Note to: Equalities and Inclusion Executive Members Subgroup
Date: 14 July 2020
Subject: COVID-19: Equalities and Inclusion Overview Report
From: Keiran Barnes, Equality, Diversity and Inclusion Manager

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Purpose: Information

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1. Introduction

1.1 From the onset of the Coronavirus (Covid 19) pandemic, it has affected different communities of identity differently. Initial scenario-setting work recognised the most at risk groups as being those over the age of 70, some disabled people and those with ongoing health conditions, because of the relatively poorer health generally experienced in those groups. Consideration was also given to other identity groups and established a relevance to some racial and religious groups, owing to traditions and practices that increased risk of contraction, and indirectly, the increased health and wellbeing risks of 'lockdown' to those people experiencing domestic violence. It also recognised that lockdown and a general social anxiety in such unfamiliar circumstances would adversely affect some people's mental health.

1.2 Over the course of the ensuing weeks, the span and scale of those identities that have been and continue to be adversely affected by Covid 19, and the nature of the impact, has become clearer. Intelligence has been produced, monitored and refined at local, regional, national and international levels and is beginning to convey a compelling narrative which addresses not only the material characteristics of a given group, but also the health, economic, environmental and social constructs that they exist within which contribute to their experience of the pandemic.

1.3 It is timely to take stock of what this continually growing intelligence base is saying, and observing that through an equalities and inclusion lens, firstly to take account of what is now understood of the effects of Covid-19 societally (and what still remains unknown), and secondly to consider how this can play into Manchester's plans for an inclusive recovery from the pandemic.

2. About This Report

2.1 This report aims to draw into one place some of the most relevant, reliable and clearly defined intelligence on Covid impact for various communities of identity for the Council's consideration, recognising that this information is varied and dispersed in its nature. The report does not seek to describe all lines of Covid-related impact, as in many cases these are universal and affect the general population; instead, an equalities and inclusion lens is applied to understand impact for those groups protected by the Equality Act 2010 (the 'protected characteristic' groups), other relevant identity groups and some thematic areas that must be given consideration. Particular attention has been paid to impacts on the following groups:

- People of different ethnicities
- People of different religions and faiths
- People aged 70+ (within a broader Age Friendly approach)

- Children and young people
- Disabled people (includes people with long term health conditions)
- People who are ‘shielded’ (includes people with long term health conditions)
- People living in poverty and deprivation

2.2 To compile this profile of equalities impact, the report draws on a range of intelligence sources, from national data produced by the likes of Office for National Statistics (ONS) and Public Health England (PHE), to more local data produced by Manchester and Greater Manchester public service providers and local VCSE&F organisations. It does not include information from press or social media articles, in the interest of objectivity.

2.3 It is important to note that, in the production of this report, it has become apparent that the breadth, depth and range of the available intelligence is changing week by week. Compelling information produced in April of 2020 has already been superseded by consequent reports and the scale and pace of change to the intelligence base looks set to continue, if not accelerate. The focus here, then, is to focus on the most recent lines of reporting available at the time of writing, to assess what is known and what lines of enquiry remain to be followed. The speed and shift of evidence on this topic though, mean that it will be prudent to review the findings of this report on a regular basis throughout the recovery planning and implementation period, to continually understand emerging issues and adjust recovery approaches accordingly.

2.4 Whilst the intelligence here demonstrates that there are disparities in how the pandemic affects different communities (based at least in part on identity) and is helpful in describing how these disparities have taken effect to date, it is less clear on causality of some of the disparities, making predicted impact more difficult too. This report then, is unavoidably an assessment of what has happened and acknowledged that there is uncertainty over what is to come. In some cases, educated estimates of causality and / or forecasting are made but clearly further monitoring, analysis and reporting is required to clarify the cause and effect more consistently, the outcomes of which should be considered in the ongoing recovery planning process.

2.5 The available intelligence, in numerous instances, draws a line between particular communities of identity, their economic, health and social circumstances and the impacts that deprivation can have in exacerbating the effects of Covid-19. A further impact of the pandemic is inescapably the budget pressures that health and social care providers will face in the immediate and mid-term future. It is important when reviewing the contents of this report then, to consider the relationship between Covid-specfic impact, pre-existing deprivation for various communities of identity (many of whom experienced disadvantageous outcomes prior to Covid-19) and the challenging budget environment that the Council finds itself in. The context of the report and associated works related to it, are to inform an approach to an inclusive recovery or Manchester; in that context it will be vital that recovery is planned in such a way as to ensure that those most disadvantaged communities of identity, for whom Covid impact has been a ‘double hit’, are not further disadvantaged.

3. Contents

4. Ethnicity

4.1 Overview

4.1.1 The Equality Act 2010 defines ‘race’ as including colour, nationality and ethnic or national origins. A racial group is a group of people who have or share a colour, nationality or ethnic or national origins. This report recognises that different ethnic groups are affected by COVID19 differently, and will seek to be as specific as the data allows to indicate which ethnic groups are affected in what ways. Whilst a person’s ethnicity can be closely related to their religion and / or belief (and associated traditions and cultural practices), separate consideration of Covid issues linked to religion or belief is dealt with later in this report.

4.1.2 Analysis of ethnic disproportionalities in health outcomes, which aggregates different ethnic groups together, masks many of the facts of ethnic inequalities, and limits the scope for understanding why they have come about. Moreover, simply comparing mortalities with overall populations fails to take account of key characteristics of different ethnic groups and oversimplifies the analysis. In addition, given the varied profiles of different ethnic groups, some are more likely to be economically vulnerable as a consequence of the Covid-related restrictions than others, and this dimension is crucial for painting a full picture of ethnic inequalities arising from Covid-19. Household structures, occupational profiles and levels of savings are all important to consider in identifying in which groups the greatest economic vulnerabilities lie.

4.1.3 Accounting for these factors and recognising that the impacts of the Covid-19 crisis are not uniform across ethnic groups, demands that specificity about which groups are affected how is required; helpfully, this is starting to become more readily available.

4.2 Hospital death ethnicity trends

4.2.1 ONS reports that per-capita, Covid-19 hospital deaths are highest among the black Caribbean population and three times those of the white British population. Some minority ethnic groups – including Pakistanis and black Africans – have seen similar numbers of hospital deaths per capita to the population average, while Bangladeshi fatalities have been lower.

4.2.2 After taking account of age and geography, most minority groups ‘should’ have fewer deaths per capita than the white British population. While many minority ethnic groups live disproportionately in areas such as London and Birmingham, which have more Covid-19 deaths, most minorities are also younger on average than the population as a whole, which should make them less vulnerable.

4.2.3 After accounting for the age, gender and geographic profiles of ethnic groups, inequalities in mortality relative to the white British population are therefore more stark for most minority ethnic groups than they first appear. Black Africans and Pakistanis would be expected to have fewer fatalities per capita than white British but at present they are comparable.

4.2.4 After stripping out the role of age and geography, Bangladeshi hospital fatalities are twice those of the white British group, Pakistani deaths are 2.9 times as high and

black African deaths 3.7 times as high. The Indian, black Caribbean and 'other white' ethnic groups also have excess fatalities, with the white Irish group the only one to have fewer fatalities than white British.

4.3 Non-hospital death ethnicity trends

4.3.1 These disparities cannot currently be accounted for by non-hospital deaths. Official deaths in care homes – for which the ethnicity of the deceased is not currently available but where nationally, over 95% of residents are white – could only explain a small part of estimated excess fatalities recorded in hospitals for minority groups. The ethnic composition of additional deaths directly or indirectly caused by the virus but not officially attributed to it is unclear at this time.

4.3.2 Occupational exposure may partially explain disproportionate deaths for some groups. Key workers are at higher risk of infection through the jobs they do. More than two in ten black African women of working age are employed in health and social care roles. Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors.

4.3.3 At-risk underlying health conditions are especially prevalent among older Bangladeshis, Pakistanis and black Caribbeans. Compared with white British individuals over 60 years of age, Bangladeshis are more than 60% more likely to have a long-term health condition that makes them particularly vulnerable to infection, which may explain excess fatalities in this group.

4.4 Ethnicity and economic vulnerability

4.4.1 Many ethnic minorities are also more economically vulnerable to the current crisis than are white ethnic groups. The fact that larger shares of many minority groups are of working age means that these populations are more exposed to labour market conditions as a whole, but even amongst working-age populations there are clear inequalities in vulnerability to the current crisis.

