GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

GREATER MANCHESTER MULTIPLE DISADVANTAGE FRAMEWORK

How to use this document

This document can be navigated using the links highlighted in the contents page and should be used as an interactive document.

The first section provides context, background and purpose of why the framework has been produced.

The middle section is split into the 3 main sections, outlining a set of recommendations to support organisations to make changes to improve outcomes for this cohort;

1) **recruitment**
2) **retain & develop** in employment,
3) **improve the experience & access to services** and delivering trauma-informed care

Finally, the last section summarises the next steps and has links to key resources and connected work.

Contents

Executive Summary

In Greater Manchester it is estimated that **120,000 people** have experienced some form of Multiple Disadvantage in their lives. Being exposed to long-term poverty, deprivation, trauma, abuse and neglect can manifest into homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health.

The overall cost to the GM system for supporting people's needs of this cohort is difficult to evaluate in to one accurate financial figure. However, as you can see from the diagram below, we are working in a complex system that could work in a more cohesive and streamlined way that adheres to a 'no wrong door' approach.

Multiple Disadvantage is not an individual issue, but a systemic problem that needs to be addressed holistically with sustainable investment at a GM-wide strategic level to effectively: improve access to services, reduce crisis intervention, support people to lead fulfilling lives and contribute fully to their communities.

People who have experience of multiple disadvantage are also a key asset for employability to the GM health and social care workforce with the unique skills and different perspectives that this cohort can offer that is currently underrepresented in GM organisations where vacancy & turnover rates continue to rise.

Supporting people with Multiple Disadvantage is a national and local priority which is rapidly gaining momentum and crosses into various connected workstreams including equality, diversity & inclusion.

After significant researching and scoping in this space, this framework has been developed to gather the key learning identified and set out some key recommendations for system leaders and policy makers to start to adopt impactful changes and outcomes for people accessing services and finding/remaining in employment within the health & care sector.

While this is the first step to making significant improvement, it is important to note that sustainable change will not only take time but also resource investment for implementation at a strategic GM level. Conversations continue to progress in this space and if anyone has any queries or questions about anything within this document, please contact **GM.Workforce@nhs.net**

Case for a long-term response to multiple disadvantage

Each dimension recognises the need to respond to it differently. This is best achieved by responding collectively.

2021-31 Gender Based Violence Strategy, Exec Summary, p77.

The Greater Manchester Probation Service will:

Deliver a range of effective and responsive group work and one-to-one interventions that address the complex needs of those supervised by them.

19% ***of women experience violence & abuse alongside another aspect of multiple disadvantage at some point in their adult lives.***

2020 Gender Matters Report, p45.

95% ***of the 700 A&E 'High Intensity Users' have left without receiving treatment; all of them list a dimension of multiple disadvantage as their main reason for attending.***

Joint Forward Plan

2. Develop collaborative and integrated working.

Deliver a GM-wide consolidated programme for those experiencing multiple disadvantages.

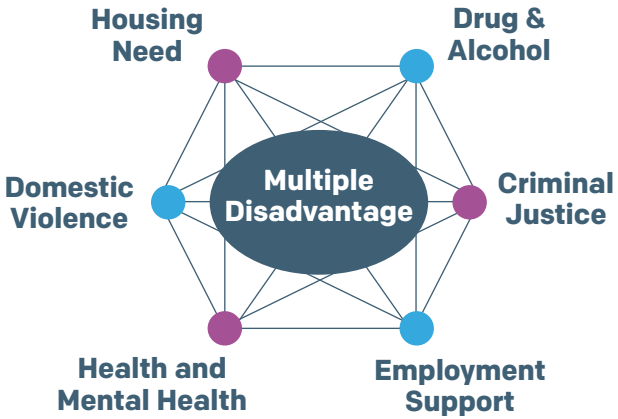
Tripatriate Agreement 24-25 Deliverable:

Deliver a GM-wide consolidated programme for those experiencing multiple disadvantages.

£29m-£133m

Cautious estimates to cost of Temporary Accommodation for Greater Manchester

GMHP Evaluation



129,300

People Long Term Sick

At the beginning of 2020, quarter of a million people in Greater Manchester claimed out-of-work benefits.

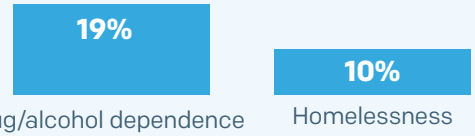
WORKING WELL

DOING THINGS DIFFERENTLY FOR GREATER MANCHESTER

Reform Board Commitments Sept 2023:

- Support for a 'no worng door approach'.
- Develop a system wide programme of work around Multiple Disadvantage and Complex Needs.

% of caseload by inclusion health group



Red Cross High Intensity Users pilot, Stockport

GREATER THAN VIOLENCE STRATEGY

PRINCIPLE 3
Partnerships for Change

Commitments

Align the violence reduction programme with those aimed at tackling gender-based violence, youth justice transformation, serious and organised crime, drugs and alcohol and mental health.

63% ***of calls to GMP are not 'Crime', of the others, 23% are for incidents involving welfare and common presentations of MD.***

Right Care, Right Person presentation, July 2023.

Figure 1: A diagram demonstrating the strategic case to the GM Reform Board for a long-term response to multiple disadvantage.

Purpose

The aim of this framework is to explore how the health and care sector might improve the way they recruit and retain individuals with experience of multiple disadvantage, and might they be better served when accessing services.
The objectives of this framework are:

1. produce a succinct report to outline the specific barriers for this cohort in gaining and remaining within employment in the health and social care sector and the opportunities to remove or reduce these challenges
2. produce a detailed understanding around the workforce development needs of staff whose work affects or connects with those experiencing multiple disadvantage, but are not necessarily experts in this area.

It can be said that the two objectives of this framework offer quite differing challenges/solutions, overall outcomes and audiences. However, it is important to look at the systemic issues currently being faced by people of this cohort accessing services and the benefits of employing people who experience multiple disadvantage in a holistic way, as they are intrinsically connected. Ultimately, this framework aims to highlight the necessary steps to upskill our staff to support the improvement of access and service experience, as well as growing and developing the unique skills and offer that people with multiple disadvantage can bring to employers in Greater Manchester.

From an organisation and system perspective, this would support addressing the current workforce challenges it is facing by purposefully reaching into an underutilised group with valuable lived experience, and importantly improve the experience and potentially outcomes for this cohort.

A note on language – it is important to acknowledge that different parts of the system may describe multiple disadvantage using different terms i.e., emergency departments may refer to frequent flyers, social care uses language such as complex needs. There is currently a lack of a shared system wide terminology and understanding of multiple disadvantage which is needed for the system to be better equipped to respond to these issues.

This document pulls together findings relating to multiple disadvantage/complex needs from a broad evidence base through the lens of recruitment, workforce development and retention. The paper draws on best practice and lessons learned from across different sectors both within Greater Manchester (GM) and outside of it. This highlights not only what can be actioned by individual organisations but identifies systemic barriers that may need to be overcome collectively, and identification of key enablers drawn from learning elsewhere.

This scoping work has culminated in a set of key recommendations for the health and social care system, to support improved work in this space.

Audience & scope

This framework aims to reach out to leaders across our health and care system to highlight the benefits and suggest practical recommendations to improving access, patient/user experience, recruitment and retention of staff who have experience of multiple disadvantage. The goal is to influence leaders and policy makers to implement changes to strategies, policies and organisational approaches that will make a real difference for this cohort.

It is recognised that the health and care system is complex and varied, meaning adoption of the suggested recommendations will be dependant on multiple factors (organisation size, makeup, ability to adopt changes, etc). Throughout the dissemination of this framework we will continue to capture organisational nuances, along with potential implementation barriers and enablers, in relation to this work.

Benefits of implementation – why should we do this?*

Improving Access to Services	Recruiting & retaining staff
Improved Health & wellbeing outcomes – early intervention and prevention can provide better treatment for people using services, resulting in overall Health outcomes and reduction in longer term issues for individuals - alleviating pressure on health and care services.	**Unique skills** – People who have experience of multiple disadvantage and trauma can offer a diverse perspective and advocacy skills in delivering care to the public, providing more empathy and understanding – overall improving service provision.
Improved mental health & empowerment – improving the experience & access to services such as mental health can have a huge impact on the wellbeing and autonomy of individuals to empower and boost confidence to have more involvement and contribution in wider society.	**Different Perspective** – someone who has overcome challenges in life often have built resilience and problem-solving skills that can provide innovative approaches which is vital in an ever changing system/pressured service.
Better engagement & equitable care – Staff that are well trained to deliver tailored care for people who have experience of multiple disadvantage means people of this cohort are more likely to engage with support and receive equitable care as other service users.	**Workforce reflecting the community** – recruiting people from different backgrounds and creating diverse role models is one of the key priorities within health and social care to ensure we have a representative workforce.
System Cost Savings – providing more education around navigating the system, managing conditions/personal welfare, and providing community-based approaches which breaks down barriers will all provide longer-term cost savings to the system when individuals have power of esteem.	**Retention & Workforce Planning** – offering a supportive and inclusive work environment creates stability and can foster a strong sense of commitment and value for someone who has faced significant barriers throughout their life. Therefore, improving retention rates and turnover in staff which is a model to replicate across the workforce.
Wider Societal benefits – addressing & supporting people's health and social care needs in a holistic way through an integrated system approach will have a direct positive impact on communities resulting in the following outcomes: happier families, safer communities, increased employment, improved economy.	**Broader societal impact** – Creating employment opportunities for this otherwise 'overlooked' cohort will have a positive impact on overall community unemployment rates, as well as closing the vacancy gap across health and care. In turn, this will have a positive impact on the social-economic stability for GM.

