needed better financial support
- 43 percent needed support with childcare
- 40 percent wanted someone to talk to (48).

The National Audit Office's interim report on the Test and Trace and Isolate system stated there were high levels of non-compliance with self-isolation with surveys finding between 10 and 59 percent of contacts were compliant. The NAO repeated the call by the Association of Directors of Public Health for better understanding of barriers and likely behavioural responses preventing people from self-isolating (49).

PROGRESS OF THE PANDEMIC AND CONTAINMENT MEASURES IN GREATER MANCHESTER

Explanations for relatively high and unequal mortality rates from COVID-19 in Greater Manchester partly lie with the high levels of deprivation, the occupational structure and the living and working conditions in the City Region and also with the way the pandemic progressed. Infections started later there than in London, but were still high when the first lockdown ended in June 2020, meaning that the disease continued to circulate at high levels throughout the summer and into the autumn. As containment measures were in place for a longer duration in Greater Manchester than for most other areas in England, the negative social and economic impacts will be worse – which will damage health and widen health inequalities.

Table 2 outlines the trajectory of the pandemic in Greater Manchester and how it has differed from the England and UK picture. The additional lockdowns and restrictions and the eventual state of emergency declared in the summer of 2020 show the additional burden of the pandemic in the City Region.

Table 2. COVID-19 timelines for Greater Manchester and England/UK

DATES	GREATER MANCHESTER (GM)	ENGLAND/UK
March 1–19 2020	• First confirmed COVID-19 case (Bury) • First COVID-19 death reported (Rochdale) • First COVID-19 Strategic Coordinating Group (SCG) and first COVID-19 Emergency Committee meeting chaired by the Mayor • GM local authority Chief Officers for Civil Contingencies COVID-19 meetings commence	• UK government orders people to "start working from home where they possibly can" and "to stop all unnecessary travel" • Hospitals requested to postpone non-urgent elective operations
March 20 2020	• GM declares COVID-19 a 'major incident' • Routine health and social care governance paused in GM	• England's schools, colleges and nurseries close, except for keyworkers' children
March 21–30 2020	• Transport for Greater Manchester reduce Metrolink service • GM begins reporting to Ministry of Housing, Communities and Local Government • GM sets up a Tactical Coordinating Group	• Stay at home measures introduced across UK • UK government orders all non-essential businesses, gyms and other social venues to close • Chancellor announces the Government will pay up to 80 percent of wages for workers at risk of being laid off • All local authorities urged to house those sleeping rough in 'Everyone in' measures
Greater Manchester COVID-19 deaths March 2020: 92		

April 2020	• GM SCG sets up Recovery Coordinating Group • Temporary Mortuary facility at Trafford opens • COVID-19 test centre launched at Manchester Airport. Etihad Campus and AJ Bell Stadium for NHS staff, care workers, other key workers • Nightingale Hospital North West opens at Manchester Central	• Stay at home measures extended
Greater Manchester COVID-19 deaths to April 2020: 1,821 (cumulative)		
May 2020		• 'Stay alert' message introduced • Hospitals restart planned procedures
Greater Manchester COVID-19 deaths to May 2020: 2,510		
June 2020	• Primary schools reopen in GM, following England, Years 10 and 12 return to school	• Primary schools reopen in England, Years 10 and 12 return to school • Non-essential shops reopen
Greater Manchester COVID-19 deaths to June 2020: 2,751		
July 2020	• Cases rise and seven of top 20 worst affected local authority areas are in Greater Manchester • 31 July increased restrictions in GM (and parts of East Lancashire and West Yorkshire) prohibiting two or more households meeting indoors or outdoors announced by Secretary of State for Health and Social Care	• England lockdown eases, restaurants, pubs, hairdressers reopen and up to two households able to meet. • Holiday accommodation reopens and some leisure facilities
Greater Manchester COVID-19 deaths to July 2020: 2,830		
August 2020	• 2 August 'major incident' declared after rise in cases, rates in Manchester and Tameside double in seven days. No new restrictions follow but public agencies able to access extra resources (e.g. restaurants, cafes, pubs, gyms remain open, indoor entertainment remain closed) • 9 August GM Mayor suggests pubs may have to close to allow schools to reopen in September • Stricter restrictions continue in Oldham prevent socialising between households but workplaces, childcare, businesses, restaurants remain open • Restrictions removed from Wigan and Stockport; two households able to meet indoors; close contact beauty services and soft play, bowling alleys and casinos reopen	• Easing of lockdown continues and indoor entertainment (e.g. exhibition halls, casinos, soft play) reopen
Greater Manchester COVID-19 deaths to August 2020: 2,830		

September 2020	• Schools reopen as in England • Planned measures to lift restrictions in Bolton and Trafford postponed to 2 September by Secretary of State for Health and Social Care. Bolton COVID-19 infection rates the highest in England • Ban on two households meeting indoors and outdoors continues in Manchester, Salford, Rochdale, Trafford, Oldham, Bury, Bolton and Tameside • Residents asked to limit use of public transport in Bolton and avoid mixing outside household • Indoor leisure facilities reopen in GM (casinos, bowling) • New local restrictions in Wigan and Stockport introduced 25 September; no indoor or outdoor meetings outside support bubble • 1,700 students at Manchester Metropolitan University told to self-isolate after outbreak • Living with COVID Resilience Plan adopted by GMCA, one-year plan to build back better	• Schools reopen • UK cases rise • Rule of six introduced, gatherings of more than six people are also prohibited in England from this date (indoors or outdoors) • Restaurants and pubs remain open with 10pm curfew, alcohol sold until 10pm only
Greater Manchester COVID-19 deaths to September 2020: 2,963		
October 2020	• GM placed in 'High' (Tier 2) measures 14 October – i.e. with all Tier 1 measures and the following additional measures: no indoor meetings outside support bubbles; avoid public transport • GM placed in 'Very High' (Tier 3) measures 23 October – i.e. Tier 1 and 2 measures and the following additional measures: household mixing banned indoors and outdoors; schools and universities remain open; soft play, pubs, bars, betting shops closed • Fallowfield has highest number of cases in England 4 October	• Three tier system announced in England, all businesses and venues in 'Medium' (Tier 1) areas remain open but closed at 10pm, rule of six continues indoors and outdoors • Tier 3 restrictions differ from region to region (e.g. gyms closed in some areas and not others)
Greater Manchester COVID-19 deaths to October 2020: 3,383		
November 2020	• Non-urgent operations suspended in GM	• Second England national lockdown begins 5 November, schools remain open and non-essential retail shut including restaurants, cinemas, leisure centres
Greater Manchester COVID-19 deaths to November 2020: 4,369		
December 2020	• Tier 4 measures introduced in GM 30 December (all non-essential businesses closed) • 16 December first COVID-19 vaccines given in GM	• Second England national lockdown ends 2 December • UK COVID-19 mass vaccination programme begins
Greater Manchester COVID-19 deaths to December 2020: 5,000		

January 2021		• Third England national lockdown begins, stay at home measures from 5 January, all schools and colleges closed • UK COVID-19 alert level at Level 5 (leave homes only for essential reasons; work from home if reasonable; all schools closed, move to remote learning; early years remains open; only essential shops open)
Greater Manchester COVID-19 deaths to January 2021: 5,738		
February 2021		• UK lockdown continues
Greater Manchester COVID-19 deaths to February 2021: 6,324		

Sources: *ONS (50), Department of Health and Social Care (51), GMCA (52), Manchester City Council (53), NHS England (54), Wales Parliament (55), UK government (56), BBC News (57) (58) (59), The Guardian (60), Manchester Evening News (61), ITV News (62) (63).*

INEQUALITIES AND COVID-19 VACCINATIONS

There is a risk that lower uptake of COVID-19 vaccinations among more deprived and certain ethnic minority communities will further entrench inequalities in infection and mortality from COVID-19 in Greater Manchester. Lower uptake is associated with difficulty in accessing vaccinations, inability to take time off work, lack of awareness about the programme and vaccine hesitancy (when individuals delay or refuse vaccination despite the opportunity to be vaccinated being provided to them) (64). The ONS's data on vaccine hesitancy are based on estimates of those who have either been offered the vaccine and decided not to be vaccinated or who say they would be very or fairly unlikely to have the vaccine if offered (65). The data from April 2021 show that in Great Britain, Black or Black British adults were most likely to report vaccine hesitancy compared with White adults. However, vaccine hesitancy decreased at the start of 2021 among Black or Black British adults, from 44 percent (13 January to 7 February 2021) to 22 percent (17 February to 14 March 2021) and rose again to 30 percent (31 March to 25 April 2021) (65).

Data on the daily uptake of vaccinations show a strong correlation between deprivation and vaccine uptake, with less deprived areas more likely to have high vaccination uptake (66) (67). In April 2021 adults living in the most deprived areas of England were more likely to report vaccine hesitancy (16 percent) than adults living in the least deprived areas (7 percent) (65). Inequalities in uptake related to deprivation and ethnicity give a good indication of where efforts to encourage vaccination uptake should be concentrated.

Some of the programmes and practices developed during the pandemic to roll out programmes and support the vaccination effort have led to insights and practices that are highly relevant for work on health inequalities. These include collaborations with excluded communities to provide appropriate support and services and multisectoral partnerships that allow a 'whole of society' response to challenges of inequality, an example set out in Box 6.

The vaccination rollout in Greater Manchester is an example of this. It has required great awareness about individuals and communities who have not had access to relevant information about the vaccination programme, are unaware about the delivery of the programme or may be concerned about safety (Box 7).

BOX 6. COMMUNITY HUBS

Community Hubs are an example of integrated neighbourhood services in Greater Manchester, developed through the pandemic. During the pandemic the Hubs coordinated support for the most vulnerable in each borough, including those who did not have any other way of sourcing food and medical supplies, and helped people access hardship grants. The Hubs aim to provide integrated neighbourhood working, based on a place-based working model. Community Hubs are led and funded by local authorities, and throughout the pandemic met regularly during the first months of the lockdown to ensure the most vulnerable residents were supported (68).

BOX 7. REDUCING INEQUALITIES IN VACCINE UPTAKE

The COVID Health Equity Manchester Group was established in July 2020 by Manchester Health and Care Commissioning (a partnership between Manchester's Clinical Commissioning Group and the City Council) to reduce inequalities in access to, and uptake of, vaccinations; it meets twice a month. To respond to the challenges, the group worked in partnership with local communities to create a forum for conversations and insights about the vaccine programme related to some ethnic groups and other communities known to experience high infection rates, high mortality and relatively low vaccination uptake. A voluntary, community and social enterprise organisations' 'sounding board' has been co-designed for each at-risk community, supported by a wider network of community influencers and 'cultural connectors'. This approach draws on community insight and intelligence with the aim of better developing culturally competent messages and delivering preventive measures swiftly and effectively to communities that do not currently have good access to timely, accurate public health information.

The vaccine equity plan includes:

- Targeting communication with tailored information through a range of media including films from multi-faith leaders and local councillors of diverse ethnic backgrounds and videos with information in different languages.
- Using the voice of community influencers to share messages through social media, webinars, community-led activities and events.
- Pop-up and mobile vaccination clinics in places where communities are present, for instance at mosques.
- 'Back to practice' offers where people can be vaccinated at their GP surgery.
- 'Quiet clinics' for people with learning disabilities or those requiring additional support.
- Pop-up booking clinics in community settings to enable people to book their vaccination appointment.

There is evidence of positive progress as a result of these programmes, improving coverage among Bangladeshi, African and Pakistani people, people with a learning disability and patients with a severe and enduring mental illness (69).

SUMMARY AND RECOMMENDATIONS

Greater Manchester has had higher rates of COVID-19 mortality than in England overall for both men and women. This partly relates to the timing of infection in Greater Manchester, but also relates to high levels of deprivation in the City Region, to living and working conditions, interconnected communities and high numbers of key workers. The timing of national restrictions was not always appropriate for Greater Manchester because the pandemic's progress there was different from the rest of the country. The City Region has experienced prolonged local restrictions in addition to national restrictions. COVID-19 mortality has also been more unequal across deprivation deciles within Greater Manchester than in the rest of England.

Given the associations between deprivation, ethnicity and mortality from COVID-19 in Greater Manchester, it is important that programmes to reduce the risk of infection and mortality and to encourage vaccine uptake are universal but with proportionately more effort in those areas and specific communities where risk is highest. These interventions will also help reduce inequalities in health more broadly. Without this focus on inequalities COVID-19 risks becoming entrenched among more deprived and certain ethnic minority communities.

Our recommendations in this section are relatively short-term measures to reduce the risks of infection and mortality. In the rest of the report we make recommendations about how to reduce the drivers of those unequal risks – inequalities in the early years, education, communities, housing, employment, income and health. We also set out how the unequal and negative impacts of containment measures will widen those inequalities in the long term, further worsening poor health and lowering life expectancy.

RECOMMENDATIONS: REDUCING INEQUALITIES IN VACCINE UPTAKE AND IN INFECTION AND MORTALITY RATES

- Advocate for local control over vaccination programmes, especially catch-up programmes, and focus vaccine rollout more on groups at higher risk and with lower vaccination rates.
- Follow the principle of proportionate universalism and direct increased resources and supply to ensure the needs of the most deprived, diverse and more vaccine-hesitant communities are met.
- Advocate for resources for adequate financial support and provide practical, clinical and wellbeing support for those who cannot work because of COVID-19 risk and those who have to self-isolate and ensure guarantees of return to employment.

CHAPTER 4

THE SOCIAL DETERMINANTS OF HEALTH INEQUALITIES IN GREATER MANCHESTER AND THEIR ROLE IN COVID-19

Despite favourable leadership and effective systems in place in Greater Manchester, there are longstanding and entrenched socioeconomic and health inequalities which blight the lives of many of the City Region's residents. Between 2015 and 2017, for both women and men, life expectancy in Greater Manchester was close to two years below the England average and healthy life expectancy three years below the England average. Poverty levels are high: twenty percent of Greater Manchester's population, 680,000 people, live in the 10 percent of most disadvantaged areas nationally (16).

As we have outlined in the previous section, Greater Manchester has been hit hard by COVID-19 infection and mortality, and experienced severe social and economic impacts from containment measures, which have lasted longer than in much of England and which will further widen socioeconomic inequalities and health inequalities. Health inequalities and mortality from COVID-19 might have been even higher had there not been substantial activity and investments in reducing health inequalities and socioeconomic inequalities before the pandemic, however, additional and more widespread action and increased resources are now urgently required. The recommendations and proposals made in this report support many of the existing approaches in Greater Manchester, but with recommendations to scale up as well as implement new approaches to reduce widening inequalities. The Build Back Fairer approach provides a coherent response to the challenges and could underpin greater population engagement, including from businesses, in order to respond to the inequitable impacts of the pandemic.

A. COMMUNITIES AND PLACE

In the *Build Back Fairer* report for England we assessed the impacts of the COVID-19 containment measures on resources and assets in places and communities, noting that more deprived areas, some of which we describe as 'ignored places', suffered greater levels of funding cuts before the pandemic and have been worst hit during the pandemic. These same communities and places are also likely to have had higher rates of mortality during the pandemic compared with better-off areas. Levels of deprivation are likely to increase in the aftermath, further harming health, as poverty and unemployment increase and local government and public service finances suffer (1).

The physical, economic and social characteristics of places and communities have an important influence over people's physical and mental health and wellbeing, and inequalities in these are related to inequalities in health (3). Community assets are important to health directly and indirectly: directly through the services and opportunities they offer that support physical and mental health, and indirectly through a sense of control and empowerment, levels of community cohesion and social interaction, all of which support good health. More deprived areas tend to have fewer community assets, unhealthier environments and often less social cohesion than wealthier areas.

Policies of austerity over the last 10 years have led to widening inequalities in the resilience and functioning of communities. Deprived communities and areas have seen vital physical and community assets lost, resources and funding reduced, community and voluntary sector services diminished and public services cut, all of which have damaged health and widened inequalities. In Greater Manchester, before the pandemic, levels of deprivation had increased (12) and the City Region has higher levels of deprivation than the average for England, including many areas of intense deprivation. As noted above, high levels of deprivation are damaging for health and closely associated with higher mortality from COVID-19 as well as all other causes of mortality and lower life expectancy and worse health. In Manchester City Local Authority, nearly 45 percent of local neighbourhoods (lower super output areas) fell among the 10 percent most deprived areas in England as measured by the Index for Multiple Deprivation (IMD) 2019 (70).

Two important dimensions of places that shape how communities affect health are levels of available funding and social cohesion and wellbeing. In this section we review both these for Greater Manchester, assessing conditions pre-pandemic, the effects of containment measures on communities and how these will likely affect health and health inequalities in Greater Manchester in the coming years.

FUNDING AND RESOURCES

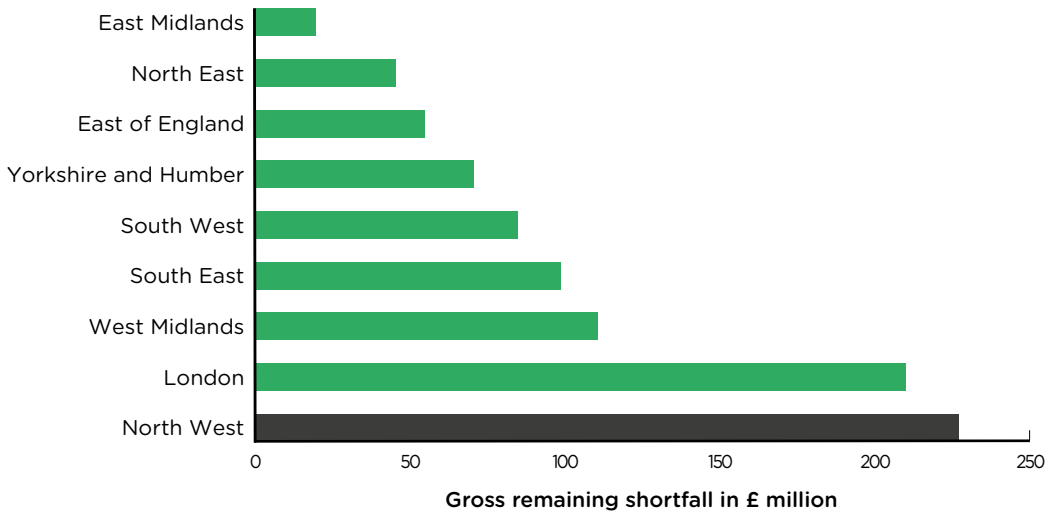
In the *10 Years On* report we set out how, in England, in the decade from 2010 cuts to local government had been regressive, with more deprived local authorities experiencing greater cuts than wealthier areas (3). Since 2009, net expenditure per person in local authorities in the 10 percent most deprived areas fell by 31 percent, compared with a 16 decrease in the least deprived areas (3).

Regional inequalities in levels of funding available to support communities have widened and in the North West region council spending per person fell by 20 percent between 2009/10 and 2019/20, compared with a cut of 15 percent in the South West, the region with the lowest cuts (71). The Institute for Fiscal Studies has estimated that councils in the North West received £378 million (cumulative) less funding in 2019/20 compared with 2011/12 while London councils received £286 million

more (71). In other words, the North West received £53 less per person between the start and end of that period and London received £33 more (71). In Manchester City, which, as noted, is particularly deprived, local authority expenditure fell by nearly 17 percent between 2009/10 and 2017/18 (72).

Given the extent of cuts up to 2020 and rising demands, Local Authority councils' reserves are severely depleted. Figure 13 shows that the North West region had the highest level of funding shortfall for councils in 2020–21 at £200m. 'Gross remaining shortfall' is the total shortfall left after local authorities have used all of their deployable reserves.

Figure 13. Gross remaining shortfall for councils in England's regions, based on own estimates of deployable reserves, 2020–21



Note: *Share of councils for which funding shortfalls exceed 'deployable' reserves, and the extent of this excess, based on different estimates of the share of reserves that are deployable. Estimates of the number or proportion of councils for which (1) their funding shortfall exceeds their own estimate of deployable reserves (or 75% of the same) and (2) their funding shortfall exceeds an alternative estimate based on the average share among councils of their type that is deployable (or 75% of the same).*

Source: *Institute for Fiscal Studies (73).*

As well as damaging communities and harming health prior to the pandemic, funding cuts harmed local governments' capacity to prepare for and respond to the pandemic and have left local authorities in a perilous condition to manage rising demand in the aftermath of the pandemic. In Greater Manchester these impacts have been particularly intense due to high levels of deprivation, the extent of funding cuts and the particularly severe damage to the social and economic conditions in Greater Manchester due to the longer lockdown.

In the *Build Back Fairer* report for England, we assessed the impacts of the containment measures on resources and assets in places and communities, noting that more deprived areas have been worst hit during the pandemic. Box 8 summarises these points.

BOX 8. COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PLACES AND COMMUNITIES IN ENGLAND – SUMMARY FROM *BUILD BACK FAIRER*

- The same communities and regions that were struggling before the pandemic – more deprived areas and ignored places – are struggling during the pandemic and this will likely continue in its aftermath. Their resilience has been undermined by the effects of regressive reductions in government spending over the last decade.
- Pre-pandemic cuts to local authorities were higher in more deprived areas, leading to greater losses in services there.
- Local authorities are now under even more intense pressure and extra government funding will not make up the shortfall (1).

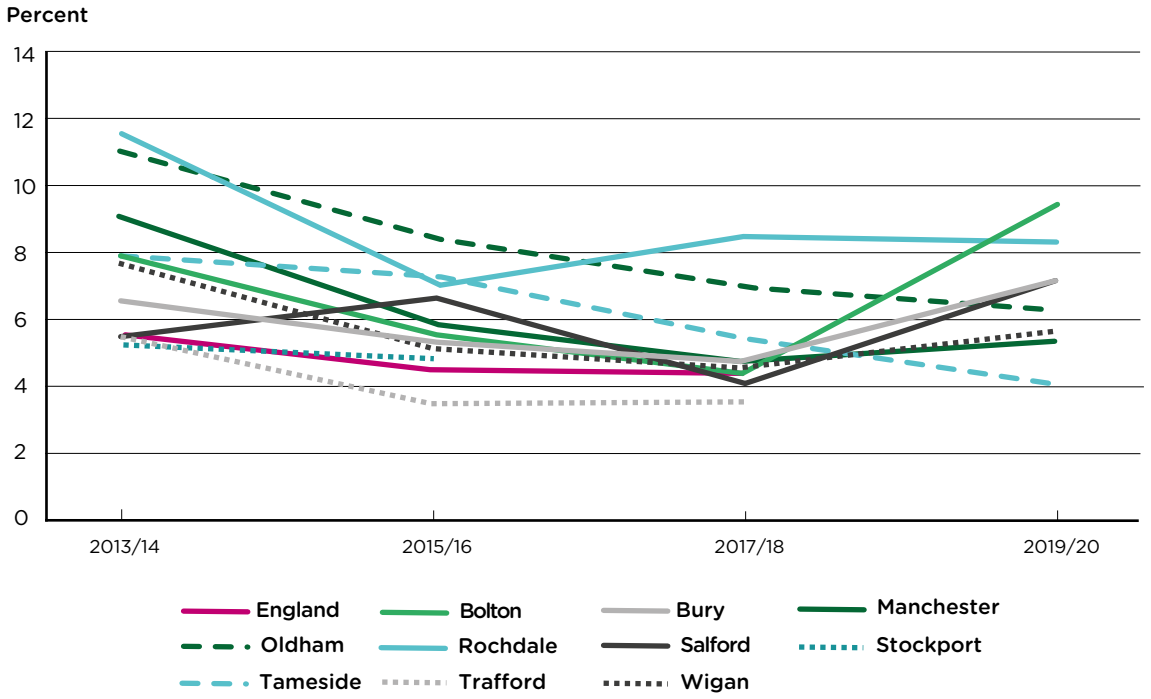
Given the highly inadequate funding available to local authorities in Greater Manchester, their capacity to respond and mitigate the impacts of the pandemic is extremely constrained and health will suffer as a result. As noted above, the shortfalls will be higher in more deprived local authorities, where need is greatest. While there is an urgent need for greater funding for essential community services and support, there are other dimensions of community resilience and assets that can be supported and fostered.

COMMUNITY WELLBEING AND COHESION

Physical and mental health and wellbeing are interrelated; having positive wellbeing translates into good health and good health supports positive wellbeing. Generating conditions that support good wellbeing is an important health and health equity intervention as well as an important goal in its own right.

In Greater Manchester, prior to the pandemic, self-reported wellbeing had been improving in more than half of local authorities, according to survey data. Figure 14 shows in most of Greater Manchester's local authorities there were reductions in those reporting low satisfaction before the pandemic, meaning levels of wellbeing had improved by 2019/20 compared with 2013/14. Feelings of low satisfaction rose slightly in Bolton, Salford and Bury.

Figure 14. Trend in the percentage of people with a low satisfaction score by local authority in Greater Manchester, 2013/14–2019/20

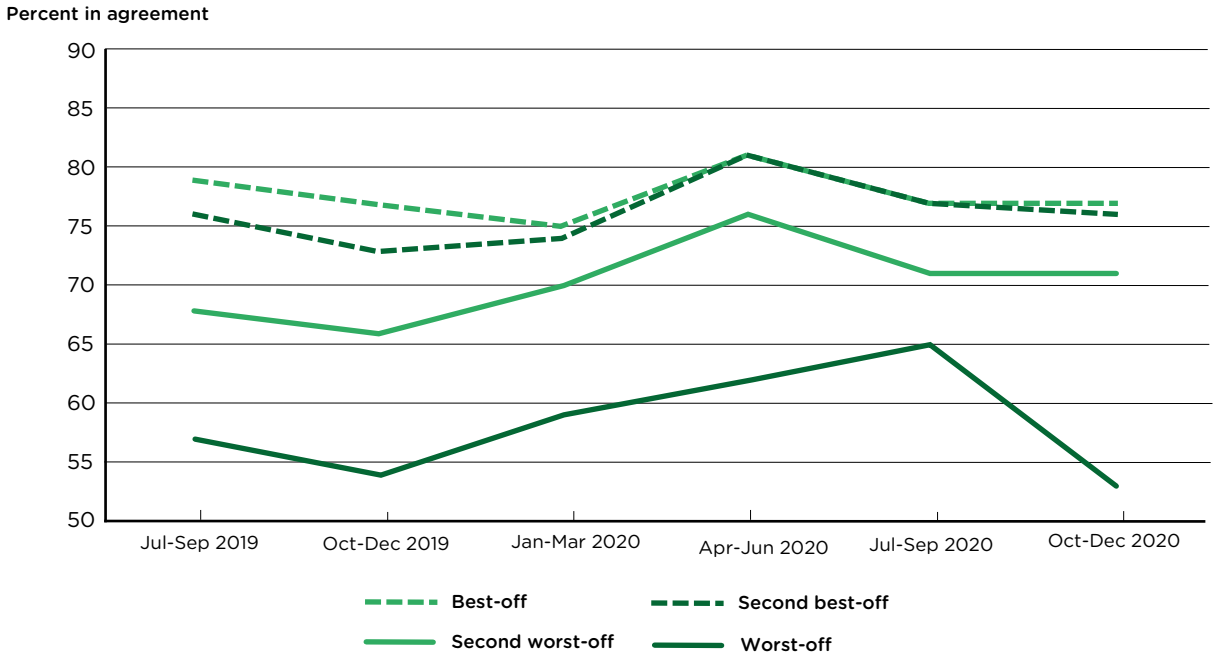


Source: *ONS (74).*

Despite these mostly positive changes in wellbeing scores, it is likely that COVID-19 containment measures will have affected wellbeing. The Greater Manchester Mental Wellbeing Survey of over 4,000 respondents conducted between August and November 2020 found the two most common factors that respondents felt negatively impacted their wellbeing were income and not seeing friends and family, and 43 percent of respondents stated they had 'very high concern' about income and friends and family. Concerns about income were higher in ethnic minority populations and those with disabilities (75).

During the pandemic there were reports of strengthened community cohesion and resilience as local residents supported each other and felt a common sense of purpose. However, this appears to have been short-lived. Figure 15 shows results from Greater Manchester Police's quarterly Community Safety Survey for July 2019 to December 2020, which indicate community cohesion increased for all income groups during the first phase of the pandemic, then levelled off for those on higher incomes and declined for those on lower incomes; inequalities in feelings of social cohesion by income groups widened. However, the early improvements do show that reducing inequalities in community cohesion is possible and lessons must be learnt from this.

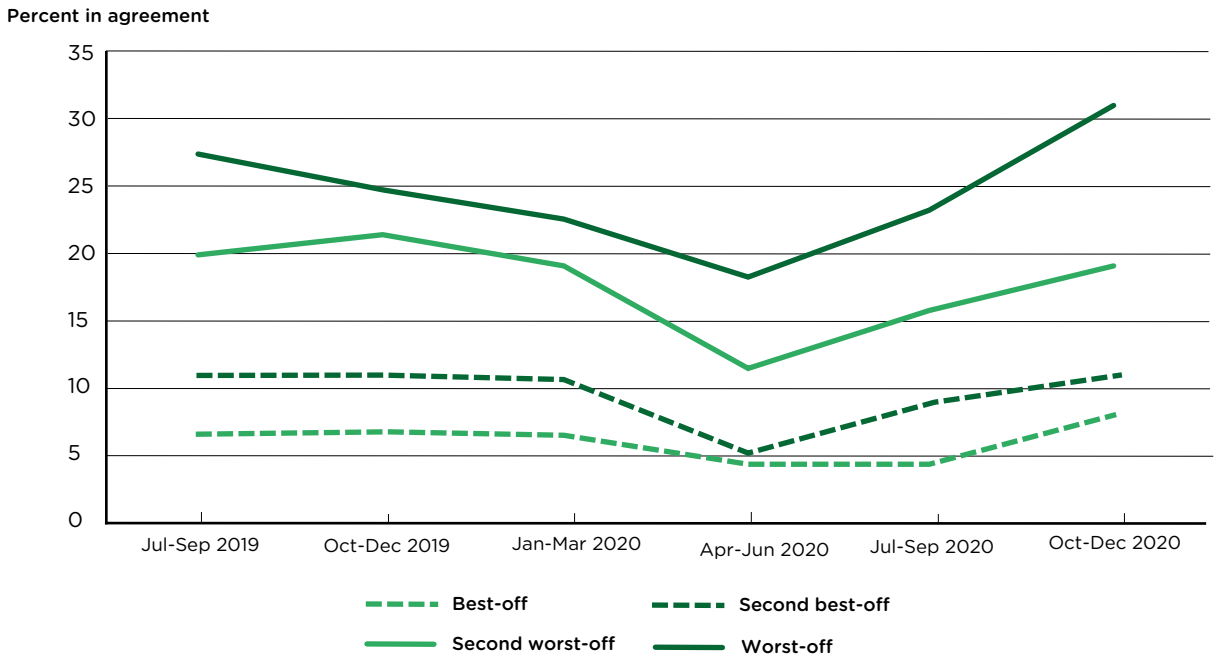
Figure 15. Percentage agreeing with the statement 'My local area is a place where people with different backgrounds get on well together', by financial subgroups, Greater Manchester, quarterly reporting July 2019 to December 2020



Source: *Greater Manchester Police (76)*

In the early phase of the pandemic, findings from the Greater Manchester Survey showed a decline in feeling unsafe, and lower inequalities according to personal level of wealth. However, feeling unsafe increased rapidly and inequalities increased as the pandemic continued (Figure 16).

