Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

Manchester Health and Care Commissioning Inclusion and Social Value Strategy 2018-23

MISSION

Everyone should have the same opportunity to lead a healthy life and to access high quality, safe and accessible health and social care services, no matter where they live or who they are.

Manchester Health and Care Commissioning (MHCC) are responsible for ensuring that high quality health and care services are provided to our population. It is our mission to ensure that in doing so we recognise and commit to closing gaps in access to, take up of and outcomes for health and social care across Manchester.

We know that inequality gaps exist for some people based on their protected characteristics and we will continue to tackle these, but will now also bring this work together with our work to address socio-economic disadvantage as it affects health and social care, such as health outcomes for those who are homeless, sex workers, seeking asylum or other high health risks circumstances.

This strategy builds on the success of our previous equality, diversity and human rights work, learning from what works well and not so well in understanding and addressing health inequalities in our communities, enabling us to focus on new challenges with our learning to hand. We have also recognised the opportunity to address health and social care service and workforce inequalities through increased use of social value levers. Increasing employment of under-represented groups is a key strand of this strategy which we can support both through our own policies and through our supply chain.

Addressing the causes of ill health, spotting illnesses earlier, providing support earlier and managing illnesses better are all core aims of our Locality Plan. Our new inclusion and social value strategy aims to ensure that we reduce and remove any disparity in these outcomes across all our communities. The five year delivery

plan sets out the actions that we believe will have the most impact in achieving these aims.

Our Mission will therefore be to:

i. Increase awareness of the inclusion and social value agenda
ii. Ensure effective communication, engagement and involvement tools are available and accessible for all communities
iii. Ensure that all commissioned providers have robust standards in place in respect of equalities, human rights and diversity, have plans in place to make improvements and are using social value to improve outcomes outside of statutory obligations.
iv. Ensure inclusive leadership and an engaged and representative workforce
v. Improve data collection and usage across all equality groups to establish a better picture of inequalities.

Executive Summary

The inclusion and social value strategy 2018 – 2023 flows from and builds on the EDHR Strategy 2015 – 2018. It sets out the new vision and aims for improved outcomes across Manchester's health and social care system by reducing inequalities and using social value as an enabler as we further develop integrated working practices.

The inclusion and social value strategy describes the current context and need for improvements in inclusion in terms of service commissioning, delivery and workforce development as a key part of successful delivery of the Locality Plan and other linked strategies. One of the overarching aims of this refreshed strategy is to present a cohesive set of actions that support the city's ambitious plans to provide the best opportunities to close the health inequalities that exist in Manchester through the way that we commission and focus on outcomes.

It aligns with the aspirations, vision and values of the Our Manchester strategy (2016 – 2025), the Population Health Plan (2018 – 2027), the Our Healthier Manchester Locality Plan and Greater Manchester wide plans to address inequalities of outcome in health and care.

The strategy has been designed to support delivery of the Population Health Plan through our role as a strategic commissioner. In order to achieve the five priorities within the plan we need to better understand why and how people in more disadvantaged communities have worse health outcomes.

We already know that some communities such as people from minority ethnic groups and people from lesbian, gay, bisexual and transgender (LGBT) communities can experience worse health outcomes. We also know that other groups, such as refugees and asylum seekers, disabled people and people experiencing homelessness may face barriers to accessing health and social care services as well as support services to move into good employment which can have an impact on their health and wellbeing. There are also gaps in our knowledge that need to inform our approach to addressing these inequalities. This strategy and delivery plan aim to develop that knowledge and allow us to act on the evidence that we develop.

We will also address inequalities within the workforce of our health and social care organisations based on strong evidence that organisations whose workforces reflect their local communities deliver better health, wellbeing and social care outcomes overall.

'Inclusion' is an overarching term that encompasses the work that we will do to address disparities in access to, take up of and outcomes for those with different protected characteristics, those whose human rights may be at risk and those who face socio-economic disadvantage. Having this overarching theme of inclusion will help to consolidate

and focus our work to address unequal health and care outcomes and avoid duplication of effort.

'Social value' incorporates the requirement to consider how we can use procurement and commissioning to derive benefit for our communities and the value that we can deliver 'in house' through our workforce. The strategy sets out how social value can act as an enabler to address health, social care and workforce inequalities.

Our strategy sets out three key areas of focus – **leadership**, **culture** and revised **systems and processes** to enable a more streamlined approach to more inclusive delivery with social value underpinning the approach.

Some of the headline work we are already scoping out includes a series of bespoke training and briefing in areas where stakeholders tell us there is less understanding and application – for example in the areas of human rights, the social model of disability, social value and improving diversity of recruitment, retention and development.

Our leaders will become more visible on key inclusion and social value priorities, using a range of channels from social media to key note speaking events – helping create the right conditions for the culture shift required for all staff to become more accountable in their own day to day practice for closing the inequality gaps some of our communities experience. Our new inclusion panel will support our leadership take a broad overview of progress towards closing inequality gaps, connect up relevant strategies more readily and avoid duplication of effort. We will be providing more streamlined delivery tools such as an easier to use equality impact assessment process to ensure that potential inequalities are designed out of services from the outset. We will address how to better recognise and tackle the health and social care issues that impact adversely on specific communities and how to better engage and ensure equitable access to health and social care services for all communities.

We will build knowledge and expertise on the 'difficult to crack' issues across our delivery and workforce, enabling better access to expertise and creative thinking, building confidence and skill sets to apply inclusion and social value measures in day to day practice.

In appendix 3, you will see an overview of some of the most recent findings from across the city on inequalities of outcome. We will be bringing together and making more accessible the rich data sources we have across the city to better benchmark and evidence progress, with an inclusion and social value panel to oversee the progress and give direction as we move through the one, three and five year delivery plan in place to measure the impact of the strategy.

Manchester Health and Care Commissioning (MHCC) Inclusion and Social Value Strategy 2018- 2023

1. Background

1.1 The transformation of Manchester's health and social care infrastructure under the devolution arrangements and continued need to address health and social care inequalities provide the backdrop to this refresh of the Manchester CCG 2015-18 Equality, Diversity and Human Rights strategy. Continuing budget pressures, recognition of the imperative to shift service delivery from acute to prevention and early intervention models and an increased focus across the city on social value, wider determinants of health and the Our Manchester approach have also informed the refresh of this commissioning strategy.

1.2 For the purposes of this strategy, inclusion incorporates equalities, diversity and human rights and both our legal requirements around the nine protected characteristics and how the values of our organisations are put into practice to address inequalities experienced by those groups and others. Social value incorporates the requirement to consider how we can use procurement and commissioning to derive benefit for our communities and the value that we can deliver 'in house' through our workforce. The strategy sets out how social value can act as an enabler to address health and workforce inequalities.

1.3 The scope of this strategy and the accompanying delivery plan is to set out MHCC's approach and contribution to inclusion and social value as part of the wider health and social care infrastructure within the city. It sets out how inclusion and social value will be embedded within MHCC's commissioning principles and lead areas within the Locality Plan and how it contributes to delivery of the Our Manchester Strategy.

1.4 The continuing aims from the previous strategy are to:

- Reduce unlawful discrimination in all of our functions as a commissioner and employer.
- Develop a holistic awareness and understanding of communities and their health and social care needs.
- Commission services from providers who are able to be responsive to the diverse needs of individuals and their families.
- Promote equality of opportunity and inclusion so that all staff and patients can achieve their potential and have the best life chances possible.
- Become a strong community leader, championing equality in all aspects of work and with other local partner agencies.
- Reduce inequalities in health, wellbeing and social care amongst different groups of people living in the city.