**the table above describes only a handful of benefits that can be applied and is not an exhaustive list*

Background

Context & overview

Across Greater Manchester (GM), we know there are many people have experience of, or have experienced, multiple disadvantage or have complex needs. These are people who have experienced a number of disadvantages created by the system, who present with a combination of multiple, interconnected needs. Public services, including health and social care, do not currently have the solution or tools to provide an effective, timely response to people with complex care needs. This creates problems in relation to continuity of care and access to services, culminating in increased pressure within certain parts of the system; for example, usage of accident and emergency services. There are a number of issues associated with this delayed access to appropriate care which include: poorer health outcomes & wider social determinants. Both of which, given the current financial and demand pressures on the system, need to be addressed as part of the overall health and social care recovery plan for GM.

GM is in a strong position given the trailblazer devolution deal, which presents an opportunity to unify public services around multiple disadvantage. Pooling of different funding streams to develop and implement a strategic approach to support multiple disadvantage at scale would add significant benefit.

The Broader Perspective

Whilst the focus of this paper is on provision in the health and social care system, it is important to note the longer-term ambitions for developing a single, multi-sector approach to multiple disadvantage. The national **Changing Futures** programme of work, of which GM is a key part, was developed to gain an understanding of the barriers and challenges people with experience of multiple disadvantage encounter when looking to gain and remain in employment, specifically within the health and social care sector.

This work is also closely aligned with the principles outlined in the **GM Good Employment Charter** to improve employment standards and practices within organisations. Implementing the recommendations within this document is a huge step to supporting the Charter Commitments.

Framework Development

This framework and recommendations are based on an extensive scoping piece. Whilst there were no programmes of work with a specific focus on multiple disadvantage with a focus on recruitment and retention within the health and social care setting, there were examples that looked at challenges and opportunities for peer support roles (people with experience of multiple disadvantage supporting others). There are examples of good practice both within GM and within the health and social care system, but more commonly outside of GM and beyond the health and social care system. Often the pockets of good practice were on a departmental basis, championed by service leads who understood lived experience and the benefits of their alternative approach. Broadly speaking, the areas who appear to be forerunners in their thinking and approach were mental health services, particularly those services working within health and the criminal justice system. Best practice relevant to the health and care sector was explored in greater detail, and key themes from that evidence base has been captured in this document.

Defining multiple disadvantage

The term **multiple disadvantage** refers to people who have experience of multiple and intersecting issues. This includes, but is not limited to:

- **homelessness**
- **substance misuse**
- **contact with the criminal justice system**
- **mental ill health**
- **domestic abuse**

For many, their current circumstances are shaped by long-term experience of:

- **poverty**
- **deprivation**
- **trauma**
- **abuse**
- **neglect**

People will often have contact with various parts of the system (i.e., health, police, housing, social care), all of whom generally work within their professional silos. There is a lack of cross sector collaboration and coordination between services. This is apparent at all levels from front line staff to strategy and commissioning. Services are traditionally set up to focus on single issues. This can be a particular challenge for those with experience of multiple disadvantage, in part as they often present with multiple complex needs that require multi-service support; this can deter individuals from successfully engaging with the treatment/support offer. Furthermore, there is a lack of understanding around multiple disadvantage amongst staff working in health and social care. The combination of these factors mean those who have experience of multiple disadvantage are often the most vulnerable within our communities, have complex needs, and experience the most harshest health inequalities (discussed in more detail later in the paper).

Key learning from transformational work in this space

There have been a number of specific initiatives developed to address the needs of this cohort. In 2012, **Making Every Adult Matter** (MEAM) developed an approach to help transform local systems and services for people experiencing multiple disadvantage (although it should be noted that work in this space predates the development of the MEAM approach).

In 2014, the **Fulfilling Lives** programme was launched, which worked with 12 local areas (including Manchester from within the GM footprint) over a period of 8 years.

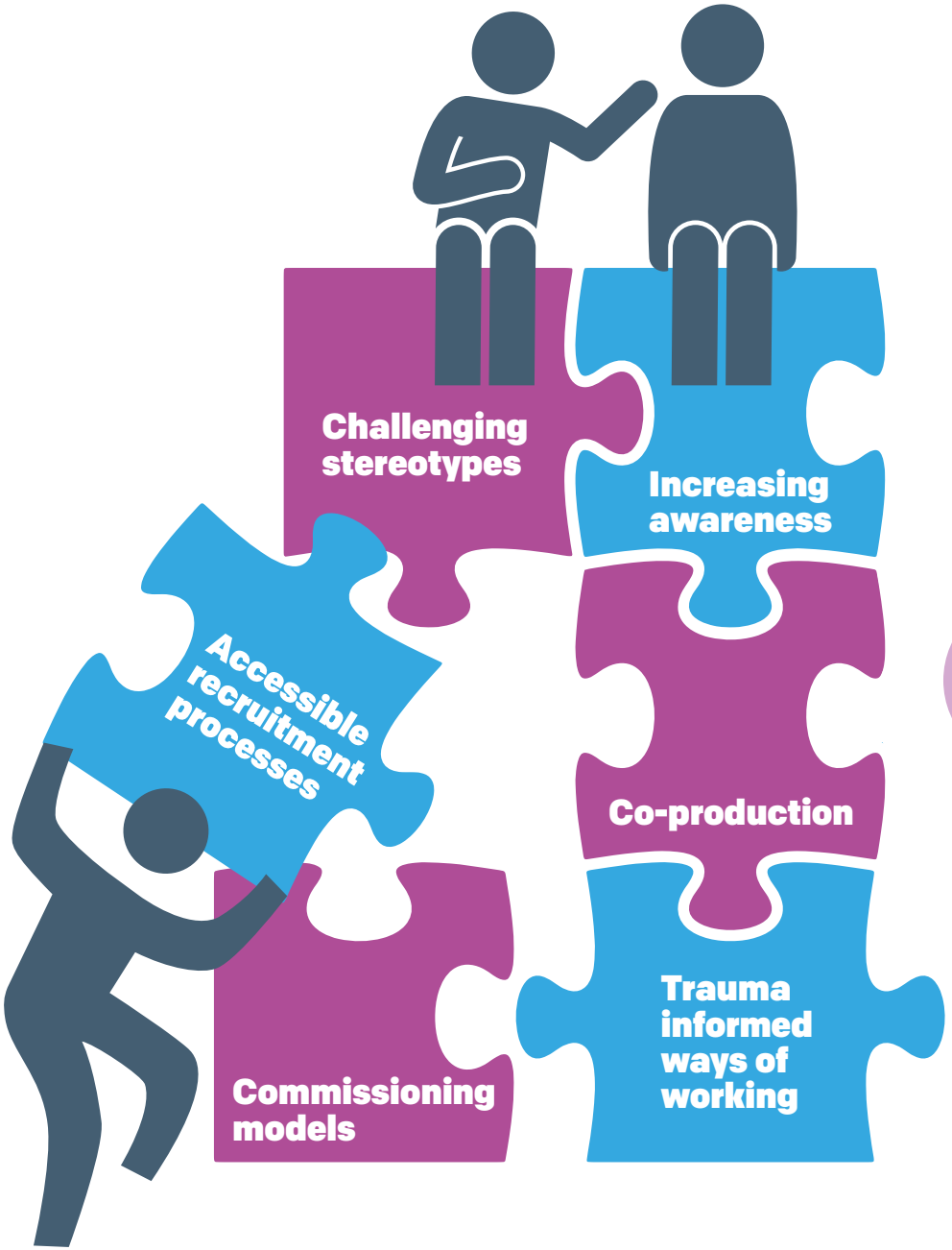
In 2021, the government sought to build on this work further by investing in the **Changing Futures** programme which aims to improve services and outcomes for people experiencing multiple disadvantage, working with 12 local areas nationally (including 4 within GM).

These programmes have benefited from detailed and comprehensive evaluation which has made a significant contribution to the evidence base. Some key points from this learning are as follows:

- Embedding **trauma informed ways of working** is critical to effecting change for those with multiple disadvantage (trauma is discussed in more detail later)
- The current **commissioning model** and provider diagnostic lines discourages collaboration between services and organisations and promotes single issue focused ways of working. This makes it difficult to deliver joined up services for this cohort, as well as making the system difficult to navigate for the individual
- The challenges identified in the above two points are illustrated when we consider the experience of an individual with a **dual diagnosis** (for example, both substance misuse and mental ill health). Individuals can find themselves unable to access either service as mental health services may refuse to see someone with a substance misuse issue, and vice versa
- **Co-production** of services with those with **lived experience** can provide valuable insight as to why people do not access or engage with services
- **Increasing awareness** of employment opportunities and taking steps to make **recruitment processes accessible** are key enablers
- Employment opportunities can be limited to certain sectors and job types, with limited **opportunities for training or progression**, or availability of ongoing personal and professional support
- People can face practical barriers to accessing and taking up employment opportunities i.e., lack of access to suitable IT equipment, overly complex recruitment processes, barriers with qualifications/previous experience, cost/distance to travel to an interview, or negative employer attitudes.

