Bury Council

Health Inequalities In Bury

BURY LET'S Do It!

June 2023

Foreword

‘In Bury we understand the wide-reaching impact of inequalities and the importance of working together to address these. We believe that everyone deserves the same opportunities to lead a healthy life, no matter where they live or who they are.

But in Bury today there is a gap in life expectancy of almost 8 years between the most and least affluent wards in the borough. Closing this gap is one of the biggest challenges we face so we must keep a relentless focus on inequalities in everything we do. A key part of this is reinforcing the message that health is about much more than healthcare or the choices we make about our diet or whether we exercise, smoke or drink alcohol. It is a result of wider social injustices that contribute to certain groups, including those living in the most deprived communities spending more years in ill health and dying sooner.

Councillor Tamoor Tariq
Deputy Leader and Cabinet Member for
Adult Care, Health and Wellbeing

We are clear that the best way of ensuring a long life in good health is to have a good start in life, a good education, a warm and safe home and an income sufficient to meet our needs.

We understand that reducing health inequalities is about jobs that local people can get, decent housing and preventing people becoming isolated, and as such recognise that places and communities have a critical role to play.

If we all work together to get this right our neighbourhoods will be more productive and prosperous. As a result people will be more likely to stay well for longer, stay in their home for longer when unwell, and stay in work for longer. This will then assure that health and wealth are truly aligned and support us in our aim of reducing inequalities.’

Foreword *continued*

‘Health inequalities are the most pernicious form of injustice, making it the most pressing issue for us to tackle as a health system.

By placing particular emphasis on solutions like tackling the social determinants of health and enhancing community power, this paper is an innovative and bold plan to do just that.

The success of this plan must be judged on whether residents can live the healthy lives that we all deserve.’

Councillor Nathan Boroda
Deputy Cabinet Member for
Health and Wellbeing

‘Tackling health inequalities is a key priority for us. I am proud to have been chosen to be Bury Council’s lead on improving women’s health and am proud to support this paper as an important step to do so.

I am pleased to see that the report includes important steps like early intervention and treatment for women; improved diagnosis and working with community groups.

In recent years, Bury has developed a great range of activities for women including, cycling, boxercise, self-defence and hikes- to name just a few! Going forward we must develop this and continue to work together towards better support for menopause.’

Councillor Ummrana Farooq
Deputy Cabinet Member for
Communities

Tackling health inequalities remains a key priority for this council. I’ve been delighted to play a part in that, with specific input into improving SEND outcomes for Bury’s children.

This paper is an important recognition and a formalisation that partners from across Health & Children’s Services will, are committed to working together to reach our objective that all children should have the same opportunity to reach their own unique potential.

Councillor Tom Pilkington
Deputy Cabinet Member for
Health and Wellbeing

Summary

- [1]Health inequalities are differences in health between groups of people that are avoidable and unfair. This means people dying years before their time and spending more of their lives ill.

- [2]Health inequalities are caused by differences in access to the basic building blocks of health. These include good jobs and enough money to live well, safe affordable homes, healthy food, healthy environments, and high-quality healthcare.

- National evidence and, where available, local data describe a range of inequalities in health among Bury's residents. This includes inequalities: between people living in more and less deprived parts of the borough, between residents of different ethnic backgrounds, faiths, genders, sexual orientation and other protected characteristics. People with learning and physical disabilities, with severe mental illness, people experiencing homelessness, people in contact with the criminal justice system, and asylum seekers experience some of the starkest inequalities in health.

- The Bury LET'S Do It strategy is a health inequalities strategy. A major aim is to improve quality of life as measured by inequalities in life expectancy. Its other aims address many of the most important building blocks of health. A wide range of action on health inequalities flows from this.

- Bury's Health and Wellbeing Board brings system partners together around a model of population health that emphasises action on the building blocks of health, healthy behaviours and lifestyles, healthy places and communities, and healthcare services.

- A wide range of work is happening on health inequalities. Examples include work on coronary heart disease, the leading cause of the gap in life expectancy; vaccinations; in early years; on inclusive economic growth; and community involvement.

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Summary of work ongoing against King's Fund 'population health' model.