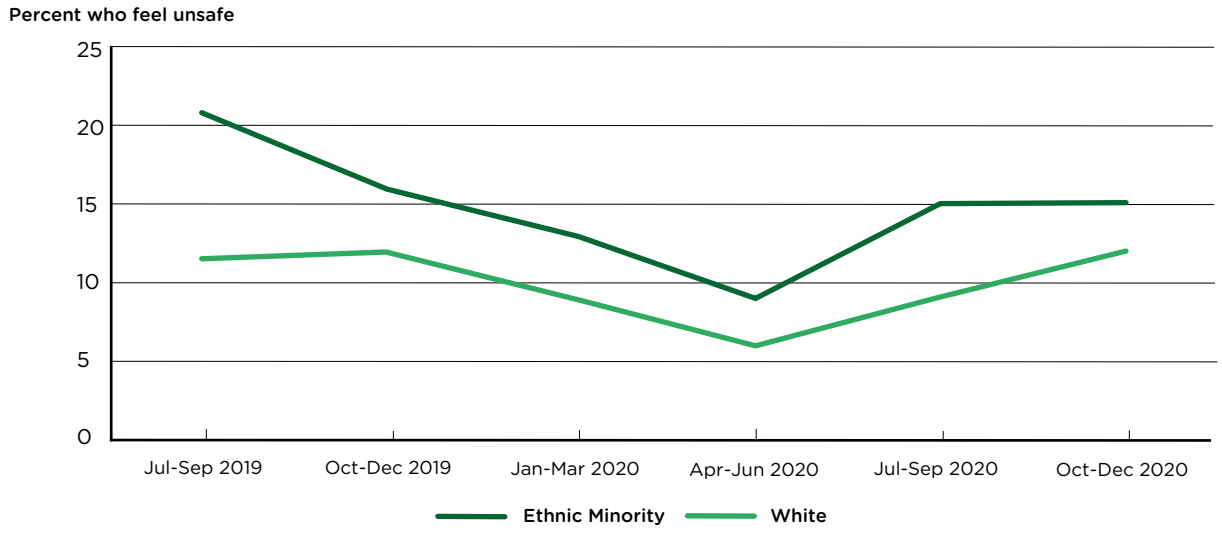
Figure 16. Percentage of the population who report they feel unsafe in their local area, by financial subgroups, Greater Manchester, quarterly reporting July 2019 to December 2020



Source: *Greater Mancester Police (76).*

Simillarly, the proportion of people who felt unsafe between the summer of 2019 and winter 2020 reduced for both White and ethnic minority respondents though this increased again after the first lockdown (Figure 17). While the data show that ethnic minority respondents were more likely to report feeling unsafe, the gap between ethnic minority and White respondents narrowed over the period shown in the graph.

Figure 17. Proportion of the population who report they feel unsafe in their local area, by Ethnicity, Greater Manchester, quarterly reporting July 2019 to December 2020

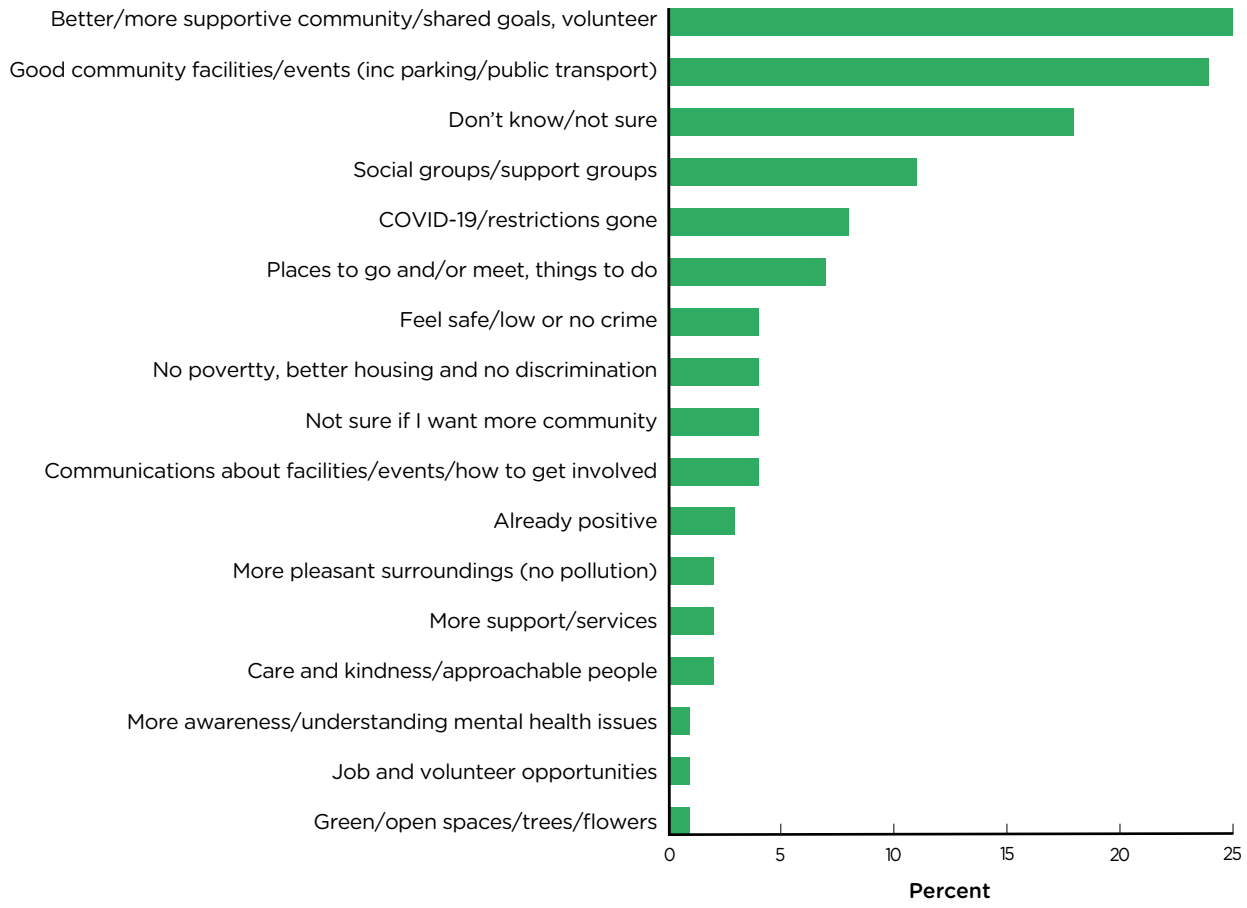


Note: *Graph shows those who reported they feel 'fairly unsafe' or 'very unsafe'.*

Source: *Greater Mancester Police (76).*

Fostering community cohesion and safety in Greater Manchester and improving the quality of more deprived local areas are important health equity interventions. How these could be achieved effectively has been highlighted by relevant surveys with communities in Greater Manchester. For example, in relation to levels of community cohesion, for nearly a quarter of residents who responded to the 'Greater Manchester Big Mental Wellbeing Conversation', community support and shared goals and good community facilities and events were deemed most important (Figure 18). Cuts to funding before, and likely following, the pandemic will have undermined both of these valued community features.

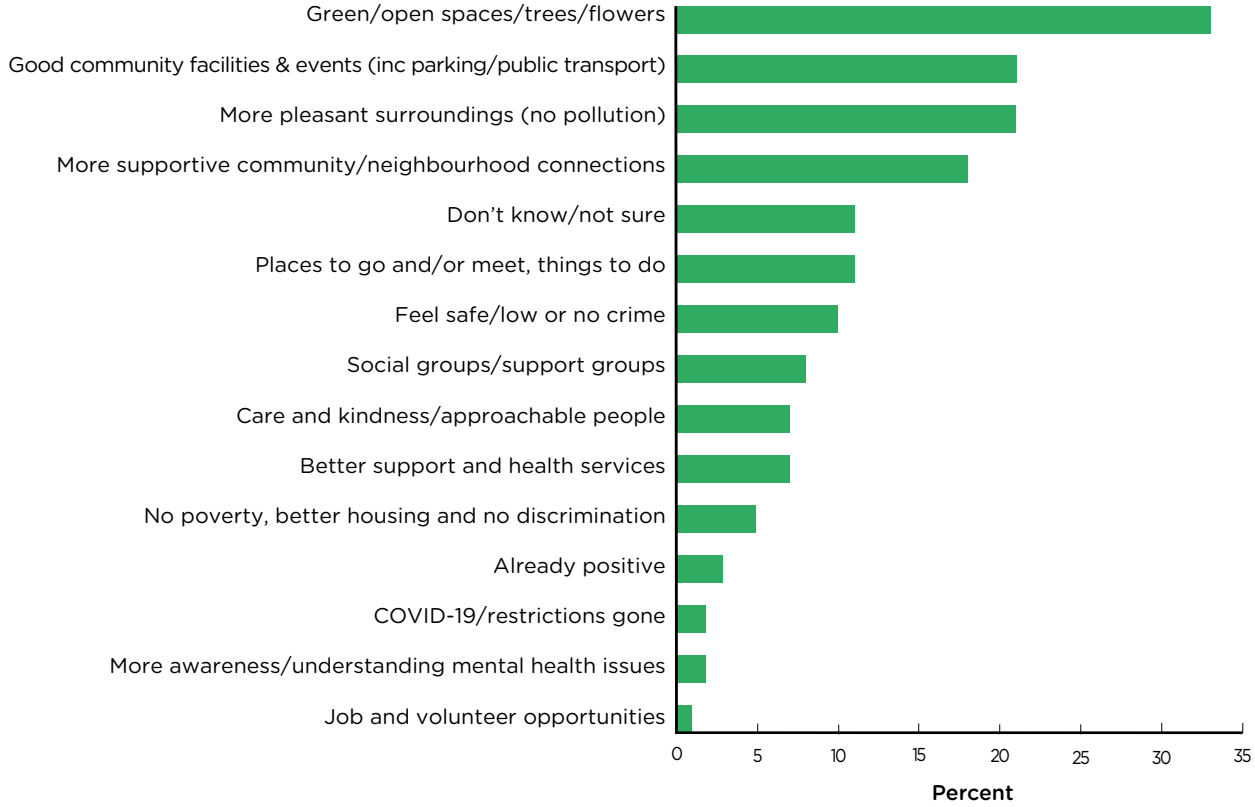
Figure 18. Responses to the survey question, 'What would make people feel more part of their community?'



Source: *Question 10 of Greater Manchester Big Mental Wellbeing Conversation Survey Aug-Nov 2020, of 3,986 people who live and/or work in Greater Manchester (75).*

Figure 19 shows further responses to the Greater Manchester Mental Wellbeing Conversation Survey about wellbeing, which indicate the ways residents view local areas could improve. Most residents noted the importance of green environments and local events and facilities to good wellbeing, which are highly supportive of good physical and mental health and help reduce inequalities.

Figure 19. Responses to survey question, 'If the local area was a place of positive wellbeing, what would it look like?'



Source: *Question 3 of Greater Manchester Big Mental Wellbeing Conversation Survey, Aug-Nov 2020, of 3,986 people who live and/or work in Greater Manchester (75).*

In communities around the world, volunteers have been a valuable part of the COVID-19 response, although the capacity of people to volunteer has been limited, due to restrictions. Since March 2020, surveys of voluntary, community and social enterprise organisations in the UK found 24 percent or organisations reported an increase in volunteers and 36 percent reported a decrease (mainly due to social distancing and lockdowns reducing opportunities to volunteer) (77). In Greater Manchester, the Big Mental Wellbeing Conversation identified volunteering as one of the main ways to make people feel more part of their community – alongside better community support and involvement, good community events and facilities (75). A consultation with children and young people showed they are keen to volunteer and support the older generation (78), Box 9 indicates some of the volunteering efforts in Greater Manchester.

BOX 9. VOLUNTEERING DURING THE PANDEMIC

In Greater Manchester there was an increase in the number of local Facebook support groups at the start of the pandemic as neighbours offered help to each other. In Tameside a group of charities delivering food to vulnerable individuals have a WhatsApp group to keep in touch, provide each other with peer support and coordinate the offer across communities. Manchester and Tameside local authorities offered peer to peer support during the pandemic, finding many people are more accepting of help from volunteers/buddy/befriending services as there is less stigma associated with this than with accepting 'official' help. For people with mild mental health needs this is an effective intervention that needs to be built on.

Interviews with Directors of Public Health across England have revealed the effect of the pandemic on their working practices. The organisational boundaries and silos disappeared, and staff worked together for a common purpose. Multi-disciplinary teams brought together in local authorities have shown that complex problems can be addressed and that place-based models could be easily implemented (79).

SUMMARY AND RECOMMENDATIONS

Area deprivation and health inequalities are likely to increase as a result of the economic impacts of the pandemic and the probable lower national funding allocations to local government and public services. The shortfalls experienced prior to the pandemic must be redressed by providing additional resources to areas that have experienced particularly high rates of COVID-19 and more restrictions, such as Greater Manchester. In these areas there has been greater damage over the last 10 years and during the COVID-19 restrictions and there will be greater damage to social and economic outcomes and to health and health inequalities as a result.

As Greater Manchester has high levels of deprivation, which have been exacerbated by the pandemic, it is vital that funding is available with which to build community assets. To support local areas to Build Back Fairer and strengthen community assets and cohesion, resources need to be allocated according to deprivation level, with greater funding and support for more deprived areas, ethnic minority communities and to enable greater integration of people living with disabilities – people in both of these latter groups report feeling less connected to their communities, as shown by relevant surveys with communities in the region. Environmental, social and economic improvements to more deprived areas in Greater Manchester will help support social cohesion, community resilience and health and should also be the focus of national advocacy from the Combined Authority.

Greater Manchester already has a number of relevant strategies and interventions to support local communities, including Our People, Our Place, which has a vision of making "Greater Manchester one of the best places in the world to grow up, get on and grow old". There are 10 priorities to achieve the vision, including Priority 8: Safer and Stronger Communities (80). The strategy stresses the importance of partnerships between civic leaders, business, the voluntary, community and social enterprise sector, and local people. We endorse this approach and note that while there is still a way to go to ensure communities are at the centre of developing actions, the pandemic has resulted in closer collaborations between service providers, community groups and residents. These must be extended as part of the Build Back Fairer approach and lead to reconfigurations in how services are designed and delivered.

COMMUNITIES AND PLACE – RECOMMENDATIONS

1. Advocate for increased deprivation weighting in funding by level of area deprivation.
2. Advocate for a greater share of resources for regions and local authorities hit particularly hard by COVID-19 and containment measures, and based on remedying shortfalls in funding from the last 10 years.
3. Develop publicly accessible data on equity in health, wellbeing and the social determinants of health within local authorities and strengthen monitoring by ethnicity at the local level.

B. HOUSING, TRANSPORT AND THE ENVIRONMENT

In this section we review key elements of healthy environments, including housing, transport, air quality access to green spaces and the quality of high streets. Poor quality, and overcrowded housing is harmful to health, widens health inequalities and inequalities in key social determinants of health, and increases the risk of contracting and dying from COVID-19. Unaffordable housing contributes to poverty, leaving people in stressful situations, with insufficient income to lead a healthy life and increasing the risk of homelessness.

Affordable public transport is important to enhance access to services and jobs, reduce poverty, improve social cohesion, and enable everyone in Greater Manchester to experience its cultural, hospitality, sporting and community assets. All of these improve health and wellbeing. Those on lower incomes tend to travel more on trams and buses than people who are wealthier, and poorer people have much less mobility due to cost and limitations in access to public transport (3).

Poor air quality damages health. Long-term exposure to fine particulate matter (especially $PM_{2.5}$) increases mortality and morbidity from cardiovascular and respiratory diseases and causes lung cancer. People living in more deprived areas are the most affected by air pollution (81). The direct and indirect impacts of climate change are a threat to health and health inequalities in Greater Manchester, as globally. Immediate action to reduce greenhouse gas emissions can also improve health and reduce existing health inequalities. Climate change has direct and indirect impacts on physical and mental health, and on inequalities. Action to reduce air pollution by reducing the burning of fossil fuels will not only have immediate health benefits, but will also contribute to achieving net-zero greenhouse gas emissions.

Improving access to good quality green space is a vital mental and physical health intervention as well as supportive of efforts to mitigate climate change impacts and protect biodiversity. Access and use of green spaces tends to reduce as the level of deprivation increases, which was highlighted during the pandemic. Healthy high streets are supportive of good health, and unhealthy high streets undermine health – there are clear socioeconomic inequalities in access to healthy high streets (3).

Our findings on housing, environment, transport and health from the *10 Years On* report and the *Build Back Fairer* report for England are summarised in Boxes 10 and 11.

BOX 10. HOUSING, ENVIRONMENT, TRANSPORT AND HEALTH – SUMMARY FROM *10 YEARS ON*

- The costs of housing, including social housing, increased in the decade from 2010, pushing many people into poverty and ill health.
- The number of non-decent homes decreased, even in the private rental sector, but this sector still has high levels of cold, damp and poor conditions, and insecure tenures, which harm health.
- Homelessness and rough sleeping rose significantly, by 165 percent between 2010 and 2017. In 2018 there were 69 percent more children in homeless families living in temporary accommodation than in 2010.
- In London 46 percent of the most deprived areas have concentrations of nitrogen dioxide above the EU limit, compared with 2 percent of the least deprived areas.
  - Harm to health from climate change is increasing and will affect more deprived communities the most in future.
  - One quarter of the UK's greenhouse gas emissions come from transport and road transport is the largest contributor to poor air quality.
  - Between 2010 and 2018 the number of children walking to school did not change and the number cycling to school increased by one percent. Active travel amongst adults has increased but inequalities have widened (3).

BOX 11. HOUSING, ENVIRONMENT, TRANSPORT AND HEALTH – SUMMARY FROM *BUILD BACK FAIRER*, ENGLAND

- High costs of housing are continuing to push even more people into poverty as incomes fall.
- Rough sleeping was eliminated early on in the pandemic, showing what is possible. However, as of winter 2020, it was already increasing again.
- The number of families in temporary accommodation has increased during the pandemic.
- Private and social renters live in unhealthier conditions than owner-occupiers and have struggled more with lockdown.
  - Air pollution is much more prevalent in deprived communities and harms health and may have contributed to higher mortality rates from COVID-19.
  - Public transport, active travel and reduction in private car use are all elements of Building Back Fairer and will require support to urgently address how to encourage people back to public transport and provide a sense of safety whilst on buses, trains and the metro and to also make walking and cycling feel safe and manageable (1).

HOUSING IN GREATER MANCHESTER

Before the pandemic housing costs in Greater Manchester had increased, as they had in England generally, pushing many families into poverty. Housing conditions in the private rental sector had deteriorated and the prevalence of overcrowding and homelessness were increasing (3) (82).

HOUSING CONDITIONS

The 2019 Greater Manchester Housing Strategy stated that the quality of housing stock needed improving: "in some of our less affluent communities, older properties often show their age, presenting substantial concerns in terms of their condition, with common issues of damp, cold and other health and safety hazards, including their accessibility for those with mobility challenges" (83). In 2018 close to 1 million owner-occupied homes and 354,000 private rented homes in the North did not meet the 'decent homes standard'. Close to half of all non-decent homes in the North have at least one person with a long-term illness or disability (84).

Nationally, rates of overcrowding have increased among social and private renters since 2014 (85). Close to one in 20 people, 4.7 percent, live in overcrowded accommodation in Greater Manchester meaning they have fewer bedrooms than they need (86). The highest proportions being in Manchester, Oldham and Rochdale and the lowest in Wigan, Stockport, Trafford and Bury (19). In the North West 11 percent of ethnic minority households were overcrowded compared with 1 percent of White British households (87).

In Greater Manchester, young people and those from ethnic minority communities are more likely to rent from the private sector, where conditions are generally worse than in the social rented sector (83). In 2016/17 the English Housing Survey found 20.3 percent of households in England lived in the private rented sector and the equivalent estimated rate for Greater Manchester was slightly higher, at 21.9 percent (83). According to surveys across Greater Manchester nearly one-fifth of private renters had rented a property in a poor condition (88) and private renters had the lowest satisfaction with their home's state of repair compared with other tenures: 18.5 percent surveyed were dissatisfied or very dissatisfied compared with 9.8 percent overall (89). Demand for social housing continues to rise. In Wigan waiting lists increased by 69 percent between 2018 and 2020 and there are more than 78,000 households in Greater Manchester waiting for social housing (90) (91).

The deteriorating housing conditions prior to the pandemic, especially overcrowding, had a direct impact on COVID-19 infection and mortality rates and contributed to socioeconomic inequalities in risk and mortality in Greater Manchester. Over the lockdowns, households have spent much of their time in their homes, and this has increased exposure to unhealthy and overcrowded conditions and added to the stress of living in poor quality housing. In response to the challenges facing the housing sector, particularly homelessness, there have been a number of significant actions in Greater Manchester, Box 12.

BOX 12. ACTIONS GREATER MANCHESTER IS TAKING ON HOUSING

Greater Manchester's A Bed Every Night scheme and Housing First policy and offer support accommodation for people who sleep rough and support to improve their physical and mental health. The NHS provides funding for the scheme as it is viewed as a form of prevention, reducing need for NHS services. The Mayor's Homelessness Fund enables businesses and individuals to donate towards supporting local services to support homelessness reduction (92).

The Let Us ethical lettings agency in Greater Manchester provides management services to private landlords through the services of housing association partners, aiming to improve the private rental sector (93).

In March 2021 the Better Homes, Better Neighbourhoods, Better Health 'Tripartite Agreement' between Greater Manchester Housing Providers, Health and Social Care Partnership and the Combined Authority was launched. The partnership aims to plan new housing and communities to enhance health, support more vulnerable households, support homeless people and those sleeping rough, and expand the ethical lettings agency to make an additional 800 homes available to those who are homeless or sleeping rough by 2024 (94).

Greater Manchester's 2019–2024 Housing Strategy has two priorities: to provide a safe, healthy and accessible home for all and to deliver the new homes Greater Manchester needs (95). It commits to providing 50,000 affordable homes, of which 30,000 will be for social rent, by 2037 (95). However, this is too few and too slow to meet the demands for affordable housing, and given the impacts of the pandemic, the Strategy's priorities are unlikely to be met in the 2019–24 timeframe.

In the aftermath of the pandemic it is likely that housing quality will likely deteriorate further as landlords, including private and social landlords, are less likely to invest in their properties; they will have fewer resources available to them due to declining incomes, plus there will be a greater demand for cheap rental properties. The shortage in the social rented sector will affect the ethnic minority population substantially as they are the most likely of all ethnic groups to live in social housing (96).

The Good Landlord Scheme mixes both hard and soft regulatory interventions, and the City Region will have the capacity to take action to ensure compliancy, penalising those landlords who do not provide decent housing (Box 13). Assessing quality of housing is an extensive task and cuts to local authorities have meant that assessments and enforcements have been scaled back (97).

BOX 13. IMPROVING THE PRIVATE RENTED SECTOR IN GREATER MANCHESTER

Many short-term and small-scale interventions have been introduced to improve the private rented sector, although problems remain. Three-quarters of renters interviewed in Salford stated they had problems getting repairs addressed (98). 1,900 complaints were made to the Manchester city's rogue landlord enforcement team in 2019/20, yet only 240 properties were inspected (99).

The Greater Manchester Good Landlord Scheme, approved in March 2021, could help to address some of the issues by placing the onus on landlords and agents to improve and maintain standards in the private rental sector (100). The Scheme addresses some of the issues by:

- Strengthening and focussing enforcement capacity in a co-produced model with districts, and potentially with improved connections to housing advice and advocacy services, and to Greater Manchester Fire and Rescue Service, Greater Manchester Police and Trading Standards enforcement activity. Work to target the poorest quality and worst managed properties in the sector should be given direct support.

- Targeting capacity building for landlords (and agents) to help them better support their tenants, particularly those on low incomes, including training and access/signposting to help retrofits, and other funding opportunities or support.

- Working with districts and key stakeholders to ensure tenants and landlords have access to accurate and up-to-date information and advice (e.g. around housing and welfare rights and dealing with personal and household debt).

- Promoting the active growth of ethical/social investors in the sector – including working with Greater Manchester registered providers to achieve this via the ethical lettings agency Let Us (see Box 12), in part to offer an exit route for landlords, including those unwilling or unable to provide decent, well-managed homes for tenants (100).

HOUSING COSTS

Unaffordable housing harms health – it increases homelessness and reduces income available for other essential services and food. The effects of unaffordable housing increase stress and the risk of suffering from poor mental health; high housing costs lead to worse housing conditions as people cannot make essential repairs and landlords have less incentive to improve conditions. Housing affordability in Greater Manchester continues to push many households into poverty and homelessness, with private renters spending a greater proportion of their income on their housing costs than those with mortgages or social renters. On average, in the UK, in 2018/19 private renters spent 33 percent of their income on housing costs, while social renters spent 26.5 percent and people with mortgages 18 percent of their income on housing (101) (102).

Housing costs were increasing prior to the pandemic. In 2019 it was estimated that around 38 percent of newly forming households in Greater Manchester were unable to afford to buy or rent a home in the one-quarter of properties least expensive to buy or rent (103). In 2018 the average monthly private rent in Manchester City required a single person to spend 45 percent of their income on rent (104). Average housing prices and private rents in Greater Manchester are generally lower than the England and Wales average, but average household incomes are also lower and close to one-third of households spend more than 35 percent of their income on private rent; those on lower incomes spend a larger proportion on housing costs (95). Box 14 outlines measures to support those on low incomes to secure deposits for housing.

BOX 14. SUPPORTING HOMELESS AND LOW-INCOME FAMILIES TO SECURE DEPOSITS FOR HOUSING

The Bond Board, established in 1993 in Greater Manchester, provides bond guarantees for people who are homeless or on low incomes. These guarantees take the place of cash deposits and provide security for landlords. The Bond Board provides a specialist housing advice service to tackle eviction issues with funding from the Greater Manchester Mayoral Fund. Their services have provided advice to residents in Oldham, Wigan, Rochdale and Bolton and they have partnered with the National Housing Advice Service and Shelter to assist with any cases that demand additional specialist support for families at risk of eviction (105).

COVID-19 has had a severe effect on the affordability of housing as incomes decrease (106). In January 2021 it was estimated in the UK that rates of arrears were "at least twice the level of arrears observed going into the crisis" and "that over 750,000 families were behind with their housing payments" (107). In the private rented sector over 174,000 tenancies have been threatened with eviction with 227,000 tenants in the UK in rent arrears. In October 2020 a poll of 2,989 private and social renters found 32 percent of private renters in the North West were worried about paying their rent over the next three months, an increase from 17 percent in the period immediately before the start of the pandemic (108).

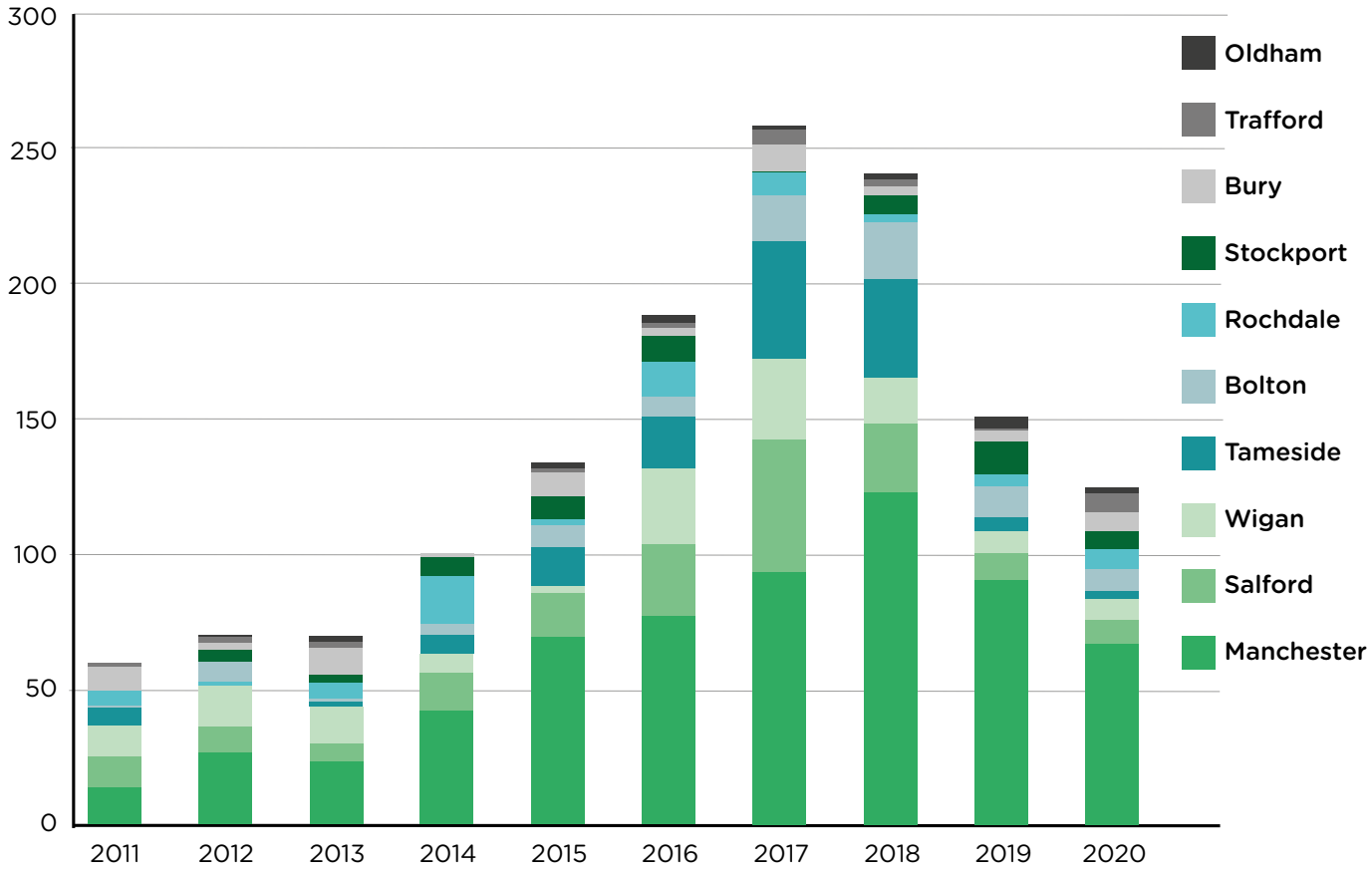
Annual rent prices in the North West region grew by 1.9 percent in the 12 months to March 2021, compared with an average of 1.3 percent for England (109). The ban on evictions is in force until September 2021, and given this and the planned ending of the £20 per week increase in Universal Credit also in September, there is likely to be a wave of evictions and increases in homelessness at that time (100).

HOMELESSNESS AND ROUGH SLEEPING

As described above, waiting lists for affordable and social housing are high and have increased, and while the Greater Manchester Housing Strategy has priorities to provide a safe, healthy and accessible home for all, given the impacts of the pandemic these aims are unlikely to be met by the target year of 2024 (95).

Nevertheless, in Greater Manchester, huge strides have been made in reducing rough sleeping and further plans made for eliminating it (Figure 20) (110). These are real achievements, which can be built on to ensure that hidden homelessness is reduced and the factors that drive homelessness are addressed before they lead to homelessness. To bolster these efforts, increasing the supply of affordable housing, providing better quality housing and implementing much tighter regulation of private sector rental housing is required.