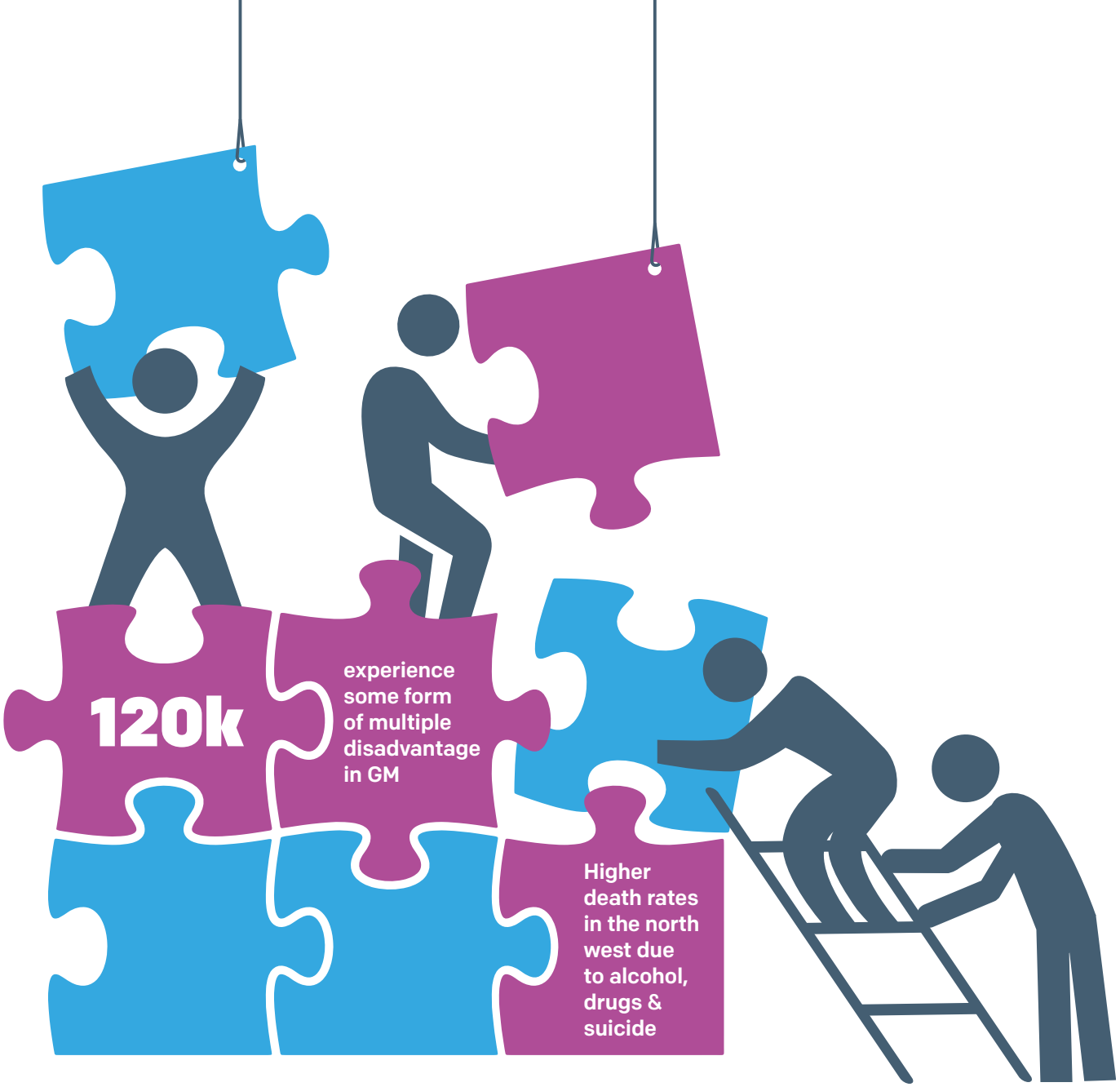
Included as part of the Changing Futures offer is the **GROW (Getting Real Opportunities of Work) traineeship**. This was developed, and also delivered, by **Shelter**. The role provides an intensive programme of support, training and development activity for people with experience of multiple disadvantage and have faced barriers to employment. This is delivered via a 12-18 month placement with a dedicated function within Shelter to provide the pastoral wraparound support; key to supporting the individual to remain within employment. The model is based on a 70/30 split, with 70% of the trainee's time spent with their placement and 30% dedicated to their personal development. This allows them to undertake any training but importantly affords them time to address any personal issues should they arise i.e., an issue related to their housing needs or an activity that supports their ongoing recovery. This is underpinned by access to a personal budget for each trainee. Fundamental to the concept is systems change and that the trainees have the opportunity to help shape and influence the service they are working within.

In addition to this focus on multiple disadvantage, there are learnings to be taken from within mental health provision and their approach to lived experience roles (particularly in relation to peer support). There are some examples of good practice in terms of inclusive recruitment and talent management to enable progression. Team members with lived experience have helped change the culture by challenging established ways of working as well as challenging stereotypes and stigma associated with some of these issues. This has had a knock-on effect in terms of the team's interaction with service users leading to increased engagement and better outcomes for the service user.



Potential extent and need

The research team at the **Greater Manchester Combined Authority (GMCA)** undertook a piece of quantitative analysis drawn from a number of datasets, to provide a starting point when thinking about the nature and scale of multiple disadvantage within GM. This data suggests there are circa 120,000 people within GM with experience of some form of multiple disadvantage. The caveat is recognising the high potential prevalence of 'unseen' people who do not feature within any of the datasets for a wide variety of reasons; for example, **women** can experience homelessness differently to men and due to the risk of violence, may hide away when rough sleeping and therefore not be captured via a rough sleeping count. The data is also limited by the available datasets, for example, it does not include adult social care.



Summary of data – size and scale of need identified in Greater Manchester

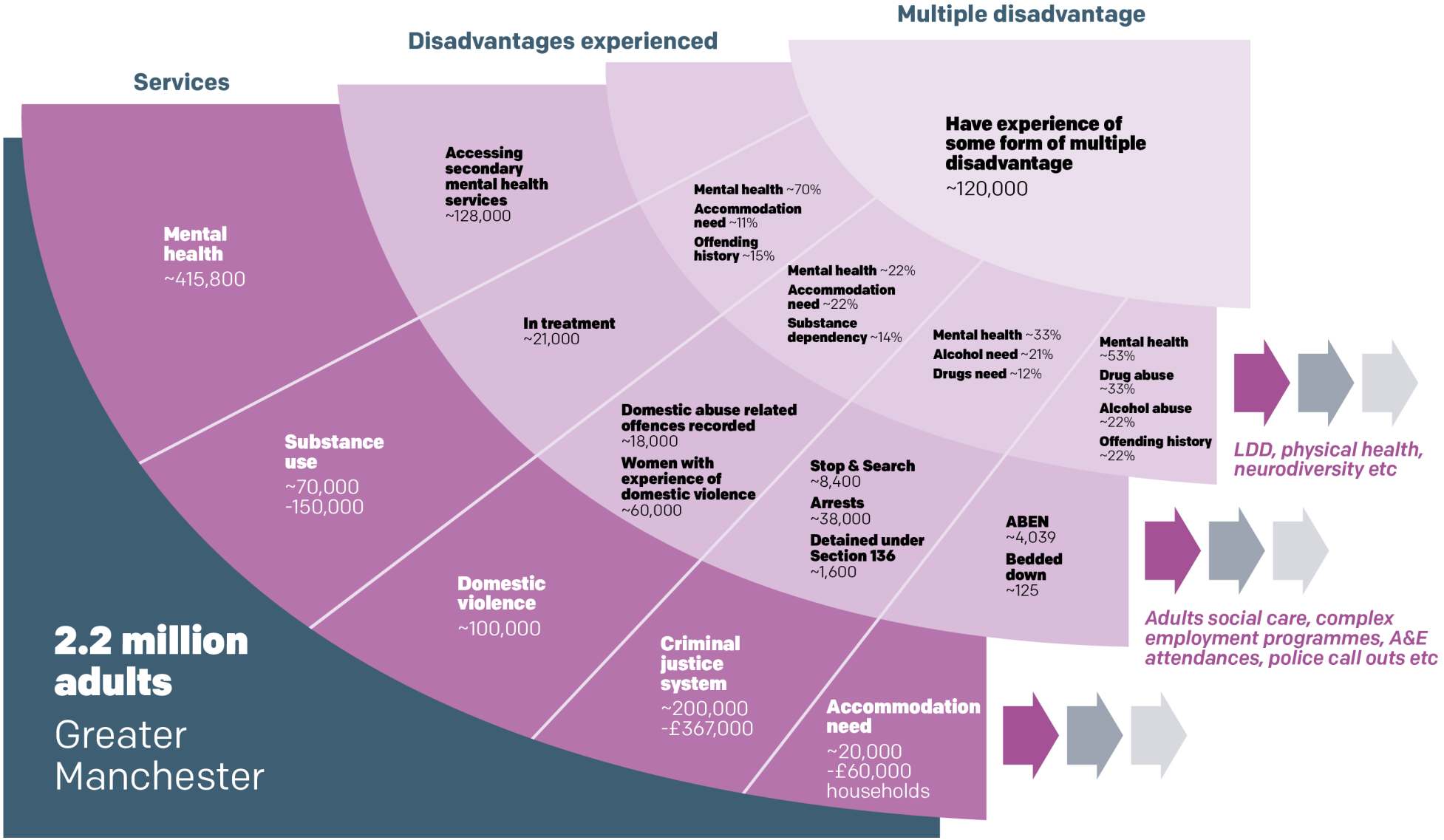


Figure 2: GMCA Data showing the size and scale of need identified in Greater Manchester

Whilst these figures may appear low compared to the overall population number, it is important to consider this within the context of service usage and associated high costs. There are **large numbers** of undiagnosed and untreated long-term conditions and a range of co-morbidities arising from mental health and substance dependence. **Accident & Emergency (A&E) attendance** is 6-8 times higher for people experiencing homelessness, and 28 times higher for people who experience both homelessness, rough sleeping and alcohol dependency. The cost to the National Health Service (NHS) relating to unplanned emergency care is **£2.5bn per year**.

Furthermore, the Health outcomes and social determinants of health for this cohort are extremely poor. The data below highlights the number of deaths within this cohort (inclusion health group in Figure 2), which far exceeds the rate of even the most deprived populations in England. This highlights that deprivation has significantly less impact on mortality than multiple disadvantage.

Recent **research conducted in Greater Manchester** revealed that Deaths of Despair (deaths from alcohol, drugs and suicide) was higher in the North of England, compounded by inequalities and socio-economic factors. Those experiencing multiple disadvantage are more likely to be impacted, and what's more, this is on the increase.

The Health and Care Act 2022 places a legal responsibility on the health and care system to reduce health inequalities. This duty extends to considering the different experiences individuals have around access to, and experience of, services - contributing factors to the disparity in health outcomes.

All of these factors provide a clear case to exploring how the inequalities faced by those experiencing multiple disadvantage can be reduced to improve overall outcomes and decrease associated costs to the health and care system.