2. Vision and aims

2.1 We will contribute towards the transformation of health and social care commissioning and delivery in Manchester in line with the Our Healthier Manchester Locality Plan , supporting the delivery of the 'Progressive and Equitable city' strand of the Our Manchester Strategy and the MHCC and MLCO operational plans by being more responsive to the health, wellbeing and social care needs of all people who live in the city. We will also address inequalities within the workforce of our health and social care organisations based on strong evidence that organisations whose workforces reflect their local communities deliver better health, wellbeing and social care outcomes overall. Embedding a robust and accountable inclusion and social value strategy will be at the heart of delivery.

2.2 We will do this by:

- Developing a better understanding of what our population and workforce need through more systematic use of evidence and insight
- Designing and commissioning services more effectively by embedding inclusion and social value objectives into 'business as usual'. This more coordinated approach will support the development of a culture of personal responsibility for building inclusion and social value in from inception through to delivery and review of services
- Continuously reviewing and improving services, based on improved data and evidence gathering to inform current and future plans and influencing delivery of contracts through continuous improvement.
- Implementing changes to the way that staff are recruited and supported to progress within and across the city's health and social care organisations, ensuring that our combined workforce reflects the communities that we serve at all levels
- Using social value as an enabler to improve inclusion outcomes

2.3 The approach will be based on the Our Manchester principles of 'listening', 'recognising strengths', 'working together' and 'better lives'.

3. Strategic objectives for the inclusion and social value strategy

3.1 The following objectives from the 2015-2018 EDHR strategy have been refreshed to include a new focus on social value and references to the new integrated health and social care context in which we are operating.

i. To increase awareness of the inclusion and social value agenda

Health, wellbeing and social care services need to be commissioned and delivered in a more inclusive way, leading to improvements in health outcomes and a narrowing of health inequalities. Key to this is deriving greater social value in-house through our workforce and through commissioning, procurement and contract management. We can deliver social value in house through our workforce policies and practice e.g. health and wellbeing policies and flexible working which support all staff to stay healthy in work

and by offering pre-employment support to under-represented groups. We need to ensure that the greatest opportunities for recognising and closing the current equality and inclusion gaps and future proofing inclusion, fairness and equity in our population's health and social care outcomes are embedded in the way that we work. We will build on strengths and streamline design, commissioning and delivery to support improvements across the system.

ii. To ensure that effective communication, engagement and involvement tools are available and accessible for all communities

Improving services also involves ensuring that we listen to what our communities are telling us about their experiences of using health, wellbeing and social care services and involving them at design and monitoring stages, adapting our approaches to address gaps.

iii. To ensure that all commissioned providers have robust standards in place in respect of equalities, human rights and diversity and have plans in place to make improvements and are using social value to improve outcomes outside of statutory obligations.

We will share resources across the health and social care system to improve understanding and delivery of a range of equalities and human rights standards and approaches to make the city a centre of good practice. To support better inclusion health, wellbeing and social care outcomes, we will strengthen the use of social value requirements within contracts and will continue to develop collaborative approaches across the system, particularly around employment of local people.

iii. To ensure inclusive leadership and an engaged and representative workforce

Ensuring that MHCC's leadership and workforce is informed about and reflects our diverse communities is key to the success of this strategy. We will strengthen our inclusion approach to recruitment and progression, taking positive action to address known disparities. Training and development opportunities around inclusion and social value will also underpin the delivery of the strategy to embed it within day to day work, as will tools such as the refreshed Equality Impact Assessment and Social Value toolkit. Both inclusion and social value clearly align with the values and support the delivery of the priorities set out in the Our Healthier Manchester Locality Plan and Our Manchester Strategy.

iv. To improve data collection and usage across all equality groups

We will develop a more system-wide evidence base to address variation in access to services and health, wellbeing and social care outcomes for different communities. This will involve the consistent collection of equalities data as well as qualitative evidence,

supported by a new, more meaningful Equality Impact Assessment approach and enhanced governance arrangements. This will enable us to have a better picture of where inequalities are present, what their impact is and the priorities we need to tackle.

3.2 This strategy and the accompanying delivery plan will support the development of an approach that will allow for monitoring of progress and pace, mitigation of regression or derailment and evidence success.

This workplace culture shift will require all of us to take more responsibility for the continuous development of inclusion and social value outcomes – using our specialist knowledge and skills - whether we are a senior consultant, a nurse, an office administrator or a sub-contractor - to determine the best approach to achieving those outcomes.

4. Governance

4.1 In order to provide direction for and oversight of delivery of the strategy, we will reshape the MHCC governance framework, replacing the current Equalities Diversity and Human Rights sub-committee with a revised inclusion and social value panel which will be equipped with the right foresight and intelligence to reach informed decisions. The panel will address the pace of progression, halt any regression and tackle any inertia or lack of traction, both holistically and individually as initiatives are progressed. It will identify opportunities to develop new ways of working to deliver both inclusion and social value outcomes as well as contribute to and support the delivery of the Locality Plan and Our Manchester Strategy in relation to MHCC's role as a strategic commissioner.

4.2 The panel will set direction and tone for the required change within MHCC and hold to account those designing and delivering services, policies and procedures for ensuring equity in take up of, access *to* and outcomes *for* health, wellbeing and social care across the city. To enable this new approach, we have considered:

• Legitimacy and voice: for relevant stakeholders to be included in the process of development

• Performance: that measurable processes and outcomes are agreed and set

• Accountability: that it is clear who is accountable to the leadership for progress and delivery

4.3 Figures 1 and 2 below show the current and proposed governance structures respectively, the latter of which has been developed through consultation with the EDHR subcommittee, Inclusion Health group and other stakeholders. It will need to be finalised in line with the wider MHCC governance review. It is expected that the inclusion and social value panel will report in to the proposed new strategy and transformation committee.