4.4.2 Men from minority groups are more likely to be affected by the shutdown. ONS finds that while in the population as a whole women are more likely to work in shut-down sectors, this is only the case for the white ethnic groups. Bangladeshi men are four times as likely as white British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector, and Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving. Black African and black Caribbean men are both 50% more likely than white British men to be in shut-down sectors.

4.4.3 Self-employment, where incomes may currently be especially uncertain, is especially prevalent amongst Pakistani and Bangladeshi communities. Pakistani men are over 70% more likely to be self-employed than the white British population. While in the population as a whole young people are more likely to be affected by the shutdown, the reverse is true among Pakistanis and Bangladeshis. While 24% of young white British and 29% of young Bangladeshis work in shut-down sectors, the figure is 14% for 30- to 44-year-old white British but 40% for 30- to 44-year-old Bangladeshis. This

also means that the family circumstances of those affected by shutdown differ by ethnicity, with older workers more likely to be living in couples.

4.4.4 The potential for buffering incomes within the household depends on partners' employment rates, which are much lower for Pakistani and Bangladeshi women. As a result, 29% of Bangladeshi working-age men both work in a shut-down sector and have a partner who is not in paid work, compared with only 1% of white British men.

4.4.5 Bangladeshis, black Caribbeans and black Africans also have the most limited savings to provide a financial buffer if laid off. Only around 30% live in households with enough to cover one month of income. In contrast, nearly 60% of the rest of the population have enough savings to cover one month's income.

4.5 Underlying health conditions by ethnicity

4.5.1 There are also notable inequalities in underlying health conditions and physical health that are likely to be relevant. Pakistani, Chinese and Indian communities are over-represented among people over 65 with health-related problems. Minority ethnic communities are over-represented in citizens with co or multi morbidities, such as latent TB, HIV, hypertension and coronary disease that can put them at higher risk.

4.5.2 Being overweight or obese has been identified as a potential risk factor, and 73% of England's adult black population is overweight or obese; 10 percentage points more than the white British population and 15 percentage points more than the Asian population overall.

4.5.3 Black and south Asian ethnic groups have been found to have much higher rates of diabetes than the population as a whole: three times more likely for people of African and Caribbean backgrounds to have type 2 diabetes, and; six times more likely for people of South Asian background. Older Pakistani men have been found to have particularly high levels of cardiovascular disease.

4.5.4 Particularly in older age brackets, Indian, Pakistani, Bangladeshi and black Caribbean individuals are much more likely than white British people to report one or more of these health problems which are likely to increase their mortality risk from COVID-19. It may well be that underlying health conditions such as these can explain part of the disproportionality in hospital death figures across ethnic groups so far.

4.5.5 These findings are further supported by the report published by Public Health England (June 2020) which found:

- Black, Asian and Minority Ethnic people are more likely to live in urban areas, in overcrowded households and in deprived areas;
- They are more likely to have jobs that expose them to higher risk;
- They are more likely than White British people to be born abroad, meaning they may face barriers in accessing services;
- Some comorbidities (e.g. type 2 diabetes) are more prevalent in Black, Asian and Minority Ethnic communities.

4.5.6 Gypsy and Traveller communities are known to face some of the most severe health inequalities and poor life outcomes amongst the UK population. However, there is a

lack of clear, consistent guidance on Covid prevention and recovery specifically relating to people living on unauthorised encampments, on Traveller sites and on boats. Overcrowding and challenges in social-isolating are high for many in this group. The Minister of State in the Ministry of Housing, Communities and Local Government has written to local authorities across England highlighting how they can support Gypsies and Travellers during the coronavirus pandemic, but this places the onus very much on the local authority to define its approach based on limited and non-specific guidance.

5. Religion / belief

5.1 UK analyses on the religion-related dynamics of Covid have adopted a similar approach to the ethnicity analysis. When taking age into account and using the Christian religion as the reference category (as the largest population), the ONS found that those who identified as Muslim at the time of the 2011 Census are 2.5 (males) and 1.9 (females) times at greater risk of a Covid-related death than those of Christian religion. Muslims had the greatest risk relative to the Christian population of the same age, although Jews, Hindus, Sikhs and Buddhists also showed a higher risk than the Christian religion.

5.2 But when these findings are fully adjusted for socio-economic factors, including ethnicity, religion does not appear to be a factor in increased risk for any religious group, other than for the Jewish community.

5.3 The ONS findings show that those who identified as Jewish at the time of the 2011 Census had the highest risk of a death involving Covid-19 compared to the Christian population; Jewish males show twice the risk compared to Christian males, with females at 1.2 times greater risk. However, despite the demonstrable disparities here, the data do not show what the reasons for this are at this stage, and uncovering this will undertake further analysis in the weeks and months to come.

5.4 Bereavement during lockdown has caused concern for everyone experiencing the death of a loved one. Burials in some cases have been delayed, which will have caused distress to many Muslims and Jews not able to carry out prescribed funeral rites. Social distancing and changed religious practice around end of life and burial for all have impacted heavily on all those for whom religious observance is a core part of their identity.

6. Disability

6.1 Overview

6.1.1 From the earliest cases of Coronavirus in the UK, disabled people have been highlighted as a group in the most at risk category, especially those disabled people with respiratory conditions. Unsurprisingly, using the Census 2011 as a guide, those whose daily activities were limited a lot have seen a greater rate of death since the Covid outbreak. Monitoring and recording Covid deaths by disability has been difficult, as a person's disability status is not recorded on the death certificate (although existing health conditions which would fall within the Equality Act 2010

definition of disability are referenced where they are relevant); this has necessitated the use of Census 2011 to measure overall rates of death and disproportionate impact on disabled people.

6.2 Social impacts on disabled people

6.2.1 The prevalence of health conditions that potentially increase risk of Covid infection amongst disabled people, along with the effects of extended isolation either due to personal circumstances or the Government's 'shielding' programme, have inevitably led to raised anxiety and life-limiting choices being made in the disability community. The ONS report 'Coronavirus and the Social Impacts on Disabled People in Great Britain' (May 2020) highlights a number of the key issues being faced.

6.2.2 The ONS report found that just over 7 in 10 disabled adults (73.6%) reported they were "very worried" or "somewhat worried" about the effect that Covid-19 was having on their life overall (69.1% for non-disabled adults); this represents a decrease compared with April 2020, when nearly 9 in 10 (86.3%) disabled adults reported this, but remained higher than the non-disabled cohort.

6.2.3 However, a starker comparison came from the proportions of disabled people versus non-disabled people who were worried about the effect of the coronavirus pandemic on:

- their well-being (62.4% for disabled people compared with 49.6% of non-disabled people);
- their access to groceries, medication and essentials (44.9% compared with 21.9%);
- their access to health care and treatment for non-coronavirus-related issues (40.6% compared with 21.2%), and;
- their health (20.2% compared with 7.3%).

6.2.4 Concerns about well-being tended to be most frequent among those with mental health and sociobehavioural-related impairments, whereas concerns about access to essentials tended to be most frequent among those with hearing-related or dexterity-related impairments.

6.2.5 Disabled adults more frequently reported their well-being had been affected through feeling lonely in the last seven days (48.7%) than non-disabled adults (29.4%).

6.2.6 Prior to the coronavirus pandemic (in the year ending June 2019), the ONS's average rating for anxiety was 4.3 out of 10 for disabled people, but disabled people's average anxiety rating increased following the outbreak of the coronavirus pandemic to 5.5 out of 10 in April 2020. In May 20202, 41.6% of disabled people, compared with 29.2% of non-disabled people, continued to report a high level of anxiety, resulting in a sustained raised score of 6 to 10.

6.2.7 About three-quarters of disabled people (73.4%) reported leaving their home in the last seven days for any reason, compared with over 9 in 10 non-disabled people (92.5%); disabled people were more likely to report leaving their homes for medical needs or to provide care or help to a vulnerable person (23.5%) than non-disabled people (13.1%) in May 2020.

6.2.8 Unsurprisingly given raised infection risks associated with ongoing health conditions, around 1 in 10 disabled people (11.9%) indicated feeling very unsafe when outside their home because of the coronavirus outbreak, compared with fewer than 1 in 25 non-disabled people (3.8%).

