

Stockport JSNA

joint strategic needs assessment

Impacts of COVID-19 on health and wellbeing in Stockport

September 2020

COVID-19 Stockport – September 2020 – Introduction

The COVID-19 Global Pandemic has already had a significant impact on all our lives, in a way none of us could have imagined at the start of this year. It has led to shift in our ways of life, limits on social contact with friends and family, changes to the way we work or educate our children, strains faced by those who have been furloughed, lost their jobs or seen their businesses suffer and unprecedented pressure put on our key workers and healthcare staff. COVID-19 has had devastating impact on health and wellbeing of those who have had a serious infection and tragically has caused loss of life that has affected so many families in our communities.

The effects of the epidemic and the measures implemented to control it's spread will be felt potentially for many years to come, and many of the impacts have not yet materialised. It is therefore to soon to quantify the full impact of the pandemic on the population of Stockport, however, we are now six months since the start of the pandemic and some initial evidence about the impacts of COVID-19 on the health and wellbeing of the population are emerging. We especially are learning about how these impacts have not been experienced equally, and often exacerbating existing inequalities..

This JSNA report aims to bring together evidence about some of the impacts of the COVID019 pandemic, and is envisaged as the first in a series of analysis which will continue to develop.

It is intended to explore what is known so far about:

- The direct impact of the first wave of the pandemic in on the health and wellbeing of Stockport's population
- Inequalities in health and wellbeing of the people of Stockport and in particular vulnerable groups
- The impact of lockdown and changes in the way we live

With the aim of summarising the situation as it's known at the beginning of September to provide an overview to help the system:

- In planning for the winter of 2020/21
- In supporting those who have particular vulnerabilities to COVID-19, especially through any future waves
- In preparing for the economic and social recovery from the effects of lockdown
- To help identify priorities for building back better.

TO BE ADDED

THIS REPORT IS STILL IN DRAFT FORMAT AND A REVISED VERSION WILL BE SUBMITTED THE HEALTH AND WELLBEING BOARD WITH FURTHER DETAILS ADDED TO THE FINAL SECTION AND CONTENTS AT THE START

Key Findings

It is likely that 17,600 people of in Stockport have been infected with coronavirus (COVID-19) – with a confidence range between 14,950 and 20,550.

Over 2,000 people have been diagnosed with COVID-19 in Stockport, and more than 500 people have been admitted to hospital as a result.

There have been around 360 deaths due to COVID-19 so far, and around 19% more deaths in 2020 so far than would have been expected (excess mortality).

44% of COVID-19 deaths were care home residents, and mortality levels in care homes in 2020 are 50% higher than average.

COVID-19 is exacerbating exiting inequalities in health and is particularly affecting:

- Older people
- Males
- Black Asian and Minority Ethnic Groups
- Those living in deprived areas

Mental wellbeing is deteriorating and rates of poor wellbeing have almost doubled from pre pandemic levels, it is likely that needs for support will be rising.

What we need to understand more about

Nationally research is underway to estimate the true rate of infection earlier in the pandemic, this is needed to help us prepare for future waves.

There still a number of scenarios for how the pandemic will progress over the coming months, and no certainty about the future.

There is sill more to understand about the long term impact of COVID-19 on those who have been discharged, the duration of these effects, and the full extent of the level of increased need in Stockport.

ONS modelling suggests that there will be both positive and negative effects on health from pandemic and the control measures, such as improvements in health due to lower air pollution but deterioration due to mental wellbeing and economic consequences. Monitoring future rates of mortality and prevalence of conditions in Stockport is key to understanding the impact of the pandemic.

COVID-19, the story so far….

On 31st December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. On 31st January the first cases were confirmed in the United Kingdom.

On 11th March 2020 the World Health Organisation declared Covid-19 a global pandemic. The UK Government moved from the "Contain" phase to the "Delay" phase on 12th March 2020 and on the 23rd March the UK moved to "Control" with a full lockdown announcement and the population ordered to stay at home.