The table below lists some of the activity happening in Bury to reduce health inequalities. These are grouped into the four quadrants described in the King's Fund's 'A Vision for Population Health'. As the King's Fund notes, these four quadrants overlap, and many actions fit in the overlaps. For example, action on licensing and planning for alcohol and fast food sales affect the environments we live in but also help improve health and lifestyles.

The Wider Determinants of Health

- Bury council becoming a real living wage employer.
- Promoting healthy workforce charter.
- Input of health into the development of the economic strategy which is essential in reducing inequalities.
- Commission a strong infrastructure organisation which helps to facilitate, support and coordinate voluntary sector organisations to work together effectively across Bury.
- Facilitated cost of living summits.
- Work to target advice to communities at higher risk of excess winter deaths on support with heating bills, and potential support with housing energy efficiency (linking to local energy advice partnership).

Health and Lifestyles

- Having a physical activity strategy that focuses on increasing activity among the least active and in all our communities.
- Having a robust active travel plan which includes significant infrastructure investment, the development of a walking and cycling forum and the role out of bike libraries
- Having a food and health strategy that takes account of food affordability and availability.
- Developing a new wellness service focussed on improving equity.
- Developed drug and alcohol plan which supports ensuring those who experience greatest inequalities get proportionate support.
- Having a robust stop smoking support offer and tobacco control strategy targeting those with highest smoking rates e.g. SMI and routine and manual workers.

The Places and Communities we Live

- Developing a licensing matrix to identify where new alcohol outlets are proposed in areas of already high supply, consumption, and harm.
- Work on developing policies on where new fast-food venues can be opened.
- Worked with grass roots organisations who specialise in hearing community voices through creative methods to engage individuals and groups who may have not previously had their voices/stories heard.
- Promoted PSR and work with and through communities in the form of integrated neighbourhood teams and more latterly the development of the children and family hubs.

An Integrated Health and Care System

- Targeted and tailored vaccination programmes based on data of low uptake rates e.g. work with Jewish community around covid vaccination, working with schools to increase HPV uptake
- Tailoring services to provide place-based services for those who have difficulties accessing services e.g. providing substance misuse clinics in Radcliffe
- Developed the Health and Wellbeing Board as a standing commission for health inequalities where all items need to demonstrate how they are reducing health inequalities and promoting inclusion.
- Developed a cancer inequalities muti-agency working group to identify and address issues contributing to cancer inequalities.
- Supporting work to improve cancer screening programmes and reducing inequalities in bowel cancer screening in East Neighbourhood.

What are health inequalities?

- Health inequalities are differences in health between groups of people that are avoidable and unfair. This means people are dying years early and spending more of their lives ill.

- [3]For example, in England, life expectancy for men in the most deprived areas is more than 10 years lower than for men in the least deprived areas. For women, the gap is over 8 years. Inequalities in health in England got worse from 2011 to 2019, before the COVID-19 pandemic widened inequalities further.

- [4]Health inequalities are caused by differences in access to the basic building blocks of health. These include good jobs and enough money to live well, safe affordable homes, healthy food, healthy environments, and high-quality healthcare.

- [5]Health inequalities are often described in terms of differences between people living in more and less deprived areas. But they also exist between people of different ethnic backgrounds, religious faiths (or no faith), sexual orientation, those with and without mental illness or learning disabilities, and other protected characteristics.

- [6]Health inequalities are built over a lifetime. Children born into poverty are more likely to experience things like poor nutrition, poor housing, stress and trauma. This makes it harder to do well at school, which in turn affects the jobs open to them. This then causes lower incomes, limiting access to good housing, good food, and so on.

- [7]Health inequalities do not only affect the worst-off. Although people in the most deprived places suffer the most harm, even people living in relatively affluent areas have worse health on average than those living in the most affluent areas.

- [8]Health inequalities are not inevitable. They can be reduced by improving access to the building blocks of health. For example, there is strong evidence that even small increases in income can improve mental and physical health by enabling access to better housing, better food, and by reducing stress.

- [9]Although universal access to good healthcare is important for reducing health inequalities, the NHS was never meant to tackle health inequalities alone. Analysis shows that over the longer run, improvements in the building blocks of health, like living standards and housing, play a bigger role in improving health than healthcare. But where access to healthcare isn't equal, healthcare can widen health inequalities.

