GM Community Co-ordination Cell meeting

Date: 16th June 2020

Subject: Equalities Stocktake

Report of: Warren Heppolette

PURPOSE OF REPORT:

This paper aims to provide a summary of the current position across the GM Health and Social Care Partnership and GMCA with regard to equalities in relation to the covid-19 pandemic.

KEY ISSUES TO BE DISCUSSED

To date we have focussed much of our energy on insight and intelligence gathering, with a set of activities and groups which haven't been necessarily pursued as a part of a describable, coherent and holistic plan. As we move from insight to action, we need to be clear how our engagement structures connect at a GM level to drive a unified plan across our public sector, but also connect to localities in a meaningful way.

REQUESTS OF COMMUNITY CO-ORDINATION CELL:

The GM Community Co-ordination Cell is asked to:

1. Note the stocktake
2. Discuss the need for a proposal to connect the various groups and contributions into mainstream governance to ensure the action follows the insight.

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Executive Summary

1.0 Introduction

1.0.1 This paper aims to provide a summary of the current position across the GM Health and Social Care Partnership and GMCA with regard to equalities in relation to the Covid-19 pandemic. It will present the following:

- emerging evidence in relation to the unequal effects of COVID-19
- an overview of the work which is currently being undertaken and the engagement arrangements / dialogue which exist with communities of identity, including what insight is telling us at the current time
- a high level analysis of how GMCA and the Health and Social Care Partnership are performing in relation to the responsibilities incumbent upon them
- key messages arising from the above

1.0.2 It should be noted that this has been an extremely rapid piece of research and further work is required before sharing more broadly.

2.0 Summary of Stocktake

2.0.1 <u>Emerging Evidence of impacts due to Covid -19</u>

2.0.1 **Appendix 1** and **Appendix 2** contains the full stocktake of information which has been gathered around the unequal impacts of Covid-19 in Greater Manchester. It should be noted that at the current time GM has limited access to the national data relating to Covid-19 deaths, and many of the statistics relate to the position in the national population, overlain on our understanding of population diversity, deprivation and health in GM.

2.0.2 It is clear that COVID-19 disproportionately affects certain groups in our population more than others. In particular the elderly, disabled people, those with multiple co-morbidities, those is certain occupational roles, often the more deprived communities in our society, but most strikingly of all is the exposure of the adverse impact across BAME groups.

2.1 <u>Engagement and gathering insight</u>

2.1.0 **Appendix 2** also describes mechanisms for gathering local intelligence from representatives of all protected characteristics which can identify issues that are specific to their community. It also provides a summary of the current insight which has been obtained.

2.1.1 The intelligence and offers are collated and fed into the Covid-19 sub-groups (of the GM Mayors Covid-19 Committee), through either formal reporting or informal personal channels, where they are considered by representatives from all districts and GM

public services. Findings are also shared with relevant policy teams in GMCA, GM public services such as TfGM, Health and Social Care Partnership and GMFRS.

2.2 Action at a GM level in response to the data and insight

2.2.1 It should be noted here that GM has taken a role of collecting insight and then sharing across key agencies. Much of the response is taking place at a locality level, targeted at specific cohorts or communities led by VCSE and public sector bodies, and is not captured here.

2.2.2 Specific areas which have been addressed at a GM level have included bereavement support and funerals affecting groups of different faiths, work in response to the effect of Covid-19 on the mental health and wellbeing of frontline staff across diverse communities.

2.2.3 In response to the SCG request for all areas of the GM emergency response to carry out Equalities Impact Assessment's, the GM Community Co-ordination Cell supported a proposal and assessment tool to carry out risk assessments of BAME staff at risk of Covid-19. The GM risk assessment draws on existing literature and local experiences to create something that provides detailed steps but at the same time is flexible enough to be interpreted locally.

2.2.4 In addition, all Councils are currently in the process of completing their own Equality Impact assessments (EIAS) on their individual Covid-19 responses and in support of these the GMCA is connecting with Locality Authority equality leads to produce selective learning. This has highlighted particular concerns, for example, accessibility issues for community hubs.

2.2.5 The GM strategy for mass testing has prioritised the need to determine how we best offer and undertake testing within local BAME communities, as well as providing advice on social distancing and isolation.

2.2.6 The Workforce Race Equality Programme is undertaking the following actions;

- Development of accountable leadership
- Capture of the BAME workforce metrics
- Development programme aimed at senior leaders in public sector
- Race Equality Change Agents Programme
- Mentoring and human library programmes.

2.3 Other opportunities

2.3.1 As part of the GM Recovery structures, it is now proposed to set up an Independent Inequalities Commission. This Commission aims to understand the inequalities which now exist in the communities of Greater Manchester, and consider how to address those inequalities, in order to build a fairer and more equitable society and economy. The Commission will gather evidence over the next 6 months and report back in the spring of 2021.

2.3.2 It is planned to reconvene the GM Population Health Board with a focus on Equalities.

2.3.3 It is proposed to hold and extensive Listening Exercise over the coming months in BAME communities across the whole of GM.

3.0 Responding to the public sector equalities duty

3.0.1 **Appendix 3** contains a high level analysis of how GMCA and the Health and Social Care Partnership are performing in relation to the responsibilities incumbent upon them under the Equalities Act. This has been structured around the following areas:

- Understanding and working with your communities – intelligence, research, engagement and insight
- Leadership and Organisational Commitment
- Responsive Services and Customer Care
- Diverse and Engaged Workforce

4.0 Key messages

4.0.1 The following key messages have been drawn from the stocktake and analysis work carried out to date:

4.0.2 Covid-19 is having an unequal impact across the communities of Greater Manchester

4.0.3 The data and intelligence is incomplete and more work is required to fully understand both the patterns and causes of deaths, but also the disproportionate impacts of the pandemic in our communities.

4.0.4 The GM Independent Inequalities Commission can be the focus for a longer term, strategic piece of work which informs medium to long term planning.

4.0.5 However, it is clear that GM should also shift the focus from insight and intelligence gathering towards influencing through existing structures and practical application and delivery now. This stocktake should be translated into a plan of action around testing, contact tracing, and safe return to work.

4.0.6 There is a discontinuous ‘infrastructure’ of engagement, planning and action which now needs to be joined up at a GM level.

4.0.7 Furthermore, there is a need to acknowledge and empower the leadership that already exists through the GMCA Portfolio holders for Equalities and clarify the governance and lines of accountability across the GM partners.

4.0.8 An immediate and short-term piece of work is required to provide assurance around leadership and governance, engagement practice and influencing commissioning and delivery.

4.0.9 The GM level work should support, enable and add value to activities being led at a district and neighbourhood level.