Figure 20. Number of people estimated to be sleeping rough in local authorities in Greater Manchester, autumn 2011–2020



Note: *Local Authorities can submit figures based on three methodologies: evidence-based estimates using local intelligence, count-based estimates from an active count carried out on a single night, and evidence-based estimates including a spotlight count.*

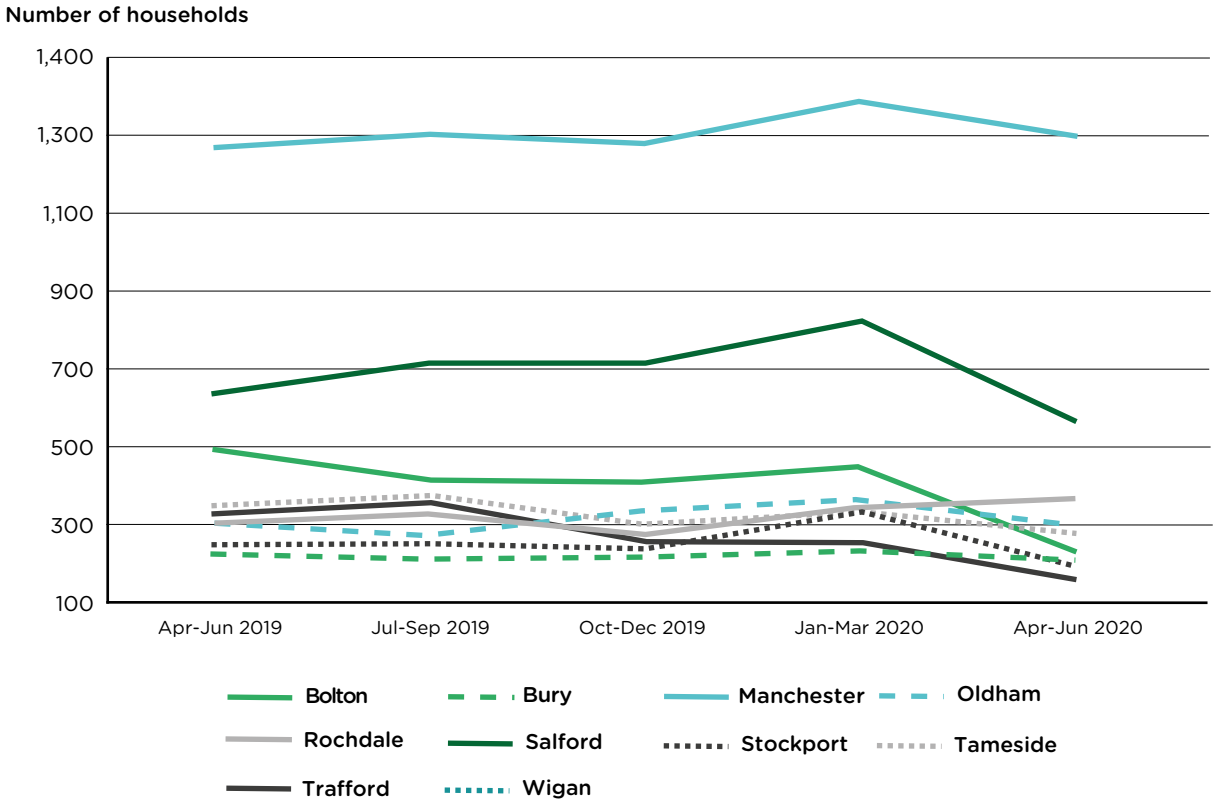
Source: *Department for Communities and Local Government (110).*

The homelessness problem is much larger than rough sleeping and includes those living in temporary accommodation, sofa surfing and other forms of insecure housing. The factors that drive homelessness – including poverty, a shortage of affordable housing, and high rates of eviction in the private rental sector – need to be addressed.

In 2020, *The Marmot Review 10 Years On* highlighted the increase in the number of children in homeless families living in temporary accommodation (3). In Manchester City the number of households with children accommodated in B&Bs for six weeks or longer decreased during the first lockdown: there were 102 households with children in B&Bs in March 2020, which reduced to 13 by the end of May 2020 (111).

Figure 21 shows the number of households deemed homeless in each of Greater Manchester's local authorities who are eligible for assistance in April – June 2019 and comparable months in 2020. In Manchester, Salford, Bolton, Bury, Oldham, Stockport, Tameside and Trafford the number of households owed a homelessness duty was flat or increasing until April to June 2020. Subsequent declines (except in Wigan and Rochdale) may be due to national government relief measures to reduce homelessness and the risk of homelessness during the pandemic. These have included suspending evictions related to non-payment of rent for three weeks and mortgage holidays of up to six months. These measures should be extended beyond September 2021, as without them, poverty and unemployment will rise and in turn lead to an increase in homelessness.

Figure 21. Number of homeless households eligible for assistance in Greater Manchester's local authorities, April–June 2019 to April–June 2020



Source: *MHCLG, October 2020 (112).*

There is expected to be a significant rise in people presenting as homeless in Greater Manchester due to the effects of the decline in incomes that have resulted from the pandemic. If the £20 per week increase in Universal Credit is removed in September 2021 as planned, the ban on evictions end, and if Local Housing Allowances do not remain in line with local rents, these will impact negatively on homelessness (100).

TRANSPORT AND ACTIVE TRAVEL

Increases in both active transport (cycling and walking) and public transport are needed to improve health and reduce health inequalities. Road transport produces almost a quarter, 24 percent, of the UK's carbon dioxide emissions (113). Greater Manchester's commitment to reach net-zero greenhouse gas emissions by 2038 will require, among other measures, shifting transport policy from road building for cars to increasing the use of public transport as well as increasing levels of walking and cycling. In 2018 in Greater Manchester, the most recently available data, CO_2 emissions had fallen by 2.5 percent from the previous year (114).

Policies aimed at increasing active travel and public transport must ensure those with the most potential to benefit are targeted. The wealthiest 10 percent of the population currently receive almost four times as much public spending on their transport needs as the poorest 10 percent in England (115); new investments should target areas currently least served by public transport and active travel infrastructure.

In 2014/16, 60 percent of trips made by car in Greater Manchester were for journeys under 2 kilometres, of which many could be made by bike, walking or bus, which would have health, environmental and cost benefits. In 2019 the bus network in Greater Manchester

had declined to three-quarters of what it was in 2010 and the number of customers on the bus network by close to 10 percent, although the passenger volume for the Metrolink tram/light rail system expanded in this period (116) (117). Between 2010 and 2018 there was a welcome, albeit slight, shift from cars to public transport, from 75 to 70 percent of journeys in Greater Manchester (118).

However, additional action is required: progress on reducing car use was harmed by the pandemic due to a significant decrease in the use of public transport during the lockdowns while private car use substantially increased due to concerns about infection on public transport as well as ongoing concerns about the cost and frequency of public transport in Greater Manchester. In March 2021, a year after the start of the pandemic, the number of passenger journeys across all types of public transport in the City Region remained more than 20 percent below the number of journeys made at the beginning of March 2020 (119). Similarly the number of journeys made by car substantially dropped during the first lockdown (from more than 5 million trips per day in Greater Manchester to close to 1 million at the end of March 2020), but by March 2021, the number of car journeys per day had almost bounced back, to more than 4 million, threatening to undo the welcome reduction in car journeys seen early on in the pandemic (119).

Efforts will be needed to encourage people back to public transport and Greater Manchester has already introduced a number of incentives. Currently, children under age 5 travel for free on Greater Manchester's buses and in 2020 the City Region began a two-year pilot offering free bus travel for 16–18 year olds: 'Our Pass' requires a one-off £10 registration free after which most bus travel is free and it gives half-price off-peak tickets on the Metrolink. The pilot ends in September 2022 (120).

In March 2021 Greater Manchester announced its buses will no longer be run by a range of private operators and will be run by Transport for Greater Manchester (TfGM), providing opportunities for further integration of the public transport network, greater affordability and a cleaner public transport system. In 2020 32 electric buses were introduced and further electrification of the entire fleet must be a priority, to meet clean air and the net-zero targets. It is hoped that the new opportunities for the bus network will encourage a move away from private cars to public transport. Greater Manchester will introduce a Clean Air Zone in 2022 to reduce car use – see Box 15.

BOX 15. ACTIONS GREATER MANCHESTER IS TAKING ON CLIMATE CHANGE, AIR QUALITY AND TRANSPORT

A Clean Air Zone is being introduced in Greater Manchester in spring 2022 as part of the Greater Manchester Clean Air Plan, which will involve daily penalties for non-compliant vehicles. Greater Manchester is seeking government funding of over £150 million to support owners and registered keepers of non-compliant vehicles with the cost of upgrading to cleaner vehicles (121).

Greater Manchester's Bee Network, the UK's largest walking and cycling network, will be delivered by 2028 (122).

Greater Manchester's Active Travel Public Health Manifesto sets out the actions the City Region will take in this area, including: more dedicated cycling/walking space; safe cycling parking facilities; prioritising walking and cycling-friendly 'active neighbourhoods'; reducing speed limits in residential areas to 20mph; more cycling training and schemes to boost access to bikes for those in lower income communities (123).

Achieving long-term, equitable and sustainable changes in transport requires more than equitable provision of active transport and clean public transport. If attention is not paid to inequalities in use and uptake, interventions aimed at reducing car use can exacerbate inequities as those who are more deprived are less likely to take up new initiatives or existing services (Box 16). An intervention offering cycle training participation programmes in the UK found both that schools in less deprived areas were less often offered the training and also that there were "markedly lower rates of participation" among South Asian and 'Other' ethnicity children, slightly lower rates among mixed ethnicity and Black children compared with White children and lower participation rates among children of less educated or less wealthy parents. When the training was offered in schools with large numbers of deprived children or children from many ethnic backgrounds, it reduced within-school inequities, suggesting targeting more deprived areas or schools is needed when population-wide interventions are introduced (124).

BOX 16. REDUCING TRANSPORT POVERTY

Transport poverty is affected by the affordability and accessibility of transport systems. Research into transport poverty in Greater Manchester found those with low incomes felt local transport was too expensive, unreliable and slow, making it harder for them to attend job interviews or continue in low paid employment (125). A Joseph Rowntree Foundation study in 2018 of residents in four areas, including Tameside and Manchester City local authorities, found that low-income neighbourhoods were served by unreliable public transport, under-served or not at all served, leading to transport being a significant barrier to employment (126). Improving the availability, reliability and affordability of buses will increase employment opportunities. Integrated transport networks such as Greater Manchester's should be used to reduce travel times, costs and distances to places of work and enable residents to be better connected and have more equitable commuting options.

ENVIRONMENTAL CONDITIONS

The direct and indirect impacts of climate change are a threat to health and health inequalities in Greater Manchester, as globally. Immediate action to reduce greenhouse gas emissions can also improve health and reduce existing health inequalities because of the co-benefits of reducing local air pollution. The direct impacts of climate change on physical and mental health include: greater exposure to extreme heat/cold and UV radiation, more pollen, emerging infections, flooding and associated water-borne diseases, and impacts of extreme weather. The indirect impacts of climate change on health and inequalities include increases in the price of food, water and domestic energy and increased poverty, unemployment and anxiety (127).

Greater Manchester aims to reduce direct CO_2 emissions by at least 50 percent by 2025 and to be carbon-neutral by 2038 (128). As part of the plan to reach carbon neutrality and improve other aspects of the environment, Greater Manchester will: increase the number of homes and businesses using renewable energy; increase use of public transport and the number of journeys made on foot and cycling; retrofit homes and buildings to reduce energy demand; improve air quality; encourage sustainable consumption and production and improve recycling rates; protect and improve the natural environment by increasing the number of trees planted in Greater Manchester and increase biodiversity (128).

The targets and initiatives to support the climate change mitigation aims will benefit local air quality and improve public and active transport systems and, as a result, health and health equity. Further efforts are required to ensure that these improvements occur in more deprived areas first so that equity is at the forefront of the improvements.

QUALITY GREEN SPACES

Green spaces have been shown to improve mental health by reducing stress and increasing relaxation and physical activity. They also improve social interaction, and community cohesiveness (129). Health benefits have also been shown to improve cognitive and immune functions, and to reduce mortality rates and health inequalities (130). Parks and green spaces are estimated to save the NHS £111 million per year in the UK, due to reducing the number of GP visits (131). In England, the most affluent 20 percent of wards have five times the amount of parks or green spaces than the most deprived 10 percent of wards (130). In Greater Manchester in 2014, people in the 25 percent richest areas enjoyed nearly three times as much green space per head as the 25 percent most deprived areas (132).

Across the UK different ethnic minority population groups use green space in different ways. For example, a study of participants in England found people of Indian origin were most likely to visit their local urban green space with someone and by walking. The survey also found people of African-Caribbean, Bangladeshi, Pakistani origin and 'Other' ethnic minority populations were less satisfied with urban green space quality and much less likely to visit green spaces throughout the year and this was particularly pronounced in people of Bangladeshi origin (133).

Use of green spaces for activity has been high across Greater Manchester during the pandemic, especially during the first lockdown, with a 30 percent increase in the public attending parks in Manchester City (134), but inequalities in access and use related to level of deprivation and ethnicity have remained, mirroring the UK picture. A UK study of the use of green spaces during the first COVID-19 wave in April/May 2020 found people from lower socioeconomic backgrounds were less likely to visit green spaces before and while lockdown restrictions were introduced (135).

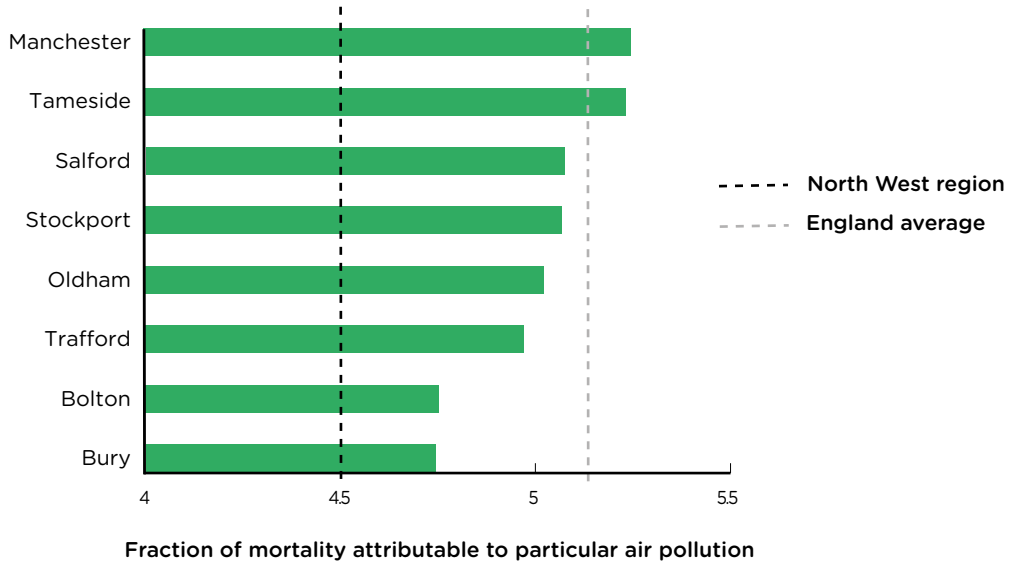
AIR QUALITY

Air pollution has serious health impacts, increasing morbidity and mortality, and inequalities in exposure to air pollution contribute to health inequalities. Respiratory conditions, cardiovascular disease and lung cancer are associated with exposure to air pollution and there is also evidence for associations with dementia, low birth weight and Type-2 diabetes (81).

The pandemic afforded a glimpse of how beneficial and desirable good quality air is for health and wellbeing, and lower car use reduced both local air pollution and greenhouse gas emissions contributing to climate change. Building on these benefits is significant to Building Back Fairer. Local authorities have a statutory role to assess and improve local air quality and doing so, particularly in more deprived areas where it is usually worst, will significantly improve health and reduce health inequalities.

The strongest evidence for effects on health is associated with fine particulate matter ($PM_{2.5}$) (81). Figure 22 shows that there are differences in mortality caused by $PM_{2.5}$ across local authorities in Greater Manchester. Manchester and Tameside have higher rates of mortality attributable to exposure to poor air quality than the English average and other parts of Greater Manchester, although all Greater Manchester local authorities have higher rates than the average for the North West region.

Figure 22. Percentage of mortality attributable to $PM_{2.5}$ air pollution, Greater Manchester, the North West region and England, 2019

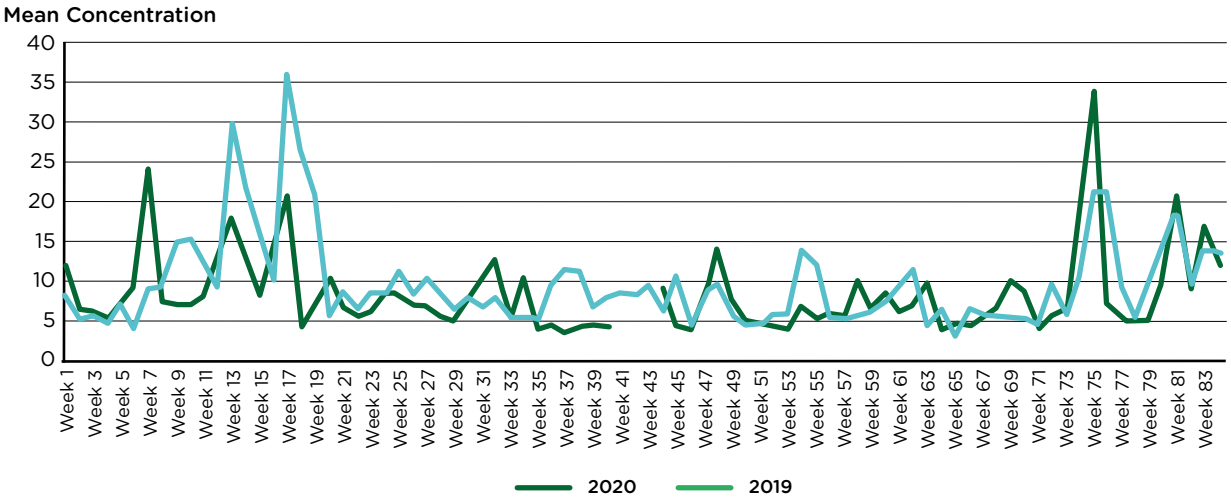


Note: $PM_{2.5}$ is particulate matter measuring less than 2.5m.

Source: *PHE, Fingertips tool (136).*

During the pandemic containment measures, traffic declined. Air pollution from fine particulate matter consequently decreased and stayed at lower levels than in 2019 until the end of 2020 (Figure 23), when it increased (29). Nitrogen oxide, another pollutant that affects air quality, also declined throughout 2020, although had increased again by the end of 2020 (137).

Figure 23. Manchester City weekly mean concentration of particulate matter ($PM_{2.5}$), March–December 2019 and March–December 2020



Source: *PHE, Fingertips tool, 2021 (29).*

HIGH STREETS

High streets and city centres have been significantly affected by the pandemic, with thousands of job losses and hundreds of store closures across the UK. In Greater Manchester, for example, by the end of March 2021 footfall in Wigan was down by 53 percent of its pre-lockdown levels and in Manchester it was down 18 percent (138). There are justified concerns about how to revitalise city centre economies and support healthy high streets after COVID-19 restrictions end.

In the UK a number of department and chain stories have closed and it is estimated the country has 40 percent excess retail space (139). Between 2000 and 2018 in Greater Manchester 1,280 retail units were lost (4.5 percent), and in nine of Greater Manchester's 10 boroughs – all except Manchester – the number of retail units was already declining (140). High streets will need to adapt as online shopping continues to accelerate; surveys suggest shopping habits have permanently altered and more than 50 percent of workers who are able to work from home state they wish to continue to do so, either all of or some of the time (141). This will negatively affect footfall in city centres but potentially increase footfall in local neighbourhoods.

Unused retail and offices spaces will provide an opportunity to repurpose high streets to support public health and reduce inequalities. High streets have an important role in the health of local communities and have direct and indirect impacts on health and inequalities. Direct influences on physical and mental health arise from a lack of diversity in products and services on high streets, high levels of traffic, crime and fear of crime, and inaccessible design (142). High streets can also affect health and worsen inequalities indirectly through rundown or inadequate communal areas, shelters, seating and focal points, deterring people from visiting or spending time in high streets, potentially preventing community activities and increasing the risk of social isolation and reducing the likelihood of community cohesion (142).

A high street that is 'healthy' and reduces health inequalities incorporates inclusive design and diversity and promotes improved health outcomes for all community members, including: the elderly and disabled, people from ethnic minority communities, families, children and young people. However, there are limits to what can be achieved by local authorities, and hence the Royal Society of Public Health recommends that the Ministry of Housing, Communities and Local Government provide local authorities with further powers to restrict the opening of outlets that might encourage unhealthy or harmful behaviours (such as betting and fast-food shops) where there are already clusters of these (143).

Planning for new high streets and city centres will be part of Building Back Fairer. Buildings used for commercial purposes may shift to residential spaces or to businesses that sell 'experiences' rather than 'goods' – for example, restaurants or entertainment and social spaces. The Greater Manchester Independent Prosperity Review has recommended investing in the 'foundational economy', businesses and organisations that are more likely to provide local jobs, stimulate local supply chains and invest in building local skills (17).

In January 2021 Manchester City Council approved plans to stop car traffic in the Northern Quarter, which had been closed to enable social distancing. This has led to questions of the feasibility of making other road closures permanent. These types of improvement are central to enabling people to easily be more active and to creating a sense of community (144). The '20 minute neighbourhood' approach (145) to providing healthy, accessible urban neighbourhoods, is another possibility for Greater Manchester and was included in the Independent Inequalities Review (11).

SUMMARY AND RECOMMENDATIONS

Poor quality and unaffordable housing remains a critical health equity issue in Greater Manchester, this has been highlighted by the higher rates of infection and mortality from COVID-19 for those living in overcrowded housing. Poor quality and unaffordable housing continues to damage the health of many residents in Greater Manchester and unaffordable housing pushes many people into poverty and homelessness. While Greater Manchester has many positive approaches to housing, these will need to be further expanded in coming years and far tighter regulation of housing quality and rogue landlords implemented. There is an increasing, and currently unmet need for the provision of more affordable and social housing.

Greater Manchester has also been making progress on improving access to public transport and reducing costs and to unifying the transport network across Greater Manchester. Further incentives to encourage people back to public transport must be made, including further lowering costs and ensuring infection control measures are fully implemented and public transport workers supported. Reducing car use will improve health and reduce air pollution and greenhouse gas emissions; the proposed clean air zones must be fully implemented and extended where possible and the electrification of the entire bus system expedited. These measures will also support action on climate change. Encouraging active travel is important but interventions must focus on more deprived communities and those less likely to take up active travel, or inequalities will widen further. Developing more green spaces and infrastructure is highly supportive of health and while we recommend extending provision across Greater Manchester, improvements must be made in more deprived neighbourhood first alongside provision of interventions and work with communities to encourage use. Similarly improving the quality of high streets, particularly given the impacts of the pandemic, is essential to good health and the social determinants of health and measures to improve quality must be taken in more deprived areas first.

HOUSING, TRANSPORT AND ENVIRONMENT – RECOMMENDATIONS

1. IMPROVE THE QUALITY AND AFFORDABILITY OF HOUSING

- Fully implement the Good Landlord Scheme.
- Strengthen and enforce decent housing regulation and advocate for resources to enforce housing regulations.
- All new housing to be built to net-zero emissions standards, with an increased proportion being either affordable or in the social housing sector.
- Continue to reduce rough sleeping and hidden homelessness and extend action to reduce risks for homelessness.

2. GREEN SPACES, AIR QUALITY AND QUALITY HIGH STREETS

- Fully implement clean air zones and monitor for inequalities in exposure.
- Improve quality of existing green spaces and prioritise provision of new green spaces in areas of higher deprivation.
- Adopt city-wide strategies that put health equity and sustainability at the centre of planning.
- Work with local communities to better include their needs when reviving local high streets.

3. TRANSPORT AND ACTIVE TRANSPORT

- Extend incentives to encourage people back to public transport.
- Improve road safety by implementing 20mph speed limit in all residential streets and implement other road safety initiatives in deprived areas first.

C. EARLY YEARS, CHILDREN AND YOUNG PEOPLE

A solid foundation in the early years of childhood and through primary and secondary school is essential for positive outcomes throughout life, including health. Positive experiences early in life are closely associated with better performance at school, better social and emotional development, improved work outcomes, higher income and better lifelong health, including longer life expectancy. Persisting socioeconomic inequalities in attainment during primary and secondary school have lifelong impacts on health inequalities (146).

The decade from 2010 damaged childhood and the subsequent outlook for many children and young people in England, particularly those from more disadvantaged households and areas (see Box 17). Child poverty increased from 2010, including for working households (3). Services were cut and more deprived areas lost more funding for children and youth services than wealthier areas.

BOX 17. EARLY YEARS, CHILDREN AND YOUNG PEOPLE – SUMMARY FROM *10 YEARS ON*

- Rates of child poverty increased in the 10 years from 2010, with over four million children affected, and are highest for children living in workless families, of whom in excess of 70 percent experience child poverty.
- More deprived areas lost more funding for children and youth services than less deprived areas, even as need has increased.
- Violent youth crime increased greatly over the period (3).

During the pandemic in 2020 and the first three months of 2021, across England inequalities in development and attainment among children increased for all age groups, which will harm longer-term prospects, particularly for more disadvantaged children (1) (see Box 18).

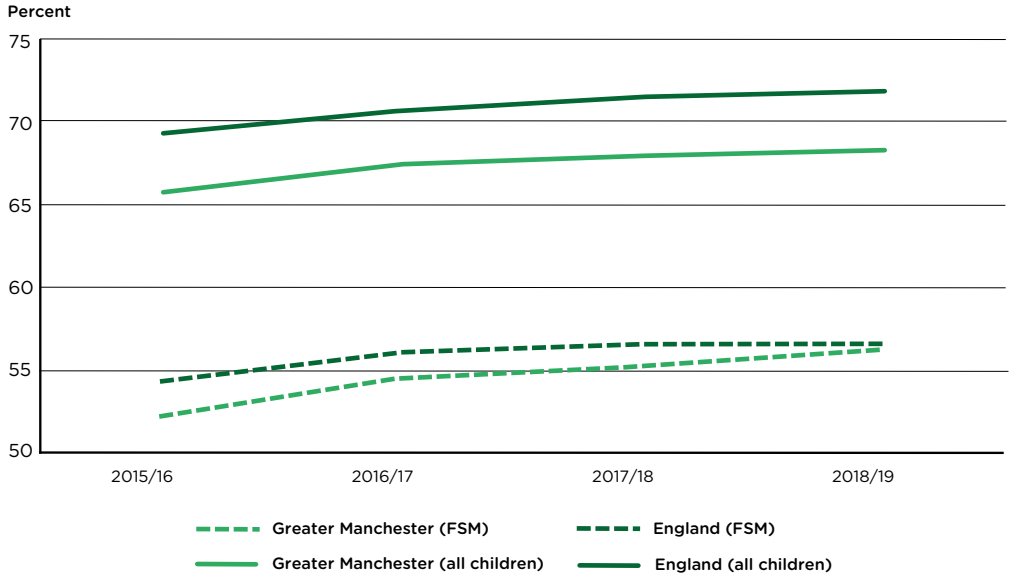
BOX 18. COVID-19 CONTAINMENT AND INEQUALITIES IN CHILDREN AND YOUNG PEOPLE – SUMMARY FROM *BUILD BACK FAIRER, ENGLAND*

- Child poverty is set to increase further.
- Food poverty among children and young people has increased significantly during the pandemic.
- The mental health of young people, already hugely concerning pre-pandemic, has deteriorated further during it, and there is widespread lack of access to appropriate services.
- Exposure to abuse at home has risen through the pandemic, from already high levels pre-pandemic.
- The numbers of unemployed young people are rising more rapidly than among other age groups and availability of apprenticeships and training schemes have declined (1).

EARLY YEARS IN GREATER MANCHESTER

Before the pandemic Greater Manchester made great progress in early years development, going against trends elsewhere in England. Inequalities in early childhood development in the City Region reduced between 2015/16 and 2018/19 and outcomes improved at a faster rate than the national average (Figure 24).

Figure 24. Percentage of children achieving a good level of development at the end of Reception, all children and those receiving free school meals, Greater Manchester and England, 2015/16-2018/19



Source: *DfE (147).*

Part of the success in reducing inequalities in early childhood development in Greater Manchester has been attributed to the Thrive model (Box 19).

BOX 19. IMPLEMENTING THE THRIVE MODEL IN GREATER MANCHESTER

Greater Manchester is implementing the Thrive model to guide the development and provision of early years services. This is a proportionate universalist approach, whereby families that need more help are identified and offered support locally. This includes specialist perinatal community mental health teams providing support to children in their first two years of life. The principles of Greater Manchester's integrated perinatal service are:

- Seamless patient/family journey across universal, targeted and specialist services
- Flexible pathways – families can weave between services to experience a tailored care package that adapts to the changing needs of the family
- Strong working relationships with teamwork and good communication
- Continual assessment of families' needs
- Promote patient-specific and individualised multi-disciplinary teams targets (148).

The Department for Education finds that in Greater Manchester the proportion of early years pupils from ethnic minority backgrounds who achieved a 'good level of development' (children achieving at least the expected level in: communication and language; physical development; personal, social and emotional development; literacy; and mathematics) increased from 41 percent in 2013 to 66 percent in 2019. Moreover, while it remains significant, the attainment gap between early years pupils from White and ethnic minority backgrounds narrowed from 10 to 4 percentage points from 2013 to 2019 (149).

COVID-19 containment measures have led to widening inequalities in early years development and in educational attainment. Sixty-eight percent of parents with children aged 2–4 years in England accessed early education or childcare services such as pre-schools or nurseries pre-COVID. During the first lockdown period only 7 percent of children who had previously attended formal early education and childcare providers continued to do so and because these are particularly beneficial to more deprived children, there will be resultant increases in inequalities in levels of development (150).

In addition, parents reported more negative impacts on the social and emotional development of children who had not attended early years settings compared with the children of critical workers or vulnerable children who continued to attend (151). Our *Build Back Fairer*

report for England showed more disadvantaged children were less likely to have a suitable home learning environment, and partly as a result of this, the closures will have further widened the widespread socioeconomic gaps in early years development (1).

Early years settings in deprived areas of England have reported great financial difficulties, more than those in wealthier areas, and have lost staff during the pandemic (1). It is estimated that close to one-third of providers of early years education and care in Greater Manchester fear they might have to close in 2021 (11). It is likely that inequalities in access and quality of early years settings will widen in the post-pandemic period.

National monitoring of school readiness was halted in 2020 due to the pandemic so it is difficult to compare inequalities in school readiness before and during the pandemic. Given that early years settings were closed for much of 2020 and that these are particularly beneficial to more deprived children and their school readiness, it is plausible to expect to see increases in inequalities in levels of development and this will have life-long impacts unless urgent mitigating action is undertaken (150). The recent policies and strategies adopted by Greater Manchester (Box 20) are valuable tools for setting a good foundation to address inequalities in early years as early years services adopt to the post-pandemic period.

BOX 20. ACTION GREATER MANCHESTER IS TAKING ON THE EARLY YEARS

Developed in 2012, the Early Years Delivery Model (EYDM) is an integrated early years service based on the principles of proportionate universalism. The EYDM uses the universal provision of maternity and health visiting services as a method of early identification of vulnerability in both parents and infants. The aim is that families will receive proportionate, multi-agency, tailored services relevant to their level of need.

Greater Manchester has made school readiness a priority outcome. Targets have been set, including all early years settings to be rated 'good' or 'outstanding' in 2020, and to close the gap in school readiness Greater Manchester and the national average.