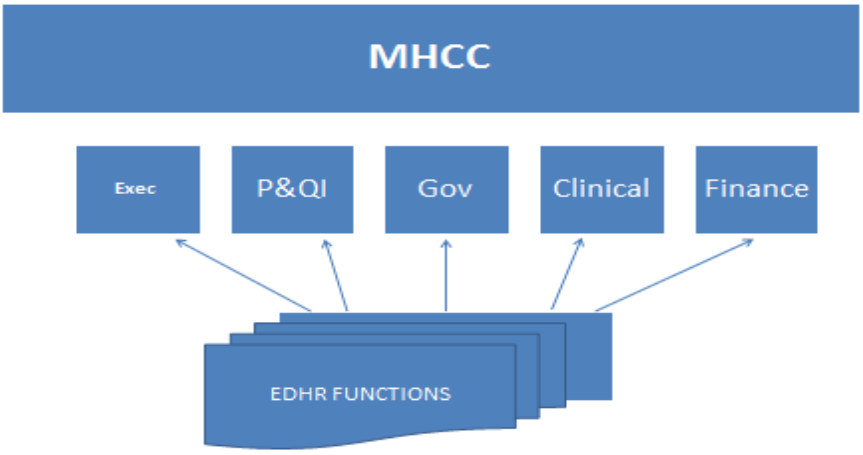

Figure 1 Current MHCC EDHR reporting structure

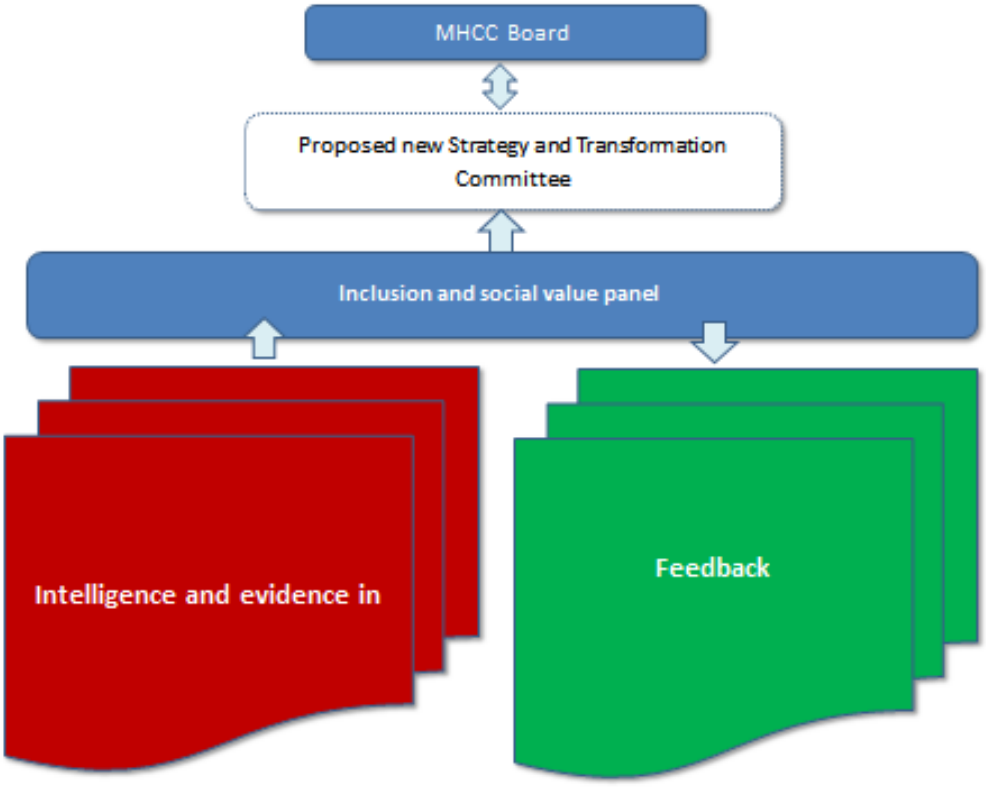

Figure 2: Proposed new MHCC inclusion and social value structure

Examples of what the panel will consider will include:

Intelligence in:	
Evidence funnel	**Feedback to**
Business case equality impact assessments	Contract performance team and
Performance and quality assurance	commissioning teams
Inclusion health progress reports	Business case decisions
JSNAs	Locality plan/ Neighbourhood teams
Communications and engagements activities	Communications and engagements functions
Business intelligence (including primary and	Providers
secondary care data)	VCS sector
Social value reports	Inspection and regulation activities
Locality workforce OD strategy	Manchester City Council related decision
Inclusion health	making e.g. Social Value Board and
Our Mcr Disability Plan progress	Resources and Governance Scrutiny
MHCC Engagement reports	Committee
Provider equality reports	Any future GM related functions

iii. Commissioning health, wellbeing and social care services

5.1 Everyone should have the same opportunity to lead a healthy life and to access high quality, safe and accessible health and social care services, no matter where they live or who they are. Health and wellbeing inequalities mean poorer health, reduced quality of life and early death for many people.

5.2 Health and wellbeing inequalities and unfair differences in health status between groups of people or communities are avoidable. Our health is determined by our genetics, our lifestyle, the health and social care that we receive and the impact of wider determinants.

5.3 We are committed to sourcing the very best health, wellbeing and social care for the diverse populations we serve in Manchester. We recognise that services need to be designed with equality, diversity and human rights (EDHR) at the core of business and decision-making. We also recognise that social value provides an opportunity to get a bigger return on our investment and reduce demand for services at the same time.

5.4 We are committed to eliminating unlawful and unfair discrimination and promoting equality of outcomes for our diverse population. We aim to do this by ensuring that the values underpinning equality, diversity and human rights are central to our policy making, service planning, employment practices and commissioning.

5.5 We are also committed to attracting, retaining and developing a diverse and skilled workforce, so that we can provide high quality effective services. Our vision is to make MHCC and the wider health, wellbeing and social care organisations inclusive organisations where everyone can realise their true potential. Social value will be an enabler in this respect.

5.6 The values that lie at the heart of MHCC's work are that we will be: positive, collaborative and fair.

MHCC's aims are to:

- Improve the health and wellbeing of people in Manchester
- Strengthen the social determinants of health and promote healthy lifestyles
- Ensure services are safe, equitable and of a high standard with less variation
- Enable people and communities to be active partners in their health and wellbeing
- Achieve a sustainable health and social care system

5.7 This resonates and sits at the heart of the 'Our Manchester' Strategy to radically improve health, wellbeing and social care outcomes through public services coming together in new ways to transform and integrate services.

5.8 There is little doubt that equality and diversity are central pillars of the ambitions of delivery of quality health, wellbeing and social care outcomes in Manchester. This strategy sets out the means by which we will deliver against those ambitions and lay the foundations for improvements in system wide collaborative plans for tackling health inequalities.

5.9 Given the scale of delivery across the health, wellbeing and social care provider base operating within the city, there is a real opportunity to collaborate to maximise social value to address inequalities.

6. The legal and policy framework

6.1 We work to a number of statutory and policy drivers, which underpin the equality and diversity agenda. The main pieces of legislation, standards, reviews and policy drivers are detailed in appendix 1[1] and shown in Figure 3. We will reduce unlawful discrimination in all of our functions by better embedding inclusion and social value within our processes and procedures such as contracting and monitoring as well as recruitment. Equally, we will ensure that our workforce is trained in all aspects of equality, diversity, human rights and social value and that this training is supported through our organisational development and leadership approaches.

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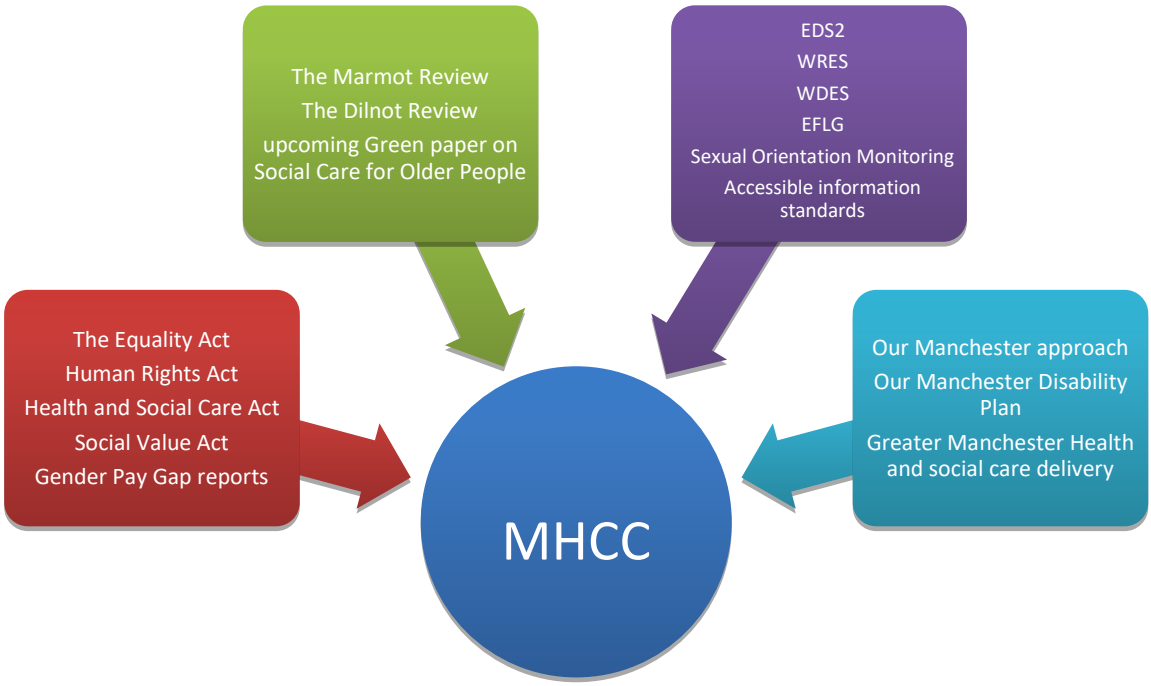


Figure 3 Equalities, Human Rights, Diversity and Social Value legislation and related strategies

7. How does MHCC compare with other health commissioners nationally?

7.1 In recent years, Manchester has experienced significant population and economic growth and a vastly improved physical infrastructure. However, the benefits of this growth have not been felt equally by all sections of the population or areas of the city and economic improvements have not been matched by similar improvements in health and social care outcomes or a narrowing of inequalities within Manchester.