Stocktake of insight and actions relating to the effects of Covid-19 on Equality in Greater Manchester

Appendix 1

1.0 Introduction

1.0.1 This paper recognises the emerging evidence that the effects of COVID-19 have traced patterns of inequality such that the negative impacts of the pandemic have been disproportionately felt across our diverse communities, both from a health perspective and in terms of our public service response.

1.0.2 It will summarise what the data and insight into the impact COVID-19 on different groups of society is already telling us, and what we understand we are already doing across Greater Manchester in response to that.

1.0.3 It will seek to expose where we believe the gaps are and where we need to do more, it will look identify priorities and shape our opportunities, where we need to take action now and, in the future, as we build back better into recovery.

2.0 Emerging issues due to Covid -19

2.1 Coronavirus and Ethnic groups

2.1.1 Latest evidence from the Office of National Statistics shows that the risk of death involving COVID-19 among some ethnic groups is significantly higher than those of White British ethnicity. When adjusting for age and other socio-demographic characteristics and measures of self-reported health and disability at the 2011 Census, BAME men and women of are still almost twice as likely to die of a COVID-19 related death than people of white ethnicity. The ONS concluded that: "The fully adjusted results show differences in risk between ethnic groups that are specific to those ethnic groups and are not caused by any of the factors listed on which members of the groups might differ,"

2.1.2 Men from Bangladeshi and Pakistani ethnic groups were 1.8 times more likely to have a COVID-19 related death than White males and for Bangladeshi and Pakistani women, the figure was 1.6 times more likely. Chinese men and men and women of mixed ethnicity were just as likely to die from a COVID-19 related death as men from white ethnicity, whereas Chinese women are less likely to die than white women.

2.1.3 A substantial part of the difference in COVID-19 deaths between ethnic groups can be linked to factors such as socio-economic deprivation. However, these factors do not explain all of the difference, suggesting that other causes are still to be identified, such as underlying health conditions.

2.1.4 People from a South Asian background are six times more likely to have type 2 diabetes and people from African and Caribbean backgrounds three times more likely. Bangladeshi, Pakistani, Chinese and Indian communities are over-represented among people over 65 with health-related problems. BAME 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 that so far are unrecognised in official lists for shielding.

2.1.5 BAME households are disproportionately likely to be poor and rely on benefits for a larger proportion of their income. People of Bangladeshi and Pakistani origin are more likely to work in distribution, hotels and restaurants and people of African and Caribbean backgrounds are disproportionately employed in the health and care sectors. Overcrowding is a significant issue for some Pakistani and particularly Bangladeshi households.

2.1.6 These findings are further supported by the report published by PHE (June 2020) which found:

- BAME people are more likely to live in urban areas, in overcrowded households and in deprived areas.
- BAME people are more likely to have jobs that expose them to higher risk.
- People of BAME groups are more likely than White British people to be born abroad, meaning they may face barriers in accessing services.
- Some comorbidities (e.g. type II diabetes) are more prevalent in BAME communities.

2.1.7 Gypsy and Traveller Communities

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 to date no clear guidance on self-isolation for people living on unauthorised encampments, on Traveller sites and on boats. Overcrowding and challenges in social isolating are high for many in this group.

2.2 Bereavement

2.2.1 Bereavement during lockdown has caused concern for everyone experiencing the death of a loved one. Burials are likely to be delayed, which will cause 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 will impact heavily on all those for whom religious observance is a core part of their identity.

2.3 Sociodemographic characteristics and ethnicity

2.3.1 When sociodemographic characteristics are not accounted for, people from ethnic minorities have a significantly raised risk of death involving COVID-19 compared with those of White ethnicity. Black males are 4.2 times more likely to die from a COVID-19-related death and Black females are 4.3 times more likely than White males and females. These results show that the difference between ethnic groups in COVID-19 mortality is partly a result of socio-economic disadvantage and other circumstances, but that a remaining part of the difference has not yet been explained.

2.3.2 Differences in the risk of dying from the coronavirus (COVID-19) across ethnic groups may be driven by differences in a group's demographic and socio-economic

profile. Existing evidence indicates that most ethnic minority groups tend to be more disadvantaged than their White counterparts.

2.4 Homelessness

2.4.1 The recent PHE report found that 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 had been diagnosed with COVID-19 with no fixed abode, likely to be rough sleepers. PHE estimates that this represents 2% and 1.5% of the known population of women and men who experienced rough sleeping in 2019. PHE notes that uncertainty remains around these figures and that they should be considered an estimate

2.5 Deprivation

2.5.1 This report also noted that people who live in deprived areas of the country have higher diagnosis and death rates than those living in less deprived parts of England.

2.5.2 The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females, and survival among confirmed cases was also lower in the most deprived areas. This is particularly clear amongst people of working age, for whom the risk of death was almost double that of people in the least deprived areas with male diagnosis rates were significantly higher than females.

2.5.3 It is possible that high diagnosis rates in this group may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed to the disease.

2.6 Sex

2.6.1 Both the health and economic impacts of Covid-19 will be gendered. Women are the majority of those providing care, paid and unpaid and the majority of health workers.

2.6.2 This means that women are 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. Women are also more likely to be employed in service sectors that have been hit hardest by social distancing measures, more likely to be on insecure and zero-hours contracts, more likely to be dependent on social security and more likely to be in an insecure housing situation.

2.6.3 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 coronavirus (COVID-19): 7.5 deaths per 100,000 females, equivalent to 130 deaths. In Greater Manchester, 99,600 women (16.1%) work in this occupational group, as opposed to 15.8% of women in the UK as a whole.

2.6.4 Single women and lone parents in particular (90% of whom are women) are already less able to afford housing. Social isolation policies will increase women's

vulnerability to domestic violence and abuse, and children's vulnerability to reduced safeguarding trigger points.

2.6.5 Women who are pregnant or having newly given birth will experience limited post-natal and maternity services during the covid-19 crisis. With reduced face to face contact and support networks, midwives or baby groups the risk of post-natal depression and anxiety may well increase. These gendered impacts will intersect with impacts as a result of age, disability, sexual orientation, gender identity, class and race.

2.6.6 However, growing global evidence also indicates the mortality rate (taken as the proportion of deaths among confirmed cases) in women and men indicate higher death rates amongst men. In the countries where data is available, it appears that in every country, men are 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.

2.6.7 The reasons why are not entirely clear, but preliminary reports of people with severe COVID-19 disease have found associations with existing co-morbidities including hypertension, cardiovascular disease and some chronic lung diseases including chronic obstructive pulmonary disease. These conditions tend to be more burdensome among men globally.