6.3 Greater Manchester Disability Panel, Big Disability Survey

6.3.1 The findings from the ONS research are, as could be expected, mirrored more locally and brought into sharper focus through the Greater Manchester Big Disability Survey. The survey was conducted by the Greater Manchester Disabled People's Panel, a GM-wide, pan-impairment Panel, made up of 14 Disabled People's Organisations (organisations that are majority led and staffed by disabled people), and convened by the Greater Manchester Coalition of Disabled People. Early on in the Covid-19 pandemic, the Panel commenced the Big Disability Survey with disabled people across GM to understand the impact on their lives and to shape a set of recommendations for improvement. 936 people completed the Survey across a broad spectrum of condition and impairment types.

6.3.2 20% of participants of the full survey received a letter from the Government to indicate that they were in the 'high risk' group for the Covid-19 outbreak. Of the 80% that did not receive this letter, 57% reported having support needs of which only 19% report they are getting all of their needs met.

6.3.3 90% of respondents said that the pandemic has had a negative impact on their mental health.

6.3.4 31% of respondents to the full survey were not at all aware of the community hubs across GM.

6.3.5 Accessibility to the GM hubs varied slightly by impairment; those who identified as being hearing impaired were the highest proportion of respondents that found the hubs 'not accessible at all'.

6.3.6 A third of disabled people surveyed believe that their local authority is not doing anything significant whilst 76% of disabled people are dissatisfied with the help provided by the government. A third of disabled people believe that the government is neglecting disabled people.

6.3.7 56% of respondents had experienced some difficulty sourcing Personal Protective Equipment (PPE) if it was needed.

6.3.8 62% of respondents have experienced one or more health visit being stopped due to Covid-19.

6.3.9 A third of disabled respondents are worried about their housing situation and 37% said that their housing was not accessible or only partially accessible.

6.3.10 Survey respondents are less satisfied with their care plans since the outbreak of Covid-19. Prior to the outbreak, 58% felt satisfied or very satisfied and this has reduced to 35% after Covid-19.

6.3.11 Whilst the findings here echo the national findings offered by ONS, and understanding community sentiment is undoubtedly useful, there are a number of important things to bear in mind:

- Neither data set is Manchester-specific, and whilst the experiences conveyed are likely to be the case in the City (for example, the data presented by the Big Disability Survey includes experiences of Manchester disabled people), continuing engagement with Manchester disabled people and their organisations would be required to more fully understand and respond to local issues (working through the Big Disability Survey recommendations in partnership with local organisations gives an opportunity to do this in a productive way).
- On the whole, both data sets consider disability in a homogenous sense. Whilst the Council does not advocate the medical model of disability, it is recognised elsewhere in this report that Covid-19 (and other clinical and social determinants of wellbeing) affects different groups differently within broader characteristics, and a more nuanced understanding of impact by condition or impairment type would be useful; this again can be explored through targeted engagement with relevant groups.
- The data, as presented, does not demonstrate the interplay between this characteristic and economic vulnerability in the same way that the ethnicity data has been assessed. This is unusual considering the long standing economic vulnerabilities faced by disabled people in the UK, for example: disabled people are a third less likely than non-disabled people to be in employment; they are almost third more likely to be living in poverty; access to services and digital support is more likely to be restricted. A more detailed analysis of this interrelationship nationally and locally is required.

6.4 Special educational needs and disabilities

6.4.1 Children and young people with special educational needs and disabilities (SEND) are similarly affected by the health risks posed by Covid to other people with health conditions and disability, but in addition, they may not be able to receive all the education, health and care provision set out in their EHC plan, due to staff having to prioritise Covid related duties.

6.4.2 Parents and carers of children and young people with SEND managing daily family life whilst meeting the needs of their child/children is challenging. With schools shut for most pupils and access to their usual support services limited these families are facing increased pressure. Short breaks for disabled children offer a much needed break from caring responsibilities and the absence of this provision will cause increased strain on families. Specialist CAMHS services are reporting an increase in calls from families of disabled children, particularly in relation to children's sleep problems and strategies to manage behaviours of children struggling to cope with an enormous change to their daily routine.

6.4.3 Only one in five disabled and older people feels the government is doing enough to support them during the Covid-19 outbreak. A snap UK wide survey by RiDC (the

Research Institute for Disabled Consumers) shows that many disabled and older people feel that the UK government is failing them during the current Covid-19 pandemic.

6.5 Learning Disability and Autism

6.5.1 Emerging evidence on the effect of Covid-19 on people with learning disability (LD) and autism suggests that this group is disproportionately affected by the pandemic. Data for this cohort of people is complex and the overall impact may not be evident for some time. However, analysis from the ONS shows that people with LD and autism tend to have other risk factors including; underlying health conditions, they often live in care homes, lockdown means less face to face contact and increased isolation which can lead to increased anxiety and more challenging behaviours and over medication.

6.5.2 Compounding the social and mental health impacts of Covid-19 for LD and autistic people is a higher rate of death amongst this cohort. Data has been assessed of all deaths notified to the Care Quality Commission (CQC) between 10 April and 15 May from providers registered with CQC who provide care to people with a learning disability and/or autism (including providers of adult social care, independent hospitals and in the community), and where the person who died was indicated to have a learning disability on the death notification form.

6.5.3 This data shows that between 10 April and 15 May this year, 386 people with a learning disability, some of whom may also be autistic, died who were receiving care from services which provide support for people with a learning disability and/or autism. For the same period last year, the figure was 165. This is a 134% increase in the number of death notifications this year. The CQC advocates that this new data should be considered when decisions are being made about the prioritisation of testing at a national and local level.

6.5.4 Of the 386 people who have died this year, 206 were as a result of suspected and/or confirmed Covid-19 as notified by the provider and 180 were not related to Covid-19.

6.6 Disability Inclusive Recovery

6.6.1 Clearly the City's economic recovery presides at least in part on being able to re-open its spaces and facilities, and increase footfall into the City in a safe and managed way including an increased use of public transport. As has been outlined above, many disabled people are very worried about the prospect of this and the associated risks of increased social contact and greater exposure to infection, resulting in heightened anxiety and some electing to remain isolated regardless of the Government's easement measures.

6.6.2 As the Council progresses its recovery activity and begins to re-open spaces and services, it will be imperative that this is done in an accessible and inclusive way where the impacts of Covid-19 to date on disabled people, as described above, are taken into account. The same principle stands for the other characteristics within this report. For those parts of the organisation that are progressing this activity, two important considerations should be had:

- Equality Impact Assessments of the service change / development to understand the potential impacts on, in this instance, disabled people, and;
- Targeted engagement, to address any gaps in the service's understanding or evidence

6.6.3 These considerations are described more fully later in this report.

7. Older Age - Age Friendly Manchester

7.1 Overview

7.1.1 Age is not a risk factor in its own right, although older age does increase the prevalence of underlying health conditions which become an associated risk factor. However age is a characteristic protected by the Equality Act 2010 and people, as they get older, experience increasing inequalities which are specifically linked to older age and ageing.

7.1.2 Government guidance is sometimes unclear and frequently unhelpful in relation to the restrictions for older people as an at risk group; regarding everyone aged over 70 as one homogenous group creates uncertainty and worry and ignores the variance in this cohort, along with the potential and contribution of older people in our communities. It is worth remembering that older age is a characteristic that cuts across all identity groups, and many older people are carers, some are disabled, and older people who are LGBT, Black, Asian or Minority Ethnicity or female frequently experience additional inequalities in later life.

7.1.3 It is useful to break this group down as there are particular circumstances where risk varies:

1. Shielded & vulnerable
2. Isolated
3. Worried and scared
4. In work / out of work
5. Other 70+

7.1.4 Although 1-4 are not age specific, most in these groups will be over 50 and a proportion of these over 70.

7.2 Shielded and vulnerable, isolated and worried

7.2.1 In common with many characteristic groups experiencing shielding and/ or those who are vulnerable or isolated, older people in these circumstances are demonstrating heightened poor mental health as a consequence. This exasperates ongoing issues resulting from loneliness, social isolation, and anxiety about leaving home that are already common facets of some older people's lives. As Manchester experiences declining mental health across all ages of the population, the impact on older residents, for whom there is very little targeted support, is particularly stark.