Standardised mortality ratios by deprivation deciles and inclusion health groups for males and females

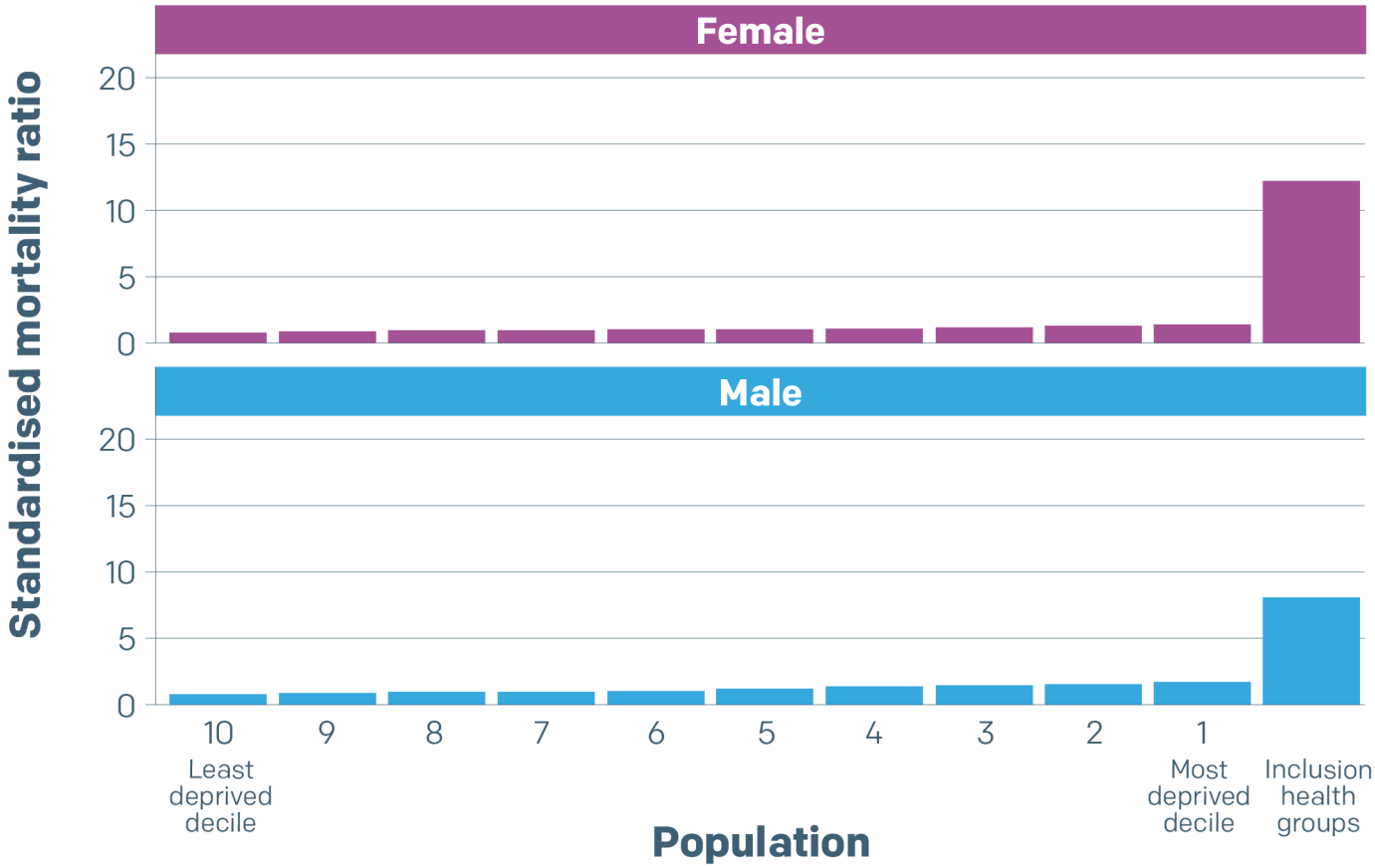


Figure 3: Source: **Office for Health Improvement and Disparities (2022)**.)

This bar chart shows the standardised mortality ratios (SMRs) for males and females across different population groups, including deprivation deciles and inclusion health groups, based on data from the Office for Health Improvement and Disparities (2022). For both males and females, the most deprived decile (1) exhibits higher SMRs compared to less deprived deciles, indicating increased mortality. However, inclusion health groups show significantly higher SMRs, with females exceeding 25 and males around 20, highlighting a much greater mortality rate for these groups compared to the general population.

Trauma awareness & adapting trauma-informed approaches

There is a strong relationship between trauma and multiple disadvantage; **research** indicates that 85% of adults who have experience of multiple disadvantage have faced trauma as children. Adverse Childhood Experiences (ACEs), which are defined as potentially traumatic experiences that occur during childhood, can impact on development of the areas of the brain associated with logical thinking and memory. The brain adapts to environmental circumstances therefore, when someone is living in a constant state of fear or stress the brain may respond to this by increasing activity in areas of the brain involved in emotional responses making this the dominant response. These changes can mean a person can struggle to regulate their emotions, making decisions and effectively manage stressful **situations**. Responses to traumatic events can vary from person to person. However, it is not uncommon to see people engaging in behaviours to manage the after affects. Of particular relevance for this cohort, unresolved trauma can lead to self-medication via drug or alcohol misuse as a means to avoid the difficult emotions relating to the trauma which the person may feel unable to cope with. Another symptom of trauma for this cohort is reenactment. This refers to when a person repeatedly relives and recreates the past situation in the present day. This can manifest as repeated involvement in **abusive or violent relationships**.

Trauma can have an impact on a person's ability to engage with services and form relationships, even in situations where the trauma is not directly connected. Feelings of being unsafe, betrayed and struggling to trust other people can all have a bearing and create heightened emotional responses, for example, anger or aggression, shame, numbing and isolation. In a health and care setting this can impact on the relationship between a service user and health care professional, and in turn their engagement with **services**.

It is therefore important for staff to have a good level of understanding in relation to trauma in order to effectively respond to people experiencing multiple disadvantage. As a result, if left unaddressed this can lead to:

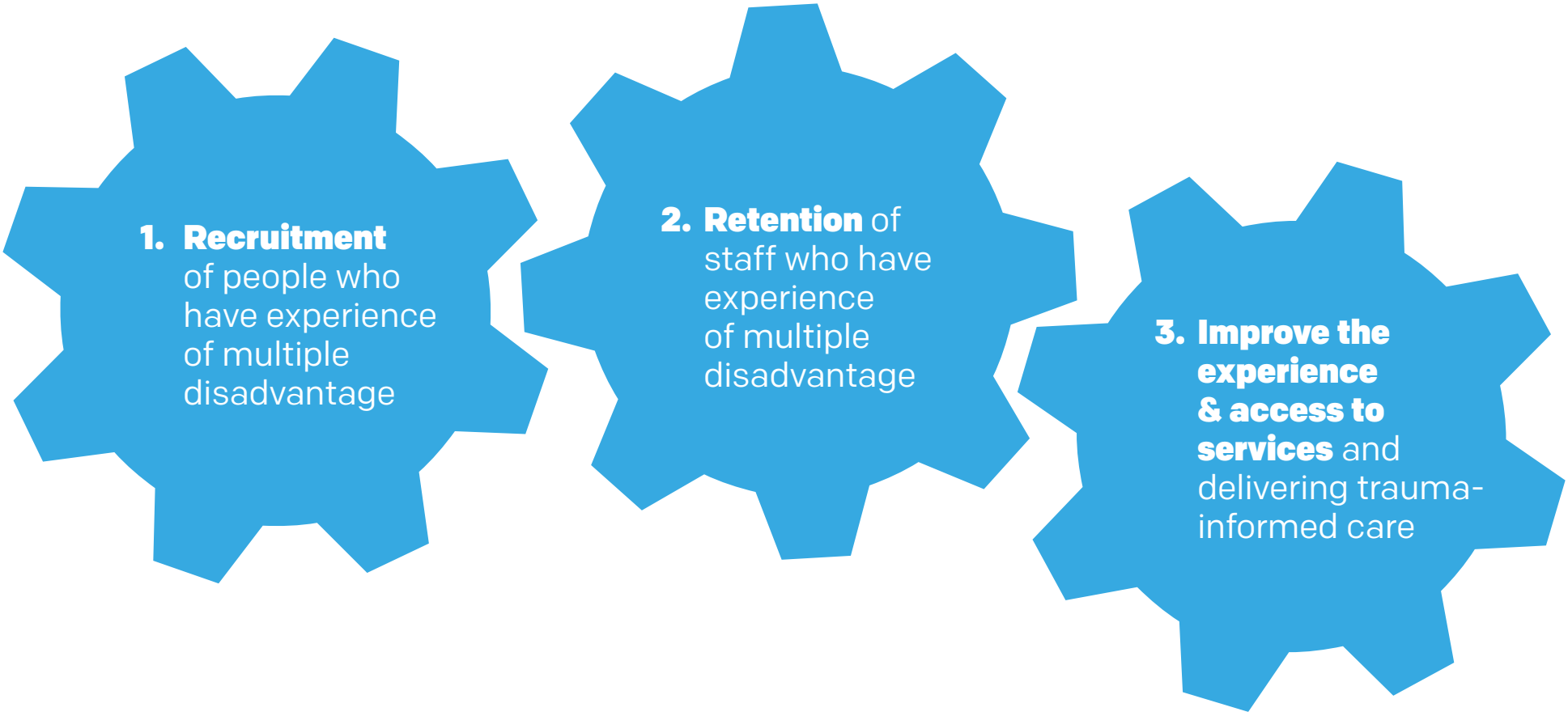
- Staff making judgements
- Individuals feeling unheard or misunderstood
- A lack of trust
- Services responding with punitive measures
- Conflict

They can experience overwhelming emotions, have difficulties communicating effectively, and controlling fear and anger. Staff lacking the understanding and skills to effectively deal with problematic behaviour can allow situations to easily escalate unnecessarily, putting staff and the individual at risk. These complexities and challenging behaviours can be **difficult for services to manage**. This further compounds the issue of this cohort being categorised as 'hard to reach' when it is the perspective of the providers and access to services that needs to shift to a 'no wrong door' approach.