2.6.8 This is further compounded by the fact that NHS data shows a huge fall in A&E attendances for April - the lowest number recorded since current records began in 2010 and 39% lower than April 2019. This would seem to indicate that a significant proportion of patients with symptoms that would normally require treatment are avoiding A&E despite urgent messaging to reassure the public that hospitals are still open.

2.7 Men and occupation

2.7.1 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.

2.7.2 Men working in elementary occupations had the highest rate of death involving COVID-19, with 21.4 deaths per 100,000 males (225 deaths); in Greater Manchester, 90,800 men (12.7%) work in this occupational category, as opposed to 10.2% of men in the UK.

2.7.3 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 (63 deaths), 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).

2.7.4 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, equivalent to 53 deaths. In Greater Manchester 25,000 men (3.5%) work in caring, leisure and other service occupations.

2.8 Women and Occupation

2.8.1 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 coronavirus (COVID-19): 7.5 deaths per 100,000 females, equivalent to 130 deaths.

2.8.2 In Greater Manchester, 99,600 women (16.1%) 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.

2.8.3 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.

2.8.4 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 in these occupations are from black and minority ethnic (BAME) groups, compared with 11% of the working population and when it comes to pay, 6 out of 16 of these occupations have a median pay of lower than £13.213, the median hourly pay across the UK.

2.9 Children and Young People

2.9.1 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 if there is an economic downturn. Many children and young people are highly anxious about the virus 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.

2.9.2 Whilst the majority of children who contract the virus are 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.

2.10 Disability

2.10.1 Disabled people with serious health conditions including respiratory conditions and diabetes are the most vulnerable to severe health impacts if they contract Covid 19

Disabled people who rely on social care including domiciliary care or unpaid care will find it harder to self-isolate and may be left without vital care services if their carers fall ill or have to self-isolate.

2.10.2 As hospitals and other health services have to cancel or postpone non-urgent cases older and disabled people will face longer waits for treatment, exacerbating existing health problems.

2.10.3 There is an increased risk that disabled people will feel isolated or experience other mental health difficulties related to being confined to home for most of the day and having limited social interactions.

2.10.4 Children and young people with special educational needs and disabilities (SEND) are similarly affected, 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.

2.10.5 Parents and carers of children and young people with SEND managing daily family life whilst meeting the needs of their child/children can be 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.

2.10.6 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.

2.10.7 People with mobility or sensory impairment experience increased difficulties for example, retail priority delivery system may exclude people who need it such as those who are visually impaired who cannot undertake social distancing and yet do not meet the shielded criteria.

2.10.8 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 the UK government is failing many disabled and older people during the current COVID-19 pandemic.

2.10.9 The GM DPP are undertaking a survey of disabled people to capture their experiences and the panel will use the information to support improvements in how Greater Manchester responds and recovers from the pandemic. The survey has been open for three weeks and has already had over 850 responses, with initial findings highlighting

- difficulties in accessing information online and in obtaining Personal Protective Equipment (PPE)
- disabled people are not on the government's shielding list but still require support,
- one third of disabled people are unable to access their healthcare needs
- two thirds of disabled people have reported their mental health has been negatively affected.

2.11 LD and Autism

2.11.1 Emerging evidence on the effect of Covid-19 on people with LD and autism suggest suggests 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, we know that people with LS 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.

2.11.2 To understand the impact in greater depth Greater Manchester is undertaking 33 Learning Disability Mortality Review (LeDeR) rapid reviews before the end of May 2020 to understand if there is any learning during COVID-19 that we need to address immediately.

2.12 LGBT

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

2.12.2 Older LGBT people are more likely to be socially isolated. They are more likely to have poor mental health, 37% of respondents stated that decreased mental wellbeing was one of their top three concerns at this time. They are more likely have issues with substance abuse and to experience unreported domestic abuse. Some Trans and non-binary people have their HRT suspended due to emergency measures.

3.0 Summary of evidence

3.0.1 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 the elderly, disabled people, those with multiple co-morbidities, those is certain occupational roles, often the more deprived communities in our society, but most strikingly of all is the exposure of the adverse impact across BAME groups.

3.0.2 The economic impacts of Covid-19 will affect the poorest families hardest. The sectors that have taken the immediate hardest hit, retail (excluding food), hotels and restaurants, airlines, travel operators, cleaning, arts and entertainment, and personal services like hairdressing have lower average rates of pay. Low-paid workers are less likely to be entitled to Statutory Sick Pay, are less likely to work from home and have lower levels of savings.

3.0.3 Whilst the precise mechanisms behind this disparity are not fully understood, it is increasingly clear that the pandemic is amplifying existing health inequalities.

3.0.4 Inequality has effectively caused significant loss of life and will continue to do so if we fail to act. With the Bank of England forecasting the deepest recession in over 300

years, it is increasingly clear that the decisions we make now will have a lasting impact on our society long after this crisis is over.

4.0 Gathering insight

4.0.1 In addition to national evidence, under the auspices of the Humanitarian Cell, the GM Combined Authority have identified and sourced local intelligence from representatives of all protected characteristics which has identified issues that are specific to their community.

4.0.2 There are increasing calls for both the Government and GMCA to review this inequality and ensure appropriate mitigating action is being taken. Underpinning this is the statutory duty for public services to have due regard to the impact of their services on protected characteristics in the Equality Act 2010.

4.0.3 This engagement effort focussed on the GMCA's equality networks. There are four established networks: Youth Combined Authority, LGBT Panel, Disabled People Panel and GM Ageing Hub. There are a further three which although not formalised yet, have established positive relationships with representatives from these communities: Faith, Race, and Women and Girls.

4.0.4 The intelligence and offers are collated and fed into the Covid-19 sub-groups (of the GM Mayors Covid-19 Committee), through either formal reporting or informal personal channels, where they are considered by representatives from all districts and GM public services.

4.0.5 Findings are also shared with relevant policy teams in GMCA, GM public services such as TfGM, Health and Social Care Partnership and GMFRS.

The intelligence gathered to date is appended to this paper in *Appendix 1.*

5.0 GM Engagement Structures

5.0.1 In summer 2019 the GM VCSE leadership group established an overarching equalities group, the GM Inclusion and Wellbeing Partnership (now named GM Equalities Alliance) under the MoU agreed with the GMHSCP. This group is currently co-chaired by a VCSE and NHS representative. Although the ambition is for the GMEA to stretch across the GMCA, the group does not currently sit in any formal part of the GM governance and struggles to be more widely recognised. The group recently acknowledged it has struggled to have the impact intended when it is set up and is currently reviewing their membership and terms of reference.