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[1]For an evaluation of progress made on health inequalities in England between 1997 and 2010 see Barr, Higgerson, & Whitehead (2017) **Investigating the impact of the English health inequalities strategy: time trend analysis.**

[2]E.g. see Senior, Caan, & Gamsu (2020). **Welfare and well-being: towards mental health-promoting welfare systems.**

What do we know about health inequalities in Bury?

Geography & deprivation

- This section describes what we know about health inequalities in Bury. What we can say is limited by what data are available. Most data is available comparing the health of people more and less deprived places in Bury. Where local data are not available, I describe what we know from national data and published research.

- [10]The most common way to describe health inequalities is between people living in more and less deprived places. This paper uses electoral wards, but it is important to bear in mind that deprivation and health can vary substantially within a ward. This means health inequalities appear smaller when measured between wards than between smaller areas.

- [11]Chart A (next page) shows death rates from all causes and at all ages for electoral wards in Bury. The wards are arranged from the most deprived at the top to least deprived at the bottom. The chart shows the tendency for more deprived areas to have lower life expectancy. East, Moorside, and Radcliffe west stand out as having the lowest male and female life expectancy and are Bury's three most deprived wards. The gap between the ward with the highest life expectancy and the ward with the lowest life expectancy is 7.1 years for males and 7.3 years for females.

- [12]The gap in life expectancy is caused by higher rates of death from several major killers in more deprived areas including heart disease, stroke cancers, liver disease, and (in 2020 and 21) COVID-19.

- [13]There are also stark inequalities in illness and disability across Bury. The major causes of illness and disability in Bury are low back pain and musculoskeletal conditions, migraines, mental illness particularly anxiety and depression, and diabetes.

- [14]Chart B shows relative levels of receipt of working age illness and disability benefits across different wards in Bury. The effect is that not only do people in more deprived areas die early, they also spend more years living with illness and disability.

- [15]Inequalities in work-limiting illness and disability are especially pernicious because they limit employment, and through that access to building blocks of health like money, housing, and quality food.

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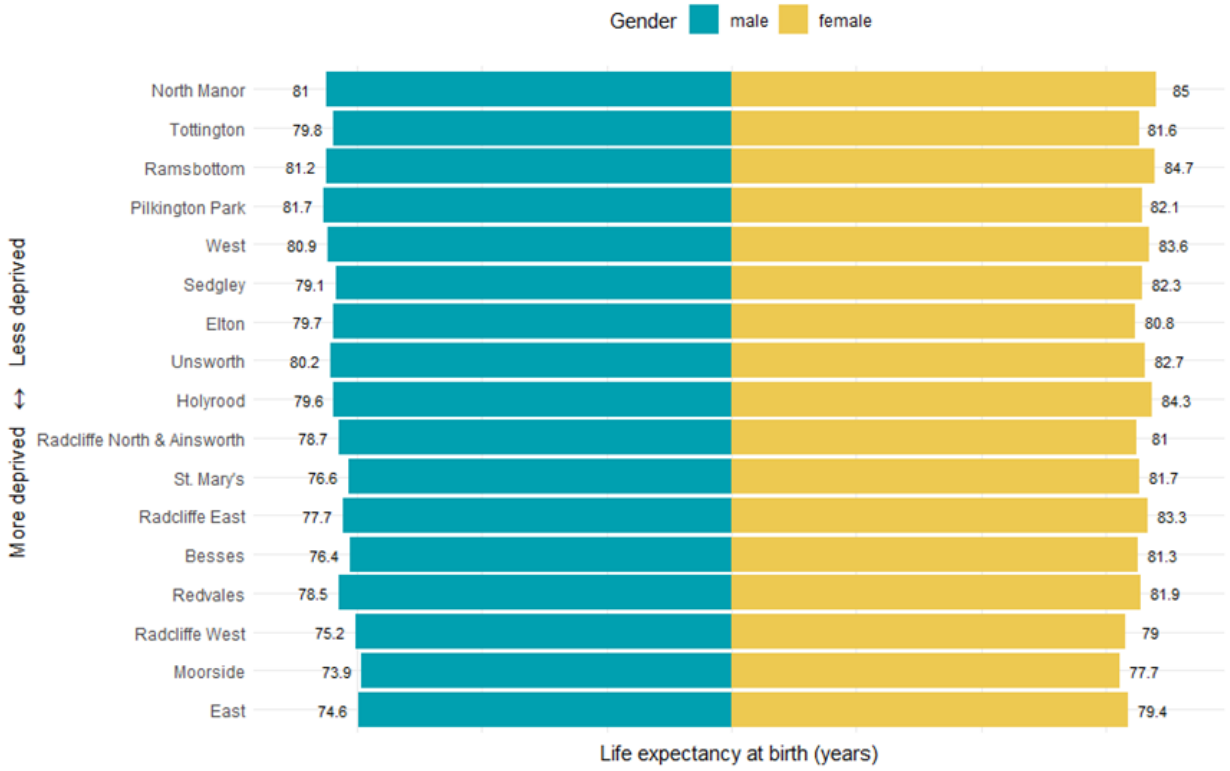
[3]*Source:* **OHID Local Health** *For visualisations of a range of health data across Bury's electoral wards, please see the* **Bury Ward Profiler** *on the Bury JSNA website.*