Adapting trauma-informed approaches is one way of improving support provision.

Key Findings – priority areas for attention

This document is split into three main sections;



Recruitment

National and Greater Manchester picture

The **NHS Long Term Workforce Plan** states in March 2023 there were 112,000 vacancies across the NHS workforce. The **Adult Social Care Workforce Strategy** acknowledges similar challenges with an urgent need to change the way we recruit to attract a more diverse workforce.

Demand for health and care services is increasingly driven by an ageing population with increasing levels of multimorbidity and frailty. Whilst numbers of staff trained has increased, this level has not kept pace with demand for services. Providers across health and social care over rely on temporary staffing to fill gaps and given the current financial pressures there is a need to reduce temporary staffing spend, which is higher than the permanent workforce. International recruitment levels remain high, which again has higher associated costs which is unsustainable, therefore an alternative solution is needed. For example, in the NHS alone current modelling estimates a shortfall of approximately 150,000 full time equivalent posts (FTE) between demand and supply. This is predicted to increase to 260,000 – 360,000 FTEs by **2036/37**. We therefore need to think differently about how we recruit to health and care services.

In **Greater Manchester**, the vacancy rate across health and social care sits at 15.5% (7% NHS and 8.5% adult social care – primary care is unknown and therefore not included). In secondary care, the highest vacancy rate is 14% within the support to nursing staff group.

Targeting communities who are currently underrepresented in our workforce, including those who have experience of multiple disadvantage, might be one such approach to tackling this challenge. This would also support fulfilling both the Adult Social Care Workforce Strategy & NHS People Plan's ambitions to increase diversity within the workforce, and therefore enable organisational workforce to become more representative of the communities they serve. However, standard recruitment and selection processes in the health and care sector put those from underrepresented backgrounds and those with protected characteristics at a disadvantage due to the inherent bias within them. Many would not view working within health and social care as a viable option available to them. Organisations need a better understanding of the barriers to employment for this group and to proactively anticipate, reduce and where possible, eliminate them.

As well as being an untapped resource, service delivery would be more effective being informed by lived experience. Increasing the number of people with lived experience of multiple disadvantage within the workforce can influence culture change from within.

There are a number of key resources available to support inclusive recruitment and retention. This includes the recent **overhauling recruitment** work undertaken by NHS England. In Greater Manchester, the **GM Recruitment and Retention toolkit** includes a wealth of best practice, resources, and alternative approaches to recruitment and retention.

Barriers to employment for those who have experience of multiple disadvantage

People who have experience of multiple disadvantage face significant barriers to entering and progressing within the workforce, this can be both in terms of real challenges as described below, but also psychological barriers experienced by the individual which may act as a deterrent to taking steps to secure employment, and particularly in the health and care system.

Equally, employers can hold negative beliefs relating to this group which can influence their decision making and have an impact on whether a person's application for employment progresses. This could be in relation to concerns over behaviours, attendance consistency, risk of relapse. These beliefs can arise from a lack of understanding in respect of trauma, and how the effect of trauma can impact on a person's behaviour.

Offending and criminal records can be a feature of multiple disadvantage and again represents a real barrier, particularly within health and social care sector for a variety of reasons. An employer may have formed judgments relating to the reliability of people who have a history of criminal convictions, despite the fact that **research** indicates people with a criminal record remain with organisations for longer periods than those who don't and are less likely to leave voluntarily. From an individual's perspective, the prospect of having to disclose a criminal record and potentially be met with judgment can understandably be off-putting and potentially re-traumatising.

Data from the **Fulfilling Lives** programme showed 59% of participants had no formal qualifications when they joined the programme and 10% had entry level qualifications; this represents a significant barrier to employment. Health and social care roles also frequently request prior experience as essential criteria to apply for roles. Furthermore, lack of confidence and self-esteem feature heavily within this cohort which means it is difficult for them to recognise and effectively articulate the skills and strength they possess to future employers.

Employers (especially those in health and social care) rely heavily on recruiting via digital methods, including advertising roles online, and completing long electronic application forms. **Digital skills**, access to technology and literacy can also be problematic. **Cross-sector recruitment events** delivered in GM provide some key insights into alternative approaches to support recruitment locally. These events were purposefully designed to address some of these aforementioned barriers.

Recruitment recommendations

Spacial level	Activity
Organisation	Completing NHSE's Overhauling Recruitment Self-Diagnostic **tool**. This will allow the organisation to self-assess their current recruitment processes against a number of set metrics. Upon completion a score is generated, thereby allowing the organisation to identify areas of strength as well as areas for improvement.
	These may include: • Streamline recruitment processes, focus on elements that create barriers. This would draw on best practice elsewhere, ideally co-designed with people with lived experience of multiple disadvantage who are the experts by experience and can highlight issues/barriers in recruitment (e.g. supporting organisations such as Shelter or Back on Track). • Remove requirement for qualifications and prior experience from person specifications/job descriptions for entry level positions/ where not essential, stripping these back to more clearly identify what skills are essential for the role i.e. the values/attributes needed and separating this from what can be learnt on the job. • Reduce the literacy/digital barriers wherever possible – could the requirement of a personal statement be bypassed for some roles? • For events, consider digital support that could be provided to make applying more accessible to the multiple disadvantage cohort. • Promote health and social care roles in your local communities, and consider communications carefully to increase perceptions of accessibility for all population groups. • Commit to a GM-wide collective agreement that includes shared risk across GM, in relation to pre-employment checks i.e. criminal convictions/ID requirements, to ensure these checks do not automatically result in withdrawal of an employment offer in instances where people are unable to comply via the usual routes.
	Review recruitment processes and policies with the aim of reducing bias by embedding accountability and transparency into decision making. This should focus on designing ways to reduce the influence of bias i.e. ensuring a thorough formal feedback process is in place for full transparency. Further work is also underway at a GM level around reducing bias that local organisations can adopt.

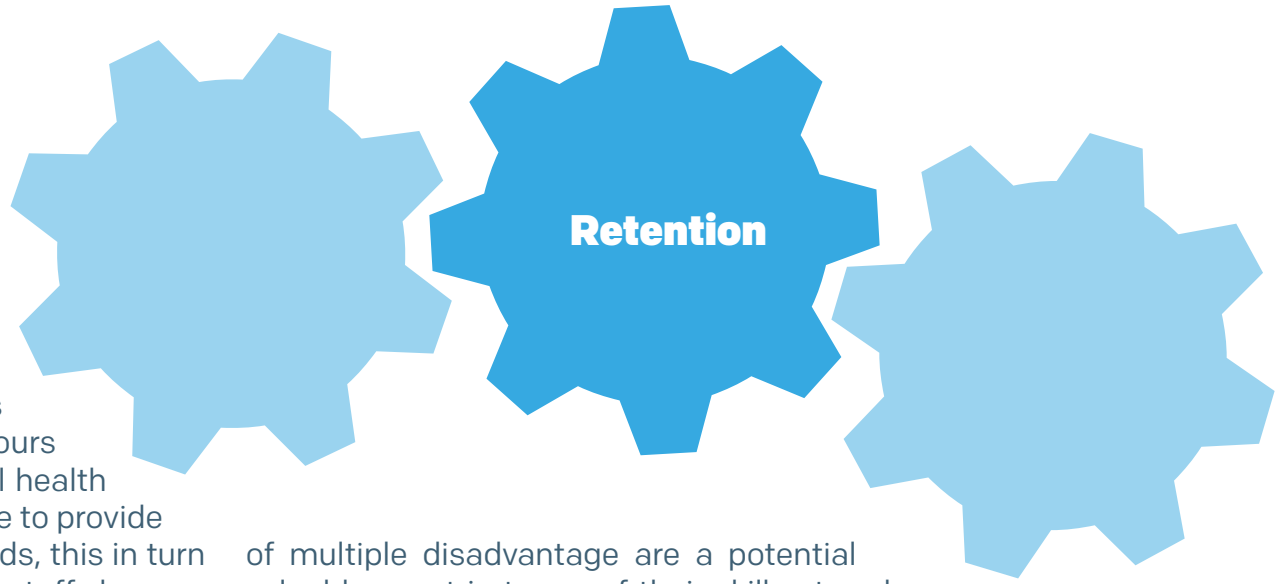
Recruitment recommendations

Spacial level	Activity
Organisation	Develop a locally developed risk assessment tool for your organisaiton (based on a GM standard to be developed), supporting guidance and clear process in relation to candidates who are unable to fully comply with any of the pre-employment checks. To include communicating with the candidate at agreed points to update on progress/next steps. Monitoring use of risk assessments and outcomes with executive oversight.
	When developing pre-employment programmes incorporate learning from the GROW traineeship into the design and delivery. Back on track is a local charitable organisation that providers specialist training to support organisations to make positive change in this space.
	Nominate a named executive lead to champion approach and oversee the work.
	Co-production with the workforce is key to embedding the learning so that it is owned within organisational culture. Ensuring that employees are actively engaged have an opportunity to collaborate/feedback and is aligned to the organisation's values.