5.0.2 Despite this the group is very active and has excellent links with communities. Recently initiating a piece of work gathering intelligence to map the impacts on both health related and more general inequalities of the impact of Covid-19 on marginalised communities in all ten localities and what is needed to aid their recovery.

5.0.3 There are currently nine engagement panels established (or being established) in GM which are sponsored either by the GMCA, TfGM, VCSE leadership group, or

funded from independent projects. The GMCA Equality panels are also very active, but similarly as with the GMEA identifying how they are anchored into, and how they influence across the GM system is unclear.

5.0.4 The GM Equality and Diversity Inclusion Forum (EDI) meet to share good practice and support on aspects of equality issues. The EDI as a function does not exist within the GMHSCP, nor within the GMCA, per se. The group has a membership from across the NHS and Local Authorities EDI leads and active members of the GM EDI Professionals Network.

Table illustrating GM Engagement Structures:

Age	Disability	Gender	Gender reassignment	Marriage and Civil Partnership	Pregnancy and maternity	Race	Religion and beliefs	Sexual orientation
Youth Combined Authority (convened by Youth Focus NW)	GM Disabled People's Panel (convened by GMCDP)	Women and Girls Panel (to be established 2020)	LGBTQ+ Panel (convened by Manchester Pride)			Engagement ongoing around setting up 'Race Equality Panel'	Engagement ongoing around setting up 'Faith Equality Panel'	LGBTQ+ Panel (convened by Manchester Pride)
Ageing Hub – Older People's Network (convened by MACC until March 2021)	Disability Design Reference Group (convened by TfGM)		LGBT Adviser to Mayor of Greater Manchester			GM BAME Leadership Group (convened by GMCVO)		LGBT Adviser to Mayor of Greater Manchester
Inclusion and Wellbeing Partnership (convened by GMCVO) New Equalities Alliance?								
Sponsor - GMCA								
Sponsor - TfGM								
Sponsor - VCSE Leadership Group								
Sponsor – independent project funding								

5.0.5 During the pandemic the Humanitarian Cell has been established, chaired by Andrew Lightfoot, this primarily focussed on support for shielding and vulnerable people through the establishment of community hubs but has since picked up the increasingly worrying issue of inequalities caused by Covid-19. This responsibility

continues to rest with individual organisations in line with the Public Sector Equality Duty.

5.0.6 As we move into recovery the GM Population Health Board will be reconvened. This is chaired by the Chief Executive of Oldham Council, and will have a refreshed term of reference with a particular focus on inequalities, linking strongly to the Marmot work.

5.0.7 It seems apparent that across the GM public sector, there is little identifiable structural architecture for equalities and defined leadership is not immediately identifiable. Whilst there is a named LA Chief Executive and LA Leader for Equalities the portfolio across GM feels fragmented. What does exist though, are a number of recognisable assets and approaches active within this space and an opportunity to connect them more effectively. And in doing so, what is noteworthy when looking across the GM leadership in general, is the lack of visible BAME leadership in the GM system.

5.0.6 Trying to navigate a path through the GM Equalities structures is turgid. There lacks a clear line of sight from the many community groups to the leadership in Greater Manchester so how they influence the equalities agenda is difficult and confusing. Consequently, many will resort to lobbying the Mayor directly to get their voice heard.

6.0 Activity at a GM level in response to the data and insight

6.0.1 Much of the activity to date has concentrated on engagement and insight collation with diverse communities across GM and links into many LA and NHS, GMHSP groups. There is a wealth of insight including that done by different community groups and VCSE organisations that we are not sighted on.

6.0.2 Most of the activity is occurring in pockets at a locality level, targeted at specific cohorts or communities led by VCSE and public sector bodies which cannot be captured here. What we are lacking is a route for better system communication, the ability to track and have assurance that unintended consequences from measures taken do not amplify inequalities even further as we go into recovery.

6.1 GMCA Networks

6.1.2 Insight from the equality GMCA networks has resulted in some rapid action. Examples of change resulting from intelligence from the equality networks so far include:

- The Ageing Hub identified digital exclusion as a key issue for older people to the Humanitarian Group, and they are now producing a pan-GM information leaflet
- Faith representatives highlighted that funding for foodbanks was only going to the Trussell Trust, yet faith groups also run them, so £20,000 has been allocated from the Mayor's Charity to support them
- The Disability Partnership highlighted that some districts were not providing textphones for their community hubs and this is now being resolved. They are also supporting the production of easy-read guides to pandemic information.
- The Compliance Covid-19 sub-group have asked for targeted communications to encourage to stay at home, and we are working with the Youth Combined Authority to find exiting impactful messaging or develop new material

- The Women and Girls Panel have highlighted a specific issue relating to domestic abuse in refugee households, and this is being further explored by the GMCA Police and Crime Team with a view to producing more targeted communications and support

6.2 Action on Bereavement

6.2.1 In recognition of the impact of Covid-19 on bereavement support and funerals affecting groups of different faiths, the multi faith sub group of the GM Mortality Planning Group has developed guidance on the care of the deceased and funeral arrangements in consultation with faith communities from the hospital setting and local authority/community setting. This has been the first step towards developing consistent guidance across Greater Manchester.

6.2.2 In addition to the Greater Manchester Wide Multi-Faith Guidance the Northern Care Alliance NHS Group has pulled together individual guidance for a number of individual faith groups, including Muslim, Hindu, Jewish and Christian.

6.2.3 The GM Bereavement Service is now established and provides support for anyone in GM bereaved or affected by death, including links to the Suicide Awareness Service. The service has direct links into other some voluntary groups including CAHN, Jewish Groups, and Asian, Pakistani and Bangladeshi groups.

6.2.4 CAHN have also produced a proposal for a bereavement service for Caribbean and African communities living in GM with culturally and religious tailored support.

6.3 Action on Mental Health

6.3.1 The scope GM Resilience Hub (RH) has been extended in response to the effect of Covid-19 on the mental health and wellbeing of frontline staff. The overarching principle is that GMRH will use its experience and expertise to provide a governance and assurance framework for all offers of psychosocial support/intervention for NHS, social care and emergency staff across GM. It will augment existing offers (national helplines and occupational health schemes for example) by providing a highly targeted offer for specific groups of essential workers, with phase 1 of the programme going live in May 2020.

6.3.2 Through the BAME VCSE Recovery Support work with the GMHSCP Mental Health programme, GM VCSE partners have identified three core priorities in the immediate/medium-term. These are:

- Information sharing
- Befriending & Mentoring
- Mental health Support

6.3.3 Each VCSE organisation will take an asset-based approach working with extremely vulnerable and marginalised communities to move from a crisis response model (which may not be possible in the longer term) to a more sustainable arrangements that include provision for social distancing and infection control alongside remote delivery where appropriate. In addition, this work will enable smaller community organisations to plan and develop ways of working that keep them viable.