What do we know about health inequalities in Bury?

A

Inequality in life expectancy at birth for males and females.

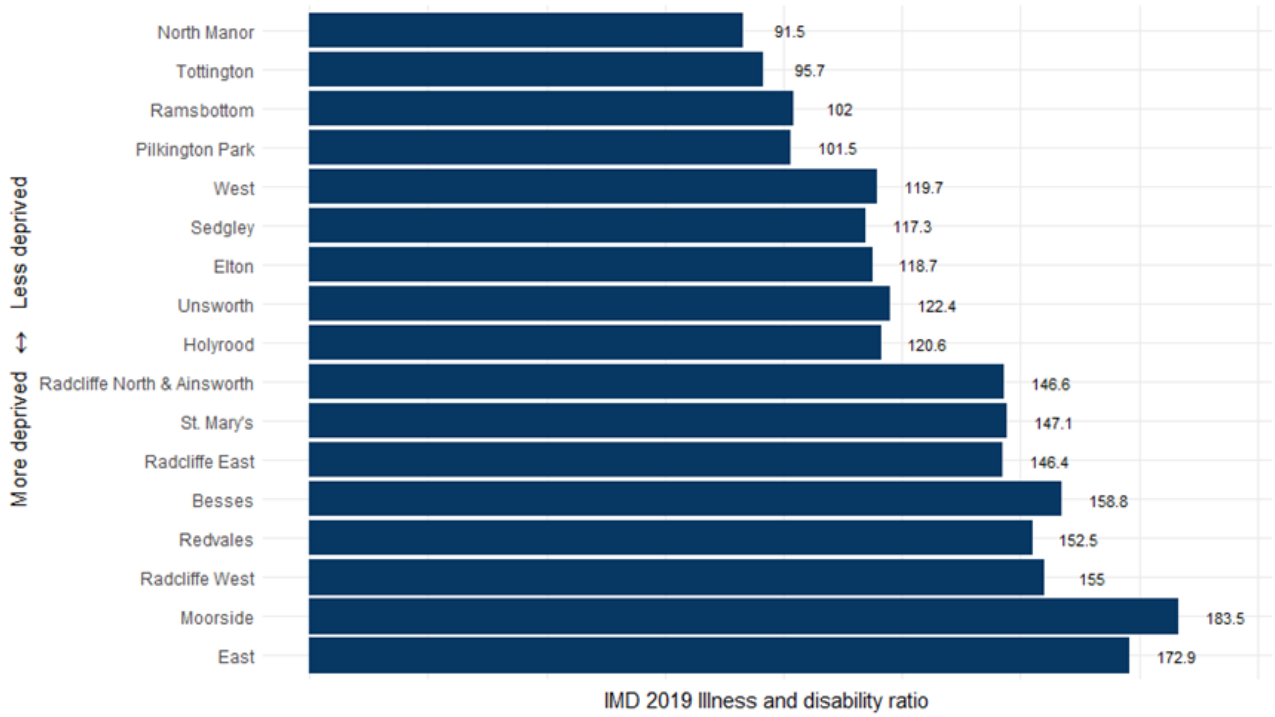
Bury electoral wards. 2016-2020.