Recruitment recommendations

Spacial level	Activity
System	• Provide GM-wide guidance around criminal convictions requirements at the point of application, identifying where they might be removed where appropriate. • Describe at what point a candidate will be asked about any convictions (best practice indicates this is at the point a candidate is made a conditional offer of employment) and the process that will be followed if a candidate has any unspent convictions. • If unable to remove disclosure request from the application form, move from the first page that the candidate views to the last. For many organisaitons that use the **Trac system**, this may be a national issue that needs to be addressed o make any amends within the IT system.
	Develop and agree a GM approach to pre-employment checks for localities working across health and care to commit to, to include, ID checks/references/DBS to ensure that in instances where an individual is not able to comply with the usual requirements there is a robust process in place to manage risk appropriately, whilst not letting this be an automatic barrier to progressing an offer of employment. This will facilitate a collective ownership and sharing of risk between providers and the ICB.
	Ensure that NHS Employers guidance & skills for care is being adopted as standard which outlines what the required level of DBS check for the role is and which people would be prohibited from working with certain groups by law.
	Ensure recruiting managers and relevant members of the team have received up to date training in relation to DBS checks and how to assess which level of disclosure is required for a role prior to a role being advertised. Compliance can be monitored via ESR.
	Review the widely used current recruitment management system (Trac) to ascertain if the system is able to support these recommendations. If not, what are the changes that need to be implemented and is there scope within the system to implement them?
	Develop resources to support communications and engagement to promote working within health and social care with accessibility for those with multiple disadvantage in mind, including outreach opportunities into communities.
	Development of recruiting manager/interview panel training offer around multiple disadvantage and trauma. Learning from best practice and working with organisations who work with people with experience of multiple disadvantage.
	Continue pushing to explore alternative approaches to **regulation** (currently led by GMCA) which would be a key enabler to organisations feeling able to adapt some of these recommendations.

Retention



Retention has a significant impact in terms of cost to the health and care system, this has been **reported** at £21.7 billion. Across **Greater Manchester** the overall health and social care turnover rate is 45% (NHS 14%; adult social care 31%; primary care unknown). Workforce shortages combined with increased demand on services puts remaining staff under increasing pressure. Long hours and difficult shift patterns can lead to poor mental health & wellbeing at **work** as staff can feel they are unable to provide the level of care needed to meet their patients' needs, this in turn increases stress and burnout is **heightened**. Further staff absence as a result of this contributes to a negative spiral of increasing pressure on those who remain in **work**. Naturally this can lead to poor levels of **morale and motivation** which have been found to have a direct impact on patient outcomes.

Across GM sickness absence sits at 9% (NHS 6%; adult social care 3%; primary care unknown). Over the last 12 months 1.5 million days were lost in secondary care due to sickness absence with 30% relating to **mental health**. The longer a person is absent from work due to sickness the less likely they are to return to their **role**.

This highlights the need to adapt a two-pronged strategic approach to address the challenge of workforce shortages in terms of both recruitment & retention. With the current turnover rate, focussing on recruitment in isolation will not address future staffing requirements.

The above statistics highlight the importance of considering retention strategies within workforce planning. As has been described throughout this document, people with experience of multiple disadvantage are a potential valuable asset in terms of their skill set and values. However, there are some considerations that need to be taken into account, particularly within the context of current staff pressures and subsequent impact on staff wellbeing.

There are particular points during employment that can be difficult for people with lived experience of multiple disadvantage to navigate, but however offer an opportunity to embed best practice in a broader sense, creating an environment that supports all staff to achieve their potential including those who have complex needs. These include the following:

- **Induction and probationary period** – well thought out, detailed induction with clear goals and time to review these. Including activities that build on each other, being cognisant to the fact that they are new and not expecting them to do everything at once. This can help a new starter become familiar with their work environment, colleagues and role. Helping to increase confidence, motivation and commitment.

- **Professional development** – supervision and training. Regular supervisions that foster a safe, confidential space to discuss anything that may affect their performance at work. Provides an opportunity to identify when things might be going wrong at an early stage and put supportive measures in place.

In relation to the above, there are some useful templates and examples of good practice that can be found **here**.

People who have experience of multiple disadvantage may have ongoing needs around their mental health and wellbeing, experience of abuse and trauma, or addiction. A supportive and understanding work environment is therefore critical and may include reasonable adjustments to effectively support their needs. It is fundamental to recognise that a person's recovery journey is unlikely to be linear.

Another factor impacting on retention relates to opportunities to progress. As people with experience of multiple disadvantage tend to have fewer qualifications, it can be difficult for them to progress beyond frontline or entry level roles. There is a perception that professional experience and formal qualifications are valued more than lived experience when it comes to managerial or strategic roles. Employers can be apprehensive around appointing someone with lived experience into roles with additional responsibility for fear of this triggering a relapse. Alongside this they may be perceived to be **unprofessional** due to the behaviours and how they go about expressing themselves which may be different to the 'norm'. That being said this can be viewed as a positive attribute in terms of challenging the status quo and challenging hierarchical structures.

The role of **Wellbeing** on performance at work and reducing absence should not be overlooked. This is particularly important when taking into account some of the barriers a person with lived experience may encounter and whether they subsequently thrive in the workplace. Adapting wellbeing action plans can be useful way to open up the conversation and introducing this as part of the normal supervision process.

Retention recommendations

Spacial level	Activity
Organisation	As part of the induction process offer a buddy system to help new starters navigate a new organisation/work environment. For people with experience of multiple disadvantage they may have been out of work for a significant period of time or may not have worked. Having a support network in place, with regular check ins, can support this step.
	Workplace adjustments to working practices and policies can support people with lived experience of multiple disadvantage get into, and remain in, employment. This includes opportunities for flexible working hours, longer induction period, opportunity for reflective practice and clinical supervision and a strong package of support. Incorporating wellbeing plans can be a useful tool in identifying any early warning signs that things may not be going well and agreeing the steps that will be taken to support the individual.
	As people with experience of multiple disadvantage may not have, or have less, formal qualifications and/or work experience it is important that conversations around progression and development form part of regular support and supervision, creating action plans to support these ambitions. Choice in terms of role/sector is important as not everyone with lived experience of multiple disadvantage will want to have, or stay in, a frontline support role. It is therefore important assumptions are not made regarding an individuals aspirations.
	As people with lived experience of multiple disadvantage may have entered the workforce via different routes, and may lack confidence, actively encouraging those staff members to apply for any progression opportunities as they arise. If people are unsuccessful, provide constructive feedback with clear areas to work on.
	Process around secondments or 'stretch opportunities' should be reviewed to ensure they appeal to a diverse group of people within the workforce and take into account different ways experience and knowledge can be gained.
	Monitoring who is selected for promotion/secondment/'stretch opportunities' to ensure there is a breadth of diversity in these appointments (linked to point around data collection below).
	Build in trauma understanding into line manager support resources to upskill and create better awareness across the breadth of the organisation.
	Develop and promote a culture whereby equal value is placed on knowledge and experience gained via non-traditional routes.

Retention recommendations

Spacial level	Activity
Organisation	Removal of unnecessary qualification/experience requests appear in job specifications, to support equitable progression.
	Equitable access to coaching and mentoring schemes, with clear communications around what this entails and the benefits. This can offer support, advice and guidance and help development of skills and knowledge with a focus on setting goals and taking action. Importantly, it can present an opportunity to look at challenges in a new way.
	It is also helpful to think about the value a person with experience of multiple disadvantage would have as a mentor. This could help organisational culture by challenging stereotypes and bias, and enable greater support for others from a similar background.
	Co-production with the workforce is key to embedding the learning so that it is owned within organisational culture. Ensuring that employees are actively engaged have an opportunity to collaborate/feedback and is aligned to the organisation's values.

Spacial level	Activity
System	Facilitate system workforce planning conversations to think about how an approach can be developed that enables flexibility whilst maintaining safe staffing levels and ensuring high quality care is delivered.
	Support the development and/or spread of mandatory or line management training and development which includes needs of those with multiple disadvantage and complex needs.
	Options developed around how experience of multiple disadvantage can be captured within workforce datasets. This will enable creation of a baseline and a means by which progress can be monitored.

Access and experience for service users who have experience of multiple disadvantage

The initial touch-points (e.g. general practice or emergency departments) for people who have experience of multiple disadvantage with staff are crucial in terms of successful ongoing access and engagement. Previous negative experiences with front line public services may create distrust of other professionals trying to engage and support them. Any additional negative instances will only serve to further reinforce this view and could lead to delays in an individual seeking timely and appropriate access to care. Delayed access to good care and support is associated with poorer & wider social determinants, and as a result, more costly from a financial perspective for the health and care system.

A workforce that lacks a good understanding of multiple disadvantage can impact on how staff and services assess and manage risk, which can result in people being excluded from accessing services. This might be the result of displaying challenging behaviours or treatment compliance, and staff unable to respond to this appropriately.

As part of the Fulfilling Lives programme, a core competencies **framework** and supporting reflective tool was developed. This was initially developed for client-facing support workers engaging with people experiencing multiple disadvantage, it has real potential to be beneficial for a wider workforce development approach. The areas identified as part of the research were as follows:

- **Meeting people where they are**
- **Building trusted relationships**
- **Working together and empowering**
- **Advocacy and joined-up working**
- **Emotional and psychological awareness**
- **Reflecting on practice and self-care**
- **Values and attitudes**
- **Trauma-informed approach.**

Working in a trauma-informed way

The role of trauma in relation to multiple disadvantage has already been outlined earlier in the paper. This highlighted the impact of trauma on brain development and function and also how a person responds to trauma; both of which can have a bearing on how a person presents when seeking access to health and care services. It is therefore important that health and care staff recognise the impact of trauma, and are able to incorporate a trauma-informed approach into their everyday practice. When considering how to adapt and embed an organisational trauma-informed approach, staff from all parts of the organisation, not just frontline staff, need to have an understanding of trauma and its **impact**.