Restrictions started to lift in May, and by 4th July the UK moved back to Contain measures with pubs and restaurants reopening and friends and families again permitted to meet. Since then the government has implemented a series of local control measures in areas where numbers of cases began to rise, which effected Stockport through August, and has implemented case identification and isolation, contact tracing through NHS Track and Trace and outbreak management, as tools to limit the ongoing spread of COVID-19.

After a sustained period of COVID crisis-response, the health and care system now faces the complex challenge of supporting those people affected by COVID-19 to recover, re-starting non-urgent services and tackling the backlog of elective care that has been on hold and building up during the crisis; while preparing for and managing any future outbreaks of the virus.

The UK has experienced a large epidemic of Covid-19 which has led to considerable loss of life, evidence suggests that the potential remains for significant future waves of epidemic as restrictions are relaxed or lifted.

During this period, the system need to identify capacity to support post COVID-19 rehabilitation and the increasing demands on mental health services. At the same time, it need to maintain critical care capacity and ensure sufficient resilience to manage a potential second wave of COVID-19.

One clear lesson from the COVID crisis has been the importance of health and care organisations working together as a system.

The following section sets out what we know about the progress of the pandemic in Stockport in terms of numbers of cases, data is emerging on a daily basis so all the findings here should be treated as interim and with caution.

Key Findings

It is likely that 17,600 people of in Stockport have been infected with coronavirus (COVID-19) – with a confidence range between 14,950 and 20,550.

So far 2,086 people have been diagnosed, meaning around 10-15% of these have been identified.

Rates of detection have improved over time and it is likely that we are now identifying around 50% of new cases.

The first wave of the pandemic peaked in April 2020, the numbers of cases identified at this time were a significant undercount.

Following national trends, Stockport residents who are older and or from BAME ethnic groups have higher rates of diagnosed COVID-19 in Stockport.

At least 18% of diagnosed cases are linked to care homes.