7.2 Statistics consistently show that residents of Manchester still have some of the worst health outcomes in England. People living in Manchester continue to experience higher levels of ill health and early death than other major cities and local authorities in England.

7.3 Inequalities within the city also persist. The chart below shows the rate of preventable, premature deaths between people living in areas with varying degrees of deprivation.

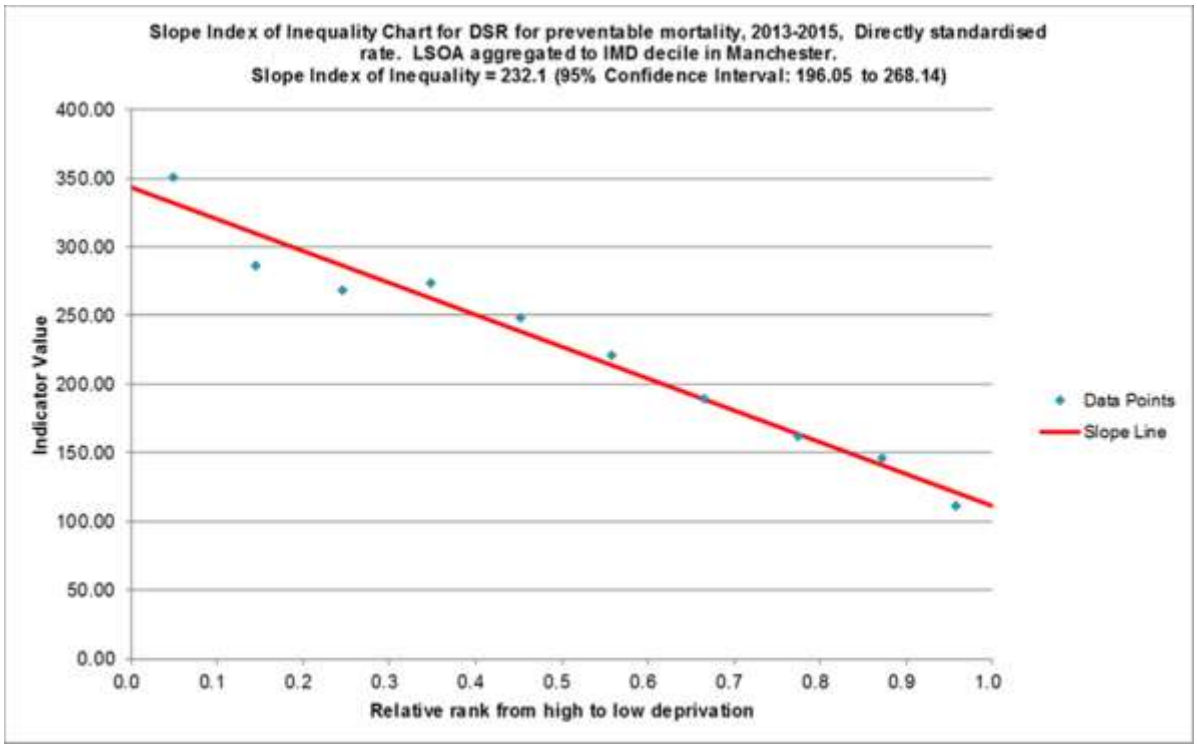
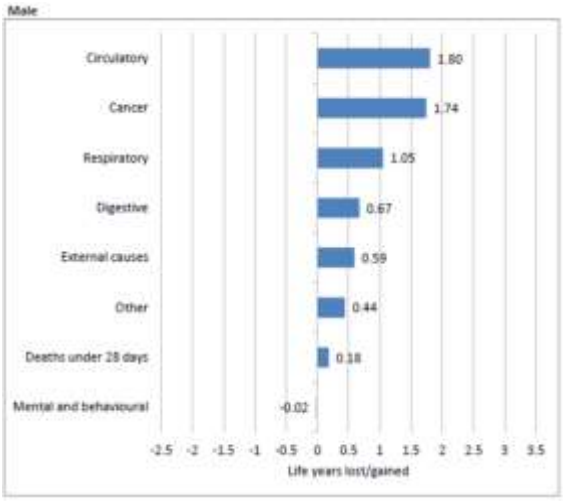
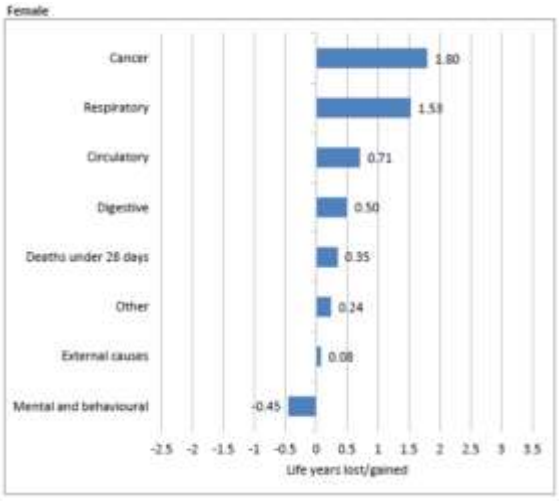


Figure 4

7.4 In the most deprived 10% of areas in Manchester there are, on average, 154 preventable premature deaths a year compared with 44 deaths a year in the least deprived 10% of areas. This means that there are 3.5 times as many preventable premature deaths in the most deprived parts of the city (primarily in the north east of the city and in parts of Wythenshawe) compared with the least deprived parts. Similarly, the rate of preventable premature deaths (which takes account of the number of people living in different parts of the city) is over twice as high in the most deprived parts of Manchester compared with the least deprived parts.

7.5 Research has shown that there is strong link between the level of inequality in society and the health of the population as a whole. Therefore, narrowing the gaps in health outcomes between people living in the most and least deprived parts of Manchester will have a big impact on improving the health outcomes of the city as whole. Analysis shows that if people living in the most deprived fifth of areas in Manchester had the same mortality rates as those living in the least deprived fifth of areas there would be significant gains in life expectancy in Manchester across a range of different causes of death (see charts below).





Figures 5 and 6

7.6 Socio-economic inequalities in health outcomes, such as preventable premature mortality are mirrored by similar inequalities in the use of health and social care services, particularly acute hospital admissions. In simple terms, the more deprived the neighbourhood that someone lives in, the sicker they tend to be and the more likely they are to require admission to hospital. Research has shown that people living in the most deprived fifth of neighbourhoods in England have 72% more emergency hospital admissions and 20% more planned admissions than people living in the most affluent fifth of neighbourhoods. Disabled people, people from BAME communities and women in particular are over-represented in these adverse outcomes. Whilst we have some data on the use of social care services, we do not know enough about how, for example lower take up of social care by some ethnic groups may impact upon secondary care.

7.7 The consequences of high levels of health inequalities are costly. Research led by the University of York found that the average hospital costs for the poorest people are almost 50% higher than those for the richest. As a result, socio-economic inequality costs the NHS in England £4.8 billion a year - almost a fifth of the total NHS hospital budget.

7.8 The social divide in hospital admissions varies dramatically across England. The worst performer on these 2015[2] York University led health equality indicators nationally was Central Manchester CCG. North Manchester and South Manchester CCGs were also in the bottom five.