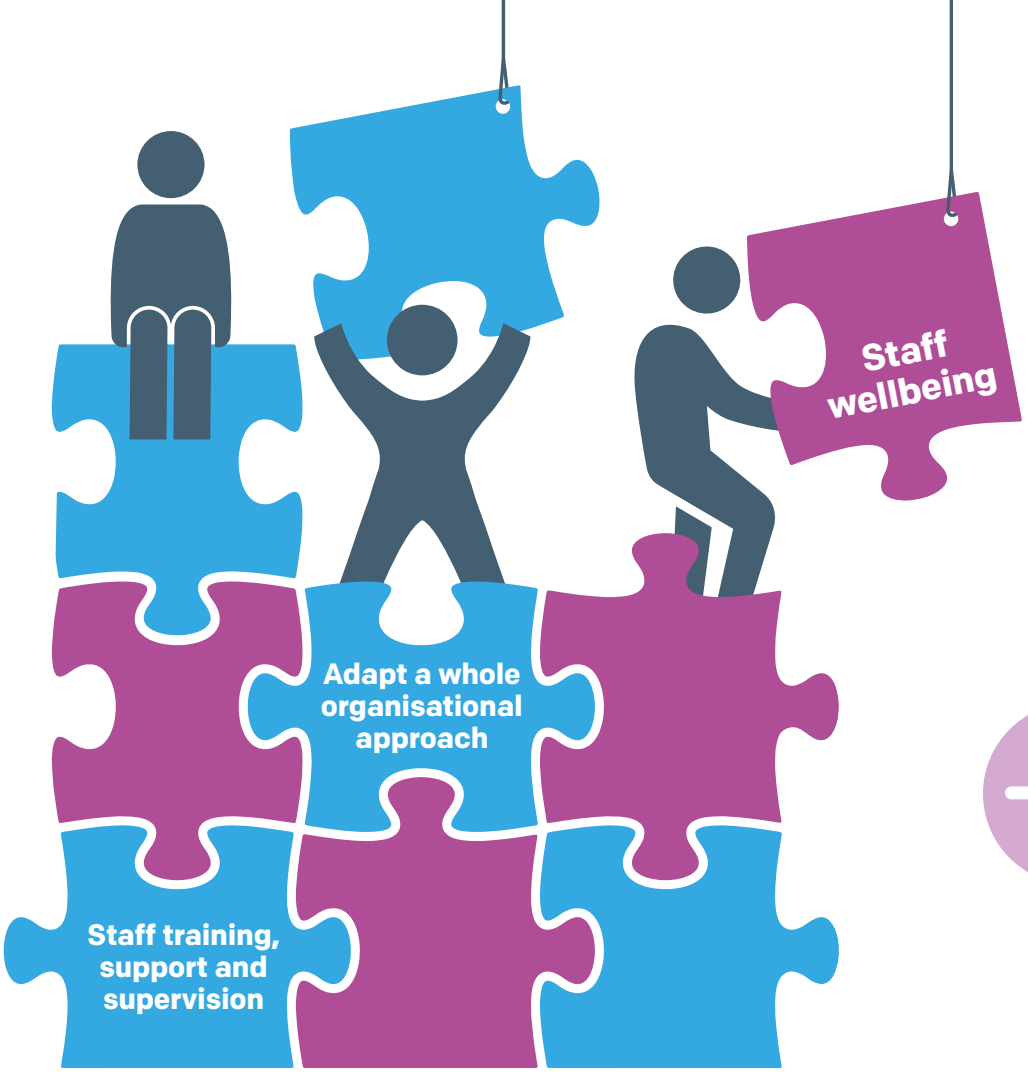
Research undertaken as part of the Fulfilling Lives programme highlights three guiding principles to effectively embed trauma informed approaches:

1. Adapt a whole organisational approach
2. Staff training, support and supervision
3. Staff wellbeing.

An outcome of working in a trauma-informed way is improved experience and engagement with services. Not only does engagement with services increase but engagement with treatment is improved, with a reduction in behaviour and incidents that require the use of seclusion and restraint.

Benefits extend to staff in terms of improvement in wellbeing, confidence, morale and resilience. Training opportunities **resulted in** enhancement of skills, leading to an increased sense of ability to do their job and overcome challenges.

From a workforce development perspective, investing in staff training and development is a key component to **improving** health and social care provision for this cohort, positively impacting on patients care and outcomes. This supports the movement away from the 'us and them' culture often present between health & care professionals and service users, which can get in the way of good care and negatively affect engagement with services.

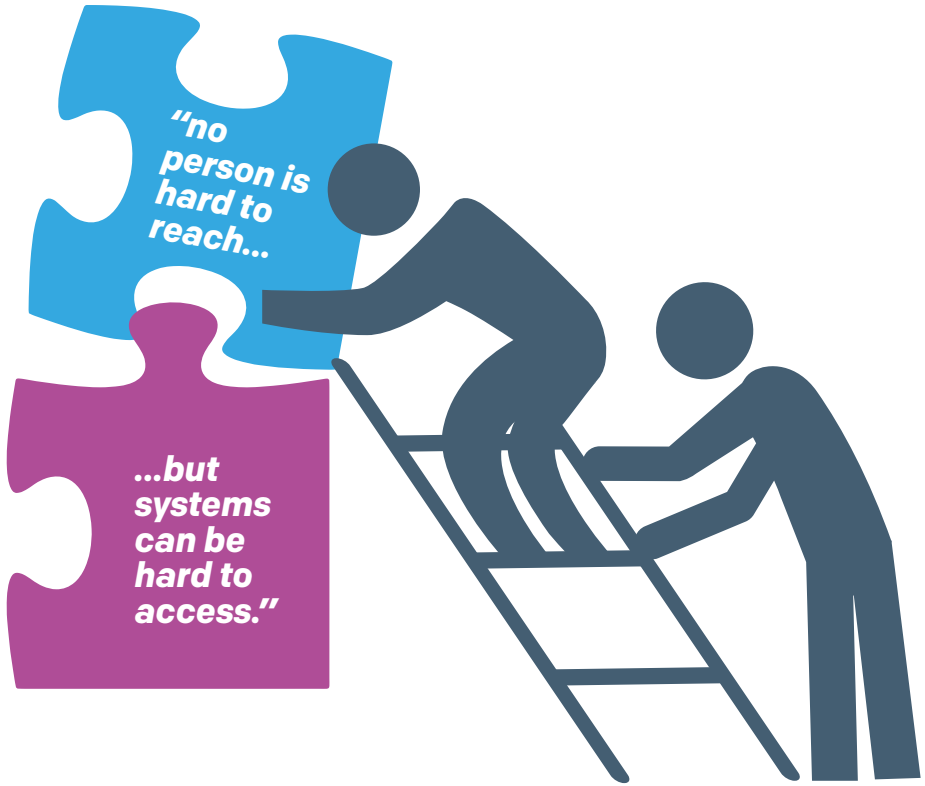


Ways of Working

Across the health and social care system, services struggle with the complexities of adults experiencing issues with drug, alcohol, mental health and wider associated issues impacting their health and wellbeing. There are significant costs associated with this repeated, yet often ineffective, contact with services. The most vulnerable adults in this situation are estimated to cost the state **five times** more per year than the average citizen.

There is a strong **evidence** base that highlights the need for greater collaboration between services and across traditional boundaries. This allows health & care professionals to take a holistic approach, viewing the person as a whole, and better understand their circumstances and the challenges they face. When this is achieved, the relationship between service users and health & care professionals is stronger and the quality of support offered improved, which can have a positive impact on that person's outcomes. This supports the need to enable services to work across disciplinary boundaries. This could take the form of multi-disciplinary meetings (MDT), which **evaluations** have found helps to develop and strengthen relationships between staff members and services. Including this as part of contract monitoring for a commissioned service is one way to support embedding this way of working.

Siloed working within services is a barrier to successful access and engagement for this cohort resulting in an inability to access appropriate support when needed. As described by the **Fulfilling Lives LSL programme**:



Mental Health and Drug/Alcohol Misuse (as Co-occurring Conditions)

There is a high percentage of people whose experience of multiple disadvantage includes both poor mental health & wellbeing alongside drug/alcohol misuse issues, resulting in specific challenges for these individuals when accessing services. Services use language such as 'inappropriate referral', and there is stigma attached to people who present with a substance misuse issue and a personality disorder within mental health services.

Many services are designed to respond to one issue at a time, with some having strict access criteria that mean a member of staff can only respond to one issue before a referral can be accepted. When people have multiple needs that require support simultaneously this can result in people being left without any support and essentially stuck between two services who will not offer support until the other is addressed and vice versa. For example service users are unable to obtain a mental health assessment while under the influence of drugs or alcohol, and unable to access support with their substance misuse due to untreated mental health **issues**.

Whilst the challenges of working with people who have this level of complexity should not be overlooked, there is a reason this cohort consume 5 times the amount of resources compared to the general population and the system needs to acknowledge the significant contribution it makes to this through the barriers that are built up for these people.

There is clear national and clinical guidance that supports this way of working. **The NHS Talking Therapies manual** states drug or alcohol use should not automatically exclude someone from accessing mental health services delivered via primary care, if following assessment, they would benefit from accessing this provision. However, the guidance states drug or alcohol use should not interfere with a person's ability to attend and engage with the offer. If this is not possible then the National Institute for Clinical Excellence (NICE) guidelines recommend the person completes drug or alcohol misuse treatment first. This highlights the need for services to work together and develop locally agreed pathways.

The **Public Health England** (PHE) commissioning guidance for people with a drug/alcohol use and mental health conditions emphasises:

> ***"meeting co-occuring alcohol/drug and mental health needs should be part of the core business of both alcohol/drug services and mental health services – it is everyone's business."***

A key enabler to working collaboratively is strong, senior and visible leadership with shared child and adult safeguarding and quality governance arrangements.

Commissioning and the impact this has on service delivery/ways of working

It is important to recognise that some of the challenges described previously are a product of the system design. It is therefore important to consider the role of commissioning in supporting a new way of working; acknowledging current commissioning models, generally speaking, do not give providers the flexibility and autonomy needed to work in this way.

Commissioning can promote and encourage risk-averse behaviours from staff, inhibiting innovation within service delivery. **Fulfilling Lives** reported instances where mental health services were unable to engage with people experiencing multiple disadvantage citing 'they were not commissioned to do that'. There is frequently a focus by commissioners on traditional performance measures which can be a barrier to delivering a flexible, person-centred service.

As described, those affected by multiple disadvantage are more likely to need to engage with multiple services simultaneously. Commissioners need an appreciation of this and factor this in when commissioning services, taking a system-wide approach to **decisions**. In particular, focusing on the interface between services as this is where most people fall through the **gaps**.