7.2.2 There is a considerable reduction in the uptake of psychological therapies across Manchester at this time; many older people report that they don't want to be a burden,

but even during ‘business as usual times’, the referral and uptake of these kinds of service is markedly lower for older people, by some margin. Only 6% of over 70s identified with depression receive a referral, while for young people identified with depression it is circa 50%. The Age Friendly Manchester Programme Team has concerns that this is indicative of a wider pattern of de-prioritisation for older residents and will be reflected across other areas too.

7.3 Economic and social vulnerability

7.3.1 Age Friendly Manchester reports that 36% of older residents are income-deprived and 59% of older residents live in the City’s most deprived neighbourhoods. In England, only 7% of housing is fully accessible for older residents and 20% of homes in England occupied by older people fail the Government’s basic standards of decency.

7.3.2 Access to public transport has often been cited as a key concern for many people as the UK starts to return to its new normal. This concern is heightened for older people, as they are being told to avoid using public transport; whilst the clinical rationale for this is reasonable, it does not take account of older people’s greater reliance upon it to access health and care services, social networks and for shopping.

7.3.3 This is one amongst many areas where the clinical response to Covid-19 is not sympathetic to the social circumstances of an identity group, and causes a ‘double hit’ for people who were already socially disadvantaged across a range of aspects of their lives; the cross cutting nature of older age, as highlighted above, means these types of age-related impacts affect all disadvantaged groups.

7.3.4 This demonstrates the need for consideration of the unique experiences and specific inequalities faced by people over 50 across other sections of this report to be acted upon; the principles of intersectionality apply. The Age Friendly Manchester Team highlight the following areas of consideration.

- Ongoing social and emotional support needs to be developed, tailored to and targeted at older residents. In particular, there is a need for increased and tailored bereavement support; the higher death rate in men may leave even more older aged women living alone in later life facing inequalities linked to their gender and age.
- Information about and access to services is heavily reliant on the internet. While significant numbers of older people have developed their ICT confidence, many are still not online and for those with certain conditions that are more prevalent in older age, online options may not be fully accessible. In Manchester, 1 in 4 older people have never accessed the internet: 23,594 people over the age of 55 have not used it in the last 3 months / or have never used the internet; this equates to 20.2% of people aged 65-74 and 64.1% of those aged 74+. Alternative routes to providing accessible information should be considered.
- Older residents are particularly susceptible to Covid-related fraud. A programme of awareness-raising and assistance with COVID-related fraud would assist older age groups; victim losses have already totaled over £970,000.

- Increasing focus is being placed on walking and cycling during post-Covid. This comes with raised safety risks for some older people and additional support is needed to ensure older people feel able and safe to leave their homes through improved walking infrastructure which is age friendly and recognises the city's health profile e.g. more frequent distribution of benches.
- Older people are now considered the last people that *should* be using public transport. At the same time, many are reliant on it to make essential journeys. Help to overcome fear or worry to use public transport is necessary, including increased provision of community transport.
- Additional support is needed for existing active ageing programmes in the City: 1) to encourage those who have started strength & balance exercises while at home during lockdown to continue doing so; 2) increase support for older people who have been inactive during lockdown as they haven't been able to attend regular activity classes, and; 3) support for those who were inactive pre- and during-Covid.
- A unified approach to all communications to and representations of people over 50 is required. One which challenges the negative Covid-19 narrative around ageing and consistently avoids ageist stereotypes, language and images. The Age Friendly Manchester Older People's Board has written to the Council to urge a 'no more wrinkly hands!' approach, and asks the Council to be a leader in the field on this.
- Manchester's over 50s employment rate was below the national average before Covid-19. The economic impact of Covid-19 on the job market will adversely affect people over 60 as well as those under 25 (according to the Resolution Foundation). Manchester's inclusive recovery plans should take account of this dynamic in its employment-related considerations.

8. Children and Young People

8.1 Overview

8.1.1 All children and young people are being affected by the virus: children's and young people's learning has been interrupted by the closure of schools, colleges and universities. There is a concern that young people leaving education this summer will have greater difficulties finding employment, particularly in light of an economic downturn. Similar to the other characteristic groups highlighted in this report, many children and young people are highly anxious about the impacts of Covid-19 and some are struggling with feelings of isolation or experiencing other mental health difficulties related to being confined to home for most of the day and having limited social interactions.

8.1.2 As is the case with older age, youth and childhood cut across all characteristic groups and adverse impacts specifically related to age will be compounded by other adverse impacts associated with other characteristics; so whilst the majority of children who contract the virus are, based on current analysis, unlikely to be badly affected, children with complex health needs, including respiratory or heart problems and diabetes are in the group that needs to be shielded, and this is having a great impact on their and their families' emotional wellbeing. Some families are reluctant to take their children to health appointments or to allow them to be admitted to hospital for planned treatment, due to fear of contracting Covid-19, so this could have

implications for children's longer-term health. Similarly, children and young people include significant numbers who are Black and Asian Minority Ethnicity, LGBT+, female etc. and as a consequence, also face heightened risk of infection and / or social impacts as outlined elsewhere in this report.

8.2 Youth and economic vulnerability

8.2.1 Figures from the ONS figures show that nationally, 408,000 people in the 18-24 age group are unemployed, while data from the Resolution Foundation indicates that the Covid-19 crisis could push a further 600,000 young people into unemployment, unless support is provided. Tens of thousands of internships, work experience opportunities and entry-level employment roles could also be cut for those new to the job markets, depending on how employers choose to respond.

8.2.2 The economic impact of Covid-19 has affected every age group but with higher increases experienced by young people and the over 50s. The Resolution Foundation reports that young people with lower levels of education attainment (GCSE level & below) could now have employment prospects as low as 40% three years after leaving education. Nationally, in April there was a decline of 74% in the start of 16-18 year old apprenticeships. It is worth noting that April traditionally has low levels of apprenticeship starts for this age group, so the extent to which Covid has 'caused' or 'contributed to' this statistic remains to be seen; the August / September period is the critical time for apprenticeship starts and a clearer understanding of the scale of Covid impact on youth apprenticeships will be available at that time.

8.2.3 Of the circa 19,000 UK domiciled students who will graduate from the University of Manchester and MMU this year, based on a recent graduate retention rate of 51%, 10,000 graduates would be expected to be seeking jobs in the City. Inevitably the lack of graduate jobs will impact on the career choices for graduates and lead to displacement further down the system.

8.2.4 There has been a 34% increase in Universal Credit claims and an 89% increase in all unemployment related benefits claims between March and May 2020. This increase affects all age groups but is particularly acute for young people and over 50s. Manchester's claimant count for the 18-24 age group stands at 5,620, rising by 60% between March and April 2020.

8.2.5 As the Government funded furlough scheme and support for the self employed comes to an end, which taken together currently support 30% of Manchester's working age population, there is a risk of further sharp increases in unemployment. This represents a double challenge of ensuring that there are opportunities and interventions in place to reconnect the newly unemployed back into work but also means that the residents who are furthest from the labour market, which includes NEET young people, are even less competitive in the labour market.

8.2.6 The Council has been working with post-16 education and training providers to plan and manage transition for Year 11 students and 66% of this year's cohort have a secure post-16 offer, recorded on the system but in reality the number is likely to be higher. This compares well with previous years. Of the 450 young people identified as high risk of becoming NEET, 300 have a secure offer and there is a programme of planned summer activities to keep them engaged. Post-16 providers are also working

intensively with their Year 12s as the transition point to year 13 is a big driver of NEET numbers in the City. NEET figures for May are 6.9% and have not seen a significant change during the Covid period. The GM Colleges Group, which includes the Manchester College, has a guaranteed offer for all 16-18 year olds who need it. The short-term picture in this respect is a reasonably stable one. The anticipated squeeze on economic and employment opportunities over the medium term though, suggests a growing challenge to maintain this stability, and is one that will require ongoing monitoring and response.

9. Clinically Extremely Vulnerable and shielded people

9.1 Overview

9.1.1 The ONS reports that in England, 2.2 million people were identified as being vulnerable to severe impact from Covid-19. These people were advised to shield from others to protect themselves from the virus. The guidance for clinically extremely vulnerable (CEV) people changed over time with the latest change on 1 June 2020.

9.1.2 From 1 June, CEV people were advised that they could leave the house for exercise and that support with personal care could be provided by a family member or nurse, care or support worker. This change occurred midway through the ONS's collection of 28 May to 3 June 2020 data for this cohort and has been reflected in the data gathered.