6.4 Action on GM level Equality Impact Assessments

6.4.1 In response to the SCG request for all areas of the GM emergency response to carry out EIA's the GM Community Co-ordination cell supported a proposal and assessment tool to carry out risk assessments of BAME staff at risk of Covid-19. The GM risk assessment draws on existing literature and local experiences to create something that provides detailed steps but at the same time is flexible enough to be interpreted locally.

6.4.2 The resource provides a high-level framework to support employers to reduce the risk to staff in relation to COVID-19 and aims to support employers to appropriately risk assess staff, putting the most appropriate mitigating actions in place. This will initially be carried out in general practice with consideration to roll out across primary care.

6.4.3 In addition, all Councils are currently in the process of completing their own Equality Impact assessments (EIAS) on their individual Covid-19 responses and in support of these the GMCA is connecting with Locality Authority equality leads to produce selective learning. This has highlighted particular concerns, for example, accessibility issues for community hubs.

6.5 Action on tackling race inequality in the workplace – Workforce Race Equality Scheme (WRES)

6.5.1 For decades, research has shown that staff from Black and Minority Ethnic (BME) backgrounds experience discrimination, harassment, and exclusion in the workplace in the UK.

6.5.2 Evidence shows that having a more representative workforce and diversity at senior leadership levels results in better outcomes for the public. It creates a more inclusive, engaged and efficient workforce.

Restarting the WRES schemes means that the NHS, local authorities, police and fire service will be working together to take tackle race discrimination in the workplace.

This will include, understanding the data, the distribution of our BAME workforce according to pay, the chance of BAME staff being recruited following shortlisting and an annual ethnicity pay gap. A proposal to deliver development to the most senior leaders of each public sector organisation over a 10-month period – raising their awareness of race equality. Restarting the Race Equality Change Agents Programme. Plans for mentoring and human library programmes aimed at supporting BAME staff across GM

6.6 Action on Safety Siren

6.6.1 This work is overseen by the GM Provider Federation Board and reports to both the Hospital cell and Community Coordination cell. The original concept: 'Is it possible to measure things happening 'on the day' in UEC to provide indications whether interventions put in place for Covid-19 have had an adverse impact on outcomes for non-covid groups.'

6.6.2 The summary report (June 2020) outlines the proof of the above concept and highlights underlying system issues which could be addressed to combat this

happening in future. Overlaying this will be work on equalities to ensure that no unintended consequences, especially relating to service changes disproportionately affect different groups.

6.7 Action on COVID testing

Our strategy for mass testing has prioritised the need to determine how we best offer and undertake testing within local BAME communities, as well as providing advice on social distancing and isolation.

7.0 Opportunities for rapid action

7.0.1 Most activity to date has focussed on insight, data and risk assessments there is less evidence how these have informed action at a GM level. The mounting importance of tackling inequalities has led to a surge in uncoordinated, disparate activity from public sector and VCSE organisations with unnecessary duplication and replication at a time when we need more clarity and focussed action to best effect.

7.0.2 To date we have focussed our energy on insight and intelligence gathering, with a set of activities which haven't been necessarily pursued as a part of a describable, coherent and holistic plan. As we move from insight to action we need to be clear how our engagement structures connect at a GM level and form a unified plan across our public sector.

7.0.3 We need to better understand the inequalities which now exist in our communities, provide a comprehensive picture of all possible contributing factors across GM and most importantly identify actions to address them. Consequences of our response and actions put into place to tackle Covid-19 have potential to amplify existing socio-economic disparities and exacerbate health, wealth and societal inequalities.
As such there is currently a proposal for consideration by the Greater Manchester leadership for an Independent Panel to be established.

7.1 Proposal for a Greater Manchester Independent Inequalities Commission

7.1.1 The mission of an independent panel would be to understand the inequalities which now exist in the communities of Greater Manchester, and consider how we should address those inequalities, in order to build a fairer and more equitable society and economy.

7.1.2 Panel is proposed as the mechanism by which a light can be shone on existing and emerging inequalities across GM, and through an evidence-based approach the Panel will ensure the design and delivery of GM's recovery to re-dress the balance of inequality across the city-region.

7.1.3 The Panel would support and influence the recovery work across Greater Manchester and ultimately influence the refresh of the Greater Manchester Strategy. It will be a catalyst for transformation, helping to shape and inform responses and actions arising, providing expert opinion, evidence and guidance as Greater Manchester's economy and society reshapes after the pandemic. The Panel should provide the appropriate expertise, challenge and support enabling Greater Manchester to lead the way, nationally and internationally, in recognising and responding to the new inequalities emerging from the Coronavirus pandemic.

The appendix below summarizes the key challenges and opportunities as identified by the equality networks.

Appendix 2

Cross cutting issues:

	Issue	Detail	Mitigation (where known)
1)	Access to healthcare	BAME people are much more likely to live in densely populated and deprived areas where NHS services are already overstretched. LGBT+ people are generally more likely to avoid accessing healthcare due to fears of encountering LGBT+Phobia.	GMHSCP messaging on continuing to access regular healthcare services as normal i.e. GP and hospitals to be shared back to equality groups for reference and further dissemination.
2)	Access to food and medicine	Current priority shopping times do not suit older or disabled people with long-term conditions/ dementia who struggle to get up in the mornings. Vulnerable young people (e.g. with Education, Health and Care Plans / entitled to Free Schools Meals) are not going to school/college.	Wider promotion of community hub numbers including references to helping family and neighbours to address food and medical supplies. Lobbying from Mayor and regional MPs to supermarkets that key workers include charity workers and volunteers. Suggestion: A GM-recognised letter/ ID so that those shopping on behalf of older / disabled / isolating people can identify themselves (Greenwich Council are already providing these). Some colleges are providing welfare food packages but this could be better coordinated.
3)	Lack of compliance with lockdown and social distancing advice	Some under 18s still going out in groups; some are being abusive and spitting at officers. GMP intel that religious gatherings may still be taking place behind private residences in the Wilmslow Rd/Rusholme areas.	YCA and youth services are exploring peer to peer and influencer messaging. Work ongoing with faith communities and local GMP/Council to engage on Stay at Home messages.
4)	Money/ cash	How people pay for goods delivered by volunteers.	Prepaid cards provided by local councils as loans has been escalated to the GM Strategic Command Group.