B

Inequality in illness and disability

Bury electoral wards. 2016 data.



Relative numbers in receipt of working-age illness and disability benefits by ward. The national average is 100. Lower values indicate lower levels of illness and disability benefit claimants. Higher values indicate higher levels of claimants .

What do we know about health inequalities in Bury?

- [16]Health inequalities make themselves felt from the start of life. Infant and child mortality are closely linked to poverty. Uptake of childhood immunisations is lower among children from more deprived families. Child development as measured by school readiness is lower for children who are eligible for free school meals (54.4%) compared with all children (71.4%) .

- [17]These inequalities cascade forward and appear later as worse educational outcomes, worse employment prospects, higher rate of harmful health behaviours like smoking, alcohol consumption, and physical inactivity. This leads to the inequalities in work-limiting illness and death shown in the graphs above.

- [18]Inequalities in disease are compounded if there is unequal access to healthcare or if healthcare is lower quality. Although the NHS principle of access according to clinical need and free at the point of use limits inequalities in care, other inequalities in access or quality remain. GP practice funding does not fully account for the differences in needs for healthcare between populations. As a result, GP practices serving more deprived communities tend to have fewer GPs per patient .

- [19]Despite this, available data suggest that satisfaction with measures of access to primary care is not worse in more deprived parts of Bury . There is, however, evidence of inequality in uptake of important preventative measures, such as vaccination and screening programmes.

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[4]Source: **OHID Child Health Profiles.** *This compares with 56.5% of children eligible for free school meals and 71.8% of all children across England (most recent data are from 2018/19).*

[5]A phenomenon called the Inverse Care Law, first described over 50 years ago by the GP Julian Tudor-Hart. For further detail see **https://www.kingsfund.org.uk/publications/articles/inverse-care-law**

[6]Source: **OHID National General Practice Profiles.**

Both of which are currently being addressed by national government and agencies.

What do we know about health inequalities in Bury?

Ethnicity

- [20]Differences in health between ethnic groups are less well understood than between groups living in areas of deprivation. This is partly because ethnicity information is not included on death certificates and is often poorly captured by health systems. But the patterns of illness and death are also more complicated when looked at according to ethnicity.

- [21]Local data on ethnicity and health are limited. National data from the Office for National Statistics (ONS) suggest that people of White and mixed ethnic backgrounds had lower life expectancy than other ethnic groups before the COVID-19 pandemic. Part of the reason for this is migrants are healthier than average (because ill people tend not to move countries).

- [22]However, the COVID-19 pandemic hit many ethnic minority communities harder, driving overall death rates higher in Bangladeshi and Pakistani men and women and Black Caribbean men and equalising death rates among other ethnic groups. This is likely due to a combination of factors, such as greater employment in work that could not be done from home and with limited sick-pay entitlements, higher levels of overcrowded housing, and of long-term illnesses. This illustrates how unequal access to the building blocks of health interacted with the pandemic to worsen inequalities.

- [23]People from most ethnic minority groups report worse health and more limiting long-term illness than White British people. Some ethnic minority groups also experience worse child health, including higher rates of stillbirths, lower levels of childhood physical activity, and higher levels of obesity. Many of these issues are caused by differences in access to the building blocks of health: for example, levels of unemployment, poverty, and overcrowded housing are higher among South Asian and Black ethnic communities.

- [24]Experience of healthcare is also often worse for people from ethnic minority backgrounds. This includes experiences of racism and discrimination. Uptake of preventive measures like vaccination and screening tend to be lower among ethnic minority communities, especially people from South Asian backgrounds. Local data on COVID-19 vaccine uptake is consistent with this.

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[7]*Source: King's Fund (2021).* **The health of people from ethnic minority groups in England.**

[8]*Source: Public Health England (2020).* **Disparities in the risks and outcomes of Covid-19.**

What do we know about health inequalities in Bury?

Religion

- [25]Even Less is known about inequalities in health between people of different faiths or no faith. Local data are not available, and faith is not captured in most NHS data sets.

- National data from the ONS suggest that people of Christian, Jewish, and Hindu faiths are most likely to say they are satisfied with their health. Christians, Hindus, and Sikhs also report better mental health. However, Muslim respondents reported worse physical health, and people of no faith are more likely to smoke.