9.2 Social impact of shielding

9.2.1 Data collected from 9 June to 18 June 2020, show that 63% of the shielded group reported to be completely following shielding guidance (an estimated 1,423,000 people). This is broadly comparable with previous data collected, when 63% (between 14 and 19 May 2020) and 62% (between 28 May and 3 June 2020) reported completely following shielding guidance. The percentage who reported not leaving the house since receiving shielding advice or only leaving the house for exercise in the last seven days, at 64%, is very similar to the percentage that reported completely following shielding guidance.

9.2.2 The government, local authorities, public and voluntary service providers and communities have provided support to enable CEV people to shield; the support mechanism that most people who had not left their home since receiving shielding guidance or in the last seven days found helpful was:

- video or telephone calls with family and friends (74%), followed by;
- prescription deliveries (59%), and;
- food deliveries or food boxes (56%).

9.2.3 Of all CEV people, 10% reported they are currently receiving support (for example, medication or psychological therapies) for their mental health and 15% reported receiving support in the past. CEV people who are currently or have previously received support for their mental health were more likely to report a worsening in their mental health since being advised to shield (68% and 56% respectively).

9.2.4 Of those CEV people who are not receiving or have not previously received support for their mental health, since being advised to shield, 60% reported that their mental health has stayed the same. Of the remainder, 29% reported that their mental health has got slightly worse, and 7% that it had got much worse. A small percentage (3%) of CEV people reported that their mental health had become much better since being advised to shield. (Percentages do not sum to 100% because of rounding.)

9.2.5 The changes in the mental health and well-being of CEV people since they were advised to shield varied by gender and age group. The age group most likely to report a worsening in their mental health was CEV people aged between 50 and 59 years, irrespective of gender.

9.2.6 CEV women were more likely to report a worsening in their mental health than CEV men, across all age groups considered. Approximately half of CEV females aged 20 to 49 years and 50 to 59 years reported a worsening in their mental health (49% and 52% respectively).

9.3 Cessation of the shielding programme

9.3.1 On Monday 22 June, the Government announced that the national Shielding Programme will end on 31 July. Those who have been shielding will be able to return to work, visit shops, places of worship etc, following social distancing guidance.

9.3.2 It is likely that the shielded group will split into three cohorts at this point: 1) those who will want to return to a 'normal' lifestyle as fully as possible; 2) those who will want to increase social activity but with hesitation and we must anticipate a further degree of heightened anxiety in these groups; and 3) those who will continue to feel unsafe (for clinical reasons, because of personal anxiety, or a combination of these) and elect to remain predominantly if not entirely shielded.

9.3.3 As well as considering how the needs of people particularly in this last cohort are taken into account and met, there is work to be done to ensure that they are not 'left behind' in the course of recovery planning. This means ongoing engagement to meet needs, as well as ensuring that service providers maintain a focus on continuing 'elective shielders' when devising activities and making policy decisions.

10. Deprivation and Poverty

10.1 Overview

10.1.1 The role that deprivation and poverty has to play in the worsening of Covid impacts for some communities of identity, and the specific nature of how deprivation and poverty affects different communities differently, means that it is does not lend itself to a stand-alone assessment, and instead needs to be overlaid with the wider social and economic circumstances affecting each community as this report has sought to do.

10.1.2 It is worth highlighting, though, some of the specific dimensions of the interrelationship between poverty and Covid impact, and what is known and not known about the further relationship with different protected characteristic groups.

10.2 Relationship between deprivation and equality

10.2.1 The ONS has regularly produced data on Covid-19 mortality by social grading. The social grading for Covid-19 mortality is not dramatically different to the social grading for all cause mortality (i.e. those in the most deprived parts of a given geography (national, regional etc.) see greater rates of poor health and mortality compared to those in the least deprived areas). The mortality rates nationally from Covid-19 in the most deprived areas have been more than double the least deprived areas, for both males and females, and survival among confirmed cases has been lower in the most deprived areas. This is particularly clear amongst people of working age, for whom the risk of death in deprived areas was almost double that of people in the least deprived areas, with male diagnosis rates significantly higher than females.

10.2.2 This means that the same set of social determiners that cause health inequalities generally are, unsurprisingly, causing health inequalities in Covid-19 with one significant difference; the excess mortality rate in Black, Asian and Minority Ethnicity populations from Covid-19, which is far more pronounced than would generally be expected. This serves to underline the dramatic role that deprivation and poverty have played in leading to the disproportionate impacts for this identity group.

10.2.3 In its report Measuring Poverty 2020, The Social Metrics Commission found that Black, Asian and Minority Ethnic households in the UK are over twice as likely to live in poverty as their white counterparts, leaving them disproportionately exposed to job losses and pay cuts caused by the coronavirus pandemic. The report finds that nearly half of Black African Caribbean households are in poverty, compared with just under one in five white families, while Black, Asian and Minority Ethnic families as a whole are between two and three times as likely to be in persistent poverty than white households.

10.2.4 Overall, 14.4 million people in the UK were living in poverty in 2018-19, up by 100,000 on the previous year, of which 4.5 million were children. About 4.5 million people (7% of the population) were in deep poverty, and 7.1 million people (11%) were in persistent poverty. The commission found Black, Asian and Minority Ethnic households were more likely to be in deep poverty than white families (around one in 10 adults from a Black British, Pakistani, Bangladeshi or mixed background were unemployed, compared with one in 25 white British people) and so were more likely to suffer heightened financial exposure to the pandemic.

10.2.5 The commission further reported that 19% of people in families where the head of the household was white lived in poverty in 2018-19. This compared with 32% of mixed ethnicity families, 39% of Asian/Asian British families, 42% of families classified as ‘other ethnic’ and 46% for Black/African/Caribbean/Black British.

10.2.6 Half of all people in poverty lived in a family that included a disabled person, the commission found. The rise of in-work poverty meant 68% of working-age adults (5.6 million people) were in families where at least one person worked part time. Just over one in 10 older people in receipt of their pension were in poverty.

10.2.7 Child poverty rates varied significantly between regions, with London (40%) and north-east England (39%) worst affected and south-east England and Scotland (both

27%) least affected. Child poverty rates for England were 33%, Wales 31% and Northern Ireland 29%.

11. Gender

11.1 Overview

11.1.1 It has been recognised from the earliest stages of the pandemic that the health and economic impacts of Covid-19 were likely to be gendered. Women form the majority of those providing care, paid and unpaid and are the majority of health workers. Scenario mapping indicated that women would therefore be more likely to be exposed to Covid-19, and more likely to be affected by the decision to close schools and nurseries and the need to move non-urgent patients out of hospitals.

11.1.2 In addition, women are also: more likely to be employed in service sectors that were hit hardest by social distancing measures; more likely to be on insecure and zero-hours contracts; more likely to be dependent on social security; more likely to be in an insecure housing situation and; more likely to experience domestic violence, with increased risks presented through the Government's lockdown measures. These gendered issues remain a priority to monitor and assess.

11.1.3 Over the ensuing weeks and months from the onset of the pandemic in the UK, a less anticipated trend materialised. Growing global evidence has highlighted that the mortality rate (taken as the proportion of deaths among confirmed cases) in women and men indicate higher death rates amongst men. In all the countries where data is available, men have been found to be more likely than women to die from Covid-19. In most countries, including in the UK, available data indicates that men have been 50-80% more likely to die following diagnosis than women.

11.1.4 The reasons why this has occurred are still emerging, but reports to date have found links with existing comorbidities including hypertension, cardiovascular disease and some chronic lung diseases including chronic obstructive pulmonary disease. These conditions tend to be more burdensome among men globally.

11.1.5 As noted elsewhere in this report, these gendered impacts will intersect with impacts as a result of age, disability, sexual orientation, gender identity, class and race.

11.2 Men and occupation

11.2.1 Men working in elementary occupations, and men and women working in caring, leisure and other service occupations were found to have a statistically significantly higher death rate from Covid-19 than the rate among people of the same sex and age in England and Wales. In Greater Manchester, a slightly higher proportion of the working population have jobs in these occupational categories than the UK as a whole.

11.2.2 Men working in elementary occupations had the highest rate of death involving Covid-19, with 21.4 deaths per 100,000 males. In Greater Manchester, 12.7% of men work in this occupational category, as opposed to 10.2% of men in the UK.