	Issue	Detail	Mitigation (where known)
5)	Digital exclusion	Disabled and older people may need more 1:1 support to be able to use sufficiently and safety, particularly around: • Online scams/safeguarding issues • Ability to access banking • Ability to do online shop • Ability to get set up/training when not able to have people in the house to help Evidence shows that marginalised ethnic groups have worse internet access. Young people already facing financial hardship do not have access to technology (e.g. care leavers, Free School Meals).	GMCA's Digital Team is supporting with funding and awareness for those without the 'know how' to use the tech are given the skills remotely. GMCA's Work and Skills and Digital Teams are looking at GM Technology Fund that businesses could contribute devices, connectivity or direct finance. GM initiative will plug the gaps missed by the DCMS' DevicesDotNow initiative
6)	Scams and fraud	People pretending to be volunteers. Fraudsters knocking on doors and offering services or virus testing. There was a 400% increase in COVID-related scams in March, with victim losses totaling almost £970,000. Most of the reports are related to online shopping scams where people have ordered protective face masks, hand sanitisers, and other products, which have never arrived.	Sharing advice digitally e.g. https://www.friendsagainstscams.org.uk/shopimages/coronavirus.png and through 'cut out and keep' information in the MEN GMCA's Digital Team developing cyber-crime campaign.
7)	Mental health and wellbeing	Older people: currently information available only digitally. Young people also feel like they are not being told how to look after their mental health.	GMHSCP developing briefing and inputting on tailored messages for older people. 'Cut out and keep' information developed in partnership with the MEN. Youth Combined Authority is sharing current content from NHS, Mind, and GM Health Hub. Specific resources expected soon for older teenagers from NHS England.
8)	Domestic abuse	Increased reports, as lockdown continues. A 2018 study found that 11% of LGBT+ people have faced domestic abuse from a partner in the last year in comparison to	GMCA's Police and Crime Team mapping capacity of victim support organisations. Victim services promotion ongoing.

	Issue	Detail	Mitigation (where known)
		6% of women and 3% of men in the general population – therefore increases in domestic abuse due to lockdown are likely to be significant.	Developing GM comms campaign to prevent domestic abuse and raise awareness how to access support. Suggestion: Increase investment in local LGBT+ and BAME-led domestic violence services.
9)	Economic hardship	BAME and women overrepresented in precarious, low paid jobs with zero-hour contracts which cannot be carried out from home.	Zero hours contractors on PAYE are, in most cases, eligible for the Coronavirus Job Retention Scheme (furlough).
10)	Resilience of voluntary sector providers	Groups supporting disabled and older people losing income from services. Losing staff due to staff and volunteers not being recognised as key workers by their families and by supermarkets (and due to illness/ self-isolation), Age UK Bury not offering services, staff have been furloughed.	Lobbying message to GM MPs to encourage support for national funding to be administered at local level so it is delivered effectively.

Issues specific to each community

Black, Asian and Minority Ethnic Communities

	Issue	Detail	Mitigation (where known)
1)	Hidden homeless	BAME homelessness is often hidden - many are sofa surfing. If they show symptoms, how can they get support without putting others at risk?	
2)	Home schooling	People for whom English is not their first language, do not understand what their children are bringing home, and are less able to support them with it.	Encourage developing and sharing appropriate resources to support home education requirements, considering issues such as language requirements, parental literacy rates and internet accessibility.
3)	Sickle cell patients	Anxiety about blood stocks running low and what will happen if specialist nurses cannot work.	Suggestion: NHS says still safe to give blood - targeted promotion.

4)	More 'at risk'	BAME groups are over-represented in the “at-risk” communities identified by the Government, e.g. South Asians have a higher prevalence of diabetes and Black Africans are disproportionately affected by HIV. They are also over-represented in key worker categories, and so have more opportunities to be exposed to the virus.	Provision of alternative accommodation for key workers to prevent higher risk to their family’s health, prioritising those living in multi-generational households or with people at higher risk.
5)	Language barriers when accessing healthcare	In addition to being more likely to live in densely populated and deprived areas where NHS services are already overstretched, language barriers are also a restriction to accessing healthcare, as COVID-19 no visitor policy means individuals are less able to communicate symptoms and needs.	In discussion with translation services in the voluntary sector to produce information leaflets
6)	Emergency measures legislation	The lack of guidance around emergency measures, such as police powers and school closures is already leading to local variation and disproportionate impact on BAME communities.	Ensure GMP and other GM public sector organisations are using powers in a consistent way - and communicating what the public can expect.
7)	No recourse to public funds	The hostile environment and particularly No Recourse to Public Funds is preventing migrants from accessing basic rights during the crisis.	

Disabled People

	Issue	**Detail**	**Mitigation (where known)**
8)	Health and social care	Existing services to be resourced to deal with the extra demand of this crisis. If no PA’s are able to work and no family or friends can fill in and the disabled person is getting no assistance they need to be able to contact adult social care or another service and have emergency cover provided. PA’s provided with PPE where their client is sick with Covid-19.	Suggestion: Ask central government release extra funds immediately to councils and the GMCA. Suggestion: Councils to allow care funding to pay for Personal Protective Equipment (PPE) and family members to act as personal assistants (PAs) where necessary. People are confused and worried about doing this without permission leading to anxiety and unnecessary time consuming phone calls, we need one blanket announcement this is ok for all in GM.

	Issue	Detail	Mitigation (where known)
		Covid-19 testing kits for PA's and more broadly for anyone who suspects they have it. PA's who are self-isolating need to have access to benefits, if Statutory Sick Pay is the only option to them, disabled people as employers need to be resourced to afford this, plus pay for replacement PA. Disabled people would be advised to have in writing their support plan and advice about medical intervention and wishes in case they have to go into hospital. There is great fear that impairments and frailty will be used/misunderstood in crisis triage situations to deny care under revised NICE guidelines. The role of Ring and Ride and community transport to support necessary appointments is not clear at the current time. DWP: There is some mitigation for existing claims of PIP and ESA and appeals but what of new claims and current sanctions?	Suggestion: GPs and Adult social care coordinate access needs so information is provided in forms people can use (text or voice calls or email) (also we welcome use of BSL interpreters and subtitles in video announcements, press conferences). Suggestion: Pooling of contacts for trades organisations for practical help.
9)	Access to information	Learning disabled people not getting information in easy read and many are already isolated from services, some will have difficulty following infection control advice without assistance.	GMCA's Media Team is negotiating with ITV and BBC, plus local radio and published press, to feature information on Community Hubs.