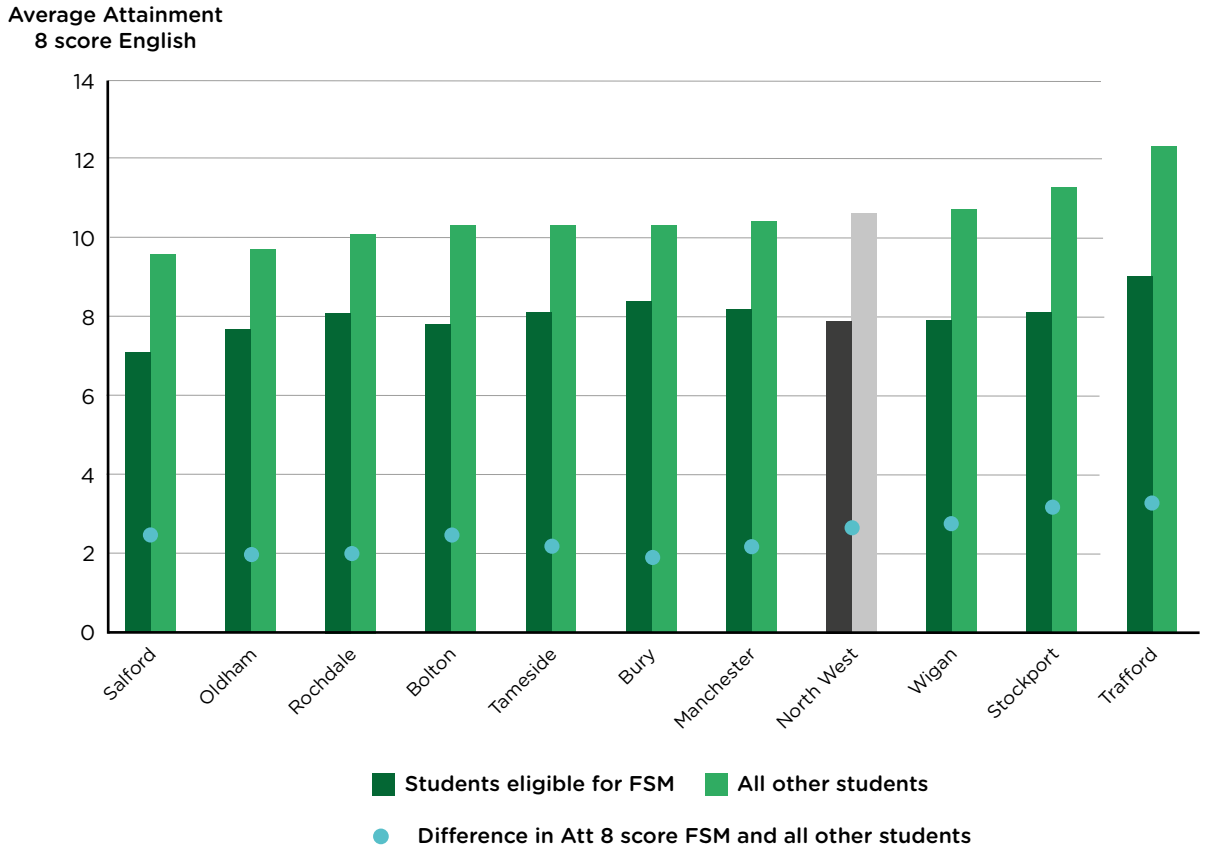
Linked programmes include:

- Support for speech, language and communication; parent and infant mental health; physical development; and social, emotional and behavioural needs.
- A focus on delivering both universal and targeted parenting and child development.
- Developing an Early Years Workforce Academy to support workforce development among all early years practitioners.
- Implementing the THRIVE model as outlined in Box 19.

EDUCATION IN GREATER MANCHESTER

Prior to the pandemic, improvements in attainment had been made for both children eligible for free school meals and children from better-off homes, although inequalities persist (152). Figure 25 shows these inequalities in average attainment-8 scores (at GCSE) for Maths among students eligible for free school meals and those not eligible in the academic year before the pandemic. Differences were present in each of Greater Manchester's local authorities and were highest in Trafford.

Figure 25. Average attainment-8 score in Maths, students eligible for free school meals (FSM) and all other students, academic year 2019/20, North West average and local authorities in Greater Manchester



Note: *Attainment-8 is a measure of performance at GCSE.*

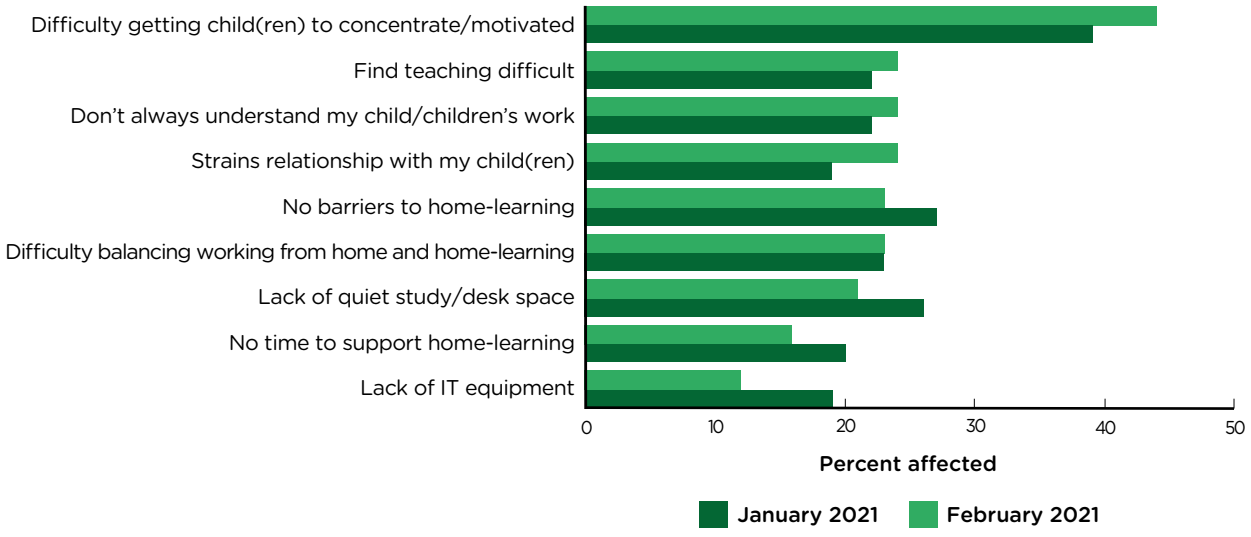
Source: *DfE. Key stage 4 performance, Academic Year 2019/20 (153).*

The *Marmot Review 10 Years On* pointed to the success of Richmond Academy in Oldham and its efforts to improve pupil outcomes (3). Part of its success was attributed to parental engagement, and to the REAL programme. The REAL programme supports literacy by working with children and their parents to improve home learning, supports parents to create opportunities for learning, recognises and values small steps, interacts in positive ways, and models explicit literacy and language interventions (154).

The pandemic has resulted in deepening inequalities in educational engagement and attainment. Children who were doing poorly in terms attainment before the pandemic are likely to have been more adversely affected during the pandemic. National data show these inequalities relate to area deprivation: more deprived households are less likely to have had the necessary financial or IT resources at home and to have adequate space to study. Greater Manchester has a higher proportion of more disadvantaged students than other areas and therefore it is likely that the damaging and inequitable impacts of containment on more disadvantaged students will be particularly severe in the City Region: an average of 18 percent of students in Greater Manchester were eligible for free school meals (FSM) in the 2018/19 academic year, compared with 14 percent nationally, and within the Region's local authorities, those with the highest percentage were 27 percent of pupils eligible in Manchester and 23 percent in Salford (155).

In February 2021 the Greater Manchester survey found that 77 percent of parents with children not attending school during the lockdown experienced difficulties with home-learning (Figure 26) (43).

Figure 26. Barriers to home-learning identified by parents in Greater Manchester, January and February 2021

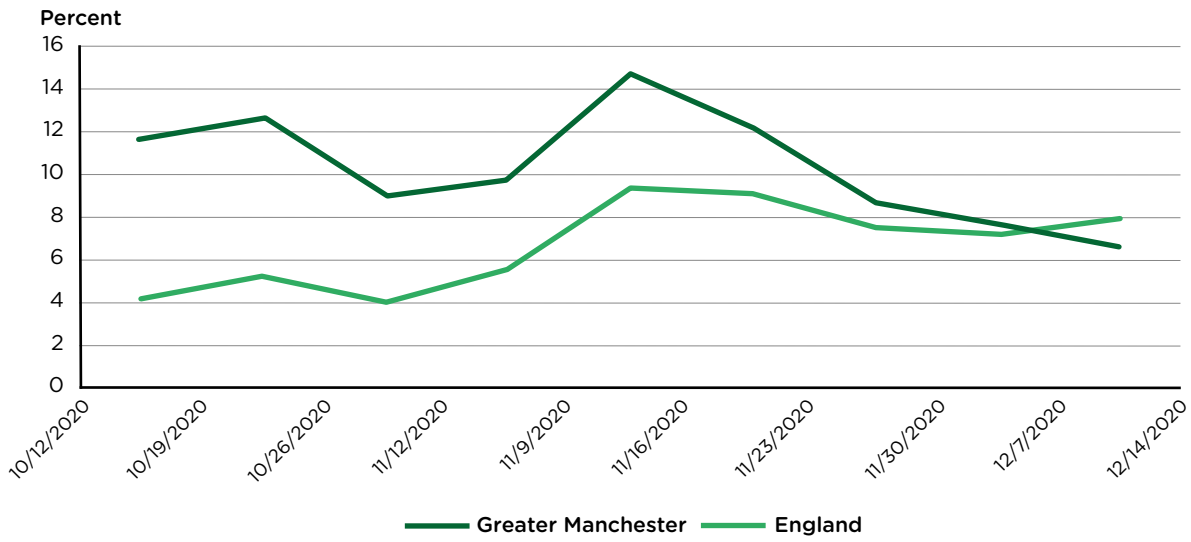


Source: *BMG, GMCA (43) (156).*

ABSENCES FROM SCHOOL

Absence from online school is one way of measuring the impact of COVID-19 on students learning. The Children's Commissioner measured absence rates in England between 9 September and 10 December 2020. Primary school children in England lost, on average, 3.5 days between September and December 2020. In secondary schools the average number of days of classroom learning missed per student was 6.3 days (157). Greater Manchester's students have been disproportionally impacted by COVID-19 in relation to absence from school (Figure 27); overall, between October and December 2020 there were nearly 4 percent more COVID-related absences from educational settings in Greater Manchester than nationally.

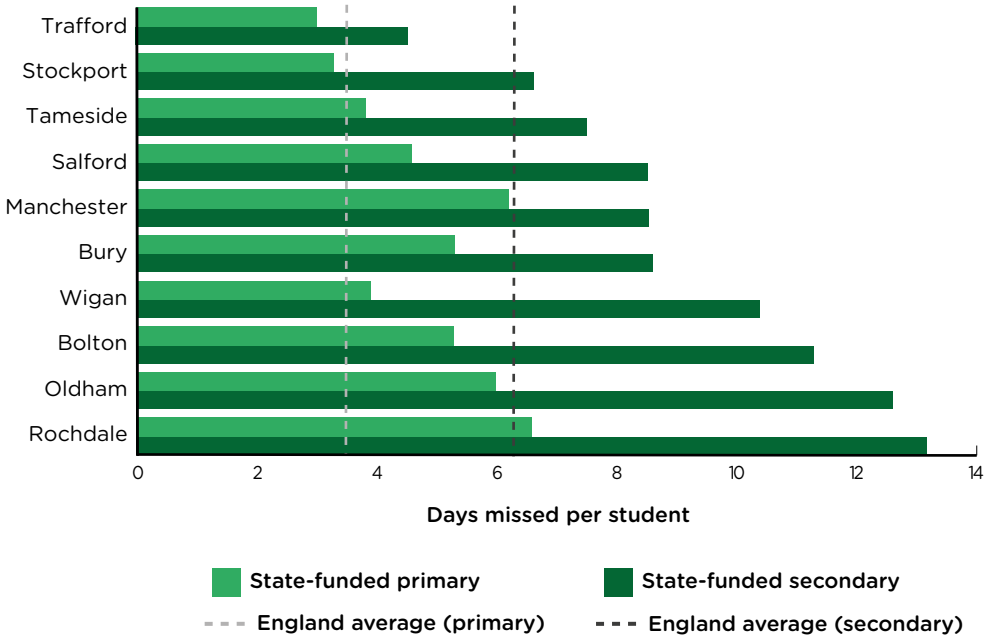
Figure 27. Greater Manchester COVID-related absence compared with England, October–December 2020



Source: *DfE Educational Settings Status (158).*

Analysis carried out by the Children's Commissioner found Oldham and Rochdale had the second and third most days of lost school compared with other local authorities in England between September and December 2020 (Figure 28). These differences in attendance by area correlate with differences in infection rates, and with other area characteristics, such as levels of disadvantage and education (as indicated by past GCSE results) (111). Clearly the trajectory of the pandemic in Greater Manchester – the high levels of inequalities in infection and mortality – have resulted in high levels of absence from school.

Figure 28. Days of classroom learning missed per student, Greater Manchester and England, September–December 2020



Note: *Days of classroom learning missed per student is calculated as the rate of additional absence (Autumn 2020 absence minus Autumn 2019 absence) multiplied by the number of school days covered.*

Source: *The Children's Commissioner (159).*

There has been much discussion about the impact of school closures on children and young people nationally. The impact in Greater Manchester is expected to be even more significant than elsewhere in the country, despite the work of school leaders and parents/carers to support continued learning at home, because it is home to the following cohorts who are known to be disproportionately impacted by COVID-19 and who are more prevalent in the city. Firstly, there are high numbers of families living with deprivation and poverty – the number of children eligible for FSM has increased by 7 percent during the pandemic and is expected to continue to rise. There is an existing gap in outcomes for children from disadvantaged backgrounds and this is expected to widen. Significant numbers of children and young people in Manchester do not have access to a digital device or Wi-Fi, a suitable space to work at home, or to support for their learning and have additional caring responsibilities. Secondly, the high numbers of children from ethnic minority groups as these communities have been more severely impacted by COVID-19 and there has been greater anxiety among them about returning to school. Thirdly, the high number of children in families who do not speak English has meant that some children accessing remote learning have been unable to access help with their work from family members. There are also high numbers of children with special educational needs and finally, there are a significant number of children who continue to be abroad and have not been able to return to the UK, of whom approximately 800 have not returned to school since attendance became mandatory after reopening on 8 March 2021. Many of these pupils are in countries classified as red and will be required to quarantine on their return. Where possible schools have been trying to make and maintain contact with these families and encourage them to return to school.

Prior to the pandemic, Salford had taken a systems wide approach to reduce school exclusions, Box 21.

BOX 21. REDUCING SCHOOL EXCLUSIONS IN SALFORD

Salford has adopted a holistic, multi-agency approach to reducing rates of school exclusions. In 2018/19 Salford's levels of permanent and fixed term exclusions were slightly higher than the England average and persistent secondary school absence rates were 19.7 percent compared with 13.7 percent for England.

Salford's 2020–2023 Education Inclusion Strategy seeks to ensure children and young people's learning needs are met and that all feel included and valued. The aim of the strategy is to reduce the number of fixed term exclusions and permanent exclusions and increase attendance by supporting schools to understand why children and young people may breach school behaviour codes and how they can make them feel they belong to their local school community. Schools and external services work together. They offer support to all children who need support and are at risk of exclusion, not only looked after children. This resulted from work Salford City Council commissioned to understand why exclusions rates were higher than elsewhere. Many of the students permanently excluded were subsequently identified as children with special educational needs (SEN) – between 2014 and 2017, 63 percent of permanently excluded students in Salford were identified post-exclusion as having SEN. As a result, Salford re-examined their SEN response and thresholds for offering support.

To develop the subsequent strategy, consultation events were held with young people, parents and key partners including schools, social work teams, the youth justice service, the police and voluntary sector, speech and language services and Children and Adolescent Mental Health Services.

Three strands make up Salford's approach. The first is the Team Around the School, working with Early Help and other teams to ensure help and support are given to children and their families, recognising that schools are often the main source of support. Mental Health Support Teams and social workers are located in eight high schools and training is provided to school staff to enable them to identify needs and deliver appropriate interventions. Local stakeholders, including health and members of the clinical commissioning group, have increased their knowledge of education and exclusion processes. In addition, Early Help is offered to any child or family with issues; they do not have to meet the social care threshold in order to access this help.

The second strand considers school settings and practices. Salford has adopted an Emotionally Friendly Schools Programme that provides tools, guidance and training developed by the Educational Psychology Service. This strand also focuses on reducing persistent absences, which covers more than 3,000 students in Salford. Currently support for reducing persistent absences is provided by a project approach within the Education Welfare Service, and a post within the Virtual School.

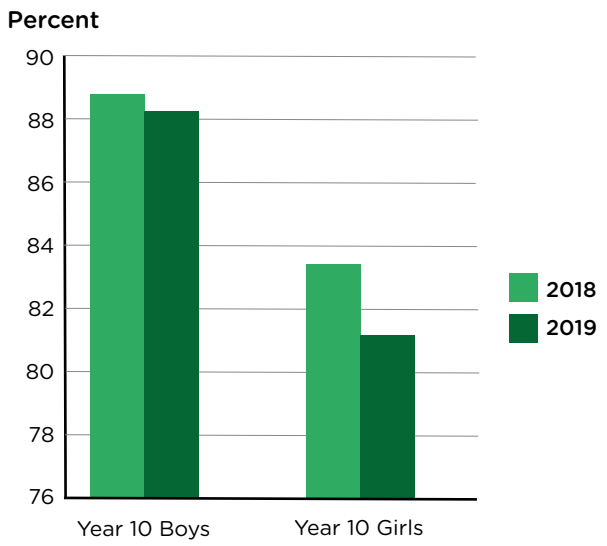
The third strand covers processes, provision and governance. This includes consistent evaluation to identify gaps in service need, adopting a flexible approach and providing a transparent service. They have an effective multi-agency Education on Track Panel to provide support for entrenched non-attendance. Salford's Neglect Strategy includes Educational Neglect as a category of need, which enables schools to increase engagement with social care partners.

The post of Virtual Headteacher and Head of Education Inclusion is a combined role in Salford whereas in most areas these are two separate posts. This means the post holder has and can provide a holistic overview of all children who need support, not only looked after children (160).

YOUNG PEOPLE'S MENTAL HEALTH

Mental health for young people was a particular concern before the pandemic and has deteriorated during it (161). In 2018, 10 percent of 11–16 year olds in Greater Manchester had a diagnosable mental health illness, and it was estimated that one in four 15 year olds could be self-harming. Prior to the pandemic in Greater Manchester there had also been slight deteriorations in future aspirations among young people. Between 2018 and 2019, one survey showed that 83.4 percent of girls in Year 10 said they felt 'hopeful and optimistic', falling to 81.2 percent a year later. Among boys this fell from 88.8 percent to 88.3 percent (Figure 29) (162).

Figure 29. Percentage of Year 10 boys and girls in Greater Manchester who feel 'hopeful and optimistic' about the future, 2018–2019

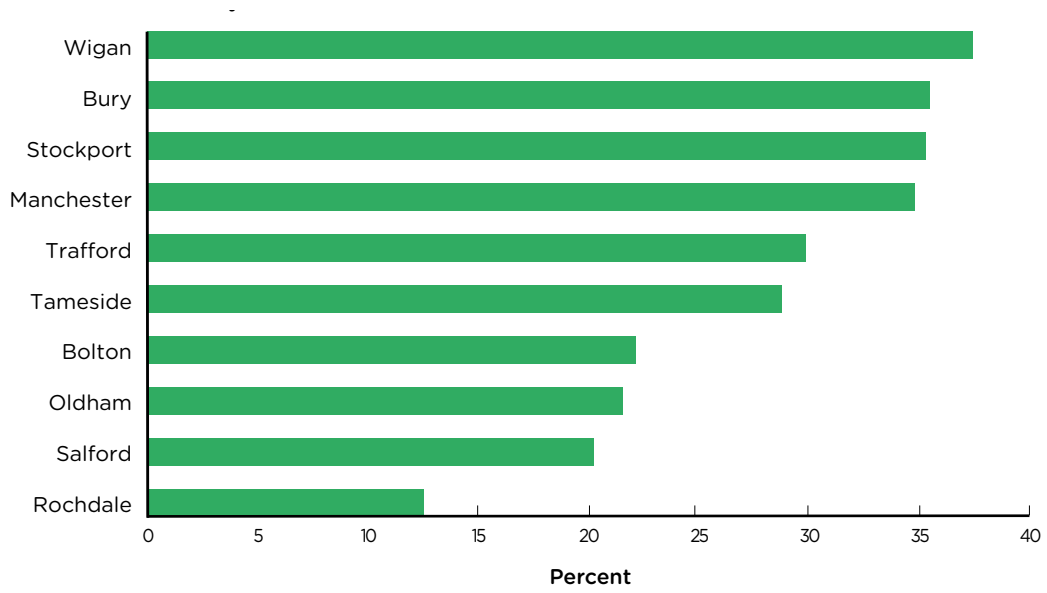


Source: *Greater Manchester Combined Authority. Year Ten Life Readiness survey (162)*

The pandemic has further negatively impacted young people's mental health: a combination of lockdowns, loss of schooling and support from school and very limited, or no, social contact have resulted in greater numbers in mental health crisis. In the North West the mental health of young people worsened between 2017 and July 2020 (163): the percentage of 5–10 year olds with a probable mental health disorder doubled from 8 to 16 percent and also doubled in 11–16 year olds (163).

In 2019 Greater Manchester was the first place in England to collate and publish waiting times for children and young people's mental health services. Figure 30 shows the high percentage of young people with mental health referrals who were waiting for their first appointment with Children and Young People's Mental Health services in September 2020.

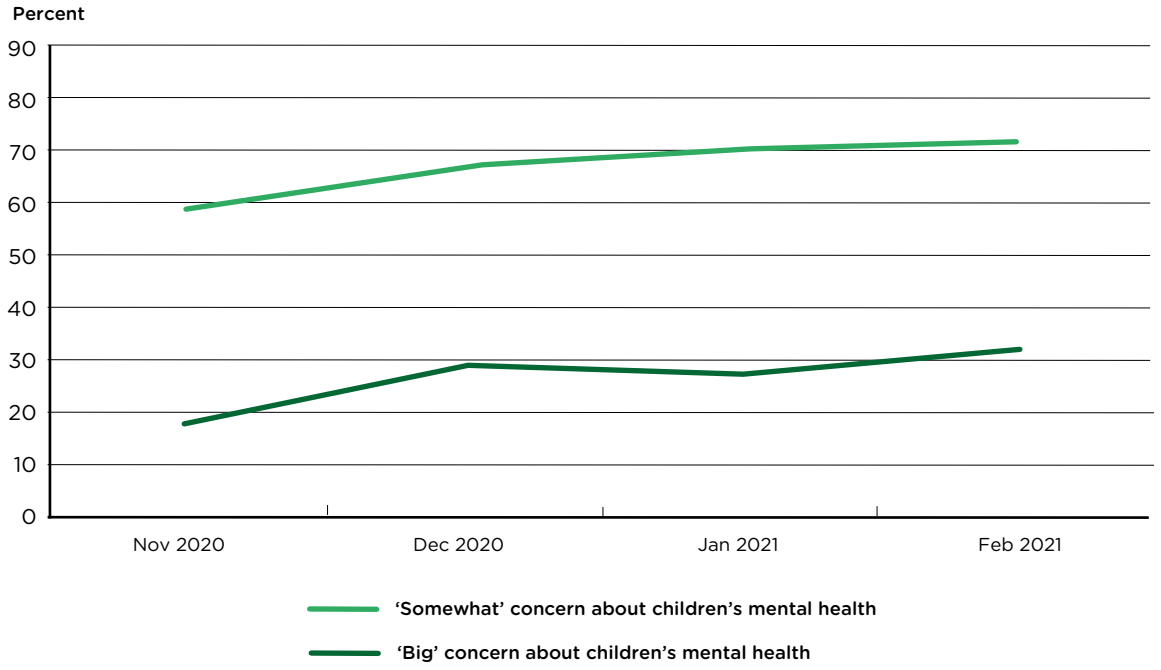
Figure 30. Percentage of referrals waiting for first appointment with children and young person's mental health services in September 2020, by Greater Manchester local authority



Source: *NHS/Greater Manchester (164).*

Nearly one-third of surveyed parents in Greater Manchester said they had 'big' concerns about their children's mental health in February 2021, an increase from November 2020, illustrating the cumulative impacts of the pandemic on mental health for young people (Figure 31).

Figure 31. Parents' level of concern about children's mental health in Greater Manchester, November 2020–February 2021



Source: *BMG, GMCA (43)*

Increasing provision and access to mental health services for children and young people, particularly those in more deprived areas, is essential. Since devolution in 2016, Greater Manchester has made important efforts to improve children and young people's access to mental health care, implementing the Mentally Healthy Schools Pilot - a package of support to 62 schools (see Box 34) (165), supporting parent and infant mental health (166) (167), and creating the Young People's Wellbeing Programme (Box 22).

Such programmes need to be further extended and to include businesses that employ young people.

BOX 22. THE YOUNG PEOPLE'S WELLBEING PROGRAMME IN GREATER MANCHESTER

The University of Manchester, in partnership with the Anna Freud Centre and the Greater Manchester Combined Authority, is working to improve the wellbeing of children and young people and their preparedness for life beyond school in the wake of the COVID-19 pandemic.

The Greater Manchester wellbeing measurement and improvement framework (WMF) will survey students in secondary schools in Greater Manchester, tracking a cohort of 18,000 young people over a three-year period, while also providing annual snapshots of a further 16,500 young people.

The data gathered will provide evidence briefings to identify the support needed for young people's wellbeing. This is a key policy priority for the GMCA, which has been undertaking a Life Readiness survey with Year 10 pupils for several years, which will be integrated into this project.

The first phase took place in early 2021, when questionnaires were agreed among stakeholders. Phase 2 will see the questionnaire rolled out to secondary schools across the City Region between April 2021 and August 2023. Years 7–10 will be assessed in state-funded secondary schools, special schools and pupil referral units across the City Region.

The project's findings will be shared using a variety of methods: blogs, academic journals, local events (e.g. GMCA Lunch and Learn seminars), networks (e.g. Schools in Mind), and engagement with local (Greater Manchester) and national policy-makers, and there will be an accessible version for young people (168).

YOUTH EMPLOYMENT

Young people's prospects have been highly adversely affected by the pandemic, particularly for those who are already disadvantaged, and young people must be a priority for Building Back Fairer. Unemployment rates for 16–25 year olds have increased more than for all other age groups and many of the sectors young people work in, including leisure and hospitality, have been particularly harmed by COVID-19 containment measures.

Those aged under 25 years were more likely to be furloughed, lose their jobs and/or working hours, and receive lower pay than any other age group (169) and inequalities in unemployment among young people have increased. Prior to the pandemic, from April to December 2019, in the UK 25 percent of economically active Black 16–24 year olds were unemployed, compared with 10 percent of their White counterparts. By April to December 2020, the unemployment rate had risen to 34 percent, a 9 point increase, among Black young people and to 13 percent, a 2 point rise, among White young people (170).

The number of apprenticeships has also fallen. During the first two quarters of the 2020/21 academic year the number of apprenticeships dropped 18 percent in England from the same period in 2019/20 (171). Young people aged 18–24 in Northern England were more likely than other young people in England to be claiming Jobseeker's Allowance or Universal Credit. Unemployment in young adulthood is particularly scarring for long-term earnings and employment prospects and damaging for health and wellbeing.

Before the pandemic, Greater Manchester had aimed to have more than 40,000 of its residents start an apprenticeship and an achievement (success) rate of 75%. However, this target was not met. In 2018–19 22,250 young people started an apprenticeship in Greater Manchester, a decrease from 22,590 in 2017/18 (133). The number of apprentices had dropped nationally after the introduction of the Apprenticeship Levy, which requires some employers to pay a levy when they take on an apprentice (172).

Currently apprenticeships in Greater Manchester are more likely to be taken up by less disadvantaged students and 86 percent of apprentices were White in 2018/19 (173). These inequalities in uptake will feed into inequalities in employment and income and widen health inequalities. To ensure that both apprenticeships and other training and educational opportunities at this stage of life are equitable, there needs to be a far greater focus on more disadvantaged students, e.g. people living in deprived areas, carers and care leavers, people with disabilities and also those from an ethnic minority.

There are opportunities for Greater Manchester to improve its apprenticeship policies to make them more effective. The Greater Manchester Inequalities Commission has recognised "GMCA's leadership in creating a vision of good apprenticeship employment for people at all working ages: aiming to remove barriers to apprenticeships (for example, free public transport for apprentices); working with the national 5 Cities Project to increase the diversity of the apprenticeship workforce; encouraging the development of part-time apprenticeships; working with the Greater Manchester Ageing Hub; launching a Greater Manchester small-to-medium enterprise apprenticeship package; working with levy-paying employers, and working to put apprenticeships are at the heart of the public sector" (11). In 2020, despite the pandemic, the Greater Manchester Levy Matchmaking Service created more than 270 new apprenticeship positions (174). Box 23 provides examples of Greater Manchester's existing commitments to young people, both examples of system-wide approaches to improving opportunities and health and wellbeing.

BOX 23. ACTIONS GREATER MANCHESTER IS TAKING FOR YOUNG PEOPLE

YOUNG PERSON'S GUARANTEE

In June 2020 Greater Manchester's Mayor established a new Youth Task Force to examine the effect of the pandemic on young people. The report and recommendations were published in December 2020. In response to consultation with young people, Greater Manchester committed to reduce digital exclusion; improve travel support; improve mental health and specialist support for young people unemployed during the pandemic; and provide higher education grants, pre-employment training and mentoring and new apprenticeships and work placements. Greater Manchester has also committed to better engage and communicate with young people, a key factor identified as needed by many in this demographic (175).

GREATER MANCHESTER'S HUB-AND-SPOKE OFFER OF CARE FOR YOUNG PEOPLE

Greater Manchester Mental Health NHS Foundation Trust delivers its services from more than 150 locations across the City Region. Despite the breadth of services, there remain gaps and variability in access to a broad range of psychotherapies needed to address the range of mental health disorders, for example trauma, attachment disorders, emotional dysregulation and a wide range of other reasons children, young people and their parents and families present to health services. A hub-and-spoke model has a central hub with spokes radiating to and from various services with the aim of referring patients to the most efficacious and efficient treatment. Offering services through a more comprehensive and equity focussed hub-and-spoke service in Greater Manchester would make it possible to better support primary care in localities, reduce variation in the service offer within the City Region and intervene earlier with a tailored suite of therapies (176).

SUMMARY AND RECOMMENDATIONS

Greater Manchester has made great strides in early years development, including reducing inequalities. The successful approaches need to be further extended in the light of worsening inequalities through the pandemic and additional support and resourcing programmes for the most deprived introduced. Adverse childhood experiences have increased through lockdowns, with highly damaging immediate and long-term impacts on health and other outcomes and additional support is urgently needed (1).

Inequalities in educational attainment were already wide before the pandemic and have increased significantly as a result of containment measures, differences in school responses and family circumstances. There is a clear case for additional national support and resources for Greater Manchester given their higher levels of infection and mortality and the longer duration of the restrictions, which have adversely impact mental health, educational attainment and employment prospects for young people in the City Region.

Before the pandemic, Greater Manchester had reduced the number of young people who were not in employment, education or training (NEET) and this success needs to be built on to mitigate the damaging effects of the pandemic. As we recommend, Greater Manchester can lead the way in England with an ambitious target to offer all young people employment or post-school training – an end to NEETs – working with businesses to increase numbers of training opportunities and apprenticeships and working with schools to coordinate access to employers. Greater collaboration is needed between schools, employers (both private and public sector), and youth and adult education schemes in order to make substantive progress towards the ambition of having no NEETs in Greater Manchester and to ensure greater equity. Increasing business offers of mentoring, internships, training, and school holiday training schemes are important additional interventions for Greater Manchester.