7.9 Work to improve the coordination of care between specialties, between primary and hospital settings, and between health and social care is already underway in Manchester. For example, where patients are at risk of repeated hospital admissions for breathing difficulties that may need follow-up care in the community to check they are taking their medicines – services are coordinating. But to coordinate care effectively, managers need better information about health and social care inequalities within their local area and to be able to effectively engage with the diverse communities that live in Manchester.

[2]https://www.york.ac.uk/che/research/equity/monitoring/

8. Locality plan, neighbourhoods and geographical inequalities

8.1 Alongside other cities, one of the challenges Manchester face is dealing with significant place based inequalities. Pockets of significant poverty, worklessness and related health and social care inequalities exist across the city and must be tackled proportionately if we are to reduce health inequalities. Our Locality, Population Health and neighbourhood plans are the frameworks to do just that, although it will take some time to develop the mechanisms to prioritise funding and services within the Integrated Neighbourhood Team model.

8.2 However, less well embedded is a system wide approach that tackles disparities across protected characteristics[3]. Unequal protected characteristic outcomes are well recognised on the whole and our equality impact assessment processes will help us to know how to mitigate known disparities.

8.3 Social value will also be a key mechanism which will need to be embedded across organisations to address inequalities. To date, it has been used inconsistently in terms of commissioning and contract setting with our larger 'rolling' contracts and is very much at the early stages in terms of 'in-house' understanding and delivery.

8.4 Alongside this, we recognise other key community inequalities such as health outcomes for those who are homeless, sex workers, seeking asylum or other high health risk circumstances and take action to address these.

8.5 Whilst these are acknowledged, the process for determining disparities in inequalities outcomes is currently rather cumbersome in part and impact assessments are process rather than outcomes driven. This can result in a 'bolt on' approach that doesn't really get to the root of addressing community of interest inequalities and misses opportunity to drive better outcomes. Evidence of equality impact assessments is also scant in some areas and it can be hard to establish what will drive mitigating actions and measure changed outcomes.

8.6 Application of a human rights framework appears even less well embedded (across both health and social care provision in the city) and is often only considered after significant national or local legal cases bringing the issues to the fore.

8.7 This piecemeal approach is costing us significant resources and duplication of effort in part. That is why the inclusion and social value strategy highlights opportunities to streamline and integrate required activities across existing strategic and operational plans. Our approach will embed inclusion measurement and tracking processes from design stages through to delivery and outcomes.

[3] Protected characteristics are the nine groups protected under the Equality Act 2010. They are:
Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9. Systemic discrimination and context

9.1 With the existing legislation, policies, standards, tools and reviews – it might be expected that everything should be in place for us to deliver full inclusion in everything we do. However, income inequality is one of the defining challenges of our time. We also know that the stresses of poverty - where there is over representation of single women, black and minority ethnic people, disabled people, lesbian, gay, bisexual and transgender people - can often overwhelm the critical thinking skills that people need to develop and follow a pathway out of their living conditions - to break the poverty cycle. Low wage employment and zero hour contracts also have an impact and can reinforce a poverty life-cycle.

9.2 Translating evidence and policy recommendations into action can be challenging, especially when the aim is to convince, engage and mobilise several sectors and diverse stakeholders. The evidence on the wider determinants of health and understanding of the root causes of inequities is strong, and the imperative for action is higher on local political agendas than ever.

9.3 So this inclusion and social value strategy will aim to form part of creating the right conditions to help people move out of poverty by working with our partners across the city on the wider determinants of health. We will align the inclusion and social value strategy and delivery plan with partners for a whole system approach. In particular, this plan will support delivery of the 'Addressing Inequality' spine of the Our Manchester Strategy and the Work and Skills, Family Poverty strategies and Our Manchester Disability Plan which all feed into it.

9.4 Social care workers, medical staff and public servants all set out to do public good. Doctors take an oath to treat all patients equally, and yet not all citizens are treated equally, despite significant commitments to address disparities in outcomes. The answer to why is complicated.

9.5 We recognise that institutional discrimination is deeply ingrained in the structures of our society. For some, these differences result in unequal access to quality education; community participation; healthy food; liveable wages; affordable housing and so on.

9.6 The Equality Act 2006 gave the Equality and Human Rights Commission (EHRC) the duty to report regularly on the extent to which equality and human rights are improving in Britain. In their 2015 report on the state of the nation, they highlight the following 8 key priorities that are needed to tackle existing discrimination, which fit well with our renewed approach to tackle the wider determinants of health:

1. Improve the evidence and the ability to assess how fair society is.
2. Raise standards and close attainment gaps in education,
3. Encourage fair recruitment, development and reward in employment.
4. Support improved living conditions in cohesive communities.
5. Encourage democratic participation and ensure access to justice.
6. Improve access to mental health services and support for those experiencing (or at risk of experiencing) poor mental health.
7. Prevent abuse, neglect and ill-treatment in care and detention.
8. Tackle targeted harassment and abuse of people who share particular protected characteristics.

9.7 Redressing the imbalance to remove discrimination - this ingrained, or structural discrimination, as well as tackling implicit bias – are all parts of the jigsaw to creating the right conditions to providing a health and social care level playing field. This is why the Marmot review recommended the refocus on the social determinants of health and the whole system approach we are now delivering in.

9.8 The Manchester Joint Strategic Needs Assessments (JSNAs) include detailed information and evidence in respect of a number of groups known to experience inequalities in both health outcomes and their experience of using health and social care services, including black and minority ethnic (BAME) communities, lesbian, gay, bisexual and transgender (LGB and T) people, faith communities, adults experiencing homelessness and carers. Further reports will be produced in response to the requirements identified by the proposed inclusion and social value panel.

10. Commissioning better outcomes - Inclusion and Social Value

10.1 MHCC spends £1.1billion each year on buying goods, works or services from other organisations across every sector. The Public Services (Social Value) Act of 2012 calls for all public sector commissioning to factor in economic, social and environmental wellbeing. It means looking beyond the price of each individual contract and looking at what the collective benefit to a community is when a public body chooses to award a contract. The purchasing power that we have across the health and social care system can be used as a way to advance inclusion and improve health outcomes.

10.2 MHCC has taken the opportunity to build upon the MCC social value model and toolkit, including social value scoring within newly commissioned services, securing proportionate social value from our large providers as well as delivering social value in house through volunteering, offering work experience and changing the way that we recruit and support progression of BAME and disabled staff in particular.

10.3 The development of an approach to generating social value from health and social care activities and commissioning is set within a context of system transformation. This provides opportunities to utilise the good practice already in place and being developed through

Manchester City Council across the evolving health and social care infrastructure but also presents a need to think differently about how social value can be derived from services which are not commissioned through a competitive process; the majority of NHS (Clinical Commissioning Group) funding is spent on contracts which are negotiated annually. Our approach will be to increase the focus on social value within commissioning intention documentation and investigate the opportunities to use CQUINs to derive more social value from contracts.

10.4 The strong evidence base around work as a health outcome as set out in the Marmot review – being in good employment can protect health and wellbeing whilst unemployment can have short and long-term effects on health – makes the case for prioritising employment as a social value focus. Building in consideration of the need to coordinate health services which support people to move (back) into work within the Equality Impact Assessment is just one way that we can address poverty and poor health outcomes.

10.5 The Equality Act 2010 sets out anti-discrimination law and the requirements of the public sector equality duty (PSED). Compliance with the PSED will help MHCC to ensure that the goods and services we procure are fit for purpose thereby ensuring we meet the needs of our citizens. As such it should also be seen as an effective tool for improving economy, efficiency and effectiveness and therefore value for money.

10.6 Incorporating inclusion outcomes, where relevant and in a proportionate way, should be a normal part of designing and specifying the services we commission and deliver.