11.2.3 Of those men in elementary occupations, the individual occupations with the highest death rate related to Covid-19 were security guards, with 45.7 deaths per 100,000; taxi drivers and chauffeurs (36.4 deaths per 100,000); bus and coach drivers (26.4 deaths per 100,000); chefs (35.9 deaths per 100,000); and sales and retail assistants (19.8 deaths per 100,000).

11.2.4 Most of the deaths within the caring, leisure and other service occupation group were among the caring personal service occupations group, with a rate of 26.3 deaths per 100,000 males. In Greater Manchester 25,000 men (3.5%) work in caring, leisure and other service occupations.

11.3 Women and Occupation

11.3.1 Compared with the rate among people of the same sex and age in England and Wales, women in caring, leisure and other service occupations had a statistically significantly higher mortality rate for deaths involving the Covid-19: 7.5 deaths per 100,000 females

11.3.2 In Greater Manchester, 16.1% of women work in this occupational group, as opposed to 15.8% of women in the UK as a whole. This is the only one of the nine occupational major groups with a statistically significant higher mortality rate for women compared to the people of the same sex and age.

11.3.3 The ONS obtained an analysis which shows a correlation between exposure to disease, and physical proximity to others across all occupations. Healthcare workers such as nurses and dental practitioners unsurprisingly both involve being exposed to disease on a daily basis.

11.3.4 There are more women working in occupations that are more likely to be in frequent contact with people and also frequently exposed to disease. Three in four workers (75%) in these roles are women. One in five workers (20%) in these occupations are from Black, Asian and Minority Ethnic groups, compared with 11% of the working population. Six out of 16 of these occupations have a median pay of lower than £13.213, the median hourly pay across the UK, underlining the links between deprivation and Covid-19 exposure within this group.

11.4 Domestic Violence and Abuse

11.4.1 The lockdown measures put in place to control the spread of Covid-19 have meant that many people will have been forced to spend more time at home with an abusive partner or other family member, and that their usual sources of support may no longer be available. Therefore, all domestic abuse services are still open for information, advice and support; providing telephone, email and online chat services in the absence of face to face provision. The City Council Domestic Violence Team is in regular contact with Manchester service providers and receives weekly updates on the volume and nature of enquiries to their services.

11.4.2 Perhaps surprisingly, GMP analysis suggests that the demand for such services during the lockdown period maintained a relatively level trend compared with other offences. The gender relationship profile (70% female victim & male perpetrator) is the same as pre-lockdown. However, there has been a small change in the age

relationship profile, with a higher proportion of domestic violence offences being committed by younger adults over the age of 18 who are between 21 and 30 years younger than their victim. This data is, or course, only reliable with regard to those offences that are reported.

11.4.3 Manchester Women's Aid reports that it has not seen a significant increase in referrals for its community based outreach services and compared with last year, they have reduced from most sources apart from Early Help and GMP. However, calls to the Helpline are increasing. Call volumes are now slightly higher than pre-Covid 19 rates and call staff are starting to pick up on potential unmet needs. In general, callers are requesting advice and information, help to leave abusive relationships and emotional support. It is important to note that 54% of callers reported that Covid-19 lockdown has made an abusive situation worse and that 59% of calls were for refuge space.

11.4.4 The number of complex cases of domestic abuse saw a significant increase over the past year, with over 1,800 cases heard at the three Manchester MARACs during 2019-20, which is an increase of 400 cases from the previous year. This pattern has continued during the Covid-19 crisis. If the number continues to rise, there is a risk that the IDVA service will be unable to meet demand.

12. Sexual Orientation

12.1 Overview

12.1.1 The LGBT Foundation recently concluded a survey into the effects of Covid-19 on the LGBT community. They found LGBT people are less likely to access health care when they need it; are disproportionately impacted by HIV; are more likely to be homeless or insecurely housed; are more likely to smoke and; are more likely to have a poor diet or exercise.

12.1.2 Similarly, older LGBT people are more likely to be socially isolated: LGBT people are more likely to have a 'chosen family' often due to biological family rejection. They may be less likely to live with their chosen family compared to their biological family so may be separated from those closest to them at this time.

12.1.3 LGBT people are also statistically significantly likely to experience poor mental health: 37% of respondents to the LGBT Foundation's survey stated that decreased mental wellbeing was one of their top three concerns due to the changes Covid has triggered. This is compounded by a greater likelihood to have issues with substance abuse and to experience unreported domestic abuse.

12.1.4 The issue of intersectionality previously highlighted applies here also. Since the commencement of lockdown, some LGBT people (particularly young LGBT people) may have been locked down in a house with LGBT-phobic parents and family members, increasing their anxiety and damaging their mental health. In a similar way, some ethnic minority and migrant LGBT people are more likely to be socially isolated from the communities that share their ethnic backgrounds.

12.2 Trans-specific impacts

12.2.1 There are a number of trends in relation to health that cut across lesbian, gay, bisexual and trans groups, for example, a reduced likelihood to access GPs and health care generally due to previous experience of prejudicial treatment and / or attitudes on the part of health providers. Many LGBT people report that they would prefer to receive support from an LGBT organisation than from a mainstream health or care provider.

12.2.2 Some health issues though, are specifically linked to trans people and bear a link with Covid risk. The prioritisation of Covid response meant that some trans and non-binary people had their HRT suspended due to emergency measures.

12.2.3 Chest binding (compressing breast tissue often done by trans men and other non-binary people) has been found to potentially increase the risk of Covid symptoms and of the infection being accelerated.

12.2.4 Trans and non-binary people report that a number of their non-essential medical appointments related to individuals' HIV-status, gender reassignment status etc. have been cancelled.

12.2.5 As is the case elsewhere in this report, longstanding inequalities in health and social outcomes for LGBT people are exacerbated in the advent of Covid-19, leading to a deepening of existing disadvantages with a Covid-related complexion on it; these are not new issues though.

13. Homelessness

13.1 Public Health England (PHE) recently reported that socially excluded populations, such as people experiencing homelessness, tend to have the poorest health outcomes. When the PHE review was compiled, 54 men and 13 women with no fixed abode (likely to be rough sleepers) had been diagnosed with Covid-19. PHE estimates this to represent 2% and 1.5% respectively of the known population of women and men who experienced rough sleeping in 2019. Uncertainty remains around these figures though, and they should be considered an estimate.

13.2 As of 23rd June, 178 people were accommodated within Covid-19 hotel accommodation across 7 hotel sites, open under the Government's 'Everyone In' programme. At the height of the response, the Council was accommodating 280 people across 11 hotel sites. The stable accommodation, meals and support provided at hotels have helped to increase engagement from people who sleep rough. On site, people have been able to access support services including primary health care, drug and alcohol support services, mental health and welfare benefits and advice provision. All occupants have had or are having a Homeless Assessment and Personal Housing Plan, a strength based assessment that identifies actions to support finding accommodation. This approach underpins an exit strategy from hotels, the principles of which are:

- An intention not to return people who have been accommodated to the streets
- A desire to exit from hotels as quickly as possible

- An intention for everyone accommodated in hotels to have an individual housing and support plan

13.3 Reconnection remains an important part of the exit strategy. Dedicated members of staff are undertaking follow up conversations with individuals and arranging for their reconnection to places where it is safe for their return if they have no connection to Manchester. Greater Manchester Immigration Aid Unit and the Booth Centre are working with individuals to manage paperwork from Embassies and apply for plane tickets as international travel becomes available. On a national level, the outreach team are working with receiving local authorities, and GMCA are providing support engaging with neighbouring Authorities to ensure that people are reconnected within the conurbation.

13.4 For individuals who do have a legal duty owed to them, appropriate accommodation will be sought from in-house temporary accommodation, Housing Related Support schemes, Housing First, social housing and the private rented sector. Creating capacity within these options, exacerbated by the lack of movement due to Covid-19 measures, remains a pressing issue.