EARLY YEARS, CHILDREN AND YOUNG PEOPLE – RECOMMENDATIONS

1. REDUCE INEQUALITIES IN EARLY YEARS DEVELOPMENT

- Increase the quality and availability of parenting support programmes run through early years centres and schools.
- The regional budget to meet the OECD average for the proportion of spending on the early years and increase funding per child for early years settings in more deprived areas.
- Develop a new measure of school readiness for Greater Manchester.
- Ensure childcare workforce wages in public and private sector meet the Greater Manchester minimum income for healthy living.

2. REDUCE INEQUALITIES IN EDUCATIONAL ATTAINMENT

- Increase catch-up tuition for more deprived students, beyond the UK Government programme, and give additional support to families with children with special educational needs and disabilities (SEND).
- Implement all recommendations and commitments in Greater Manchester's Young Person's Guarantee.

3. PRIORITISE AND IMPROVE MENTAL HEALTH AND OUTCOMES FOR YOUNG PEOPLE

- Prioritise improving the mental health of young people including through providing further mental health support/first aid training in all schools in Greater Manchester.
- Improve mental health treatment options for children and young people rapidly.
- Work with primary care and local charities to provide a whole-system and early response to improve mental and physical health and wellbeing in children aged 0–5 years through the hub-and-spoke model and to address the social determinants of health in local communities.
- Increase the provision of local youth services for young people, advocating for national resources.

4. IMPROVE TRAINING AND WORK PROSPECTS FOR YOUNG PEOPLE

- Extend offers of apprenticeships and training for young people linked to requirements for social value employers to participate.
- Achieve no NEETs in Greater Manchester by guaranteeing an employment or training offer for 18–25 years olds.
- Advocate to raise the minimum wage for apprentices.
- Increase mentoring opportunities (including in public services; the voluntary, community and social enterprise sector and business) and add provision of mentoring to the social value framework and Good Employment Charter.

D. INCOME, WELFARE AND DEBT IN GREATER MANCHESTER

The COVID-19 containment measures have had significant negative economic impacts for much of the population. However, the level of impact has varied considerably between households, according to prior socioeconomic position, region, occupation, age, ethnicity and disability. These economic impacts have been made more intense and inequitable because of economic conditions going into the pandemic, which are summarised for England in Box 24.

BOX 24. INCOME AND POVERTY – SUMMARY FROM *10 YEARS ON*

- Child poverty in England increased in the decade from 2010 and will increase further; this risks causing lifelong harm and widening inequalities, including in health.
- Wage growth has been low since 2010 and wage inequality persists.
- Rates of in-work poverty have increased.
- Real pay is still below 2010 levels and there has been an increase in the proportion of people in poverty living in a working household.
- Incomes have risen slowly and inequalities persist.
- Wealth inequalities have increased.
- Regional inequalities in wealth have increased: London and the South of England have increased their share of national wealth compared with the North.
- The number of families with children who do not reach the minimum income standard has increased.
- Food insecurity has increased significantly.
- Social mobility in England has declined.
- Tax and benefit reforms have widened income and wealth inequalities (3).

The groups of people and places in England who were struggling financially before the pandemic are the same people and places that are now facing the greatest risk of poverty, and entrenchment of persistent poverty, reflecting the unequal impacts of COVID-19 containment measures (Box 25).

BOX 25. INCOME AND POVERTY - SUMMARY FROM *BUILD BACK FAIRER*, ENGLAND

- Young people and ethnic minority groups have been most affected by decreases in income.
- Poverty is increasing for children, young people and adults of working age.
- Increases to benefit payments have protected the lowest income quintile (the poorest) from the effect of decreases in wages, but have not benefitted the second quintile to the same extent.
- The two-child limit and the benefit cap are harming families and pushing people into greater poverty (1).

Poverty is associated with worse long-term physical and mental health, increased mortality at all ages and lower than average life expectancy. As well as placing decent housing, sufficient food and heating out of reach, reducing access to employment and other resources, and harming educational attainment, poverty is stressful. It undermines the capacity to have control over one's life. Coping with day-to-day shortages, facing inconveniences and adversity and perceptions of loss of status all affect physical and mental health in negative ways. High levels of personal debt (aside from mortgages) are also harmful to health.

In the first stage of the pandemic, between 20 March and 31 May 2020, 35 percent of surveyed households in Greater Manchester reported they could not afford to pay an unexpected, but necessary, expense of £850. This rose to 36 percent in the period 7 January–28 March 2021 (177). Estimates indicate that by November 2020 700,000 more people were living in poverty in the UK and a third of the UK population were living below the minimum income for health living (178).

Pay has decreased across England during the pandemic and there were over 2 million jobs where employees were paid below the legal minimum in April 2020, more than four times the 409,000 jobs in that category a year earlier. Projections from the Resolution Foundation estimate relative poverty in the UK will be at its highest in 2021–22 since 1987 (179). Although the data are not yet available, reports suggest increases in poverty in Greater Manchester as a result of the pandemic.

INCOME AND POVERTY IN GREATER MANCHESTER

UNEMPLOYMENT AND POVERTY

As unemployment increases, rates of poverty will increase too, and numerous reports point out that Universal Credit is too low to prevent people from being in poverty, although the £20-per-week uplift introduced in April 2020 has helped, it is not sufficient to prevent poverty in all households in receipt of this benefit (180) (181). In February 2021, 8 percent of Greater Manchester's population was a claimant (Universal Credit and Job Seekers Allowance), doubling from 4 percent in February 2020 (181) (182).

Universal Credit (UC) was introduced in 2013 and in 2020 it was estimated to be worth around 12 percent less than at its introduction. Overall, the amount of benefits the poorest households in the UK receive has decreased. In 2010–11 the cash benefits received by the poorest households in the UK amounted to 60 percent of their gross income; by 2018–19 cash benefits amounted to 43 percent of their gross income (183). The Social Security Benefits Uprating Order 2021, passed on 9 February 2021, increased social security payments by the rate of consumer price index inflation (0.5 percent) from 1 April 2021. However, if the £20 a week uplift to UC is not made permanent in the 2021 Budget, the benefits of this uprating will be negated, and the Basic Allowance for UC will be worth 11.5 percent less in real terms than in 2013. It could cause 6.2 million families to lose £1,040 from their annual income, resulting in 500,000 more people being pulled into poverty, including 200,000 children, in the UK (184). The impact would be greatest in the North of England, Wales, the West Midlands and Northern Ireland, areas that already have high rates of poverty (185).

The Greater Manchester Mental Wellbeing Survey of over 4,000 people in August–November 2020 stated they had 'very high concern' with regards to income, as well as concerns about their friends and family. Concerns about income were higher in the ethnic minority population and those with disabilities in Greater Manchester (75).

The Coronavirus Job Retention Scheme (CJRS) (furlough) was announced by the UK Government in March 2020 and extended until September 2021. In February 2021, 16.5 percent of Greater Manchester's population were furloughed (186). The scheme, which provides 80 percent of usual wages, has given economic support to millions of workers. However, 80 percent of an already low income is insufficient for healthy living and will have pushed many more people into poverty, with consequent immediate impacts on health and long-term significant damage to health. The CJRS scheme also excludes many workers in the 'gig economy' and in SMEs, resulting in great hardship for people who did not qualify for the CJRS but were unable to continue working during the pandemic. Furthermore, despite the CJRS, job losses have occurred and unemployment is at the highest level in the UK in four years (187).

The Joseph Rowntree Foundation conducted analysis in early 2021 of the 20 places in Great Britain most reliant on government financial support (Universal Credit and unemployment benefit) and the places that had a high number of people furloughed. Manchester City is included in the top 20, indicating it is, heavily reliant on multiple support packages, and ending the CJRS will hit Manchester hard because of its high reliance on the scheme, Table 3.

Table 3. Furlough, unemployment claimant and Universal Credit rate in Manchester City, February 2021

Furlough rate	16.5%
Unemployment claimant rate	9.1%
Universal Credit claimant rate	20.9%

Source: *JRF analysis of HMRC & DWP data (186).*

WAGES

Wage growth in England has been low since 2010 and rates of in-work poverty have increased (3). The introduction of the living wage was insufficient to prevent increases in rates of in-work poverty and modifications to the tax and benefit system resulted in widening inequalities in incomes and wealth.

In Greater Manchester, average resident earnings dropped by 0.8 percent per year between 2010 and 2016 and wages fell by 6.6 percent between 2006 and 2016 (10). Women are more likely than men to work in low-paid jobs: 28 percent of women in England and in Greater Manchester are paid below the living wage. There are persistent gender and income inequalities within Greater Manchester: Figure 32 shows women in the City Region's local authorities are more likely than men to be paid less than the living wage.

Figure 32. Percentage of women and men paid below the voluntary living wage set by the Living Wage Foundation, Greater Manchester local authorities, 2018

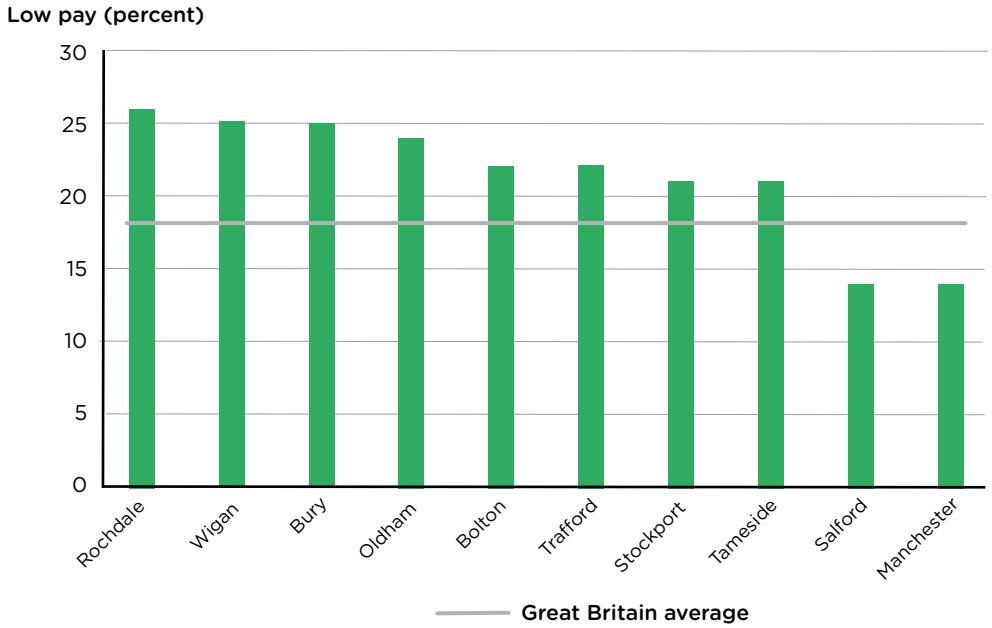
a) Women

b) Men

Source: *On Gender (188).*

In another calculation of low pay, Figure 33 shows the proportion of jobs in 2017 that were low paid in Greater Manchester, where there were higher rates of low pay than the average for Great Britain in all local authorities except Salford and Manchester.

Figure 33. Proportion of employee jobs that were low paid in Greater Manchester local authorities, and the Great Britain average, 2017



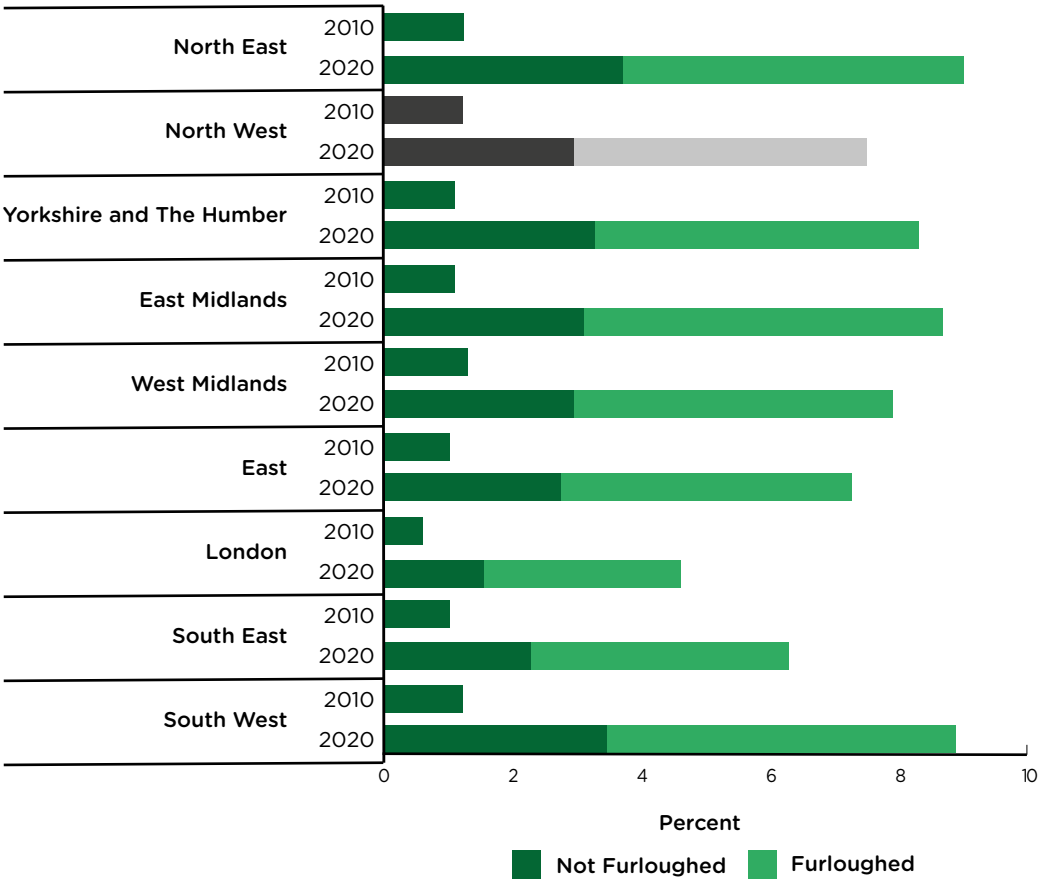
Note: *Low pay is the definition used in the Greater Manchester Prosperity Review Low Pay report, and is hourly pay either: below two-thirds of median earning; below the voluntary living wage; or at or very close to the minimum wage.*

Source: *Resolution Foundation analysis of ONS (189).*

There are inequalities related to pay and ethnicity in Greater Manchester. One-third of Black or Black British workers are low-paid, compared with 27 percent of Asian workers and 21 percent of White workers (189).

Figure 34 shows significant increases in low paid jobs since 2010 in every Region and for 2020 that more furloughed jobs are below the minimum wage than non-furloughed jobs.

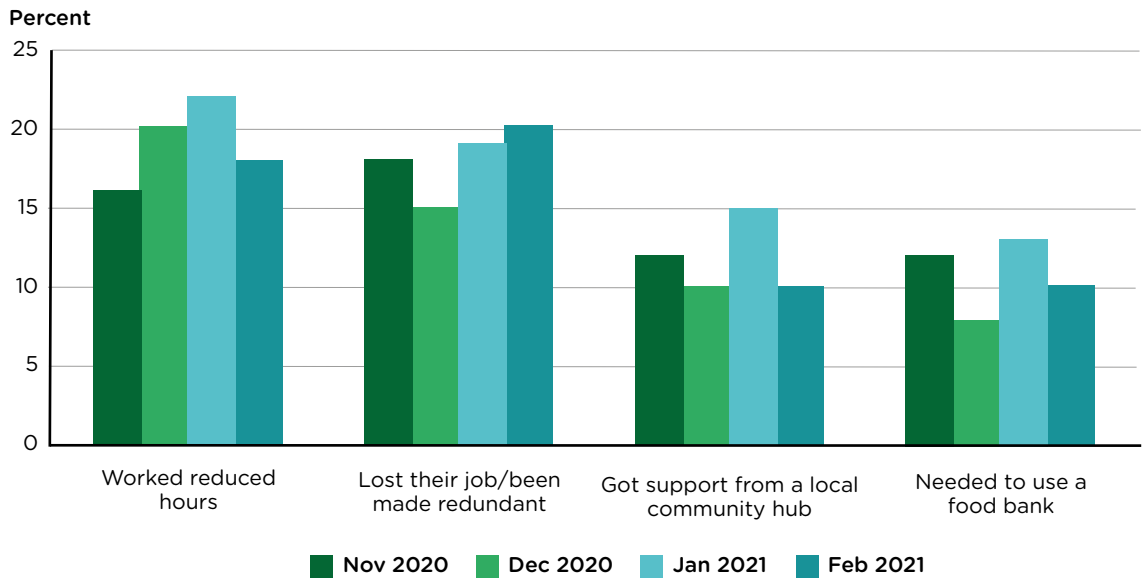
Figure 34. Percentage of jobs paid below the national minimum wage by region in England, 2010 and 2020



Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (190).*

The financial impact of the containment measures increased between November 2020 and January 2021, as the effects of lockdowns on household finances accumulated. Figure 35 shows that in January 2021 around one-fifth of those surveyed in Greater Manchester were working fewer hours than November 2020, that there had been increasing redundancies and the use of food banks was higher.

Figure 35. Percentage of people financially impacted by the pandemic in Greater Manchester, November 2020 to February 2021



Source: *Safely Managing COVID-19: Greater Manchester Population Survey. Survey 3 Report. February 2021 (156).*

Impacts on income have been unequally felt. Lower-income households have been forced to spend their savings while people on higher incomes have been able to save (Figure 36).

Figure 36. Net balance of UK households reporting changes in savings due to COVID-19, by household income band (July 2020)

Source: *Bank of England (191).*

As national minimum wages are set at the national level, there are limits to what can be achieved at the City Region level, however Box 26 shows the actions Greater Manchester is taking to improve incomes amongst its workers. Central to our recommendations are that Greater Manchester establish its own minimum level of income for a healthy life – to set the level for minimum wages and welfare payments to meet.

BOX 26. ACTIONS GREATER MANCHESTER IS TAKING ON WAGES

Innovation Greater Manchester is a business-led platform, spearheaded by the Local Economic Partnership and supported by the GMCA, to support recovery, innovation and economic growth (192).

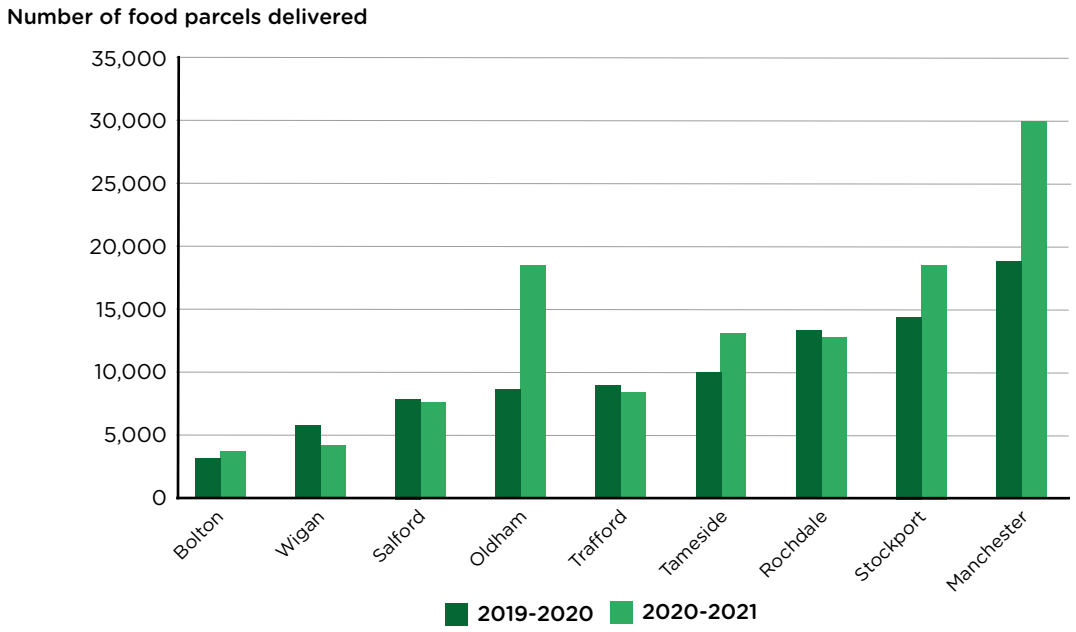
The Greater Manchester Access to Finance Team (Growth Company) has been working with SMEs to develop business cases for grants and administering funds for loans to support businesses adversely affected by the pandemic (193).

In November 2020 Greater Manchester stated there were 270 Living Wage Employers in the City Region (194) (195). The Good Employment Charter includes the real living wage as one of the seven characteristics of good employment.

FOOD POVERTY

Greater Manchester has been actively working to reduce food poverty, increasing support through the pandemic (Box 27). However, further support is urgently required as incomes decline further. Between 2019 and 2021, the number of food distribution centres in Greater Manchester increased from 56 to 64 and food parcel distribution increased by 29 percent, with the highest increases in Oldham at 115 percent, followed by a 60 percent increase in Manchester and a 30 percent increase in Tameside (Figure 37).

Figure 37. Number of food parcels delivered in Greater Manchester, April 2019–March 2020 and April 2020–March 2021



Source: *The Trussell Trust (196).*

When schools were closed during the pandemic, children who normally receive free school meals in England temporarily ceased to do so, increasing the financial strain on families. A government food voucher scheme mitigated the impacts, but still there have been increases in hunger and food poverty among young people. The Food Foundation reports that one in five households with children experienced food insecurity in the first two weeks of lockdown in March 2020, which fell to 12 percent from May to July 2020, and to 10 percent in January 2021 (197).

The charity the Trussell Trust states in its latest strategy that its aim is to eliminate the need for foodbanks in the UK. Eradicating the need for food banks should be at the core of a local authority strategy relating to poverty, an ambition we also advocate (198).

Research shows that cash payments in place of in-kind support provide people with dignity by removing the stigma that often comes with using in-kind support, providing control by enabling people to use support in a way that works best and to meet often multiple needs; therefore this is the preferred option for most people on low incomes (198) (201). Research by the Child Poverty Action Group in the summer of 2020 found that families had high levels of satisfaction with school meal support being provided in cash: 81 per cent of surveyed families receiving payments said this works extremely or very well, and 90 per cent said they would pick this method if they had the choice. Successful examples of this type of support can be found in Wales and other parts of the UK (202) (203) (204).

BOX 27. ACTIONS GREATER MANCHESTER IS TAKING ON FOOD POVERTY

In 2021 Greater Manchester supported the Right to Food campaign and called for changes in the law to make access to food a legal right (199).

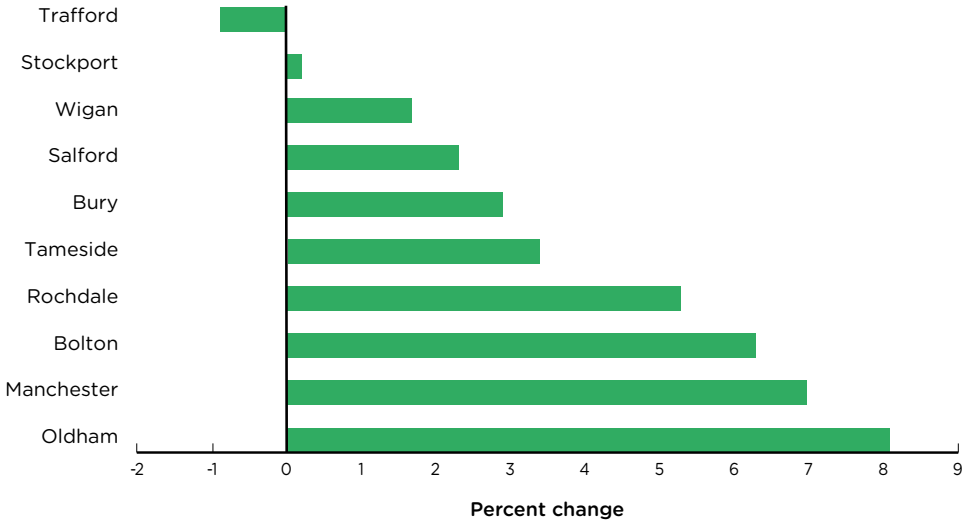
In 2020 the GMCA launched the No Child Should Go Hungry initiative, providing 3,000 emergency food cards to children and young people in need over the Christmas period and targeted support for families through local VCSE organisations (200).

The Salford Food Share Network consists of a range of organisations in the Salford area that work together to support residents in food crisis. Within the food network, foodbanks are seen as just one element of the provision; the key focus is about how residents who enter the network in crisis and in need of a foodbank can be supported so that they are in a position to access more sustainable food sources in the long term. Residents are signposted to, or receive support from, many of the organisations to help address underlying financial challenges, reducing the need for the food network in the longer term (198).

CHILD POVERTY

The Resolution Foundation estimate that around 730,000 more children will be living in poverty by 2024–25 in the UK and relative poverty will be at its highest in 2021–22 since 1987 (179). In Greater Manchester in 2019, 34.7 percent of children were living in poverty, calculated after housing costs, close to 200,000 children (205). Before the pandemic, rates of child poverty increased in all local authorities in Greater Manchester except Trafford from 2014/15 to 2018/19 (Figure 38) (205). Oldham and Manchester were among the 20 local authorities with the highest increase in child poverty rates in the UK, and together with Bolton and Rochdale, among the 10 areas in the North West to experience the largest increase.

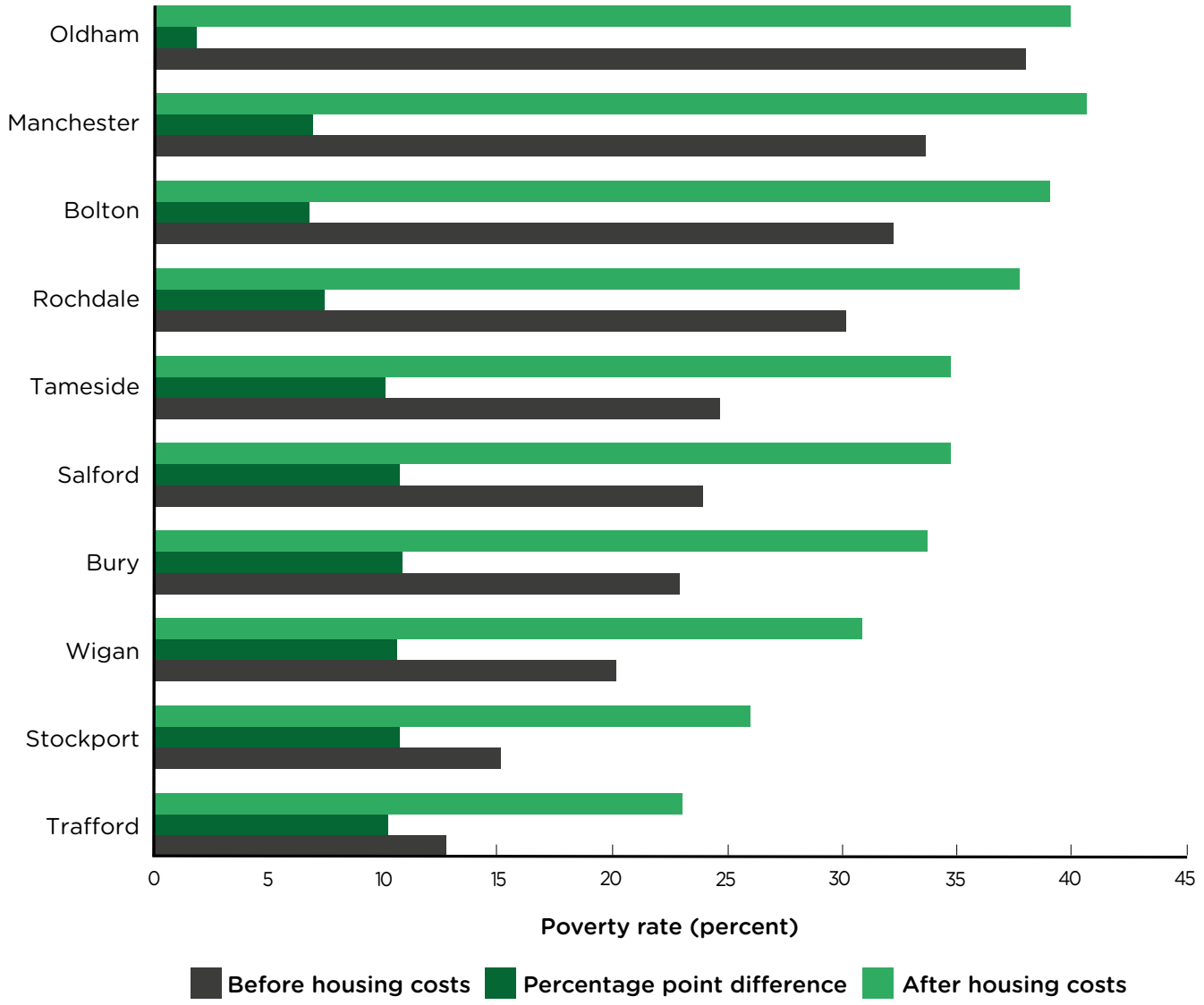
Figure 38. Percentage of children in households below 60 percent median income, after housing costs, percentage point change between 2014/15 and 2018/19, local authorities in Greater Manchester



Source: *Greater Manchester Poverty Monitor 2020: Child Poverty (205).*

Figure 39 shows rates of child poverty before and after housing costs, and the effect of housing costs on child poverty rates in local authorities in Greater Manchester in 2018/19. In several Greater Manchester local authorities housing costs resulted in increases of 10 percent or more in child poverty, compared with rates calculated before housing costs.

Figure 39. Rates of child poverty in local authorities in Greater Manchester, before and after housing costs, and percentage point difference, 2018/19



Source: *Greater Manchester Poverty Monitor 2020: Child Poverty (205).*

The 2021 Inequalities Review for Greater Manchester reports that areas within the City Region that have a higher proportion of residents from ethnic minority backgrounds have higher levels of child poverty: 15 of the 20 wards with the highest proportion of ethnic minority residents had child poverty rates, calculated after housing costs, of above 50 percent in 2019.

Across the UK rates of poverty among families with children in which at least one member is in part-time or full-time work are still high, and poverty rates continue to increase for couples with children where one or two members are in part-time work (206).

The End Child Poverty coalition of charities and campaigners, including Greater Manchester Poverty Action (GMPA), are calling on the Government to make the £20 a week increase to Universal Credit permanent, which we endorse, and to expand it to other legacy benefits[1], and commit to a joined-up strategy across government for reducing and ending child poverty (207).

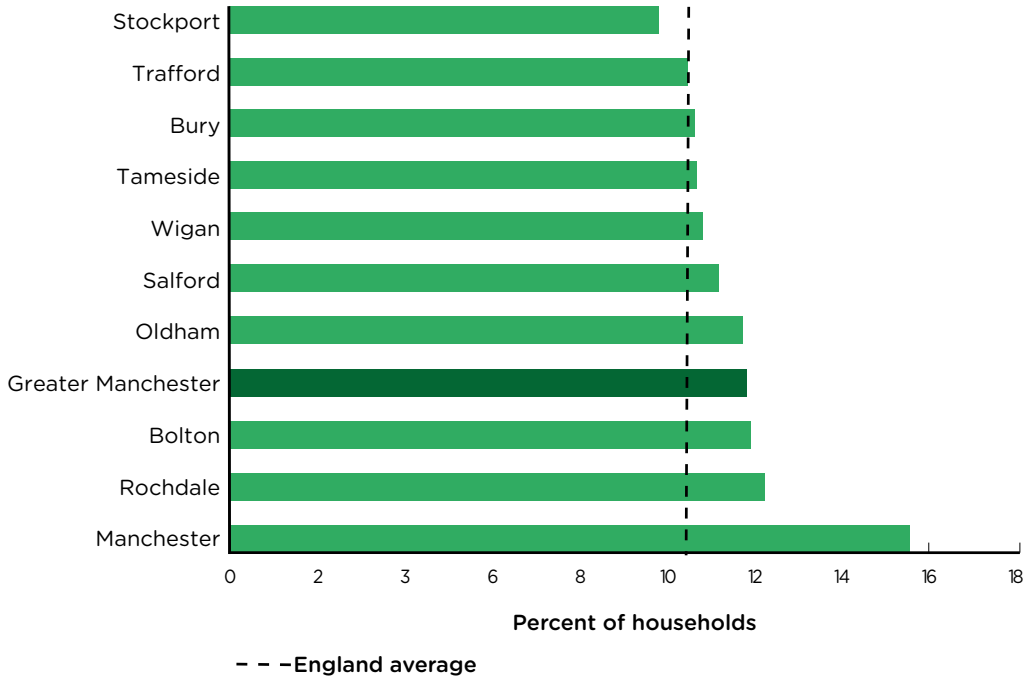
1 These include the benefits replaced by Universal Credit: Working Tax Credit, Child Tax Credit, income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Income Support and Housing Benefit.