10.7 Inclusion outcomes are practical improvements for people who may experience discrimination and disadvantage and delivering them will help us to meet our strategic objectives. For example, an inclusion outcome might be an increase in the proportion of disabled people living in homes suitable for their needs, which would satisfy a strategic objective to support disabled people to live in the local community and reduce demand on health and social care services.

11. Human rights

11.1 Health and social care which respects, protects and fulfils our human rights also has an important role in ensuring we can all live dignified lives and participate as active members of our communities.

11.2 Human rights are the hallmark of a democratic and fair society; providing the rule book for how we treat our citizens. In this way, human rights provide a vital safety-net for us all, setting down in law the basic minimum rights that everyone should have simply because we are human.

11.3 A human rights approach means putting citizens and their legally protected rights at the centre of both policymaking and day-to-day practice. It should be applied to all areas of public life that affect human rights, including housing, education, policing, social care and health.

11.4 Healthcare and human rights have always had a close relationship. Seventy years ago, in 1948, the UK championed international human rights laws whilst at the same time creating the NHS. So it is hardly surprising that human rights values such as fairness, respect, equality, dignity and autonomy underpin our public health and social care service ethos, as well as the NHS Constitution, professional codes of conduct, and various health and social care laws and policies.

11.5 The Human Rights Act (HRA) is a "framework law", with legal duties on public authorities, including health and social care services, designed more for culture change than rafts of litigation. The HRA offers fresh ways into the age-old problem faced by health and social care services - how to keep citizens, rather than systems or targets, at the heart of delivery. Many human rights matters that have been tested through the courts have set precedents and transformed the way we work.

11.6 In health and social care, some of the more recent cases indicate where breaches of human rights have led to changing the way we commission and deliver services.

11.7 Our identified weakness on understanding and application of human rights both within and between health and social care features in this plan – in particular – the revised approach to inequality impact assessment will embed human rights considerations at the heart of decision making.

12. The changing landscape

12.1 We are grappling with significant reforms and meeting increasing needs in tighter economic times. An inclusion and human rights approach does not eliminate hard choices about where to spend resources, but it does help ensure fair decision-making to guide policy development, service redesign and resourcing decisions. Social value provides an opportunity to stretch our resources to support our inclusion objectives.

12.2 Using a well embedded inclusion and human rights approach can help clarify expectations of fair and dignified treatment and provide redress when standards fall short.

12.3 It can also provide the basis for ensuring and driving up quality as well as a tool to change the culture of services towards one that supports person centred approaches, co-production, safeguarding and personalisation. These are all approaches which are fully aligned with the Our Manchester approach.

13. Current known health and social care inequalities

13.1 Manchester's Population Health Plan 2018 - 2017 recognises that up to 80% of a population's health status is attributable to factors outside the health services and so adeptly streamlines the priorities across over 13 other related strategies around poverty , housing homelessness, education, work and a range of other social determinants of health.

The vision is that by 2027, the people of Manchester will be living longer, healthier lives and we will have narrowed the health inequalities gap within Manchester and between Manchester, the national average and other comparable cities.

13.2 Community reports tell us about the lack of access to health and social care services and the unequal outcomes. We receive a strong range of community health reports and enjoy strong stakeholder relationships with a wide variety of communities but their voices are not as embedded as they should be across the way in which we commission and deliver services. Providing an overview of these community reports to the proposed inclusion and social value panel will allow for greater transparency and informed decision making for the panel so that these reports do not go unheard and that they reach the parts they need to, to influence better outcomes for the future. The engagement tracker will feature in the new reports to the inclusion and social value panel, allowing the panel to understand how community reports are informing design and delivery of our programmes.

13.3 National trends and patterns through information such as the Office for National Statistics equality data monitoring will be made available to the inclusion and social value panel. What we know about our population and how and where it is forecast to change will also be a significant part of the input into the inclusion and social value panel to assist them to make informed decisions.

13.4 For example, if we take the forecast rate of growth in the resident population in Manchester compared to the GP list size, establishing how many people might potentially need to be registered with a GP in the future by protected characteristic would be invaluable in planning ahead to determine whether we have enough GPs to cope with the demand. This is a critical part of the development of the Integrated Neighbourhood teams.

13.5 Current forecast data indicates we might expect the total registered population in Manchester to increase from the current figure of around 628,000 to over 743,000 by 2026/27. Understanding more about the makeup of these increases will be important to shape the type of services we will need to develop. That is why we are beginning to monitor protected characteristic data on the new universal registration forms for GPs.

14. Future proofing

14.1 The Our Manchester Strategy (2016-2025) sets out the long-term vision for Manchester's future and provides a framework for action with partners across the city. The overarching vision is for Manchester to be in the top flight of world-class cities in 2025. The annual State of the City Report reports on progress in the following areas:

It will be a city:

- with a competitive, dynamic and sustainable economy that draws on its distinctive strengths in science, advanced manufacturing, culture, creative and digital business to cultivate and encourage new ideas
- with highly skilled, enterprising and industrious people
- that is connected, internationally and within the UK

- that plays its full part in limiting the impacts of climate change
- where residents from all backgrounds feel safe, can aspire, succeed and live well
- that is clean, attractive, culturally rich, outward-looking and welcoming.

14.2 According to the Manchester City Council Forecasting Model (MCCFM), the population of the City has increased by nearly a third since 2001 and forecasts indicate that this growth is likely to continue in the future. The MCCFM suggests that, by 2027, there will be over 661,000 people living in the city, up from 503,000 at the time of the 2011 Census. There has also been a similar increase in the number of patients registered with GP practices in the city.

14.3 Whilst we remain unclear as to what form Brexit will take, it is forecast to mean less money for public services generally, including the NHS, due to lower economic growth and productivity. This of course comes on top of existing funding pressures. Should these pressures become more acute after Brexit, there will be direct knock-on effects on waiting times, and thus recovery rates, as well as the quality of care that can be delivered.

14.4 In terms of staffing, EU nationals play a crucial role in health and social care services. Health and social care employers face the dual challenge of retaining skilled staff already in place and attracting sufficient numbers in future to fill vacancies. Traditionally, social care employment has not offered good working conditions in the main. Addressing this forms part of the social value part of this strategy and accompanying delivery plan; by signing up to the Ethical Care Charter and supporting our supply chain to make use of the apprenticeship levy to train their workforces, we can start to effect lasting change.

14.5 This type of foresight into potential future impacts on tackling health inequality outcomes will be an important part of the intelligence that will support the inclusion and social value panel.

15. The inclusion and social value strategy

15.1 We have taken the opportunity to embed community reports and stakeholder engagement into intelligence gathering to inform commissioning and workforce development. This will be supported by a revised approach to governance as described earlier.

15.2 Five of the early actions in year one of the delivery plan which support the strategy will be as follows;

- Refining inclusion/EDHR governance structures and recognising the place of social value within this work, enabling a single inclusion and social value panel to make informed decisions more holistically, system-wide from commissioning stages through to delivery
- The review and consolidation of the equality impact assessment process
- Improving the use of quantitative, qualitative and anecdotal evidence to inform decision-making and service improvement. The Manchester Joint Strategic Needs

Assessment (JSNA) is a vehicle for bringing together the rich and varied sources of inequalities intelligence to form a cohesive narrative on impacts to inform future actions

- Building up understanding and delivery of social value as an enabler both in house and within commissioning and procurement – commitment to a 20% minimum score for social value where MHCC is commissioning services and strengthened requirements for providers with rolling contracts through the annual contract negotiation process.
- Beginning to shape a better cultural understanding of human rights

15.3 Building these foundations will help enable longer term actions to address the systemic discrimination that remains through the accompanying delivery plan. It will also allow for performance indicators to measure impact on closing inequality gaps rather than simply improving individual equality outcomes and succinctly capture system wide risks, issues and mitigating actions.

Appendix 1 - Relevant legislation, policies, standards and reviews

The Equality Act 2010

This Act requires everyone to have equal access to employment as well as to private and public services, regardless of age, disability, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief, sex and sexual orientation.