In a similar way, the way in which mental health services are commissioned leads to people falling between service thresholds. The stepped care model used in mental health services can lead to people falling between step 3 and step 4, and they are often perceived as too complex for primary care services but do not meet the threshold for more specialist services delivered within secondary care. Increased demand for services coupled with constrained resources has led to increasingly high thresholds for specialist secondary **care** further compounding this issue. The way in which mental health services and many other health and care services are commissioned, via block contracts, does not incentivise providers to see more people. All of these barriers, created by the system, mean people often hit crisis point before being able to access support or may seek support via emergency departments. Both of which are potentially avoidable, costly episodes of care.

The way in which services are commissioned can mean staff feel unable to work outside of the traditional models of delivery. People with experience of multiple disadvantage can struggle to engage with the 'appointment' **model** of healthcare. This model relies on people remembering appointments, attending appointments at a specified time and place, often in a clinical setting, having to wait long periods between assessment and treatment.

Previous work in this space has highlighted the need for person-centred, individualised support. Recognising that everyone's journey of recovery is different, and relapses are a normal part of this. Service providers need to be able to accommodate this rather than punish it by excluding people from services or closing their case. This needs to be factored into contracts and outcomes frameworks. Services that are short-term or have a time limit on working with people are unlikely to deliver the care required. This links to the point around challenges with the commissioning cycle being too short which makes it difficult to provide a full evaluation of the service.

Access and experience recommendations

Spacial level	Activity
Organisation	Recognising the critical role of leadership in terms of embracing the principles of trauma-informed care and practice, nominate a named executive lead to oversee and provide assurance against working towards becoming a trauma-informed organisation.
	Nominate a trauma-informed champion within each service area.
	Complete **trauma-informed care and practice organisational audit tool.**
	All staff (not limited to frontline roles) to complete NHSE's Trauma Informed Care **e-learning.** Adding NHSE's Trauma Informed Care **e-learning to the organisations mandatory training**. Compliance monitored via ESR.
	Organisational culture empowers staff to make changes to how care is delivered in line with a trauma informed approach for example, staff are able to change the physical environment where care takes place, this could be a waiting room that is made to look less clinical and institutionalised to help create a welcoming environment and help put service users at ease.
	Assessing policies, practices and environments to align with trauma-informed principles and support the required culture shift in line with the **principles** of trauma-informed care and practice.
	Include questions in local staff surveys asking how trauma informed staff consider the organisation to be and invite feedback around what is working well and what could be improved.
	Cultivate a culture whereby people are not reduced to being an 'inappropriate referral' and therefore not accepted because of a failure to meet referral criteria attached to the provision, but enabling flow through provision.
	Co-production with the workforce is key to embedding the learning so that it is owned within organisational culture. Ensuring that employees are actively engaged have an opportunity to collaborate/feedback and is aligned to the organisation's values.

Access and experience recommendations

Spacial level	Activity
System	Support the spread of Fulfilling Lives programme recommendations within health and care, to aid building a GM-wide trauma informed approach.
	Development of trauma-informed champion role.
	Commissioning leads (e.g. for drug/alcohol and mental health) explore development of a joint commissioning model for these services to support local pathway development and better integration between services.
	Support commissioning to enable services to respond collaborative, effectively and flexibly (including times and location) to presenting needs, preventing exclusion and delivering care in a non-judgemental, person-centred way.
	Joint across health and care services (e.g. drug/alcohol and mental health) review referrals that haven't been accepted as part of contract monitoring to identify areas within the service design and process that could be improved.
	Service specifications to be explicit in relation to (e.g. drug/alcohol services and mental health) and the need to jointly develop local pathways and the agreed ways of collaborative working.
	Contracts include incentives for providers to support people to engage, and remain, with services; for example, through simplifying financial arrangements and reducing bureaucracy thereby giving the provider the autonomy to deliver person-centred care.
	Organisational development and/or leadership support (e.g. for drug/alcohol and mental health) frontline teams to come together and start building relationships.

Summary

Thank you for taking the time to read and engage with this report. The recommendations outlined above collectively form the Multiple Disadvantage Framework. This framework is intended to form a foundation to support greater employment access into health and social care roles across Greater Manchester, support improved retention, and explore how those who have experience of multiple disadvantage and complex needs might have improved experiences in accessing health and care services as a user/patient.

Acknowledgments

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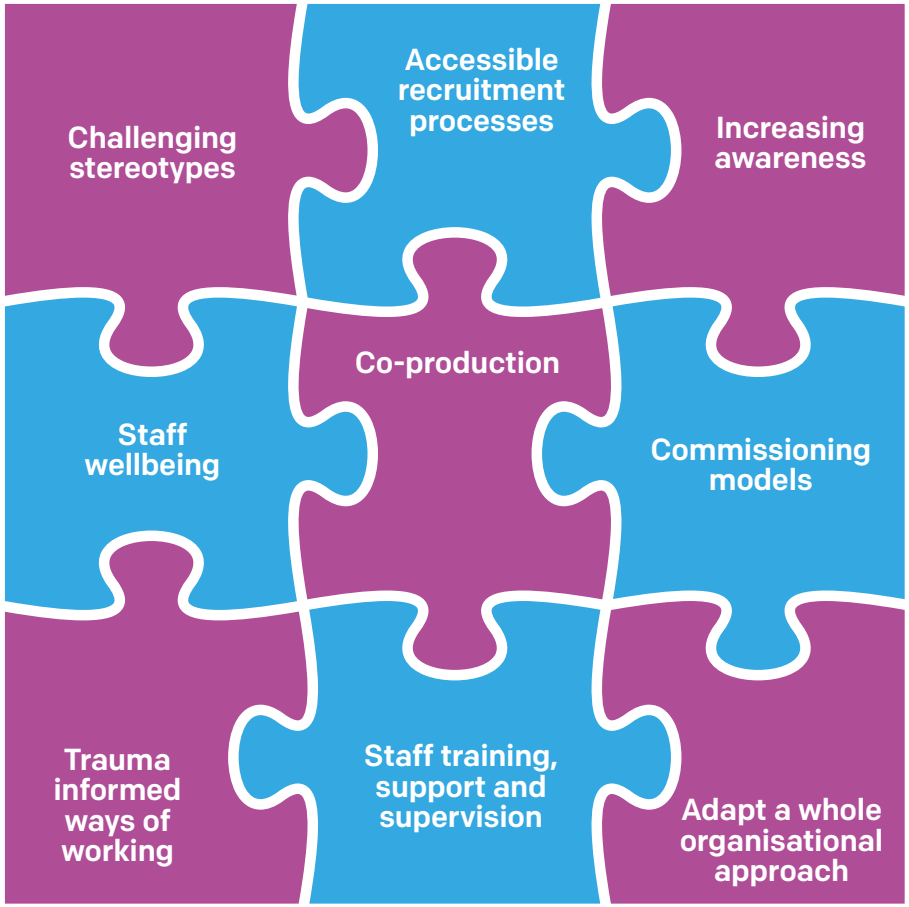
Contact

If you have any questions or comments on this framework, please contact: **gm.workforce@nhs.net**



Appendix

Below is a list of key linked resources or programmes of work at a local and national level. This is not an exhaustive list and will evolve as roll out of the communications plan for the framework and implementation progresses. If you think there are key connections that need to be linked into this work, please do get in touch: **gm.workforce@nhs.net**

National work programmes & policies

- Changing Futures Programme
- Making Every Adult Matter
- Fulfilling Lives
- Shelter – GROW Programme
- NHS Staff and Learners' Mental Wellbeing Commission
- NHS Long Term Workforce Plan
- Health & Care Act
- Learning Disability & Autism Plan

Locally connected work & strategies

- Good Employment Charter
- Working Well Programme
- Live Well
- NHS GM Equalities & Inclusion
- Fairer Health for All
- NHSE Overhauling Recruitment
- GMCA Work and Skills
- GM Recruitment & retention Toolkit
- Foundations for Change – GM Workforce Equality Scheme
- NHS People & Culture Strategy – addressing inequalities
- NHS North West – Anti-racism Framework
- Recruitment support from Skills for Care

Related research & papers

Referenced within the framework:

- What is multiple disadvantage?
- Gendered patterns of severe and multiple disadvantage
- A national framework for NHS – Action on inclusion health
- Improving Inclusion Health Outcomes
- Living in the North of England increases risk of death from alcohol, drugs and suicide
- Adverse childhood experiences and the developing brain
- Understanding the Impact of Trauma
- Defining Trauma

Recruitment

- Criminal Background and Job Performance
- Involving people with lived experience in the workforce: Workforce development and multiple disadvantage
- How to recruit local talent differently: an implementation guide

Retention

- Transforming regulation through collaboration: Why we need to talk more about accountability in public services
- The impact of an NHS worker exodus
- Can we expect NHS staff to be the shock absorbers of a system under pressure?
- NHS sickness absence: let's talk about mental health
- Health in the workplace: patterns of sickness absence, employer support and employment retention
- Employing People with Lived Experience & Complex Needs
- Workforce development and multiple disadvantage

Access

- Supporting People with Multiple & Complex Needs
- An introduction to Psychologically Informed Environments and Trauma Informed Care
- Systems change for people experiencing multiple disadvantage
- Trauma-informed approaches to supporting people experiencing multiple disadvantage
- What enables people with multiple and complex needs to access primary healthcare?

Ways of working

- Evaluation of Fulfilling Lives: Supporting people with multiple needs
- NHS Talking Therapies for anxiety and depression manual
- Better care for people with co-occurring mental health and alcohol/drug use conditions
- Improving access to mental health support for people experiencing multiple disadvantage
- Trauma-Informed Care and Practice Organisational Toolkit
- E-Learning for Trauma Informed Care

Other useful resources:

- Future focus – where next for policy on multiple disadvantage?
- Essay collections for multiple disadvantage
- Recruiting, employing and retaining people with convictions: Guide for organisations
- Inclusion Health Toolkit – fairer health for all
- What makes an effective multiple disadvantage navigator?
- Tackling Multiple Disadvantage
- Tool to tackle high levels of maternity disadvantage
- Exploring the UK's digital divide – Office for National Statistics
- Recruiting people with experience of homelessness