FUEL POVERTY

Fuel poverty is highly damaging to health and the social determinants of health (208). Fuel poverty, which can lead to cold, damp housing conditions, was already high in parts of Greater Manchester and is set to increase as poverty increases as a result of the pandemic.

The most recent data on fuel poverty from 2018 show that before COVID-19, around 12 percent of households were in fuel poverty in Greater Manchester (209). As shown in Figure 40, all local authorities in Greater Manchester except Stockport had higher rates of households in fuel poverty than the England average.

Figure 40. Proportion of households in fuel poverty in Greater Manchester, 2018



Note: *Fuel poverty refers to the percentage of households in an area that experience fuel poverty based on the 'Low income, high cost' methodology.*
Source: *Department for Business, Energy & Industrial Strategy (210).*

Three of the main drivers of fuel poverty are poor energy efficiency, high energy prices and low income. Improving any one of these can contribute to bringing a household out of fuel poverty (208).

There is a need to retrofit older homes to improve their energy efficiency, which as well as having health benefits will also reduce carbon emissions. As part of Greater Manchester's strategy to reach net-zero emissions by 2038, the aspiration is to lift 38,000 homes out of fuel poverty (211).

Eighty percent of Greater Manchester's 1.1 million homes are more than 40 years old and highly energy inefficient and improving their energy efficiency is a very significant health equity intervention, along with reducing fuel poverty through financial support. The Sustainable Energy Association estimates 9,800 jobs could be created in improving homes in the North West, which would also contribute to local supply chains, achieving net-zero emissions, increasing incomes and reducing health inequalities (212).

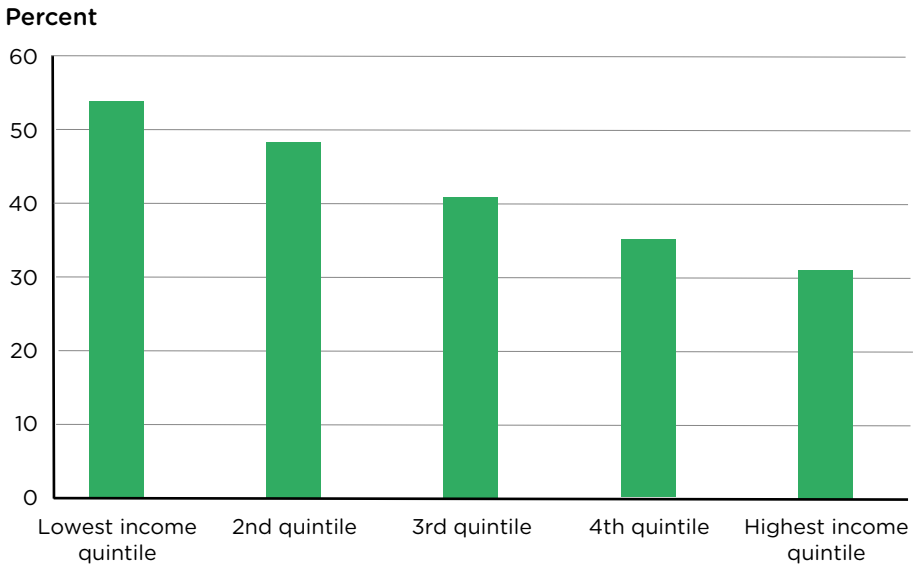
DEBT

Getting into problematic debt is most related to relationship change, loss of home, inability to get a home, or a phone contract. The impact of debt on health is associated with depression and other mental illnesses and in some cases suicide, as well as physical health problems. Distribution of debt, excluding mortgage debt, is unequal with low-income families experiencing many more problems associated with debt; and debt contributes to widening health inequalities between groups (213).

Debt was already high prior to the pandemic in the North West, with over half of households in financial debt. In Greater Manchester before the pandemic two-thirds of the population reported that they did not have access to a bank account overdraft facility, and a quarter reported borrowing money to pay for everyday living costs and bills. Over a third said they would buy new household items on credit through a rent-to-own store or catalogue. Levels of debt declined slightly from 2016–18 but are likely to rapidly rise again due to increasing poverty and unemployment as a result of the pandemic.

More than 30 percent of working-age adults were relying on additional borrowing or support for everyday living costs during the pandemic, in every family income quintile in the UK. The highest proportion reliant in this way was in the lowest income quintile and the proportion decreases to the highest income quintile (Figure 41). The impact of debt therefore is unequally borne and lower-income adults have been the most significantly and negatively impacted.

Figure 41. Proportion of working-age adults relying on additional borrowing or support for everyday living costs during the pandemic, by pre-pandemic family income quintile, UK, September 2020



Source: *Resolution Foundation analysis of YouGov, UK Adults Age 18 to 65 and The Coronavirus (COVID-19) – September wave (214).*

Research by Turn2Us in April 2020, early in the pandemic, shows that one family in three in the UK got into debt as a result of the pandemic; and one person in five was 'always or most of the time' running out of money before pay day; pre-COVID this number was closer to one in nine. Younger age groups, those with a disability or those from a Black or Asian background were all more likely to run out of money before payday than other groups. Data from the Turn2Us report show that one month after the pandemic began, families in the UK with three or more children were more likely to be increasing their debt. The report highlighted the need for a change to the welfare system in the form of removing the two child limit for Universal Credit and ending the Benefit Cap (215). By January 2021, 24 percent of Greater Manchester's population surveyed stated they needed to borrow money from friends/family or take out extra credit. High interest rates associated with payday loans, which can exceed 1,500 percent APR, mean that those lower income groups who cannot access affordable credit options pay more for credit (213). The *10 Years On report* outlined the effectiveness of credit unions to help local residents better manage their money and reduce dependence on high interest loans (3). In Greater Manchester credit unions are also playing a role in improving financial literacy and providing short-term low interest loans (Box 28).

BOX 28. LOCAL FINANCIAL SUPPORT IN GREATER MANCHESTER FOR THOSE IN CRISIS

Eight Community Credit Unions have joined together to launch a COVID-19 recovery plan that will offer £15m in financial support to millions of people across Greater Manchester. The Sound Pound consortium, launched in November 2020, provides financial support, including affordable credit, to individuals across the City Region. Its aim is to rebuild communities, support people and lend responsibly (216).

Stockport Council has also worked with the Credit Union to secure loans of £100–200 to the most vulnerable, thereby reducing the risk to the union and allowing a lower interest rate. This approach is working, with a low default rate, making it profitable for the credit union, and therefore low cost for the council (198).

Gambling can lead to problematic debt. The online gambling market grew in 2020; both the number of accounts and the number of bets increased (217). In Greater Manchester, 12 percent of people surveyed in December 2020 stated they were gambling more often than before the pandemic; those who were more likely to say they were gambling more often included people aged 25–44 years (18 percent), Muslim residents (22 percent), and carers (19 percent). When asked if they wanted support related to gambling, 9 percent of Greater Manchester's surveyed residents stated they wanted support (218).

Debt services are provided by local authorities, often in partnership with the VCSE sector. There is no City Region strategy to reducing levels of individual debt. Citizens Advice provides debt management services throughout Greater Manchester. In December 2020 approximately 20 percent of clients using Citizens Advice in Greater Manchester were contacting the service about debt, and of these approximately 20 percent were concerned about 'fuel debts' or 'council tax arrears'. Calls to Citizens Advice in Greater Manchester were declining before lockdown but in March 2021 they had surpassed the level of calls in March 2020 (Figure 42). The query that increased the most in the year from March 2020 to March 2021 in Greater Manchester was related to fuel debts (219).

Figure 42. Calls to Citizens Advice's debt management service, April 2019–March 2021

Source: *Citizens Advice (219).*

SUMMARY AND RECOMMENDATIONS

Welfare budgets and council funding have declined in the last 10 years (3). At the same time, poverty rates have increased and have been exacerbated during the pandemic. Greater Manchester does not have the powers to increase welfare budgets or individual incomes but it is taking actions to encourage employers to adopt the real living wage, reduce debt and reduce food and fuel poverty, and must continue to do so, increasing pressure on employers if necessary.

Developing a suitable level of income to allow a healthy life is vital and an assessment of the level of minimum income for healthy living in the City Region is required. The Universal Credit uplift must be retained or even extended. The rise of unregulated loan sharks in the aftermath of the pandemic needs to be stopped and further regulation of debt agencies and loan sharks is required.

INCOME, POVERTY AND DEBT – RECOMMENDATIONS

1. Reduce poverty

- Establish a goal for everyone in full-time work to receive a wage that prevents household poverty.
- Develop a regional standard for minimum income for healthy living, to be used to establish the minimum wage for Greater Manchester.
- Support food aid providers and charities, and advocate for better national funding.
- Continue to advocate for additional £1,000 annual uplift to Universal Credit and explore other ways of providing this if it is cut.
- Extend eligibility for free school meals.
- Advocate for an end to the five-week wait for Universal Credit and extend cash grants for low-income households.

2. Reduce levels of harmful debt in Greater Manchester

- Increase financial management advice in schools and workplaces.
- Further support community and voluntary sector provision of debt advice.
- Work with Credit Unions to reduce the use of high interest loan businesses and further regulate loan agencies.
- All local authorities in Greater Manchester to offer support for those who are in debt due to non-payment of council tax.

3. Monitoring for poverty and inequity

Improve local data collection and collation of national and voluntary sector data to estimate inequalities in income and debt within local authorities.

E. WORK AND UNEMPLOYMENT

Being in good work is usually protective of health, while poor quality work, stressful jobs, and unemployment, particularly long-term unemployment, contribute significantly to poor health, low wellbeing and increase the risk of mortality. Full-time, good quality employment that offers regular, sufficient pay with good terms and conditions and fulfils other criteria for good work is the healthiest type of work (220). Greater Manchester needs to ensure all jobs are of good quality as efforts to increase employment are introduced after the pandemic.

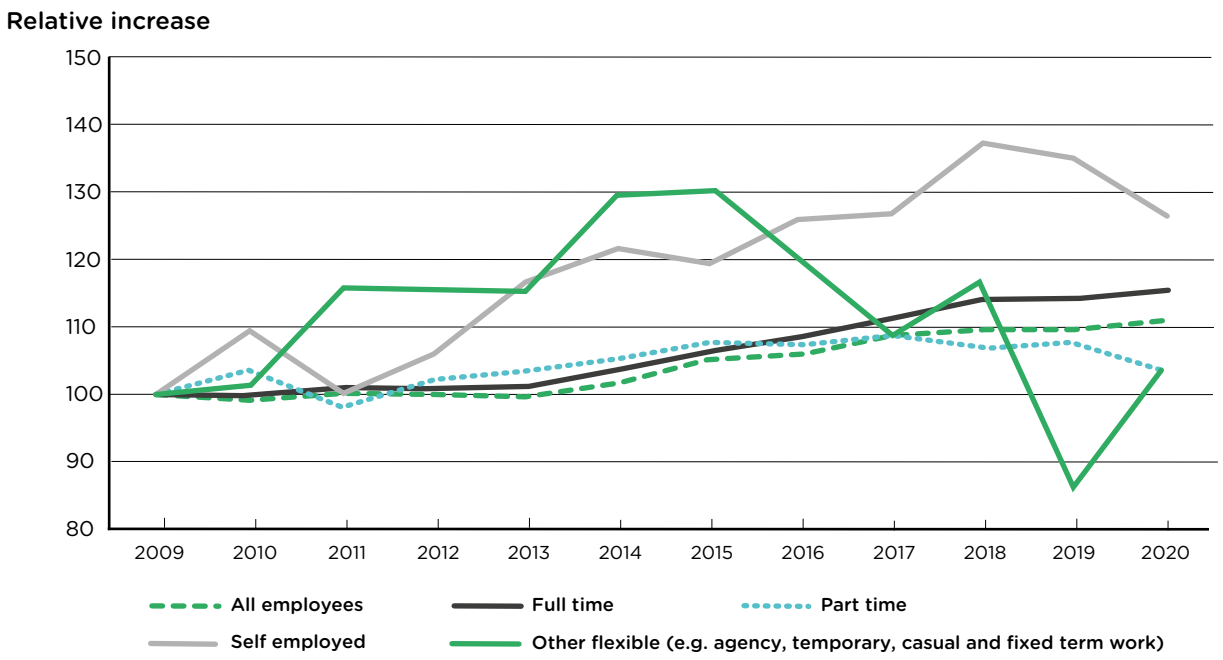
The labour market situation before the pandemic influenced and impacted the labour market during the pandemic. The numbers in employment in Greater Manchester have been lower than the North West and Great Britain since 2010 and in March 2020 the employment rate in the City Region was 3.3 percent lower than the average for Great Britain (221). White people, married men, people with no disabilities and those with higher qualifications have higher employment rates than ethnic minority groups, women, lone parents and people with disabilities (222). The Greater Manchester Independent Inequalities Commission found that the working-age employment rate of people from ethnic minority groups is over 10 percentage points below the overall rate in Greater Manchester and 6 percentage points below the national average (11). The national context for work and unemployment for the decade from 2010 is set out in Box 29.

BOX 29. WORK AND UNEMPLOYMENT – SUMMARY FROM *10 YEARS ON*

- Employment rates increased over the decade from 2010.
- There has been an increase in poor quality work, including part-time, insecure employment.
- The number of people on zero hours contracts has increased significantly since 2010.
- The incidence of stress caused by work has increased since 2010.
- Real pay is still below 2010 levels and there has been an increase in the proportion of people in poverty living in a working household.
- Automation is leading to job losses, particularly for low-paid, part-time workers, and the North of England will be particularly affected by this in the future (3).

Since 2009 in Greater Manchester there have been increases in the numbers who are self-employed and who are in full-time employment (Figure 43). The number of people in flexible employment, which includes agency, temporary, casual and fixed-term (including zero hours) contracts, peaked in 2015/16 (223).

Figure 43. Relative increase in numbers employed, by type of contract, Greater Manchester, 2009–2019 (indexed to 2009 level)



Source: *NOMIS ONS APS (24).*

The Northern Health Sciences Alliance found that 30 percent of the productivity gap with the UK average could be reduced by raising participation in the workforce through addressing ill health; decreasing rates of ill health by 1.2 percent and mortality rates by 0.7 percent would reduce the gap in productivity between the Northern Powerhouse and the rest of England by 10 percent (224). The Greater Manchester Prosperity review in 2020 also outlined the link between health and employment, emphasising the importance of improving health and wellbeing to reduce unemployment (17).

In September 2018, 60 percent of Greater Manchester's adult population (aged over 16 years) were in employment compared to 47 percent with health conditions or illnesses lasting more than 12 months, leading to a potential loss to Greater Manchester's economy of £4.1 billion per year (225). In 2020 Manchester City reported over half of its residents with low or no qualifications were not in employment, emphasising the importance and significance for health of building skills and supporting those at risk of unemployment with training and apprenticeships (226). While poor health undermines productivity and employment, the principal motivation for improving health is for the benefit of the population.

FURLOUGH AND IMPACTS OF COVID-19 CONTAINMENT MEASURES ON EMPLOYMENT

The impacts of COVID-19 containment measures have fallen the most on low-paid workers and have had significant health and health inequality impacts. Temporary workers who lack job protection and thus have high levels of job insecurity were particularly affected throughout 2020. Young people have experienced the greatest loss of employment and damaging impacts have also been experienced by ethnic minority groups, older workers, disabled workers, women, part-time workers and the self-employed (227). Workers in insecure employment are not only more likely to have seen their income drop since COVID-19 but also earn less on average (215). People from ethnic minority backgrounds, in particular those from Pakistani, Bangladeshi and Indian backgrounds, were more likely to work in insecure and casual forms of employment, therefore COVID-19 is likely to have had disproportionate impacts on the income of these groups in particular (215).

Box 30 summarises the impacts of the pandemic and associated containment measures on employment and good work in England. Much of the analysis is highly relevant to the Greater Manchester context and to understanding the likely impacts on health in Greater Manchester.

BOX 30. EMPLOYMENT AND GOOD WORK – SUMMARY FROM *BUILD BACK FAIRER, ENGLAND*

Low-income groups and part-time workers are most likely to have been furloughed and therefore experienced a 20 percent wage cuts from their already low wages.

Compared to other groups, older Pakistani and Bangladeshi people were more likely to be working in sectors shut down during the pandemic.

There were over 2 million jobs where employees were paid below the legal minimum in April 2020, more than four times the 409,000 jobs a year earlier.

Countries that have controlled the pandemic better than England have had a less adverse impact on employment and wages.

Rising unemployment and low wages will lead to worse health and increasing health inequalities (1).

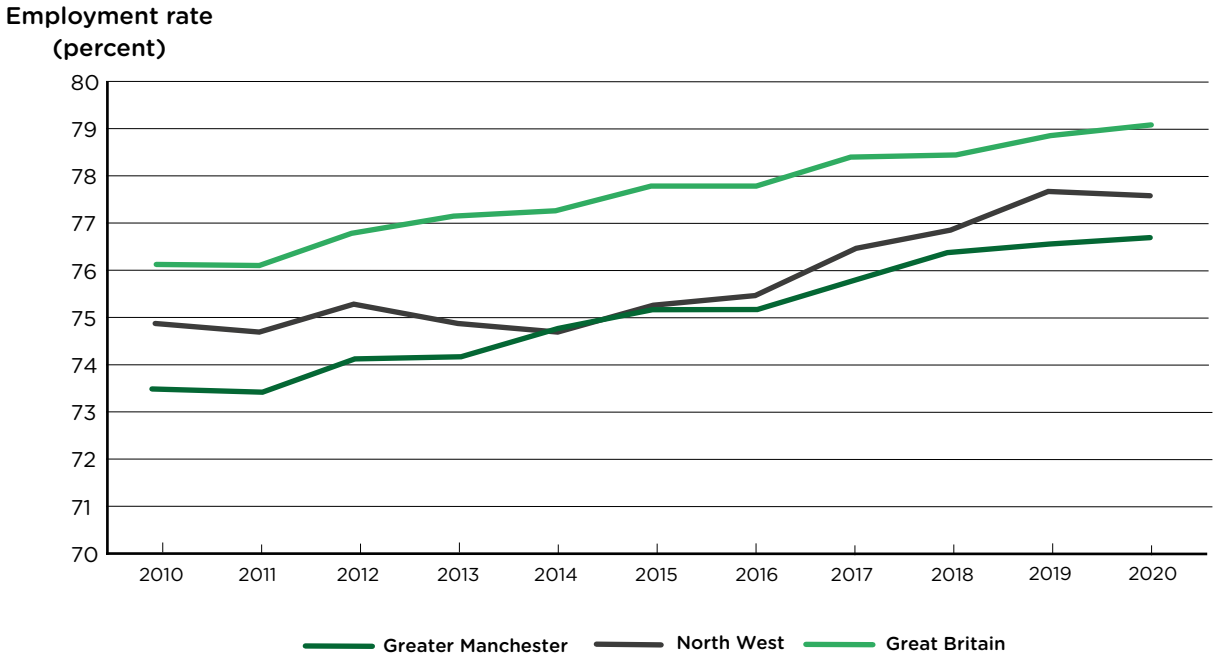
The Greater Manchester population survey of February 2021 showed 18 percent of respondents in employment said they have been furloughed at some point since March 2020, 17 percent had had their hours reduced, and 9 percent had had their income reduced (43). Nearly half of those employed have experienced at least one of these; this proportion increases to three-quarters among 16–24 year olds and those who have served in the armed forces and to around two-thirds among residents for whom someone in the household is at high risk of COVID-19, and among Asian residents (43). Of the self-employed respondents to the Greater Manchester population survey of December 2020, 61 percent had experienced a reduction in the volume of their work, 24 percent struggled to make ends meet and 15 percent considered closing their business as a result of the pandemic (218).

UNEMPLOYMENT

Increases in unemployment are highly concerning for health as well as for a range of other important social determinants of health – including food security, access to decent housing, having a minimum income for healthy living and for mental health and health behaviours that tend to deteriorate during unemployment.

While employment rates had increased in Greater Manchester between 2010 and 2020, they remained lower than in the North West and Great Britain in the decade to 2020 (Figure 44).

Figure 44. Employment rate in population aged 16–64, Greater Manchester, the North West and Great Britain, 2010–20

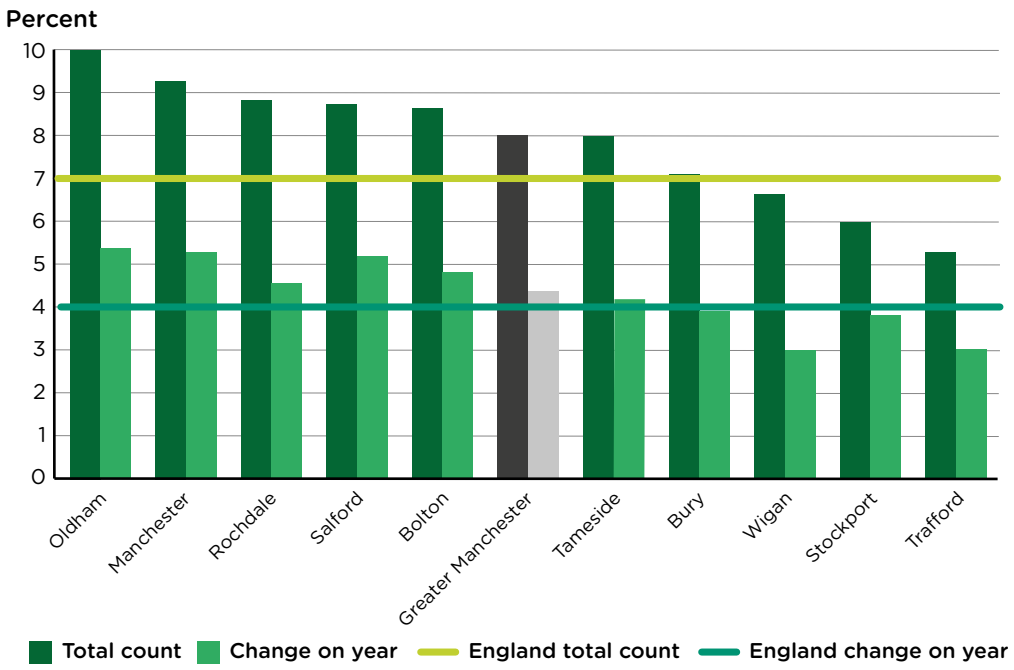


Source: *ONS. Economically active time series (221).*

During the pandemic unemployment increased across England. In the Greater Manchester population survey of 1,000 residents in December 2020, one in 10 respondents stated they had lost their job or had been made redundant as a result of the pandemic; this proportion increased to one in five among 16–24 year olds, students, Asian residents, those for whom English is not their first language, and those with young children aged 0–4 (218). Among Muslim residents and those who have served in the armed forces one in four said they had lost their job or had been made redundant as a result of the pandemic (218).

Figure 45 shows the proportion of people claiming Jobseeker's Allowance and some Universal Credit claimants on 11 March 2021 in local authorities in Greater Manchester. In March 2021 more than one in 10 men in Oldham, Manchester, Bolton, Rochdale and Salford were claimants; the highest rates of female claimants were in Oldham and Manchester (182). The Figure also shows the annual increase for England and the higher increase in Greater Manchester. All local authorities in Greater Manchester experienced increases in benefit claimants, but Stockport, Trafford and Wigan experienced smaller increases over the year than the England average.

Figure 45. Benefit claimant count by local authority and change on year in Greater Manchester, and the England average, 11 March 2021



Note: *Includes claimants of Jobseeker's Allowance (JSA) and some Universal Credit (UC) Claimants. The UC claimants that are included are 1) those that were recorded as not in employment (May 2013-April 2015), and 2) those UC claimants who are required to search for work, i.e. within the Searching for Work conditionality regime as defined by the Department for Work and Pensions (from April 2015 onwards).*

Source: *ONS (182).*

The various national government measures to support employment during the pandemic, including furlough, mean that so far increases in unemployment have been mitigated and are less severe than they would have been without such measures. However, in the longer term, as these support measures are rolled back, unemployment and poor-quality work, both damaging for health, will likely increase significantly. These impacts will be felt differently in different areas of Greater Manchester and for specific groups including younger people, women, ethnic minority communities and disabled people, who are most likely to be at risk of unemployment (228).

CREATING HEALTHY JOBS IN GREATER MANCHESTER

The impacts of the pandemic have undermined prospects for good quality work and are highly likely to increase unemployment and increase unhealthy working conditions in Greater Manchester. People in low pay, young workers, women and some ethnic minority groups have suffered most through the pandemic and will be highly vulnerable in its aftermath to joss losses and degradations to job quality. Prior to the pandemic Greater Manchester had taken a number of important steps to improve the quality of employment and reduce unemployment (Box 31). The COVID-19 pandemic has meant that these strategies need to be expanded and the importance of that for health and health equity needs to be made clear.

Action to reduce the impacts in Greater Manchester after the pandemic must include establishing and strengthening criteria for healthy employment, so that all employers are encouraged, even required, to offer better quality employment. Unemployment is bad for health but encouraging employment in low-quality jobs is not the correct response. Businesses must strengthen their role in improving health and reducing inequalities through employment practices and through offering more and extensive training and apprenticeships. These efforts must be highly attentive to equity.

BOX 31. ACTIONS GREATER MANCHESTER IS TAKING ON EMPLOYMENT AND WORK QUALITY

One of the key aims of Greater Manchester's 2019 Local Industrial Strategy is to reduce inequalities. The Skills Action plan, part of the Strategy, aims to improve labour market opportunities for young people and adults by, for example, increasing the number of apprenticeships, improving career education and shifting adult education to meet employers' needs (18).

During the pandemic, Employ Greater Manchester was developed to support individuals to find employment and training, offered to furloughed workers in SMEs, and it developed short retraining programmes for those at risk of redundancy (229).

Working Well supported more than 5,000 people during the pandemic to gain employment, and a specialist programme was launched to support people with a learning disability, mental illness or physical disability into work (174).

The Greater Manchester Good Employment Charter, introduced in January 2020, aims to improve employment standards across Greater Manchester. Membership of the Charter requires employers to demonstrate a commitment to excellent practice in seven key employment characteristics: secure work; flexible work; real living wage; engagement and voice; recruitment; people management; and health and wellbeing (230).

Greater Manchester is to support the long-term unemployed to enter employment through the Working Well programme and has piloted ways of addressing skills gaps linked to jobs (174).

In 2020 the Greater Manchester Levy Matchmaking Service created more than 270 new apprenticeship starts (174).

Greater Manchester's Economic Vision focusses on driving good employment "to tackle inequalities, embrace diversity and balance profit with people and sustainability" (192).

SUMMARY AND RECOMMENDATIONS

As Greater Manchester's economic challenges deepen through 2021, it is important that those most at risk of being employed in poor quality work or of being unemployed are supported the most in order to protect their health as well as livelihoods. This includes younger people, those on low pay and insecure contracts and some workers from ethnic minority groups.

Quality of work is an increasing and pronounced health inequality issue and improving it must be at the centre of efforts to Build Back Fairer. Establishing and enforcing minimum standards for employment quality, particularly in low-skill and low-paid employment and among small businesses in Greater Manchester, is an important step forward for reducing health inequalities. In addition, actions such as giving workers the option of working four days week can be taken to improve health equity, reduce sickness and increase productivity (231) (232). The Greater Manchester Good Employment Charter, introduced in January 2020, aims to improve employment standards in the region. This charter offers important ways forward for improving the quality of work in Greater Manchester but efforts to achieve improvements in the seven employment characteristics must be focussed on SMEs, low-income jobs, and the gig economy, as well as large employers.

WORK AND UNEMPLOYMENT – RECOMMENDATIONS

1. Improve the quality of work in Greater Manchester

- Fully implement the Greater Manchester Good Employment Charter and Local Industrial Strategy and monitor for inequalities, particularly the proportion of employers signing up to the Charter offering lower paid jobs.
- Provide incentives via the Good Employment Charter to reduce precarious and insecure work.
- Define and implement a Greater Manchester quality of work guarantee which extends commitments in the Good Employment Charter and is publicly available for each employer.
- Lead discussions about a four-day work week.

2. Reduce unemployment and build skills

- Build on actions to increase local recruitment into all jobs and work with employers to improve retention rates.
- Increase funding for adult education more in more deprived communities and link to job market demands. Offer training and support to older unemployed adults.
- Incentivise the private sector to participate in training and skills development and link this to the social value framework.

F. PUBLIC HEALTH – BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

The pandemic containment measures have affected health, health behaviours and damaged the social determinants of health in England, as outlined in this report and in our *Build Back Fairer* report for England, summarised in Box 32.

BOX 32. COVID-19 CONTAINMENT IMPACTS ON PUBLIC HEALTH – SUMMARY FROM *BUILD BACK FAIRER, ENGLAND*

- The priority and importance of public health have increased during the pandemic and public health is now a central concern of the public and Government, with a new focus on the importance of protecting and improving health in England.
- The longer-term health impacts of the containment measures are creating a new public health and health equity crisis.
- Inequalities in health behaviours and health have contributed to inequalities in COVID-19 mortality.
- There have been some significant changes in behaviours during lockdown – including possible increased inequalities in smoking and obesity, increased consumption of alcohol, declines in mental health and increasing violence and abuse within households.
- We have set out the concept of the causes of the causes: health behaviours are causes of non-communicable diseases (NCDs); social determinants of health are causes of inequalities in these health behaviours. The causes of the causes of NCDs have to be addressed during the pandemic and as part of Building Back Fairer.
- Inequalities in health behaviours should also be a priority area for action.
- The public health system needs a strengthened focus on the social determinants of health. Deteriorations in these determinants as a result of containment measures make this focus even more critical.
- The public health system needs higher levels of investment and resourcing from central government – sustained cuts of 22 percent in real terms to the budget since 2015/16 have undermined action on health and health inequalities and will lead to worse health and higher inequality.
- Underfunding and planned reorganisation of public health organisations and their workforces has undermined capacity to contain the pandemic and improve health through the containment measures (1).

Throughout the pandemic, in addition to providing leadership and guidance on reducing risks and infection from COVID-19, and running infection control and vaccination programmes, public health teams have continued to work on essential public health programmes, such as running stop smoking programmes and using licensing powers to restrict outdoor smoking in cafes and bars.