These characteristics refer to the groups of people who are specifically offered protection by the Equality Act. Every person has one or more of the protected characteristics, and so the Act protects everyone against unfair discrimination.

We use Equality Impact Assessments in the design and delivery of our employment and service delivery in order to determine where detriment or adverse impact on protected characteristics can be eliminated.

The Equality Act introduced a public sector equality duty which consists of a general duty and specific duties. As required under the act, Manchester Health and social care Commissioning produce an Annual Equality Report which provides information on how the general equality duties are being met, along with information relating to workforce and services.

Human Rights Act

The Human Rights Act 1998 (HRA) came into force in 2000. Everyone in the UK is protected under the Act. MHCC as a public authority is obliged by law to respect the basic human rights of all citizens. As a public body we must at all times act in a manner compatible with rights protected in this Act and safeguard these for patients and staff in our care and employment.

Human Rights are underpinned by a set of common values and have been adopted by the NHS under the acronym FREDA. Whilst there is some recognition of human rights principles in delivery in services, there is less so in the design of services – and we need to embed a greater sense of meeting human rights right at the beginning of shaping up services for greater cost effectiveness. Consideration of Human Rights is also given in our Equality Analysis process, to ensure that our policies and strategies are compatible with the rights afforded by this Act.

Human Rights Cases

In 2014 the Cheshire West case - where the living arrangements of three mentally incapacitated people were judged as being a breach of their right to liberty. "A gilded cage is still a cage", said the Supreme Court. Mentally incapacitated people had the same rights as everyone else – and deprivation of liberty should a key consideration for all commissioners of care to ensure they do not breach citizens' human rights.

The Rathbone case in 2012 changed the way hospitals need to consider their duties under article 2. In this case, a hospital should have done more to prevent the suicide of Melanie Rathbone, a voluntary mental health patient. She was at an immediate risk of suicide, so the hospital had a duty to protect her right to life.

The Eweida case, heard in 2013, requires employers to consider potential breach of article 9. Mrs Eweida, a British Airways employee, was prevented from wearing a visible Christian cross with her uniform. She won her case - her right to religious freedom had been violated. BA changed its policy.

Health and Social Care Act 2012

The Act builds on the core principles and values of the NHS – a comprehensive service that is available to all, based on need and free at the point of use. It charges the National Commissioning Board with an explicit duty to address inequalities in outcome and achieve fair equitable access to health services.

MHCC is committed to upholding the NHS Constitution which outlines a number of commitments and pledges to uphold patient dignity and human rights.

The Public Services (Social Value) Act 2012

This Act calls for all public sector commissioning to factor in or have regard to economic, social and environmental well-being in connection with public services contracts; and for connected purposes. This Act is a tool to help commissioners get more value for money out of procurement. It also encourages commissioners to talk to their local provider market or community to design better services, often finding new and innovative solutions to difficult problems.

Manchester City Council (MCC) and MHCC are keen to make sure that our supply chains contribute as much as possible to the overall wellbeing of our residents and we therefore include social value as part of the procurement process. In 2015 the Council increased its weighting for social value considerations from 10% to 20%, meaning that all companies and organisations bidding for our contracts have to give social value serious consideration when putting tenders together.

MCC Social Value toolkit
www.manchester.gov.uk/info/200095/tenders_and_contracts/2612/business_opportunities_and_working_with_us/12

Policy and standards

NHS Equality delivery system 2 (EDS2)

The main purpose of the EDS is to help NHS organisations, in discussion with local partners including local people and NHS staff, to review and improve their performance for people with characteristics protected by the Equality act 2010. By using the EDS2, We are also helped to deliver on our Public Sector Equality Duty.

Workforce specific standards

NHS Workforce Race Equality Standard (WRES)

NHS England has introduced a Workforce Race Equality Standard which requires organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BAME Board representation.

NHS Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant organisations to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality. MHCC and its providers are committed to meeting the standards which will flow from these metrics once finalised later this year.

The Equality Framework for Local Government (EFLG)

The Framework comprises five performance areas: Knowing your communities; Leadership, partnership and organisational commitment; Involving your communities; Responsive services and customer care; a skilled and committed workforce.

In addition, it has three levels of achievement: 'Developing', 'Achieving', 'Excellent'

Manchester City Council has been rated as ‘excellent’ under the Equality Framework for Local Government (EFLG) by peer review and it continues to drive forward its’ commitment to mitigate potential adverse impact on people from protected groups or other residents where this is possible and appropriate..

Gender Pay Gap report

By April 2018, public, private and voluntary sector organisations with 250 or more employees have had to report on their gender pay gaps, using six different measures. MHCC Gender Pay Gap report

Service delivery specific standards

Accessible Information Standards -

NHS England has provided a standard for ensuring information is accessible for all. The standard aims to specifically improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision making about their health, care and well-being.

Our Manchester Disability Plan OMDP (Incorporates meeting Disability confident standards)

Disabled people face significant barriers, and experience disadvantage and discrimination accessing services, opportunities and facilities in Manchester. The Our Manchester Disability Plan (OMDP) is Manchester's pledge to support disabled people in Manchester to remove these barriers so they can fully integrate into all the opportunities, facilities, activities and communities in the city.

The Marmot Review 2010

The Marmot Review into health inequalities in England proposed an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.

The report, titled 'Fair Society, Healthy Lives', proposed a new way to reduce health inequalities in England post-2010. It argued that, traditionally, government policies had focused resources only on some segments of society. To improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across the social gradient.

Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the national annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS. The report argued that action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community.

Dilnot Commission into social care

The current social care system provides care for adults of working age and older disabled people and people with mental health problems, sensory loss or general 'frailty'. Personal and practical support can be provided in a care home, in the community, in hospital or in someone's home.

For those with less than £14,000 in capital and savings the system covers the cost of all care, but pays nothing for those with more than £23,250. Dilnot said that in its present form it creates a "massive sense of inequity and encourages a significant amount of cheating". Changes to the means test were due to come into effect in April 2016 but have been delayed until April 2020, after which the £23,250 upper limit will be raised to £118,000 and the lower limit to £17,000.

Appendix 2 – Evidence pack

MHCC Workforce

The first NHS Workforce Race Equality Scheme (WRES) report for the Manchester CCGs was published in July 2016, followed the report in July 2017. In the first two years, there have been improvements in some areas, although as outlined in the report there is still some way to go to ensure representation is reflective of the population of the city. We are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the numbers of BAME board members supporting the governance of the organisation.

Manchester Health & Care Commissioning	**Headcount 365**
Comprising:	
NHS Manchester Clinical Commissioning Group	**273**
Manchester City Council	**92**

Proportion of BAME staff as at 31 March 2018 (MHCC): Table 2

Proportion of BAME staff within the organisation	**BAME Workforce (Headcount)**	**BAME Workforce (%)**
Manchester Health & Care Commissioning	**61**	**16.71%**
Comprising:		
NHS Manchester Clinical Commissioning Group	**49**	**17.95%**
Manchester City Council	**12**	**13.04%**

Black and Minority Ethnic (BAME) employees make up 16.71% (excludes White British, Irish and any other white category) of MHCC's total workforce. The local BAME population of Manchester is approximately 36.2% (this includes all ethnic groups except White British and White Other). MHCC appears to be on the journey to becoming a more diverse organisation, some this may be also be attributable to improvements in the quality of the information held and gathered on ethnicity.