- As with ethnicity, many religious communities were worse affected by COVID-19. Between 24 January 2020 and 28 February 2021 people from Muslim, Jewish, Hindu, and Sikh communities had higher rates of death compared to Christians, while people of no faith had lower rates of death.

[9]*Source: ONS (2020).* **Religion and health in England and Wales.**

[10]*ONS (2021)* **Deaths involving COVID-19 by religious group, England**

[11]**OHID Public Health Outcomes Framework.** *Despite reducing life expectancy by around 1.3 years COVID-19 made relatively little difference to the gap between men and women (women were more likely to catch COVID-19, partly due to being more likely to work in caring sectors where exposure to the virus was higher, but among those who caught COVID-19 men were more likely to die).*

[12]*King's Fund (2022)* **Acting on the evidence: ensuring the NHS meets the needs of trans people.**

[13]*Public Health England (2016).* **People with Learning Disabilities in England 2015.**

What do we know about health inequalities in Bury?

Other Protected Characteristics

- Although health inequalities are most often described in terms of deprivation and ethnicity, there are systematic differences in health between groups of people defined in other ways. A complete description of health inequalities affecting all these groups is beyond the scope of this paper, but some important health inequalities are described below, with local data where possible.
- Differences in health between men and women are well described. Men die younger on average than women. For Bury residents in 2019, life expectancy for men was 79.3 years compared to 82.9 years for women – a gap of 3.6 years. However, women can expect to spend more of their life ill: healthy life expectancy for men in 2018 – 2020 was 63.4 compared with 62.2 for women – a gap of 1.2 years.
- Very little data on transgender people is collected by the NHS, but there is ample evidence that transgender people face a wide range of inequalities, including in worse mental health, and worse experience of healthcare. Sexual orientation also affects health, with lesbian, gay, and bisexual people experiencing a range of additional health risks and needs for health care.
- National data show that people with learning disabilities die on average around 20 years earlier than people without learning disability. Uptake of preventive services like screening and vaccination are worse, particularly in Bury.
- Similarly, people with severe mental illness have worse health and worse experiences of healthcare. Local data shows that rates of premature death in people with severe mental illness are especially high in Bury – among the ten worst in England. This is mainly due to very high rates of death from cancer in this population in Bury, which are the worst in England.8
- Other groups of people where there is evidence of systematic differences in health include:
    a. Homeless people (including rough sleepers and those in temporary accommodation) who die up to 30 years early;
    b. Refugees and asylum seekers who experience worse mental health exposure to violence and trauma, and difficulty accessing services;
    c. People in contact with the criminal justice system, for example prisoners who experience a mortality rate 50% higher than the general population and experience worse mental and physical health;
    d. Sex workers, who face high rates of sexually transmitted infections, sub stance misuse, risk of violence, and worse access to services; and
    e. Military veterans, who experience higher rates of mental illness and back pain than the general population.

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[14] *Source: ONS (2022).* **Deaths of homeless people in England and Wales.**

[15] *For example, see: Cogo et al (2022).* **Suicide rates and suicidal behaviour in displaced people: systematic review.**

[16] *Public Health England (2017).* **New advice on reducing health inequalities in the criminal justice system**

[17] *Potter et al (2022)* **Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers.**

[18] *Senior (2018).* **Health needs of ex-military personnel in the UK: a systematic review and qualitative synthesis.**

What are Bury Council and its partners doing to reduce health inequalities?

- The Bury LET'S Do It strategy is a health inequalities strategy. A major aim is to improve quality of life as measured by inequalities in life expectancy. Its other aims such as improving early years development, educational outcomes, and adult skills; inclusive economic growth; and carbon neutrality address many of the most important building blocks of health.
  Bury's Health and Wellbeing Board has adopted the Greater Manchester Population Health Model. This groups activity into four areas:

  a. The wider determinants of health (referred to here as the building blocks of health);
  b. Health behaviours and lifestyles;
  c. The places and communities we live in;
  d. An integrated health and care system.

- The overlaps between these areas are as important as the areas themselves. For example, the relationship between primary and community healthcare and the places and communities they serve is vital.