13.5 Whilst all reasonable measures are being pursued to implement the exit strategy and secure appropriate housing options, there remain a number of critical points to address:

- Ongoing funding issues with government and clarity on the extent of funding for Everyone In
- Access to private rented sector stock and supported housing across Greater Manchester to fairly spread the burden being borne by the Council
- Continuing development of guidance on managing people who display Covid-19 symptoms and/or are tested positive

13.6 There remains approximately 40 individuals who are continuing to sleep on the streets in Manchester. Most of this group had either refused accommodation or been evicted through extreme and unmanageable behaviour. There is serious concern that the numbers on the streets will rise as lockdown measures are further eased. In addition, it is anticipated that there will be a significant increase in the number of people presenting as homeless as lockdown eases and the wider economic impact of Covid-19 presents itself over the coming months.

14. Carers

14.1 Overview

14.1.1 Given the role that carers (paid and unpaid) play in the lives of people who fall within the at risk groups on contracting Covid-19, their safety and wellbeing in the course of undertaking their caring role is vitally important. This is reflected in the guidance that has been issued for carers both by statutory bodies and by charities and community organisations. The Government's 'Guidance to Those Who Provide Unpaid Care to Friends or Family' was published on 8 April, and has since been promoted and enhanced by organisations such as Carers UK. For those in paid care roles, clear guidance on health and safety measures aimed at employers of carer staff has also

been forthcoming, and yet the available data show that people in this group have been significantly adversely affected.

14.2 Deaths involving COVID-19 among health and social care workers

14.2.1 The ONS records deaths among health and social care workers in a range of occupational groups. In its analysis, rates of death involving Covid-19 among male and female social care workers were found to be statistically significantly higher than the rates of death involving Covid-19 among those of the same age and sex in England and Wales. A total of 131 deaths involving COVID-19 among social care workers were registered up to, and including, 20 April 2020, with rates of 23.4 deaths per 100,000 males (45 deaths) and 9.6 deaths per 100,000 females (86 deaths). This group included occupations such as care workers and home carers, which accounted for most of the deaths (98 out of 131 deaths, or 74.8%), social workers, managers of residential care institutions and care escorts.

14.2.2 Among healthcare workers (occupations such as doctors, nurses and midwives, nurse assistants, paramedics and ambulance staff, and hospital porters), rates of death involving Covid-19 were not found to be statistically different to rates of death involving Covid-19 in the general working population, with 10.2 deaths per 100,000 males (43 deaths) and 4.8 deaths per 100,000 females (63 deaths).

14.2.3 Of all the individual healthcare professions, a reliable rate could only be calculated for female nurses, which was 6.7 deaths involving Covid-19 per 100,000 females, equivalent to 31 deaths. This rate was not found to be statistically different to the rate of death involving Covid-19 among females of the same age in the general population.

14.2.4 Some healthcare workers may have had reduced exposure to Covid-19 during lockdown, for instance, because of people not having dental or optician appointments. As lockdown measures continue to be eased and more deaths are registered, it will be important to monitor the ONS analyses to see if there are any changes in the rates of death involving Covid-19 among healthcare workers.

14.2.5 Of course, the data above only accounts for those paid care staff who are known and recorded; not all carers are paid or known, and so the total impact of Covid-19 on this cohort is not fully understood from the available data. The Council has ongoing relationships with VCSE&F sector carers' organisations, and targeted engagement with these groups would help the Council to more fully understand the extent and nature of the impact locally, to inform an appropriate response.

14.3 Economic support for carers

14.3.1 A national Carers Allowance is paid via the DWP subject to income and eligibility criteria. The local authority also has a statutory responsibility to support the health and wellbeing of carers subject to assessment and eligibility criteria. This duty is usually exercised via a support plan and Carers Personal Budget. The Council has sought to ensure that barriers are removed which may inhibit prompt and continued payment of benefits and allowances and to make provision for emergency / hardship payments or material requirements.

14.3.2 Recognising the exacerbating effects of Covid-19 on the challenges already experienced by carers, a Carers Hardship Fund seeks to avert carer arrangement breakdown and bridge any resulting service gaps. Carer assessment and payment arrangement are being simplified and operated remotely to expedite payments.

14.3.3 In addition, the established network of VCSE&F carer support organisations in Manchester has switched to telephone support arrangements and socially distanced arrangements to address shopping, utilities and prescription requirements. Information has also been posted to known carers providing advice on safety and contact tracing, and granting participation in key worker retail support schemes.

15. Digital exclusion

15.1 Overview

15.1.1 As a result of lockdown measures, dissemination of information and access to services has swiftly and heavily shifted towards a reliance on the internet. Whilst this has been a necessary, and in some areas welcome shift, it is not a universally accessible one and has highlighted a number of issues that exist nationally and locally regarding digital exclusion. There are two primary dynamics at play when considering digital exclusion:

- **Deprivation and poverty:** some communities and individuals cannot access 'digital by default' services and information for reasons of affordability (of devices, or broadband services), and;
- **Access:** some groups (including but not limited to some older people, some disabled people, people whose first language is not English) are more likely to rely on web-based services that are not designed to be fully inclusive and accessible, and are more likely to lack key skills and / or confidence to use them.

15.1.2 These issues, which are not mutually exclusive, prevent digital-only information and services being fully accessible to all on equal terms, leading to exclusion of some groups. Covid-19 has taken the UK to a point in digital reliance, arguably, from which it cannot / will not retreat, placing the onus on service providers like the Council to remove or minimise these barriers and ensure that their functions are fully accessible to all residents, either digitally or otherwise.

15.2 Deprivation, poverty and affordability

15.2.1 There is no quick solution to digital exclusion stemming from deprivation and poverty. As has been outlined elsewhere in this report, the extent to which UK households experience poverty, and the degree to which some identity groups are disproportionately affected by this, is a huge challenge which is compounded by the further financial pressures brought about by Covid-19. In-roads however, can be and are being made.

15.2.2 In Manchester, the Digital Inclusion Project run by the Work and Skills and Libraries teams has worked with the Contact Centre to provide tablets and wrap around support to provide the basic skills to use if for some residents. In relation to the scale

of the issue, the work to date is modest although the Council recognises the potential to do more. A lack of funding for technology and data for adults, and a targeting of Government schemes at young people in schools and colleges, present significant challenges to this. Officers are working closely with Manchester Adult Education Service and the Manchester College though, on support for adult learners, and it is likely that there will be an allocation from the City Council's Covid hardship funding to provide technology, data and basic skills to residents at risk who will use it to access more services independently in the future.

15.3 Access

15.3.1 As noted above, residents at risk (which includes some of those resident groups who are most frequently digitally excluded) are prioritised for support on basic skills to access and use digital technology. In many cases though, support for the user of the digital technology does not overcome the access barrier, as these are in-built at the provider end; for example, visually impaired people unable to access websites that do not have settings adjustment, people whose first language is not English not being offered information in other languages and / or formats.

15.3.2 Again, these are not simple barriers to correct and in many cases, they are beyond the Council's influence. Where digital information and services are provided by the Council though, and especially in relation to Covid-19 support, it is vital that these are made as accessible as possible. Some good progress has been made; the Council's Covid information is available in the range of main different languages spoken in the City, and officers have worked with sensory impairment charities to enable Deaf and hearing impaired people to access information and services. Engagement continues with VCSE&F organisations representing various communities of identity to ensure that residents are aware of and able to access information and updates on Covid-19 in the coming weeks and months.

16. Manchester is a Marmot City

16.1 In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy was to include policies and interventions that address the social determinants of health inequalities.

16.2 The central themes for the Review were that: 1) health inequalities are a matter of social justice; 2) there is a social gradient in health and health inequalities; 3) addressing health inequalities is a matter of fairness; 4) health inequalities are linked to the economic context and; 5) tackling health inequalities involves tackling social inequalities and climate change.

16.3 The resulting 2010 report, 'Fair Society, Health Lives - the Marmot Review', identified a range of social determinants of health: 1) early years and health status; 2) education and health; 3) work, health and well-being; 4) income and health, and; 5) communities and health. Fair Society, Health Lives concluded with a set of key policies over the lifecourse to tackle health inequality, with a different emphasis at each stage of the life course, from pre-birth to age 65+:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standards of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

16.4 In 'Health Equity in England - the Marmot Review 10 Years On', Professor Sir Michael Marmot has reassessed the indicators that underpin the original research and has uncovered that a decade of austerity and Government policy have seen a deepening in health inequalities and social impacts, and that there is a worsening of healthy life chances for those in the most deprived areas. This, in the context of Covid-19 compounding existing social disadvantages and health inequalities, is deeply concerning.

