Assura Community Fund Greater Manchester Health & Wellbeing 2026 programme

Manchester Community Central
Collaboration Team

Insights from grantees

June 2026

INTRODUCTION

The aim of the Fund is to improve the health and wellbeing of unpaid carers from global majority ethnicities in Greater Manchester.

Manchester Community Central (Macc) manages the programme on behalf of 10GM, with funding provided by Cheshire Community Foundation on behalf of the Assura Community Fund.

Grants of £5,000 were awarded to community organisations who hold trusted relationships with unpaid carers in their community, to deliver health and wellbeing projects between January and December 2026. More details about the Fund can be found on our website.

In June 2026, Macc invited representatives from these organisations to come together to network, provide updates, share insights on what works, listen to learning and challenges and offer support to one another. This report is a summary of these conversations.

Context of the Fund

Unpaid carers are often hidden in society and not engaged with mainstream services or activities that support their health or wellbeing. For the majority, being a carer is a responsibility attributed to being part of an intergenerational family.

Many of these families are already struggling due to low paid, unstable jobs and the strains of health inequalities. This is exacerbated by increasing isolation due to barriers to support such as language, lack of awareness of what's available, and limited access to culturally appropriate services.

Read more about health inequality in Greater Manchester in these reports:

- Independent Inequalities Commission
- Build Back Fairer in Greater Manchester
- Fairer Health for All

Who's providing unpaid care?

The picture that emerged was consistent across organisations:

- **Overwhelmingly women** (~90%), often carrying multiple simultaneous caring roles: parents, parents-in-law, and children — alongside cooking, cleaning and household management, with little or no rest.
- Many are from **Pakistani, Bangladeshi and other global majority communities**, including significant numbers of new arrivals with limited English.
- Common conditions being cared for include **dementia, cancer, autism and other complex needs**.
- Many live in **multigenerational household**s, where the boundaries between paid and unpaid care, and between family obligation and personal capacity, are blurred and contested.
- Several are **isolated,** including older people living alone who have assets but lack access to appropriate financial or legal guidance
- **Transport is a real barrier**, particularly where men take the family car to work, leaving women without independent mobility.

What do carers actually need?

The needs described went far beyond formal care support:

- **Getting out of the house** — this was cited repeatedly as foundational. Face-to-face contact outside the home allows carers to speak freely in a way phone calls do not.
- **Someone to talk to, laugh with, and trust** — coffee mornings, 1:1 sessions, and peer support were all valued. One carer said: "Coffee morning has helped me understand what I'm going through."
- **Practical navigation support** — help with PIP, social services, benefits, housing, school uniforms, life admin, and crisis situations.
- **Culturally appropriate financial advice** — particularly for older people who have assets but are vulnerable to exploitation, and who need trusted, language-appropriate intermediaries.
- **Rest** — simply put, people are not resting, and this is a health issue.
- **Emotional space** — stigma, denial and guilt (especially around family members) mean carers often don't acknowledge their own needs. The word "mental health" doesn't work as a framing; approaches that get people out of the house and into community work better.
- **Faith-informed responses** — particularly for families of children with autism, who want practical answers but also responses that connect with their spiritual frameworks.

“Referrals are going round in circles”

What’s working?

- **1:1 trust-based relationships** built slowly over time — particularly valuable in the Pakistani community for working through conflict, family boundaries, and confidence building.
- **Coffee mornings and community outings:** low-key, social, outside the home. Day trips have been effective once trust foundations are built.
- **Word of mouth** as the main referral route.
- **Memory work -** a "Journey of Memories" group at Oldham Library in partnership with people with dementia and the memory service, is continuing beyond its funding through self-organised WhatsApp groups.
- **Wellbeing check-ins -** one organisation does colleague check-ins after 1:1 sessions, recognising the emotional labour on staff and volunteers
- One carer has enrolled in an **NHS peer supporters course**, a sign of growing confidence.

Language, culture and limits of current systems

A consistent thread was the failure of mainstream systems to meet these communities where they are:

- **Interpreters are often inadequate;** not all are trained in mental health contexts, dialects aren't always recognised, and there aren't always direct translations for key concepts. People hold back when using interpreters.
- **The NHS sends letters in English** asking if people need a translator, a basic failure.
- **Paid carers often lack cultural competence,** there is an "it's not my job" attitude, a lack of continuity of care, and even carers who speak the same language may not understand the cultural context.
- **Social workers are not explaining the system -** families aren't being helped to understand how care works, diagnoses take a long time, and by the time they arrive families are already in crisis.
- **Referrals are going round in circles;** most people are being bounced back from adult social care and NHS to these community organisations, which then have to do the work the system should have done.
- **Macmillan Cancer Care** was mentioned as a referral source - the group felt large organisations like this should be funding this work.

Monitoring, measurement and impact

- There is **no agreed framework** for measuring impact in this sector, and gathering feedback is difficult.
- The **Work and Social Adjustment Scale** was suggested as a familiar and useful tool, given its connection to mental health and wellbeing services.
- There is appetite for **AI-assisted data input** to reduce admin burden.
- Organisations noted they **underestimated costs** when planning; building in contingency and resource to 'secure' delivery is important.
- **Plans always adapt:** "When you apply you have a plan and that plan adapts to what users need." Outputs are described as positive, with more welfare-focused work than originally anticipated.

> "Unpaid carers are a crucial part of community care"

Support needed for organisations

- **Continuation funding** was flagged as a significant need; time-limited projects cannot sustain the trust and relationships they build.
- Knowledge of free or low cost **community spaces** to meet people, linking to Macc's Alternative Venues Network
- A **WhatsApp group for peer-support,** to continue conversations, initiated by Macc with one of the organisations taking it over
- Continue connecting with other voluntary, community and social enterprise orgaisations for **local signposting** (food, housing, other services)
- **Wellbeing** support for leaders and volunteers of organisations supporting unpaid carers

SUMMARY

These community organisations are doing intensive, trust-based, culturally grounded work that statutory services are not set up to provide and are increasingly being relied upon to pick up the gap.

The carers they support are mostly women, often isolated, frequently without language support, navigating complex systems alone.

What works is relationships, community, and presence.

The ask to funders and systems is clear:

- longer funding
- better recognition
- genuine integration into care pathways

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Voluntary, community and social enterprise sector

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