Faith Communities

	Issue	Detail	Mitigation (where known)
10)	Faith restrictions on food - eating meat sources	Complying with religious beliefs whilst struggling to access to food.	Feedline by FeedMyCity - a cook and delivery of HOT veggie meals. Operate 7 days a week and have the capacity to deliver >1000 meals a day. This has been shared by the Engagement Team and via #SpiritofGM comms campaign.

11)	Funerals	Communities are unsure of guidelines for funerals and they are unsure of where to go for this information. They feel the NHS doesn't have links into communities to share guidelines - but they can help with this.	GMHSCP to clarify guidelines, including reinforcing social distancing, and work with community leaders to disseminate this information (the GMCA Engagement Team can help with this).
12)	Social isolation	Closure of cultural spaces and places of worship, particularly as important religious festivals like Passover, Easter, Vaisakhi and Ramadan approach, isolation and loneliness will be further compounded.	Proactive work between GMCA, GMP and the GM Council of Mosques to promote public health messages

LGBT people

	Issue	**Detail**	**Mitigation (where known)**
13)	HIV	Increased risk of severe COVID-19 in people who are on antiretroviral treatment and are not immunosuppressed. People with a CD4 of under 50 and diagnosed with an opportunistic infection in the last 6 months should stay at home for 12 weeks.	
14)	Trans and non-binary health	Reports that trans and non-binary people have been denied access to hormones. Gender affirming surgeries have been cancelled and waiting lists frozen. Trans and non-binary people are more likely to be disabled and therefore may need more support.	
15)	Substance misuse	LGBT Foundation's substance misuse team have seen relapses attributed to COVID-19.	
16)	LGBT+Phobic family	LGBT+ people are unable to access face to face confidential support - especially young people. Particularly difficult for young people who are at home with LGBT+Phobic family members.	
17)	Capacity of trusted organisations to support	LGBT Foundation have seen increases in calls about: • mental health and wellbeing (100%) • isolation (64%) • homophobia (50%) and transphobia (40%)	

18)	Social isolation	Events that would usually take place over the next few months, particularly Pride events and community activities are now not happening. People involved in the planning, and those looking forward to the celebrations may feel more isolated, particularly at this time where they may need that connection and support.	

Older People

	Issue	**Detail**	**Mitigation (where known)**
19)	Ageism	Press publishing negative messages about older people. Impacts how people view themselves, and has the potential to influence the allocation of resources.	13/03/20 – open letter from GM Older People's Network and the Centre for Ageing Better to media calling on them to be more responsible Suggestion: Challenge ageism including any suggestions of rationing services based on age. Use 'older people' not 'elderly' in language. Highlight positive role older people are playing.
20)	Clear information about who is 'vulnerable'	Confusion around who is vulnerable. Government previously said people over 70 would be asked to self-isolate for 12 weeks as some point, and Ageing Hub is receiving lots of calls about whether they should go to supermarkets or not.	
21)	Accessing volunteer support	Concern around older people not known to services, especially those living alone, may fall through net. Disabled people and older people concerned about accepting help from volunteers they don't know. Age UKs are seeking clarity on how volunteers are linking in with NHS volunteers. There is a requirement of an email address and mobile phone number for people registering, which excludes many people.	

22)	Accessing information	Most advice and information is provided digitally. Ageing Hub have identified a range of issues where advice exists on line, but would be helpful to provide physical copies for older people: • Mental health • Nutrition and hydration • Physical activity • Falls prevention/ strength and balance exercise/ info on how to get up after a fall (Ambulance Service response time significantly increased) • Scams and fraud • Money (hopefully info on getting a prepaid card to pay for shopping) • Local info including community hub, local VCSE operating in area, what's open and times (supermarket, post office etc) • Opportunities to volunteer e.g. phone befriending (which don't require doing so online) • Government guidance	GMCA's Comms Team is working in partnership with the MEN to produce 'cut out and keep' advice in their physical paper.
23)	Physical activity	Increased risk of falls for older people inactive in the home due to deconditioning. People who fall at home likely to be left a long time due to Ambulance Service priorities.	Advice will be provided via MEN in 'cut out and keep' physical copies: How to get up after a fall plus exercise, nutrition, hydration and mental health – Ageing Hub in discussions with Greater Sport and UoM re content. Ageing Hub sharing Greater Sport and University of Manchester content https://www.greatersport.co.uk/ways-to-keep-moving.
24)	Social isolation	Particular concerns for older people who were not know to services prior to lockdown.	GMCA's Culture Team is working with the Ageing Hub regarding offers for older people.
25)	Lockdown exit strategy	Anticipating challenges around encouraging older people to go back outside once lockdown is relaxed. There may be anxiety and fear around being vulnerable to the virus without a vaccine in place. This may make them concerned about accessing food, healthcare, services, and may also affect mental wellbeing, as many live in fear.	Suggestion: Keep current means of accessing services in place for a while after lockdown restrictions are relaxed, to allow older people the chance to adjust back.

Women

	Issue	Detail	Mitigation (where known)
26)	Economic hardship	BAME and women are overrepresented in precarious, low paid jobs, including zero-hour contracts which cannot be carried out from home. These roles are often not eligible for Statutory Sick Pay. • 74% of women are in part-time employment • 69% of women are low paid earners • 54% of women are on zero-hours contract • 36% of young women work in sectors that have been closed down - retail, travel and tourism, hospitality	
27)	More "at risk" due to being more likely to be a keyworker	• 83% of the social care workforce are women • 77% of workers in occupations described as being at high-risk of contracting COVID-19 are women (over a million of which are paid below 60% median wages) • 77% of healthcare workers are women • 60% of keyworkers are women	
28)	Maternity leave	Women on maternity leave are uncertain about pay and some are being told they no longer have a job. Many advice services are only operating remotely so some women may struggle to access timely advice and miss the short deadline for employment tribunal claims. Self-employed women who have taken maternity leave in the last three years are also impacted with the support package they are entitled to.	Promote services that offer employment advice and increase awareness of quick timescales
29)	Increase in automated work	Employers are accelerating plans to automate roles while workers stay at home. This causes future uncertainty for women who are likely to be disproportionately impacted.	
30)	Self-employed women		Signpost to Growth Hub, grants and Government financial support.
31)	Unpaid work	Most women in heterosexual relationships are responsible for the bulk of domestic labour and care duties. Women carry out 60% more unpaid work than men. Women are also most likely to	Raising awareness that workers who have caring responsibilities can be furloughed.

		home school children and care for relatives in intergenerational households.	
32)	Working from home	When working from home, men's work is often prioritised in a quiet space while women are more likely to be in a space where they can be disturbed by family members.	