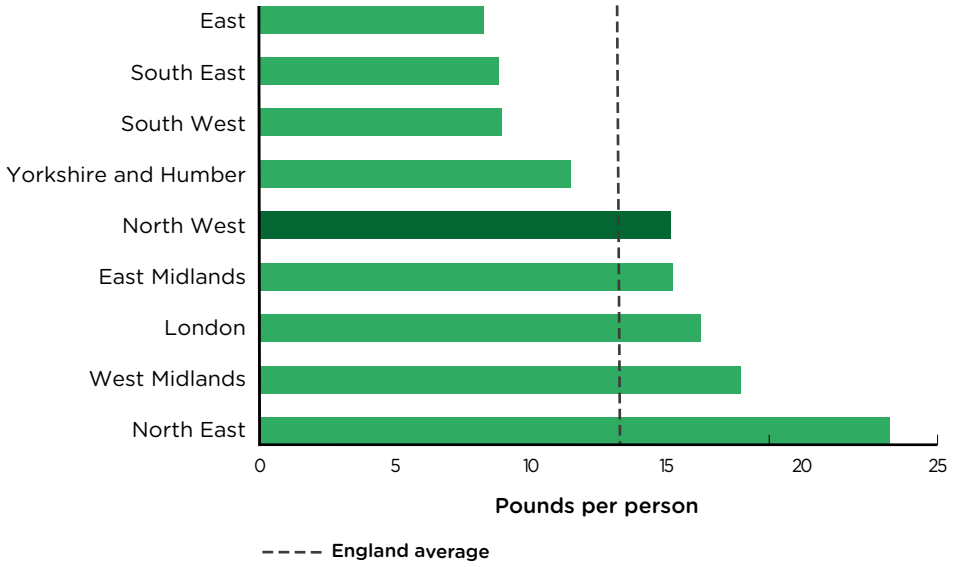
In addition to the continuation of public health programmes and the requirements for enhanced health protection, there needs to be additional focus on health behaviours as these have altered during the pandemic. In November 2020, the City Region population survey carried out for the GMCA found 37 percent of respondents stated they were eating more (while 11 percent said they were eating less), 25 percent were drinking more (17 percent were drinking less) and 27 percent were doing less exercise than before the pandemic and its lockdowns but 28 percent were doing more exercise (218). There are specific actions for public health to undertake to prioritise and bolster good mental health and to reduce harmful health behaviours, but the primary requirement for improving health and reducing health inequalities is that health equity is at the heart of government and governance in Greater Manchester. This requires enhanced roles for public health leaders and the whole public health workforce, and more funding.

One of the impacts of the COVID-19 pandemic that may benefit future action on health inequalities has been the high profile of public health, with an increased awareness of the social determinants on health and a widespread recognition of the unequal impacts of COVID-19. The heightened profile of public health and health inequalities through the pandemic provides an important opportunity to greatly extend action on the social determinants of health. The Association of Directors of Public Health, led by the Director of Public Health in Tameside, has stated that public health has three primary goals in the next few years in Greater Manchester: to tackle the health inequalities the pandemic has exposed and deepened; to develop greater understanding of the impact of the pandemic on the general population; and to learn from the pandemic to improve health protection and resilience against continuing threats and future disease outbreaks (79).

PUBLIC HEALTH FUNDING

In England, public health has experienced sustained cuts of 22 percent in real terms to its budget since 2015/16. The cuts have undermined action on health and health inequalities and will lead to worse health and higher inequality in health outcomes. The North West experienced cuts of approximately £15 per person in public health spending between 2014 and 2021 (Figure 46). The five English regions with the highest number of deaths per 100 people involving COVID-19 between March and July 2020 were also the five regions with higher cuts over this period (233).

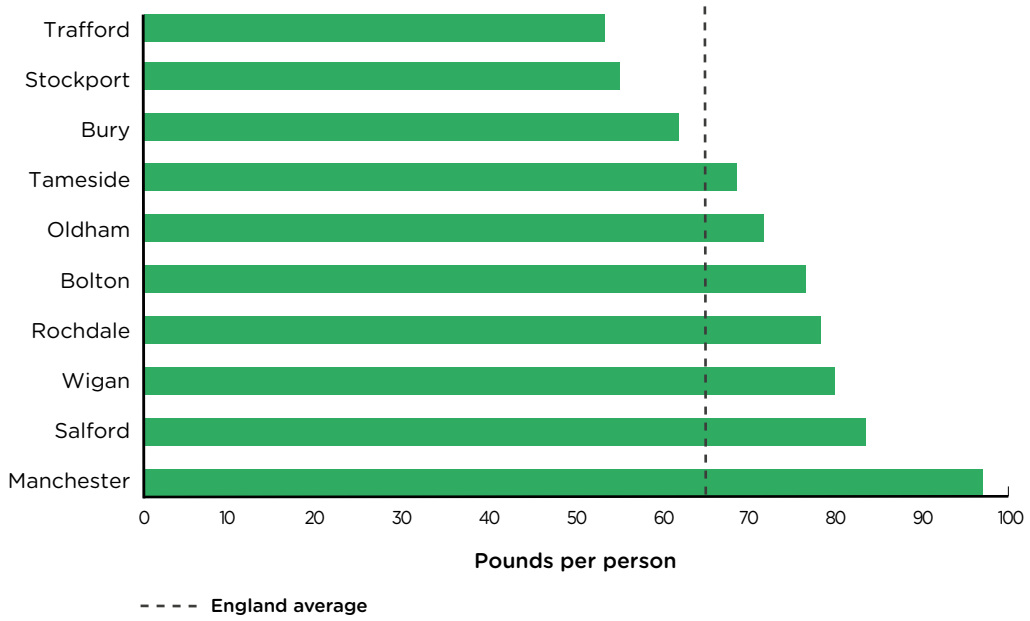
Figure 46. Public health spending reduction in real terms (£/person), 2014–21, regions in England and England average



Source: *MHCLG (2020) and PHE (2020) from IPPR (233).*

The Public Health funding allocations for 2021/22 were announced in March 2021 and within Greater Manchester, Manchester City received the highest allocation per head at £97 (Figure 47). The average for England is £64.87 per head. Every local authority in England received an increase of at least 0.67 percent in cash terms; this increase, however, does not compensate for the 24 percent decrease in real terms funding that has been experienced since 2015/16 (234) (235).

Figure 47. Public health local authority allocations (£/person), Greater Manchester, 2021–2022



Source: *Department of Health and Social Care (236).*

Greater Manchester's first Population Health Plan, Box 33, adopts a life-course and proportionate universalist approach to improve health and wellbeing for all residents in the City Region.

BOX 33. ACTIONS GREATER MANCHESTER IS TAKING ON PUBLIC HEALTH

As part of the devolution agreement to take control of reforming health and social care, Greater Manchester developed its first Population Health Plan, for 2017, and delivered a range of programmes to improve health outcomes across the City Region. The Taking Charge: 2017–2021 Population Health Plan identified five areas on which to focus to transform health and social care in Greater Manchester:

1. Reducing the number of very low birth weight babies.
2. Increasing the number of children who are 'ready to learn' when they start school.
3. Reducing the number of children living in poverty by raising the number of parents in good work.
4. Reducing the number of falls so more people are living independently at home.
5. Cutting the number of deaths from the big killers – cancer, heart disease and lung disease or respiratory problems (15).

The programmes supporting the Population Health Plan focussed on four areas: starting life well, living well, ageing well and reforming Greater Manchester's health and social care systems (15). Starting and developing well prioritises the early years and partners with schools, further education and higher education establishments and the community and voluntary sector to address the health and wellbeing of children and young people. Living well is an evidence-based model that includes specific models of primary care for deprived communities, adopting a proportionate universalist approach to improve population health. Ageing well aims to create and sustain age-friendly neighbourhoods in Greater Manchester, to reduce social isolation and loneliness and increase the number of 50–64 years olds in employment (80).

The Population Health Plan has introduced ill health prevention place-based services and sees health inequalities as an issue across a wide range of organisations, including the police, social care, local authorities, health, housing, fire services and the voluntary sector.

In January 2020, prior to the COVID-19 pandemic, the population health ambitions were refreshed and a model for a unified approach was created with four priorities to address in the next phase: wider determinants of health; behaviour and lifestyles; public service reform and place-based and person-centred approaches.

HEALTH BEHAVIOURS AND THE PANDEMIC

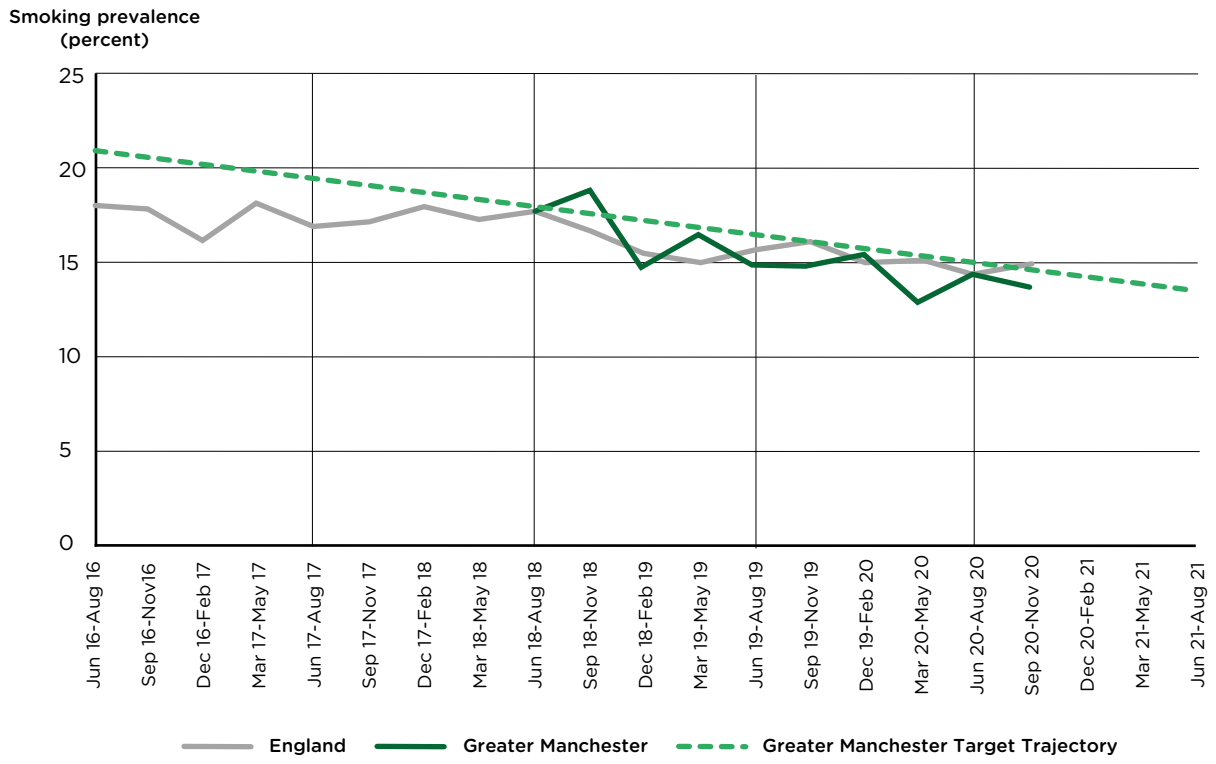
As we have set out, health behaviours are closely related to the social determinants of health and across the UK there are higher rates of smoking, obesity and harm from alcohol in lower socioeconomic groups. During the pandemic behaviours shifted somewhat, and it is not yet clear whether these changes are permanent or will shift again as restrictions loosen. In this section we overview smoking, obesity and alcohol misuse and assess levels of mental ill health.

SMOKING

There is a close link between smoking and inequality, and a North/South divide in England in smoking prevalence. In the UK, smoking rates by ethnicity are highest among those identifying as mixed or other ethnic origin, at over 20 percent, and high among men identifying as of Pakistan or Bangladesh ethnic origin (237).

Each year there are an estimated 5,212 early deaths in Greater Manchester caused by smoking and over 150,000 people who suffer from serious smoking-related diseases (238). However, overall smoking rates continued to decline in Greater Manchester through 2020 and the prevalence of smoking there was below the England average in September–November 2020 and had reached the target set for 2021 (Figure 48).

Figure 48. Smoking prevalence among adults aged 16 and over, Greater Manchester and England, 2016–2020



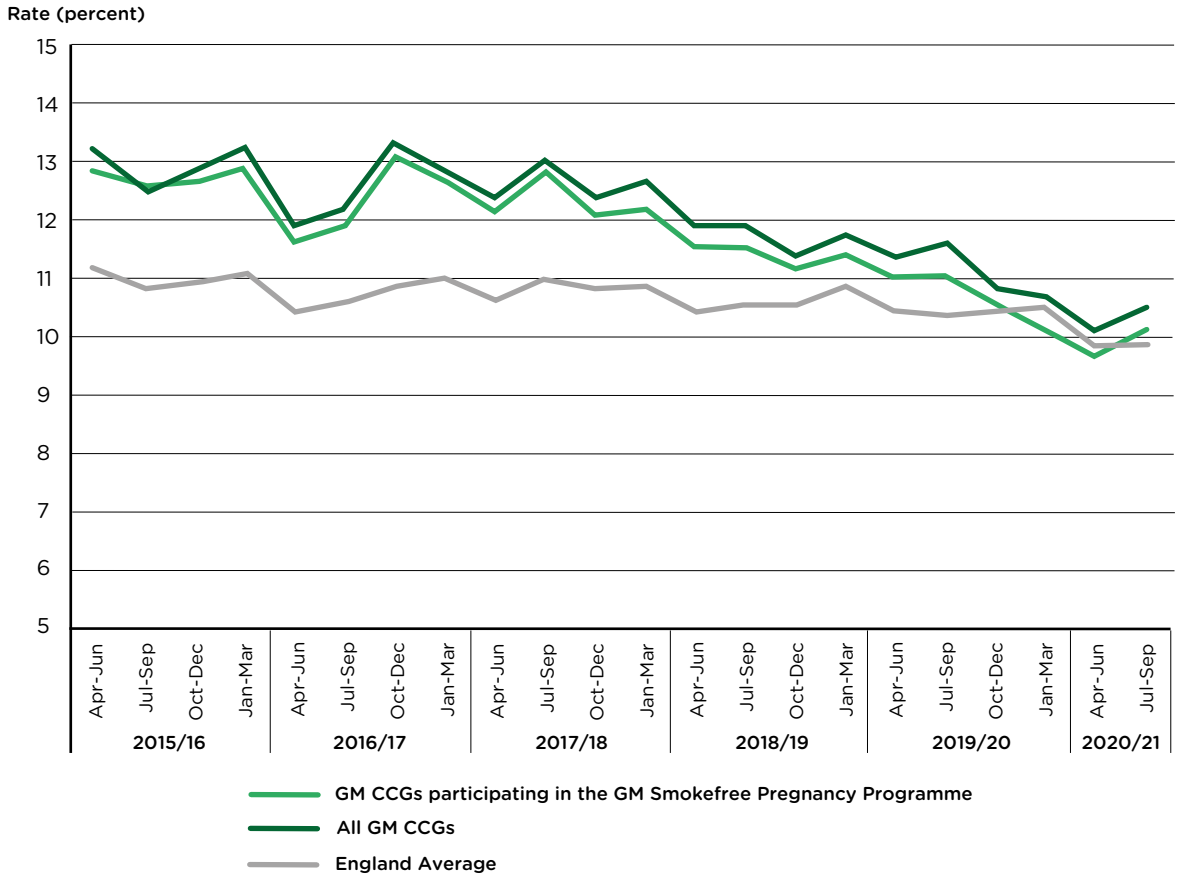
Source: *Greater Manchester Health and Social Care Population Health Programme Board, October 2020 (239).*

Average figures for the City Region and for its local authorities mask local inequities in prevalence; high smoking rates persist in some areas of even the more affluent Greater Manchester boroughs like Trafford and Bury, where overall prevalence has fallen to 9.1 percent and 12.8 percent respectively.

'Making Smoking History', Greater Manchester's Tobacco Control Strategy, aimed to reduce adult smoking prevalence by one-third by the end of 2020 and to 5 percent by 2035 (240). There has been a reduction of 52,000 smokers in Greater Manchester (or 18.4 percent) since the introduction of the strategy in late 2017 and the ambition appears to be on track. Smoking rates among people in 'routine and manual' jobs have reduced faster in Greater Manchester than in England as a whole and in other parts of the North, from 28.8 to 24.5 percent between 2012 and 2016, closing the gap with England (23.2 percent) (239).

Greater Manchester has implemented a comprehensive system-wide programme including focussed behaviour change campaigns and engagement activity supporting routine and manual groups to quit smoking. As part of the strategy a programme of support for smoke-free pregnancies, families and communities has reduced smoking at time of delivery rates by almost a quarter in the nine participating localities, supporting healthy starts for babies and closing the gap with the England rate. All 10 local authorities are now delivering this programme (239). Greater Manchester's ambitions around reducing smoking in pregnancy progressed in spite of significant disruption during the pandemic (Figure 49).

Figure 49. Smoking rates at time of delivery in the nine Greater Manchester local authorities engaged in the Smoke Free Pregnancy Programme and England, April 2015–March 2021



Note: *CCG= clinical commissioning group*

Source: *Greater Manchester Health and Social Care Population Health Programme Board, October 2020 (239).*

The pandemic has also resulted in more smokers being motivated to quit. In Greater Manchester there have been more attempts to give up smoking than in England over the last two years and attempts continued to increase in September–November 2020, during the pandemic (241).

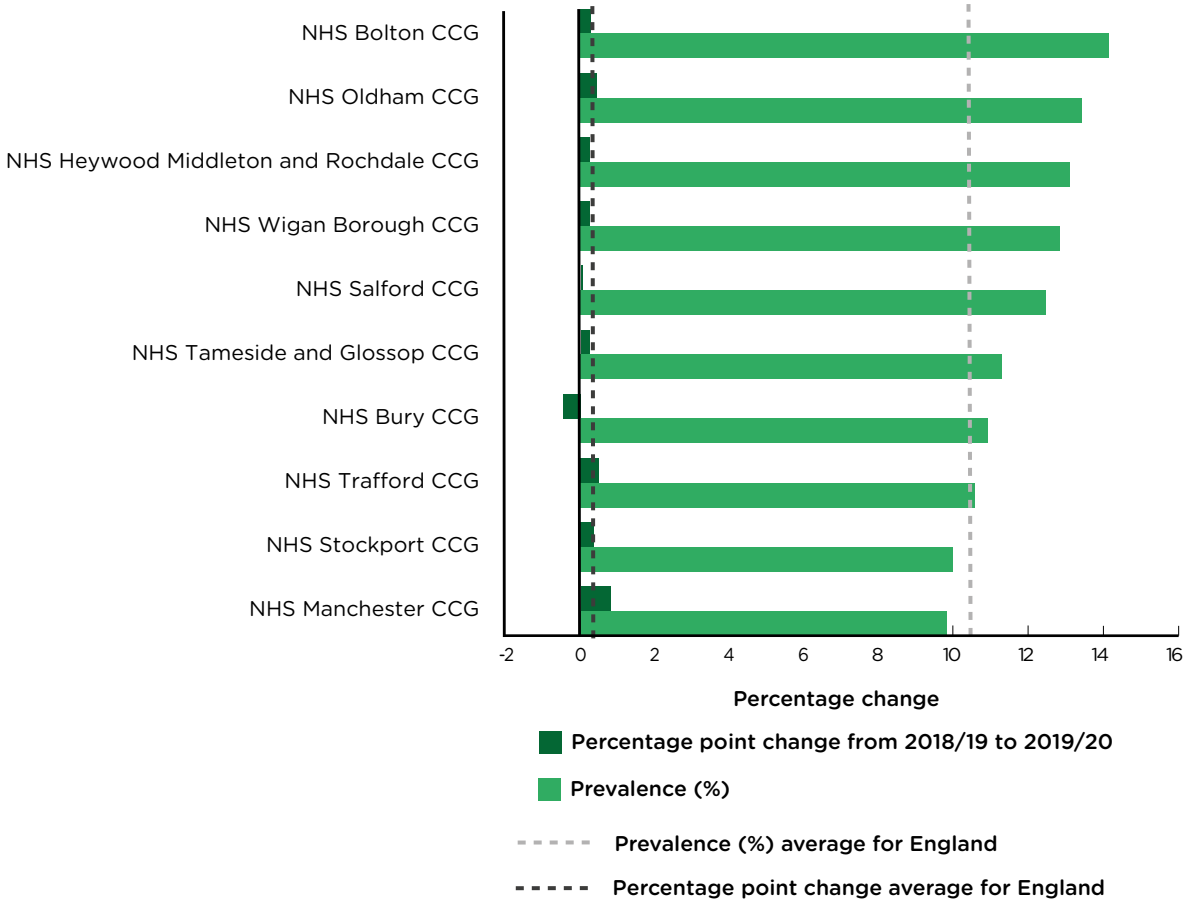
OBESITY

National data from the start of the pandemic show that a disproportionate number of people critically ill in intensive care units with COVID-19 were morbidly obese (242). Public Health England estimated having a body mass index (BMI) of 35 to 40 could increase a person's chances of dying from COVID-19 by 40 percent and a BMI greater than 40 could increase the risk by 90 percent (243). Obesity is closely related to deprivation.

Prior to the pandemic, in 2014/15, 65 percent of adults and 28 percent of children in Greater Manchester were classified as overweight or obese, significantly higher than the UK average. In line with England, every clinical commissioning group (CCG) in Greater Manchester except for Bury showed a rising prevalence of obesity between 2018/19 and 2019/20.

Figure 50 shows the prevalence of obesity among all Greater Manchester's CCGs. Eight out of the 10 CCGs had a higher prevalence than for England. Bolton had the highest and Manchester had the lowest prevalence from 1 April 2019 to 31 March 2020. In line with England, every CCG except for Bury showed a rising prevalence of obesity from the previous year.

Figure 50. Prevalence of obesity at ages 18 and over by Greater Manchester CCGs, 2019/20 and percentage change from previous year



Note: *All Greater Manchester's 10 local authorities are coterminous with their respective CCGs, with the exception of Tameside and Glossop, where Glossop is part of Derbyshire County Council and Tameside is part of Tameside Metropolitan Borough Council.*

Source: *QOF (244)*

There is no data available so far on levels of obesity in Greater Manchester through the pandemic. Across England, however, there is evidence that the COVID-19 containment measures impacted on people's weight-related behaviours, with increases in the likelihood of overeating and increasing alcohol consumption (245).

Overall, one in four surveyed Greater Manchester residents said they want help to stay active and eat healthily, more than half of Muslim residents said they need more help with staying active (54 percent), and half of residents with children aged 0–4 (49 percent) and for whom English is not their first language (50 percent) needed more help eating healthily (43). In Oldham there has been a 350 percent increase in demand for the local authority's peer-led services (dealing with all topics, not just obesity), which are the preferred option over clinician led therapy interventions (78). Thirty-one percent of the population in Greater Manchester are inactive, compared with 27 percent in England (15).

In March 2020 Manchester City was set to sign the Food Active Healthy Weigh Declaration and launch a Healthy Weight Strategy but this was delayed due to the pandemic (246).

ALCOHOL

Greater Manchester's mortality rates from alcohol-specific conditions are among the highest in the country. In 2014/15 there were nearly 70,000 alcohol-related admissions to A&E departments in Greater Manchester, and in each local authority's admissions per 100,000 were higher than the England average. Greater Manchester's Alcohol Strategy 2014–2017 addressed issues related to licensing, regulation and compliance as well as alcohol campaigns and awareness-raising, with a particular focus on young people (15).

In the UK, the effect of the pandemic on alcohol consumption has been mixed. Around one in three surveyed adults (36 percent) increased their consumption of alcohol during the first lockdown and 45 percent stated they decreased their consumption (247). There have been increases in the proportions of both higher risk drinkers and non-drinkers (248) and higher risk drinking has increased since the pandemic began. In February 2020 7.9 percent of those in manual occupations were higher risk drinkers; this rose to a high of 18.29 percent in September 2020 from which it declined to 13.59 percent by March 2021 (249). Healthcare workers responsible for taking care of individuals with COVID-19 increased their weekly drinking on average by between 0.45 and 1.26 units (247).

Findings from the Safely Managing COVID-19 survey in December 2020 found one in four people in Greater Manchester stated they were drinking alcohol more often; higher for those between 25-44 of whom thirty percent of Greater Manchester residents said they drank more often; those with children aged 0–4 years or primary school-age children, and residents who work full-time were also more likely to say they were drinking alcohol more often (218).

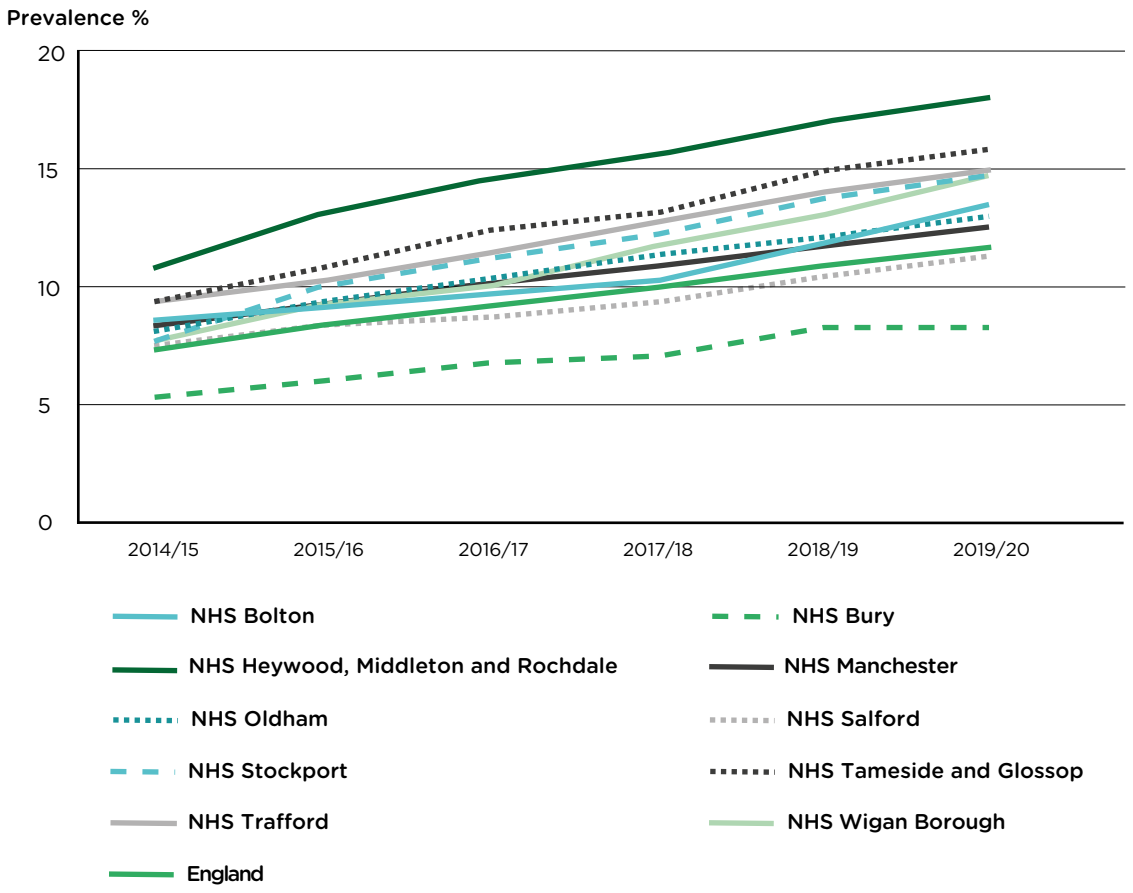
Eight percent of all Greater Manchester residents said they were using illegal substances more frequently than usual. Higher rates were found in 16–24 year olds and Asian and Muslim residents (218).

MENTAL HEALTH

The Greater Manchester Mental Health Strategy has shifted the focus of care in the City Region to prevention, early intervention and resilience, and delivering a sustainable mental health system. As noted in Section 4.C, Greater Manchester has made widescale efforts to improve children and young people's access to mental health care (15), (166). In 2016, there were 3,981 people in Greater Manchester in contact with mental health services for every 100,000 of the population, nearly double the national figure of 2,176.

Mental health deteriorated for all age groups during the pandemic, though the decline in mental health had started prior to the pandemic. Figure 51 shows the prevalence of depression across Greater Manchester's CCGs; six of the eight CCGs had levels of depression higher than the England average, and depression increased in line with the national trend for all 10 CCGs between 2014/5 and 2019/20.

Figure 51. Trend in the prevalence of depression in people aged 18-plus, Greater Manchester CCGs, 2014/15*–2019/20



Notes: *2014/15 – NHS Manchester comprised of NHS Central Manchester, NHS North Manchester and NHS South Manchester. All Greater Manchester's 10 local authorities are coterminous with their respective CCGs, with the exception of Tameside and Glossop, where Glossop is part of Derbyshire County Council and Tameside is part of Tameside Metropolitan Borough Council.*

Source: *QOF (250).*

The effects of containment measures on mental health have been studied throughout the pandemic and evidence shows mental health worsened the longer containment measures were in place, particularly for people under the age of 70. Given that Greater Manchester experienced longer periods of restrictions in 2020, it is likely that the toll on mental health was particularly high (177).

Over half, 52 percent, of those surveyed between August and November 2020 for the Greater Manchester Mental Wellbeing Survey, said they had 'very high' levels of anxiety (75). The three population surveys of Greater Manchester residents in November and December 2020 and January 2021 also found high levels of anxiety, with the proportions reporting high levels increasing from 39 percent in November and December 2020 to 42 percent in February 2021

(43). In all three surveys more than half of the population stated their mental health had become a concern as a result of the pandemic.

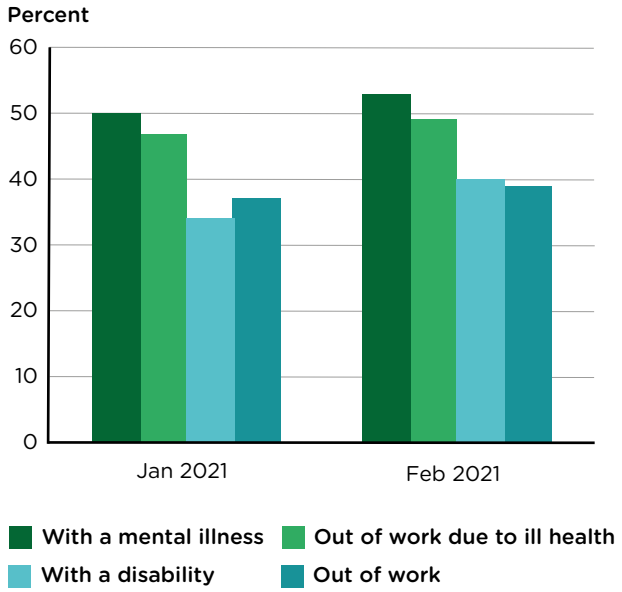
Table 4 shows the fairly rapid increases in the percentage of people in Greater Manchester with low levels of life satisfaction through the pandemic. In 2018 average life satisfaction scores (from 0-10, where 0 is 'not at all' and 10 is 'completely' satisfied) in Greater Manchester averaged at 7.67 and in January 2021 had fallen to 6.11 (251).

Table 4. Percentage of respondents with low levels of life satisfaction, Greater Manchester November 2020, December 2020 and January 2021 surveys (adults) (252) (43).

	2018 (average for year)	November 2020	December 2020	January 2021
Percentage with low levels of satisfaction	N/A	16 percent	19 percent	22 percent
Mean score	7.67	6.56	6.21	6.11

Levels of low life satisfaction are higher among respondents where someone in the household is at high risk of COVID-19 (31 percent), from ethnic minority backgrounds (30 percent) and women (25 percent compared with 19 percent of men). Higher levels of dissatisfaction were recorded among the unemployed and those on low incomes and, in particular, those who have been out of work for at least six months and those out of work due to ill health, respondents with a disability and particularly those with a mental health illness (43), shown in Figure 52.