16.5 For this reason, in partnership with colleagues in Manchester Health and Care Commissioning, the Council has started to populate a working document called Manchester is a Marmot City. This recognises that the City would benefit from taking a Marmot type response to Covid-19, implementing strategies that better serve to reduce and not widen health inequalities. The document aims to consider more than clinical factors alone to measure risk under Covid-19. It also allows for officers to assess progress to date and outline any outstanding areas of need. As such, it forms the backbone of an action planning approach relating to communities of identity.

16.6 The Manchester is a Marmot City document will be incrementally updated throughout the recovery period. The latest iteration of this is attached as Appendix 1 of this report.

17. Summary Points

17.1 Whilst it is true that everyone has the potential to be affected by Covid-19, what is becoming strikingly clear from the data and insight is that it affects certain groups disproportionately more than others. In particular, its impacts on older people, disabled people, Black, Asian and Minority Ethnic groups and those with multiple comorbidities are stark. This report though, has sought to underline that an individual's or group's material characteristics are not the sole determinants of risk and susceptibility to infection and in fact, the wider social and economical environment, which were already contributing to unequal outcomes for many people across the UK and in Manchester, are compounding the already dangerous risks caused by Covid-19.

17.2 The health impacts of Covid-19 continue to unfold and more is known about the infection and clinical response options every week. The economic fallout from the pandemic is more variable; a range of industries are coming out of lockdown measures and re-establishing a revised offer, which will no doubt ease the economic impact to some degree, but with social distancing to remain in place for the foreseeable future and a knock-on effect to how retail, leisure and cultural industries can operate, a considerable financial hit for the UK is unavoidable. The closure of a

great many small businesses and the resulting spike in unemployment, which will be felt in Manchester just as anywhere else, will likely affect the prospects of a generation.

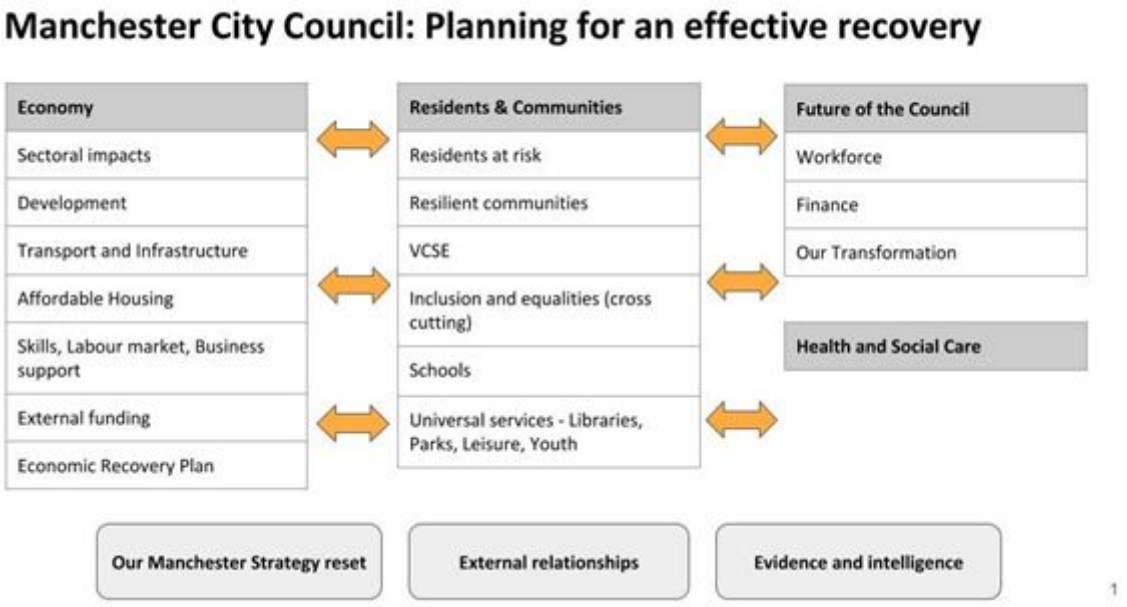
17.3 As the lockdown is eased, there is a need to shift the focus of local COVID-19 monitoring systems towards the early identification of an emerging 'second wave' of coronavirus in Manchester. Directors of Public Health are now starting to receive data aggregate data sets for local authority areas from pillar 2 testing sites and have been promised that this data will soon be broken down by postcode, age, sex, ethnicity and occupation.

17.4 To progress the Covid-19 recovery planning, four recovery workstreams are in operation. These are highly interdependent, as illustrated in the diagram below. Each workstream involves a significant portfolio of work, and each is in the process of identifying short, medium and longer term priority actions. The workstreams are:

- Economy
- Residents and Communities
- Future Council / Impact on the Council
- Health and Social Care

Underpinned by:

- Evidence base and impact for each of the above workstreams
- External relationships with a range of key partners
- Reset of the Our Manchester Strategy



17.5 The Equalities and Inclusion work reports in through the Residents and Communities workstream for governance purposes, but it is acknowledged that equality considerations are a cross cutting theme. It is through this governance arrangement

that service-level action planning and the harmonisation of equality inputs and outcomes can be managed. A cumulative review of the actions planned across workstreams and assessed through an equalities and inclusion lens, will give assurance of where the issues highlighted in this report are being addressed and where there are areas outstanding.

17.6 Across health and care, the 'Community Cell' has been set up to lead the out of hospital care system within the City during the period of Covid-19 response and recovery. The Community Cell will seek joint working opportunities with Trafford, and other GM Localities where it makes sense to. The three workstreams for the Community Cell are listed below. Each will have its own leadership, and coordinating group, to oversee it and report into the Cell.

- Coordination of the Manchester Covid 19 response
- Overall capacity and demand planning
- Care home and home care capacity increase

17.7 The Cell will work closely with the Manchester Hospital Cell arrangements and also connect to the wider system response at City and GM level.

17.8 The Manchester Covid-19 Response Group (the CRG) (previously called the Manchester COVID-19 Locality Planning Group (MCLPG)) fulfils the role of the Manchester Health Protection Group, which is the established group for all health protection issues in Manchester. Addressing inequalities / Health Equity is a key workstream under this group. The purpose of this workstream is to improve experiences of, and outcomes for, communities that suffer disproportionate adverse impacts from Covid-19.

17.9 This will involve reducing the risk of transmission, severe disease and death among groups of people who have been identified as most risk including*:

- Black African, Black Caribbean and Asian people
- People born outside the UK or Ireland
- People in specific occupational groups
- People with learning disabilities
- Inclusion health groups -Asylum Seekers and Refugees, Gypsies & Travellers, Sex Workers, Ex-offenders*

*This will be kept under review based on emerging and evolving understanding of the disease. Note the needs of other vulnerable groups e.g. people who are homeless, older people, clinically at risk/shielded groups are being addressed through other workstreams.

17.10 Across the Council and health and care, a continued use of Equality Impact Assessments (EIAs) seeks to ensure that activities and decisions related to Covid-19 are advanced with due regard for equality at their heart. The Council has undertaken EIAs of its emergency response measures (i.e. the Community Hub) and early stage recovery plans (i.e. re-opening sections of the City Centre). Health colleagues have produced EIAs of Hot clinics, Hot care homes, Testing service, MHCC Bereavement policy and digital primary care. This activity continues across the system.

17.11 In tandem with this work, the Council is also working to strengthen its approach to workforce equality, recognising that successful services are best provided by a workforce that reflects the communities in which they operate. A wide-ranging workforce equality strategy is in the early stages of development which builds upon, but is not limited to, the outcomes of the workforce race review conducted in 2019. Workforce considerations are also embedded within the Covid-19 recovery planning, with the health and safety of the Council's employees a primary concern. Risk assessments, safe return plans, guidance and regular communication are in place and under regular review.

17.12 As noted above, the Covid-19 recovery planning work sits within the context of the reset of the Our Manchester Strategy. The City is at the midway point of its 10 year strategy and good progress has been made against a number of its aims. A review of the strategy was already planned, but the revised social, economic and health context that the City now finds itself in casts a new complexion on the reset.

17.13 Just as the Our Manchester Strategy was based on extensive consultation with residents and stakeholder groups, the reset will be underpinned by engagement including targeted (with identity groups) and neighbourhood engagement, as well as universal engagement. Equality and inclusion is being embedded as a cross cutting / horizontal theme within the Strategy reset.