Young People

	Issue	**Detail**	**Mitigation (where known)**
33)	Exam results	BAME young people more likely to be disadvantaged by predicted grades being used to determine college and university places.	Support the recommendation called for by the Runnymede Trust and other key experts that an Equality Impact Assessment should be undertaken on the final GCSE and A-Level grade predictions.
34)	Access to services	Staff furloughed across the Youth and Community Sector (public and voluntary) means there are gaps in support for young people.	

GM Equalities – summary of current position and outstanding issues

Appendix 3

Please note headings are taken from LGA Equality Framework for Local Government[1]

1. **Understanding and working with your communities – intelligence, research, engagement and insight**
2. **Leadership and Organisational Commitment**
3. **Responsive Services and Customer Care**
4. **Diverse and Engaged Workforce**

ACTIVITY	LED BY	PURPOSE	ISSUES
Understanding and working with your communities – intelligence, research, engagement and insight • Collecting and sharing information • Analysing and using data and information • Effective community engagement • Fostering good community relations • Participation in public life			
Stocktake of intelligence currently available	GMH&SCP	Provide baseline for agreeing future work programme	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 the elderly, disabled people, those with multiple co-morbidities, those is certain occupational roles, often the more deprived communities in our society, but most strikingly off all is the impact on BAME groups. Most activity to date has focussed on insight, data and risk assessments there is less evidence how these have informed action at a GM level.
Engagement and gathering insight	GMCA	GMCA has identified and sourced local intelligence from representatives of all protected characteristics which has identified issues	Currently established GMCA Panels cover young people, older people, LGBTQ+ and disabled people. Gaps will be addressed within one month for Race Equality and Women and Girls Panels. Faith Advisory Panel to be convened later this year.

[1] https://www.local.gov.uk/our-support/guidance-and-resources/equality-frameworks/equality-framework-local-government

ACTIVITY	LED BY	PURPOSE	ISSUES
		that are specific to their community.	The panels are very active, but their links into governance and routes to influence could be clearer.
Engagement and gathering insight	GM VCSE Leadership Group	In summer 2019 the GM VCSE leadership group established an overarching equalities group, the GM Inclusion and Wellbeing Partnership (now named GM Equalities Alliance) under the MoU agreed with the GMHSCP.	A review is currently being undertaken of the role and membership of this Alliance. This represents an opportunity for further insight and engagement – but the role of the Alliance currently lacks clarity.
Independent Inequalities Panel / Review	GMCA	Strategic review of a wide range of data and intelligence undertaken by independent panel of experts	Arrangements and scope currently being developed. Will need to be informed by engagement structures. Will this review ensure that the wider inequalities which COVID has shone a light on translate into how we mitigate in the future.
Work with Operation Black Vote	GMCA	Aim to increase visibility of BAME in public life	Scope and details to be developed
SCG investigation into Covid-19 impacts	GMP	Collection of data and insights into impacts of Covid-19 on different communities	Scope tbc with Umer Khan
Fostering good relations			Do we have a consistent approach to this? Should we be influencing /consider/reference things like education & schools- giving children a greater understanding of black history for example, employment and opportunities?
Leadership and Organisational Commitment • Leadership • Priorities and working in partnership • Assessing equality impact in policy and decision taking • Equality objectives and annual reporting • Performance monitoring and scrutiny			

ACTIVITY	LED BY	PURPOSE	ISSUES
GM Portfolio for Equalities	Cllr Brenda Warrington, Pam Smith	All GMCA activities should be channelled through Cllr Warrington.	At the current time, the portfolio across GM feels fragmented, what is noteworthy is the lack of visible BAME leadership across the GM (public sector) system.
GM Population Health Board	GMH&SCP	Reconvened to concentrate on equalities	How will this link to other programmed work around tackling inequalities?
Equalities Impact Assessments for emergency structures	SCG (co-ordinated by TfGM)	SCG request for all areas of the GM emergency response to carry out EIA's. Also all LAs undertaking district level EIAs.	Where are these published? Is good practice shared? Is there a co-ordinated approach?
Publishing equalities objectives	GMCA, H&SCP	Publish clear objectives on how PSED is delivered	Not done?
Leadership programmes - NHS Leadership academy, Leading GM course			It is noticeable how few BAME people are in leadership positions across GM and it is reflected in the membership in the COVID Cell governance.
Performance and scrutiny			Could we do more?
Co-production and co-design			How are we engaging with diverse communities?
Responsive Services and Customer Care • Commissioning and procuring services • Integration of equality objectives into service planning • Service delivery			
Safety Siren work	NWAS		There is an opportunity to explore the following additional pieces of work: 1. Look at high risk high consequence conditions with a focus on urgent and emergency care – mortality, urinary sepsis, MI, CVA, 2. For the above conditions and a range of other 'siren ' measures look at actual incidence now versus expected incidence- we have a large number of these – suicide, self-harm, section 136, severe dental abscess, paediatric sepsis, ischaemic limbs, ruptured aneurysms, cancer referrals, etc

ACTIVITY	LED BY	PURPOSE	ISSUES
			3. Analyse the data to look for inequalities – demographic, cultural, age etc and also to see if system changes to help with COVID could have been causative in unintended harm.
Responding to issues raised through engagement channels	GMH&SCP, GMCA	Responding to specific issues raised via equalities panels and other engagement channels	A large number of issues have been escalated, however, there is a lack of a systematic approach to addressing (and responding back on) the issues raised.
Action on bereavement	GMH&SCP	Several versions of bereavement guidance have been prepared either by or in consultation with faith groups	Where is this shared?
Supporting mental health	Various	Mental health guidance and support has been developed for specific protected groups	Have all protected characteristics been covered in new guidance and support? Does this inadvertently create discrimination?
Testing	GMH&SCP	Mass testing has prioritised the need to determine how we best offer and undertake testing within local BAME communities, as well as providing advice on social distancing and isolation.	
And other work??			
Diverse and Engaged Workforce • Workforce diversity • Inclusive strategies and policies • Collecting, analysing and publishing workforce data • Learning and development • Health and wellbeing			

ACTIVITY	LED BY	PURPOSE	ISSUES
GM Equality and Diversity Inclusion Forum (EDI)		The Forum meets to share good practice and support on aspects of equality issues.	EDI as a function does not exist within the GMHSCP. The group has a membership from across the NHS and Local Authorities EDI leads and active members of the GM EDI Professionals Network.
Risk Assessments		Primary care have started the risk assessment and have developed an assurance template together with a best practice guide for completing risk assessments. They are also collecting examples of good practice eg Buddying schemes, remote working, resilience hubs, the GM workforce bank.	
And other work?			,
NHS / GMCA Graduate schemes			do we know how many BAME people are offered a place on the graduate training schemes?