Figure 52. Reporting of low life satisfaction by health and work status, Greater Manchester, January–February 2021



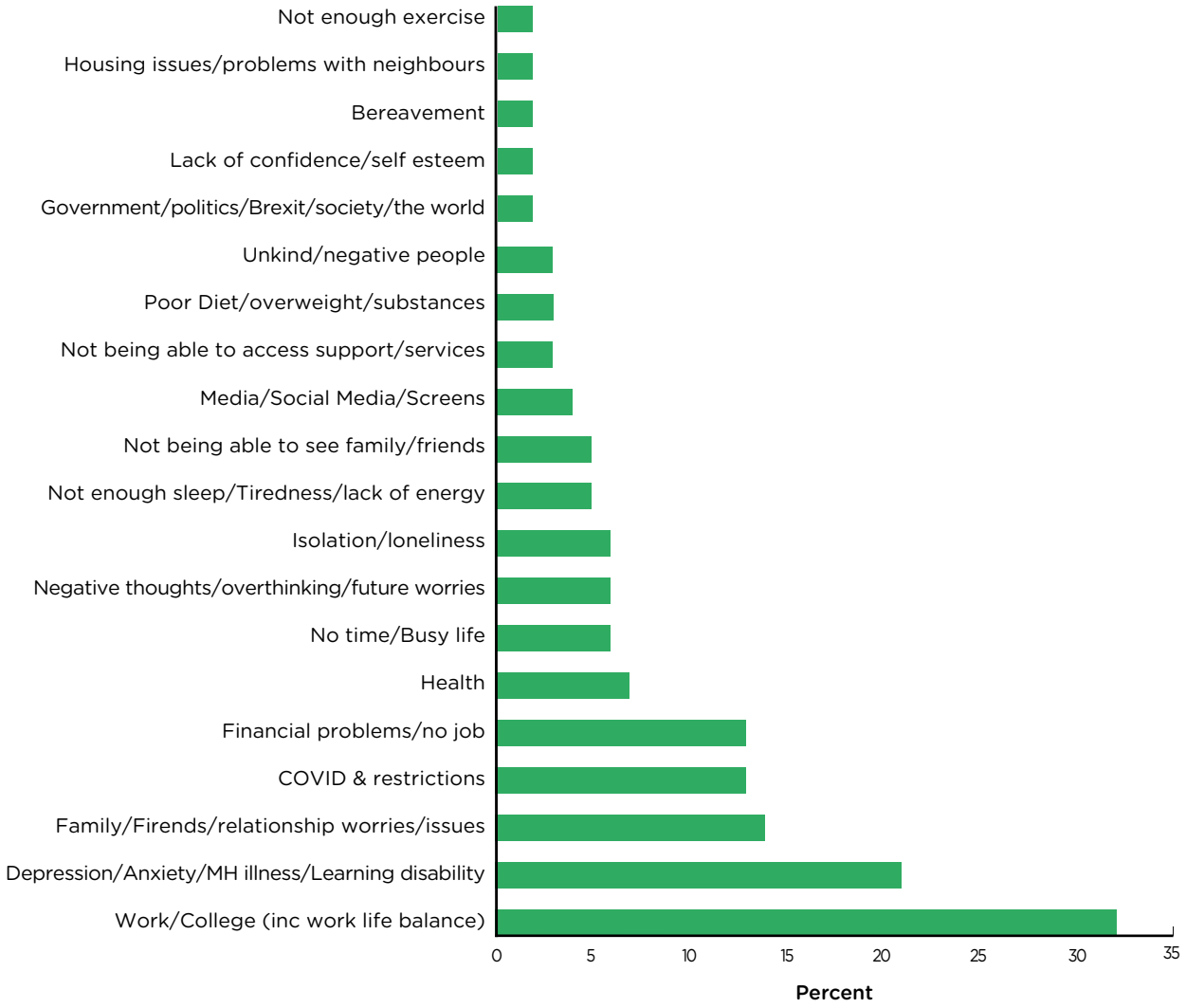
Source: *BMG, GMCA (156) (43).*

Among working age adults some of the reasons for worry, anxiety and/or depression and reduced wellbeing are lack of opportunities for peer support and socialising, an increase in COVID-19 related scams (78) and missing key milestones such as graduation, exams, weddings, birthdays and funerals. The most vulnerable were asked to shield which often led to mental health impacts and, at the same time, there has been reduced access to therapeutic environments/usual coping mechanisms. There has also been some reduction in service capacity during COVID-19, e.g. due to staff illnesses (78).

The financial impacts of the pandemic, including job loss, loss of income and increasing debt, are also driving greater anxiety. There are particular challenges for people on zero hours contracts and those who are self-employed. As set out in Section 3.C, missing school and being unable to socialise has harmed the wellbeing of many children, young people and their parents and carers. There have been many reports of increased domestic conflict and abuse (78).

In Greater Manchester during the pandemic in 2020, the survey of residents found 'work' and 'college' were the single biggest factors associated with poor mental wellbeing, followed by existing illnesses/disabilities, according to one survey (Figure 53).

Figure 53. Causes of poor wellbeing in people who live and/or work in Greater Manchester, August–November 2020



Source: *Question 3 of Greater Manchester Big Mental Wellbeing Conversation Survey Aug-Nov 2020, of 3,986 people who live and/or work in Greater Manchester (75).*

The Greater Manchester Disabled People's Panel carried out a survey on the impact of COVID-19 and lockdown measures on the population with disabilities in June 2020. Ninety percent of respondents stated that the pandemic has had a negative impact on their mental health (253). Some of their main concerns related to access to personal protective equipment (PPE) (56 percent), cancelled health appointments (62 percent) and housing (37 percent related to inaccessible/partially accessible housing).

The Greater Manchester Mental Health Strategy has shifted the focus of care in the City Region to prevention, early intervention and resilience, and delivering a sustainable mental health system. Boxes 34 and 35 outline actions taken by Greater Manchester to address the mental health needs of its residents during the pandemic, and its attempts to mitigate impacts on inequalities by targeting actions for key workers and particularly hard-hit populations.

BOX 34. ACTIONS GREATER MANCHESTER IS TAKING ON MENTAL HEALTH

Greater Manchester, through its devolution capacity, has supported mental health with a £130 million investment, allocating 60 percent of this budget to supporting children and young people. Greater Manchester has a whole-systems, single mental health programme to support the City Region that works with each of the 10 place-based systems, recognising inequalities in mental health as well as in the capacity of the workforce. This model allows the pooling of resources, avoiding duplication, standardising support and having a collaborative approach.

Greater Manchester offers: the Mentally Healthy Schools programme; university mental health service; parent–infant/perinatal services; early intervention in psychosis; children and young people eating disorder services; Thrive and i-thrive models; crisis care redesign (ongoing) and rapid mobilisation of crisis care helplines during the COVID-19 pandemic; digital delivery of mental health services during the pandemic; mental health support aimed at ethnic minority communities through VCSE organisations during the pandemic; and specialist children and mental health services, with access improved by over 35 percent and above national targets (148) (254).

A preventive mental wellbeing training programme called Connect 5 training continued to be offered during the lockdowns to NHS and social care staff and was offered to other frontline workers. In September and October 2020 the Greater Manchester Health and Social Care Partnership and the Independent Mental Health Network held a Big Mental Wellbeing conversation to better understand the population's experiences of the pandemic and their needs going forward, surveying over 4,000 people (255) (256) (16).

To address mental health, new social prescribing projects have been funded by the Greater Manchester Health and Social Care Partnership as part of the Green Social Prescribing Test and Learn scheme, with two-year nature-based pilot projects. Social prescribing schemes have expanded during the pandemic and 75 percent of referrals are for mental health support (257). Partners in Greater Manchester have also published the Greater Manchester Mental Health Toolkit for Employers to help business, public sector and VCSE organisations to support the mental health and wellbeing of their employees (258).

The Greater Manchester Resilience Hub, which was set up after the Manchester Arena attack, has been extended so that staff, including cleaners, porters, security, and other ancillary workers, across health and social care, can access it. Specific support is offered to health and care workers; managers and leaders; staff from ethnic minority backgrounds; families of health and care workers; and to people suffering a bereavement (259).

Living Life to the Full courses also continued during 2020 and the associated booklets have been translated into 15 languages spoken in Greater Manchester and made available digitally.

Greater Manchester published a 'Wellbeing and Mental Health' during COVID-19 booklet, disseminated across localities. In May 2020 the Greater Manchester Health and Social Care Partnership initiated the Mental Wellbeing Grants Programme for micro/small and medium-sized grants to local voluntary community groups and social enterprises in the City Region. Between May and December more than £149,000 was awarded to 85 projects. An evaluation found a variety of projects were funded, aimed at improving mental health in a range of communities using a range of activities. Many of the activities were simple – e.g. telephone calls and walking – and showed small amounts of money (less than £500) could have short-term effects on improving mental health (260).

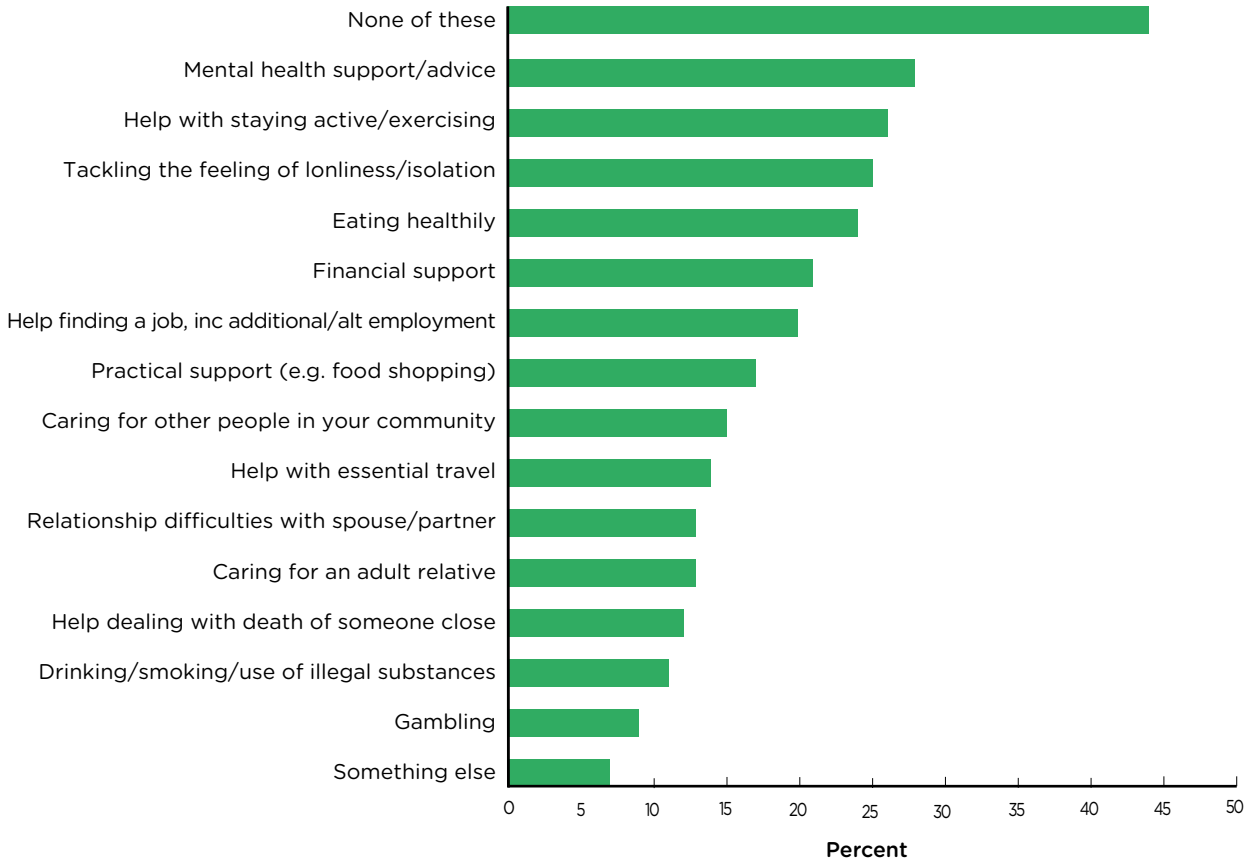
BOX 35. CASE STUDY: INCREASING MENTAL HEALTH DEMAND ON LOCAL GROUPS – YARAN NORTHWEST

Yaran Northwest, set up in 2013, is a bilingual team of community health workers, psychologists, therapists and community connectors specialising in working with Farsi/Iranian communities. They work with women, men, refugees and asylum seekers, people with disabilities and health conditions (including learning difficulties, mental health, drug and alcohol dependency, long-term health conditions), people aged 50 and over as well as ethnic minority communities (261).

In the 11 months from April 2019 to February 2020, Yaran Northwest received 860 referrals from Greater Manchester residents, equal to 78 referrals a month. In the eight months between March to October 2020, Yaran received 841 referrals, equal to 105 referrals per month. The calls increased by 140 percent between March–June and July–October 2020 (261).

In November 2020 a number of Greater Manchester residents were surveyed about the support needed to improve their mental health. Figure 54 shows the range of answers and the different ways suggested to improve mental health, from providing mental health advice to finding employment to eating healthily.

Figure 54. Support needed by Greater Manchester residents, November 2020



Source: Safely Managing COVID-19: Greater Manchester Population Survey. Survey 1 Report (218) .

SUMMARY AND RECOMMENDATIONS

Public health organisations and their workforces must be at the forefront of efforts to contain the pandemic, while continuing efforts to improve health and reduce health inequalities. These actions have been undermined by insufficient funding, planned reorganisations and weakening of public health leadership. Public health and associated sectors urgently need to have their capacity strengthened, budgets increased and to be at the centre of political decisions and decisions about resource allocations in order to ensure that action is directed proportionately at those communities where health harm is highest. Local public health teams have the knowledge of local places and resources and have established partnerships with other sectors. These are essential requirements for taking action on the social determinants of health and reducing health inequalities.

In the *10 Years On* report we assessed how best to implement action on the social determinants to reduce health inequalities – Box 36. These are national recommendations, but also have relevance, in part, to Greater Manchester.

BOX 36. PRINCIPLES FOR IMPLEMENTING ACTION ON HEALTH INEQUALITIES AND THEIR SOCIAL DETERMINANTS – FROM *10 YEARS ON*

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.
2. Ensure proportionate universal allocation of resources and implementation of policies.
3. Intervene early to prevent health inequalities.
4. Develop the social determinants of health workforce.
5. Engage the public.
6. Develop whole systems monitoring and strengthen accountability for health inequalities (3).

The pandemic has reemphasised the importance of Public Health experts' clear and effective communication with the public. While there has been a welcome focus on the social determinants of health among public health systems in recent years, this still needs to be strengthened.

Greater Manchester's health and care partnership has developed collaborative approaches to public health, with a focus on the social determinants of health prior to and during the pandemic. Further support for the partnership and for other sections to take action on the social determinants are now required and recommendations for Greater Manchester are listed below, and in Chapter 5 we outline the Marmot Beacon Indicators developed through our work with Greater Manchester, which will support and monitor activity in health inequalities and underpin the framework for Building Back Fairer set out in this report.

PUBLIC HEALTH – RECOMMENDATIONS

1. Allocate public health resources proportionately, with a focus on the social determinants

- Advocate for real terms percentage increase in the regional budget for public health.
- Strengthen the public health focus on the social determinants of health.
- Public health to provide a key leadership role post-COVID-19 in plans to Build Back Fairer.
- Continue to support Greater Manchester's integrated health and care system to be a true population health system, working in partnership with the 10 local authorities and the GMCA.
- Develop equity targets for local authorities and the City Region, with clear lines of accountability to reflect priorities for reducing health inequalities and inequalities in the social determinants in the longer term.

2. Prioritise inequalities in mental health

- Increase mental health provision in workplaces.
- Continue and expand existing programmes which focus on preventing mental health problems, and strengthen monitoring and evaluation for equity.
- Work with planners to develop mentally healthy high streets and access to good quality green space within a 15–20 minute walk for all in Greater Manchester, including specific actions to reduce noise and air pollution, improve community safety and reduce anti-social behaviour.

3. Give prevention interventions time to succeed

- Invest for the long term, measure success over five and 10 years, and improve sharing of best practice between local authorities in Greater Manchester.
- Identify and embed learning from the COVID-19 pandemic, including the value of place-based services and other 'bottom-up' approaches.
- Place prevention and taking action on the social determinants at the centre of integrated care system in Greater Manchester.

CHAPTER 5

MARMOT BEACON INDICATOR SET

FRAMEWORK FOR MONITORING THE REDUCTION OF HEALTH INEQUALITIES

The success of any strategy that aims to reduce health inequalities requires, at a minimum, the monitoring of performance in addressing inequalities in both health and its social determinants. In view of the often lengthy pathways from action on the 'causes of the causes' of health inequalities to their final impact on levelling-up health outcomes, the indicators need to include those relating to input, output and outcomes. These need to be sufficiently timely to feed into a continual process of monitoring and review of the effectiveness of actions in contributing to achieving health inequality reduction. This is illustrated in Figure 55.

Figure 55. Framework for indicators and targets

Source: *IHE, Fair Society, Healthy Lives (146).*

Two broad categories of indicators are required: indicators of action on the social determinants and indicators of progress made on the social determinants. Action indicators can be further categorised by the type of intervention that they measure into: indicators of interventions on governance related to social determinants, those that measure social interventions that promote health and health equity, and indicators of environmental interventions that promote social and health equity (262).

Our identification of emerging trends in inequalities across Greater Manchester and applying these principles to the types of indicators required resulted in a preliminary identification of 43 indicators early in 2020.

The COVID-19 pandemic led to a reprioritisation of the Greater Manchester/IHE collaboration from March 2020 onwards, with work reoriented to supporting the City Region through its COVID-19 response, recovery and ambition to Build Back Fairer. To develop a monitoring framework to assess the impacts of COVID-19 from an equity perspective, the process of identifying indicators was refocussed to enable a wider understanding of the inequality impacts of the pandemic and related containment measures. The intention was to encourage an equity-focussed and whole-system approach to recovery and to align with Greater Manchester's overall approaches to mitigating equity risks and developing a more equitable and sustainable future.

DEVELOPMENT OF THE MONITORING FRAMEWORK AND SELECTION OF INDICATORS

Following agreement on the overall areas that are important for monitoring the inequality impacts of COVID-19, the development of the Greater Manchester COVID 19 inequality framework and the selection of indicators was based on a three-stage process:

1. Framework

2. Prioritisation by Greater Manchester analysts

3. Additions by Directors of Public Health

In 2020 the WHO European Regional Office developed a framework for assessing the impact of COVID-19 and its containment measures and identifying mitigating actions at country level. This recognises different mechanisms that either derive from existing inequalities or give rise to new ones:

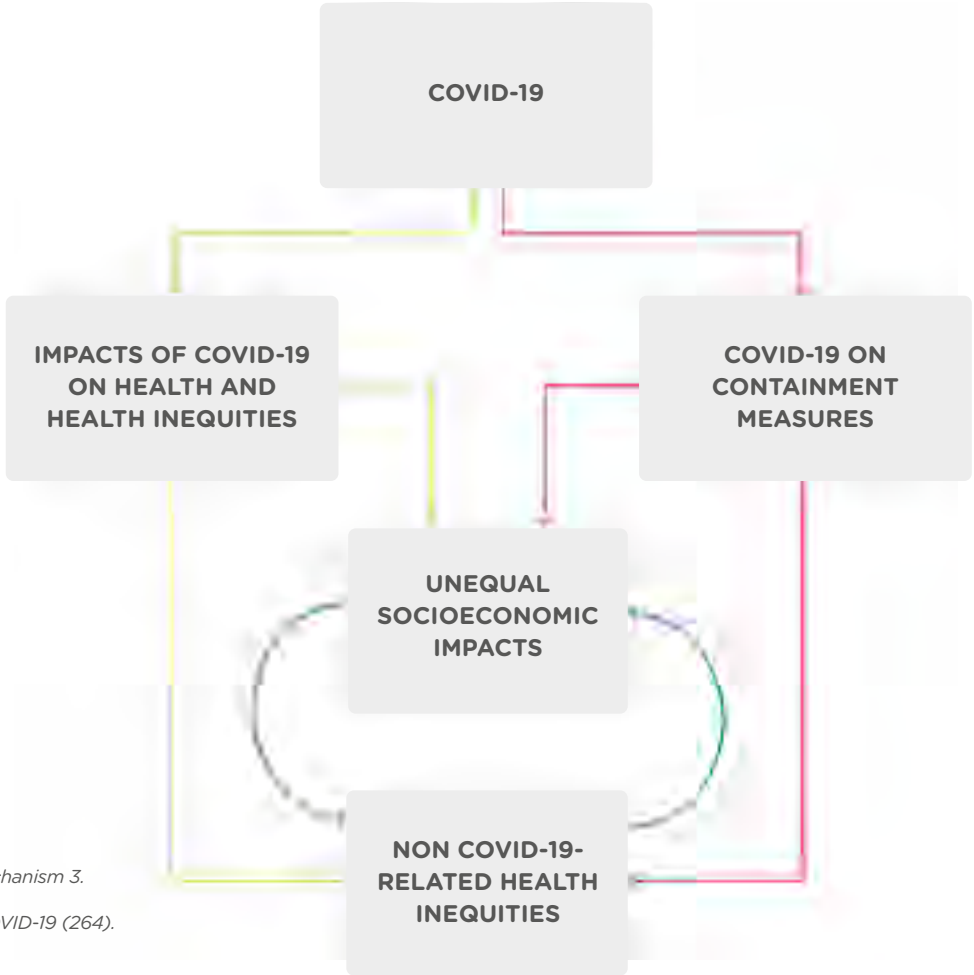
Mechanism 1: Health inequities follow from exposure to infection and the risk of severe health outcomes, including Long-COVID (263) and death. These health effects may go on to generate or enhance pre-existing socioeconomic inequities and non-COVID-19 conditions.

Mechanism 2: The unequal socioeconomic impacts of COVID-19 containment measures may generate non-COVID-19 health inequities, and these conditions may themselves predispose to subsequent inequities in adverse outcomes of COVID-19.

Mechanism 3: Socioeconomic inequities can increase the risk of further non-COVID-19-related health inequities. Conversely, non-COVID-19-related health effects that are indirectly generated by containment measures or as the consequence of health problems caused by contracting COVID-19 may lead to further socioeconomic inequities. This cyclical mechanism can reinforce health and socioeconomic inequities.

The relationship between these three mechanisms is illustrated in Figure 56.

Figure 56. Three mechanisms for COVID-19 socioeconomic impacts and their inequities



Note: *Green arrows = Mechanism 1; red arrows = Mechanism 2; blue arrows = Mechanism 3.*

Source: *Health inequity and the effects of COVID-19 (264).*

Indicators were derived by WHO to measure these mechanisms, selected based on understanding of the likely inequality impacts from COVID-19, existing frameworks used by UN agencies, and the latest evidence on equity-monitoring in Europe (265) (266).

The indicator set comprised 40 indicators, covering:

- Health system activity
- Health system quality and quality of support services
- Non-communicable disease risk factors
- Mental health
- Human rights abuses and discrimination
- Safety in the home and in the community
- Community participation and perceptions around community cohesion
- Pollution and the environment
- Poverty and food scarcity
- Employment and social assistance programmes
- Transport and infrastructure
- Media and press monitoring. (264)

We compared these indicators with the 43 indicators from the IHE-Greater Manchester Phase 2 mapping work (see Figure 57 below). The two indicator sets (83 indicators in total) were then grouped under the following subheadings, which included areas that will be impacted by COVID-19 and are both priority areas for Greater Manchester and for WHO EURO:

1. NHS activity, health outcomes, and self-reported health
2. Risk factors for chronic disease
3. Perceptions of the community, security, isolation
4. Poverty and deprivation
5. Work and income
6. Early years and education
7. Transport and the environment
8. Housing

Any duplicates or unrelated indicators from the WHO framework (such as 'adequate water and sanitation facilities', not designed to be used by high-income countries) were removed.

INPUT FROM GREATER MANCHESTER ANALYSTS

Further discussion with lead analysts at the GMCA, Greater Manchester Health and Social Care Partnership (GMHSCP) and local authorities (including those with expertise in data relating to food security, crime, drug misuse, smoking and housing), added 10 additional indicators to the framework. Indicators were chosen that could support the monitoring of the equity impacts of COVID and containment measures, outlined in the eight areas described above. Priority was given to data sets that are disaggregated, data that are available routinely and frequently, data that show health impacts in the short term and data on key social determinants.

Engagement with GMCA, GMHSCP and local authority colleagues also enabled IHE to reduce possible duplication of effort of similar workstreams operating across Greater Manchester. For example: the indicator mapping taking place as part of Greater Manchester's health and justice strategy, the Greater Manchester System Siren work and the COVID-19 indicator mapping being undertaken by the GMCA. After cross-checking the indicators with these other sources and receiving regular feedback from Greater Manchester analysts, a total of 38 indicators remained.

To ensure that reporting requirements for the final indicator framework were appropriate, and to test consensus among colleagues in Greater Manchester, IHE asked Greater Manchester analysts working in population health to score each of the 40 indicators across three separate domains, as either high, medium or low priority, for inclusion in the final indicator framework.

The prioritisation criteria were adapted from a similar template used by Greater Manchester's analysts to assess indicators from the 2011 Census. The three domains and corresponding subdomains were:

1. **Policy priority for monitoring inequalities relating to specific strategic goals**
   a. Relevance to Greater Manchester's strategic priorities
   b. Availability of alternative sources
   c. Geographic availability of the indicator
2. **Identification of important inequalities or vulnerabilities emerging from COVID-19 and its containment measures**
   a. Existing/emerging/predicted inequalities across Greater Manchester
   b. Needed for continuity/trends-monitoring
   c. Quality of data collected/will represent the true picture of inequality or people in vulnerable situations (i.e. validated)

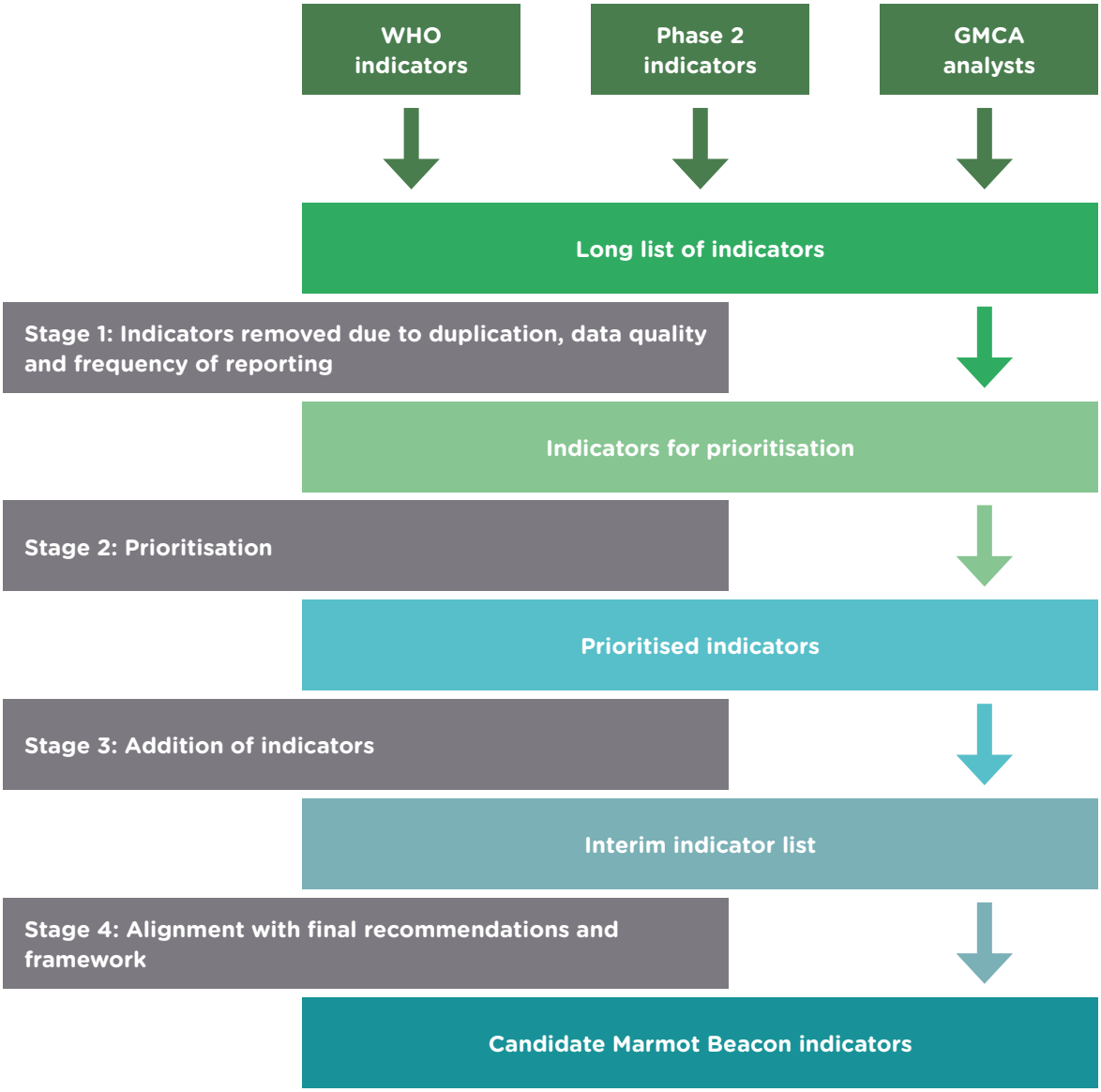
3. Cross-related topic

a. Related to several other key variables in the indicator framework

b. Needed for several variables to be considered simultaneously e.g. impact of age, ethnicity and employment.

Following this prioritisation process, the indicators were assessed by Directors of Public Health (DsPH) from Greater Manchester to ensure alignment with Greater Manchester's public health priorities. The DsPH suggested an additional 10 indicators for inclusion. The combined list was then reviewed in the light of the parallel development of policy recommendations, the framework in Figure 1 and the emergence of new data collections and/or availability. The overall process for deriving beacon indicators is summarised in Figure 57.

Figure 57. Indicator selection flow diagram



We propose that, for the five areas in the framework (Figure 1) for which indicators are needed, the availability of suitably frequent, disaggregated data is explored for the potential indicators listed below, so that these can be used to inform a biannual assessment of health equity in Greater Manchester. Even where some data are currently available, they may not be at the level of granularity needed to monitor inequalities within local authorities or be sufficiently timely. For some of the indicator areas data may not yet exist at all. It will be for Greater Manchester system partners to take forward the following candidate Marmot Beacon indicators.

The indicators cover the areas and recommendations outlined in this report and are considered critical in driving down health inequalities and in delivering on the potential to Build Back Fairer.

MARMOT BEACON INDICATORS

Early years, children and young people

- Indicator 1: School readiness
- Indicator 2: Low wellbeing in secondary school children (#Beewell)
- Indicator 3: Pupil absences
- Indicator 4: Educational attainment by FSM eligibility

Work and employment

- Indicator 5: NEETs at ages 18 to 24
- Indicator 6: Unemployment rate
- Indicator 7: Low earning key workers
- Indicator 8: Proportion of employed in non-permanent employment

Income poverty and debt

- Indicator 9: Children in low income households
- Indicator 10: Proportion of households with low income
- Indicator 11: Debt data from Citizens Advice

Housing, transport and the environment

- Indicator 12: Ratio of house price to earnings
- Indicator 13: Households/persons/children in temporary accommodation
- Indicator 14: Average public transport payments per mile travelled
- Indicator 15: Air quality breaches

Communities and place

- Indicator 16: Feelings of safety in local area
- Indicator 17: People with different backgrounds get on well together
- Indicator 18: Antisocial behaviour

Public health

- Indicator 19: Low self-reported health
- Indicator 20: Low wellbeing in adults
- Indicator 21: Numbers on NHS waiting list for 18 weeks
- Indicator 22: Emergency readmissions for ambulatory sensitive conditions
- Indicator 23: Adults/children obese
- Indicator 24: Smoking prevalence

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