Proportion of staff who have self-reported their Ethnicity: Table 3

Proportion of total staff who self-reported their ethnicity	**Total (Headcount)**	**Total Workforce (%)**
Manchester Health & Care Commissioning	**334**	**91.51%**
Comprising:		
NHS Manchester Clinical Commissioning Group	**255**	**93.41%**
Manchester City Council	**79**	**85.87%**

The above table shows that overall 91.51% of the MHCC workforce have reported on their ethnicity; broken down by completion rates of 93.41% for MCCG and 85.87% for MCC. 8.4% of employees across MHCC had either incomplete ethnicity details or chose not to state or did not wish to disclose their ethnic origin.

Percentage of staff in each of the AfC Bands 1 - 9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce

2018			
	BAME	**White**	**Not Stated/Unspecified**
AfC Pay Bands 1-4	21.15%	71.15%	7.70%
AfC Pay Bands 5-7	17.09%	75.21%	7.69%
AfC Pay Bands 8a to 9	17.17%	77.78%	5.1%
***Executive Senior Manager**	14.3%	85.7%	0%
2017			
	BAME	**White**	**Not Stated/Unspecified**
AfC Pay Bands 1-4	20.63%	68.25%	11.11%
AfC Pay Bands 5-7	13.04%	76.52%	10.43%
AfC Pay Bands 8a to 9	10.2%	84.69%	5.1%
***** **Executive Senior Manager**	33.3%	66.7%	0%

*ESM includes Executive Directors who are paid outside of Agenda for change

The table above relates to MCCG employees only, between AfC bands 1 – 9, however for ESMs the 2018 data includes Executive Directors who are outside of the Agenda for Change pay structure; this does not apply to the 2017 data as MHCC had not been formed at that time. There has been some improvement in BAME representation across all grades for the past year.

The most significant increase has been in AfC bands 8a – 9 which have seen an increase from 10.2% in 2017 to 17.17% in 2018. AfC bands 1- 7 have also seen a considerable improvement in the quality of the information held with a reduction in the unspecified category over the past year.

Executive Senior Managers is at 14.3% which is a change from last year's figure of 33.3%. This is as a result of including Executive Directors who are outside of Agenda for Change in this year's report to reflect the senior management makeup of MHCC.

Comparative Workforce Data 2015-2018

Year	**2018**	2017	2016	2015
BAME	**17.95%**	14.4%	13.6%	11%
White	**75.56%**	77.2%	76.2%	78.8%
Not Stated/Unspecified	**6.59%**	8.4%	10.2%	10.2%

The above table shows there is a gradual year on year increase of BAME employees within the CCG. In 2015 the workforce was at **11%**, whereas in 2018 the workforce is at **17.95%.** Improvements in data quality, in relation to non-stated/unspecified, have also been

improving year on year. It should be noted that the workforce both in the CCG and across MHCC is still not reflective of the local population which is in the region of 36.2%; however, the general direction of travel is positive.

Appendix 3 – Recent Findings on Health and Care Outcomes

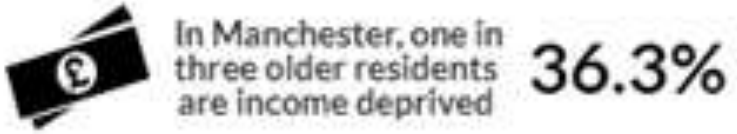
Here we have drawn highlights from some of the most recent findings – either from our in house research and intelligence functions or by listening to our communities. This provides a snapshot of some of the qualitative and quantitative evidence that we have around inclusion in terms of service delivery.

General

- One of the fastest growing cities in England
- Poor air quality is a significant public health issue
- Significant variation in health outcomes across the city

Age

- Younger age structure
- Less likely to be school ready
- Obesity an issue, higher prevalence across some BAME communities
- Isolation as issue, particularly with some LGB and T communities



Adult Social Care in Manchester

- The latest published report of Manchester Adult Social Care activities references the creation of an extra care facility for older LGBT to address in part the experience that many older LGBT people had of homophobia.

- The report does not provide a breakdown of take up of services by protected characteristics. The 2017/18 report will include some information on referral and take up of service by gender, age, learning disability and ethnicity.

Migration

- 2015 saw 18,000 new migrant registrations by GP practices in Manchester
- A rate of 33.1 per 1,000 resident population.

18,000

New migrant GP registrations in 2016

33.1 per 1,000 residents compared to 12.1 for England

Source: ONS, NISRA, Patient Register Data Service (PRDS)

Ethnicity

- 41% BAME in Manchester
- 90 detailed ethnic groups
- Significant BAME health inequalities in physical and mental health outcomes

149th
out of
150
local authorities

Heart disease and Stroke - 150th
Lung disease - 150th
Cancer - 149th
Liver disease - 145th
Injuries - 144th

539
premature deaths per 100,000

Source: Public Health England. - Healthier Lives tool

Gender

- White British women have similar rates of illness as White British men.
- White Gypsy or Irish Traveller women - high rates of limiting long term illness
- Black/Black British women more likely to have experienced a common mental health disorder in the past week.
- One in five women in England and Wales have experienced some type of sexual assault since the age of 16
- The mortality rate from suicide in Manchester in 2013-2015 was 16.4 per 100,000 males, compared to a rate of 4.6 per 100,000 females in the same time period.


Disability
improve information provision and accessibility
Disability awareness training
low uptake of learning disabled people and health screening
Manchester's disabled people tell us we need to:
engage and involve disabled people
use BSL interpreters and make reasonable adjustments
improve attitudes towards disabled people

Transgender and non-binary

- 80% of trans people experience anxiety before accessing hospital treatment due to fears of insensitivity, misgendering and discrimination
- Lack of Gender Identity services
- non-binary people report being denied treatment due to their gender identity
- Lack of available monitoring

Sexual orientation

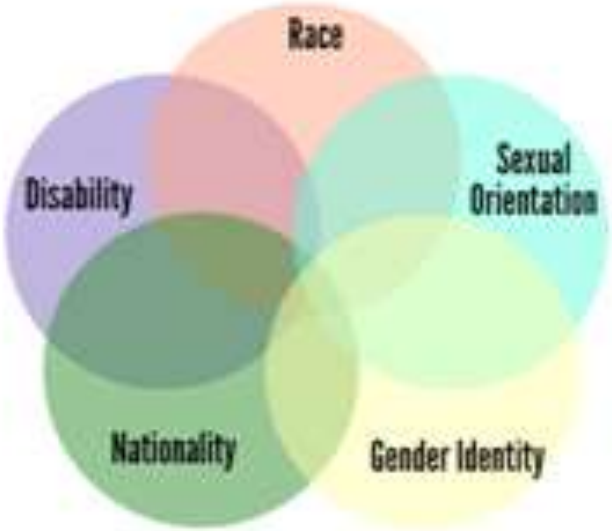
- LGB Mancunians report negative experiences of healthcare
- Bisexual women are more likely than heterosexual women to experience mental ill health
- 14% of lesbians in Manchester have been actively refused or discouraged from having cervical screening test by a health professional
- Significant barriers exist to seeking information, advice or help among LGB people

Religion and belief

- Faith-based groups are actively engaged in delivering and supporting community health and health-care activities and services in Manchester.
- Hospital Chaplaincy services play an important role in providing pastoral, emotional, religious and spiritual support to patients, visitors and staff, primarily in acute care settings.
- Inclusive practice means considering different diet, modesty, cultural practice and beliefs when providing services.
- Differences in religious faith-based viewpoints on human life, acceptable behaviour, health-care technologies and health-care services also exist. These can include family planning, child protection, stigma and harm reduction, blood transfusion, sexual and reproductive health and HIV, gender and end-of-life issues.

Intersectionality (Compounded Discrimination)

- Paucity of data
- Intersectionality of identity is not always considered in service provision
- disproportionate health inequalities experienced by LGB people are likely to be exacerbated for BME LGB people



Homelessness

- Manchester has a major challenge in dealing with the impact of homelessness on health, not just the rough sleeping population but also those living in Bed and Breakfast and hostel accommodation and those families registered as homeless.

Asylum seekers and refugees