- This is reflected in the development of the neighbourhoods in Bury. These bring together healthcare, social services, and wider services (integrated health and care system), including the wellness model and social prescribing (health behaviours and lifestyles) connected to local assets of local communities (places and communities). They are backed by regeneration, economic growth, and other plans that aim to improve the wider determinants (for example plans in Prestwich and Radcliffe).

- Other examples include the ways that health behaviours, such as healthy eating, are influenced by the wider determinants of health, such as the availability of affordable, healthy food; or work on how hospitals can influence the building blocks of health by providing good, well-paid jobs. Work on the former is happening under the food strategy and healthy places work stream. Work on the latter is being led by partners in NHS Greater Manchester and the Northern Care Alliance with support from the public health team.

- This work is underpinned by a good understanding of what the available data tell us about the health and inequalities in health of people living in Bury. The Council is refreshing its Joint Strategic Needs Assessment, which brings together data on health and health services in Bury. This includes needs assessments for individual services or populations. Recent examples include the Special Educational Needs and Disabilities (SEND) needs assessment and a veterans' health needs assessment.

- The full range of the response to health inequalities is too large to cover in detail here. Some important examples are described below.

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[19] *Available on the* **Bury Council website.**

[20] *Based on the King's Funds* **vision for population health.**

Tackling coronary heart disease

- Coronary heart disease is the leading cause of death in Bury and one of the biggest causes of the gap in life expectancy between the most and least deprived. The public health team has worked with NHS commissioners and primary care on a programme of work designed to reduce coronary heart disease and reduce inequalities by improving diagnosis rates across deprived and ethnic minority communities and be ensuring that effective interventions reach everyone who can benefit.

- Beyond healthcare, the public health team commissions a range of work designed to improve physical activity and diets and reduce smoking specifically among the least well served residents. This includes developing proposals for a new wellbeing model which puts improving physical activity among the least active at its core as well as ensuring weight management services reach those who can benefit most, and targeted work aimed at reducing smoking among people with severe mental illness, responding to one of the starkest inequalities in health in Bury.

- Cold weather also increases risks for people with coronary heart disease and people in fuel poverty find it hardest to stay warm. The public health team has also worked across the council on the response to the cost of living crisis and has developed materials to help people stay warm in winter. These actions address key building blocks of health that prevent a wide range of health inequalities.

[21] *Available on the* **Bury Directory** *website.*

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Reducing gaps in vaccine uptake

- Vaccinations are among the most effective and cost-effective ways to prevent disease. They have been responsible for some of the biggest public health successes – from the eradication of smallpox in the mid-20th century, to dramatic reductions in cervical cancer following the introduction of the human papillomavirus (HPV) vaccine and the COVID-19 vaccine programme more recently.

- The public health team has worked closely with NHS Greater Manchester commissioners and local vaccine providers to make sure inequalities have been central to the delivery of the COVID-19 vaccine programme throughout.

- Data analysis provided by the public health team made sure that health inequalities were accurately described, and initiatives were targeted to improve uptake where they were most needed. This included deciding where the main vaccine sites were set up, as well as pop-up temporary vaccination clinics, targeted communications campaigns, text messaging, phone calls, and letters, and work with community health champions. Communities supported in this way have included those in Bury East, Radcliffe, Besses and Whitefield, Sedgley Park, and homeless people.

- Similar work has been done around uptake of childhood vaccines, particularly polio triggered by the public health team following reports of polio spreading in London. We are working with NHS Greater Manchester immunisations and local primary care commissioning teams, and with general practices to identify practices with lower uptake of polio vaccines. A particular focus has been on practices serving the local Jewish community, informed by data suggesting that the London outbreak may have been disproportionately affecting the Jewish community there.

- The council public health team is also working closely with the school-aged immunisations team (provided by the NCA) and NHS Greater Manchester to minimise inequalities in HPV vaccine uptake. School nurses have worked closely with parents and schools to understand and respond to parents' concerns. This has included specific work with Jewish and Muslim parents, and we are planning further work with academic partners to understand views of parents of children attending Bury's special schools.

[22] *Available on the* **Bury Directory** *website.*

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Tackling inequalities at the start of life

- Tackling inequalities in early life is especially important as they tend to snowball later in life. Evidence suggests investment in early years is particularly cost effective. This is reflected in the emphasis LET'S Do It puts on improving child development and educational outcomes.

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- Work in Bury on early years starts prenatally, with work on reducing the number of alcohol-exposed pregnancies and smoking in pregnancy, both of which disproportionately affect children in more deprived communities. Our focus on inequalities continues after birth through our health visiting model, and the Holding Families programme which provides whole family support for children and family members affected by parental substance use. Plans for a children's hub in Bury East will, once realised, offer further support for some of the boroughs most disadvantaged children. As will the developments of the family safeguarding model which is set to be implemented later this year.

[23] *For evidence on inequalities in HPV vaccines across schools see Senior et al (2019).* **Local authority variation in uptake of the HPV vaccine in Greater Manchester and school-level factors: a cross-sectional ecological study.**

Inclusive economic growth and responding to the cost-of-living crisis

- Improving living standards is one of the most important causes of increases in life expectancy, just as health is an important driver of economic productivity. For economic growth to reduce health inequalities it must be evenly shared and benefit the least well off most.

- We are working across numerous departments, teams and partners including business growth and infrastructure, planning, public health, education and skills and local businesses to develop an inclusive economic growth strategy which supports all elements of the community to gain good quality secure employment.

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- Examples of specific actions include: the council becoming a real living wage employer in 2021 increasing the wage of over 5,000 Bury residents to ensure opportunities for a good standard of living; implementing the Greater Manchester Good Employment Charter; and the council working with a range of partners and local businesses to roll out the healthy workforce charter to ensure the health and wellbeing of individuals was prioritised by Bury employers who signed up.

  Just as economic growth is an important cause of improvements in health, the current fall in living standards is a public health crisis in the making. Its effects will be felt most by the worst off and it is likely to worsen health inequalities. The Council and its partners have acted to try to protect those most vulnerable to cost-of-living increases

[24] *Consultancy LCP recently estimated that most of the increase in economic inactivity since the COVID-19 pandemic has been caused by increases in long-term sickness, not early retirement. For details see LCP (2023):* **The Great Retirement or the Great Sickness? Understanding the rise in economic inactivity.**

[25] *The Northern Health Science Alliance estimates that around a third of the productivity gap between the North and South of England is caused by poor health. For details see: Bambra et al (2018).* **Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity.**

Ensuring local community involvement

- Health inequalities exist because some groups of people lack access to power and resources available to others. But affected communities often know best what is needed. Part of the approach to reducing health inequalities is the commitment of Bury to develop of community led approaches. This means working creatively with and through partners to engage communities and groups to understand the factors which influences people's health, and to work with them to understand what changes would benefit them and their community. Then based on the findings work through:

    a. what communities can do for themselves,
    b. what can communities do with help and
    c. what statutory services or the council must do.

- One of the things Bury Council has done to improve communities' involvement is commission a strong local VCSE sector infrastructure organisation which provides practical capacity building support for VCSE sector groups and organisations; facilitates connections and relationships within and between sectors and enables voice, advocacy and influence for local communities.

- Bury has also commissioned and worked with grass roots organisations who specialise in hearing community voices. They use creative methods to engage individuals and groups who may have not previously had their voices/stories heard. For example, the organisation 'The Elephants Trail' is working with individuals with substance misuse issues who have accessed local services. They have worked with them to create stories around their experiences which is then used to feedback to the substance misuse service to help shape service development to better meet client's needs.

- We have also held several cost-of-living summits and through partners (namely food banks) have invited community members who have been experiencing hardship to share their stories of their experiences and challenges – again to help to shape services responses.

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Conclusion

- This paper has described what health inequalities are, what we know about health inequalities in Bury, and some of the things the Council and its partners are doing about them. In LET'S Do It, Bury has a comprehensive health inequalities strategy and Bury's Health and Wellbeing Board provides a standing commission on health inequalities.
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- Health inequalities are persistent and difficult to reduce because they are caused lack of access to a range of building blocks needed for health, and because of self-reinforcing feedback loops between health and prosperity. Meaningful progress on health inequalities requires coordinated action addressing many different parts of the problem at the same time. Evidence shows this is possible but takes time and commitment. There are no magic bullets or quick fixes.

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