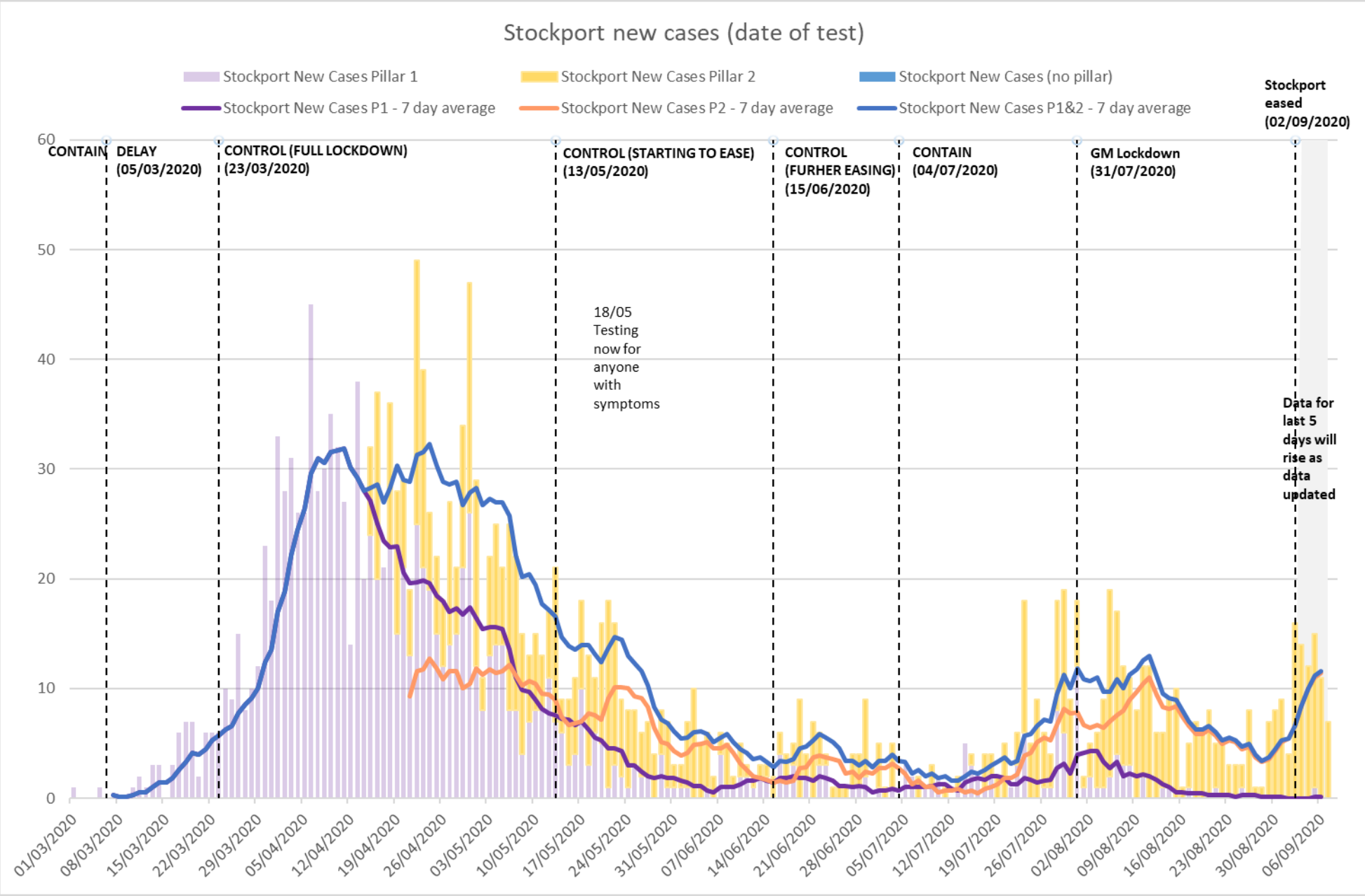
What we need to understand more about

Nationally research is underway to estimate the true rate of infection earlier in the pandemic, this is needed to help us prepare for future waves.

Data is improving, but we still do not understand comprehensively locally how different occupational groups or those with specific needs such as learning disability and serious mental illness have experienced COVID-19 so far.

There still a number of scenarios for how the pandemic will progress over the coming months, and no certainty about the future.

COVID-19 Stockport – September 2020 – total diagnosed so far



2,086 so cases of COVID-19 have been diagnosed so far (9th September) for Stockport residents.

Following national trends the number of new cases in Stockport peaked in April, though these cases are a significant undercount to the true value as initially testing capacity was limited and targeted.

From 18th May testing has been available to all and therefore data from this point forward is more reliable, though still a likely significant undercount as many may not have had symptoms.

The number of new cases per day has varied, over time and is currently rising. These trends are regularly reviewed and responded to by the COVID-19 Health Protection Board.

COVID-19 Stockport – September 2020 – estimate of total volume of infections in Stockport

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The ONS COVID-19 Infection Survey shows that as of 23rd August 2020, 6.0% (95% confidence interval: 5.1% to 7.0%) of individuals aged 16 years and over tested positive for antibodies to the coronavirus (COVID-19) from any blood sample taken during the study.

This equates to 2.7 million people in England (between 2.4 and 3.2 million people).

Applying this data to Stockport suggest that

- **14,200 people aged 16+ have been infected with COVID-19** – range between 12,050 and 16,550.
- **17,600 people of all ages have been infected with COVID-19 –** range between 14,950 and 20,550

In total 2,086 Stockport residents have been diagnosed with COVID-19 so far so between 10 and 15% of the probable total number with COVID-19 have been diagnosed.

Caveats to this survey limit the findings:

- *It is based on a small sample - 7,093 blood samples received since the start of the study on 26th April 2020, 350 tested positive for antibodies – this in particular means it cannot detect differences in infection rate at the small area level.*
- *It takes between two and three weeks for the body to make enough antibodies to fight the infection, so the survey may miss those who have recently been infected*
- *Antibodies don't show when the infection occurred so a true timeline for the pandemic cannot be estimated.*
- *Due to the method and sample size the survey doesn't pick up differences in occupational settings, we know in particular that the infection rates are likely to be higher for hospital and care home staff.*

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/latest

COVID-19 Stockport – September 2020 – estimate of current rate of new infections in Stockport

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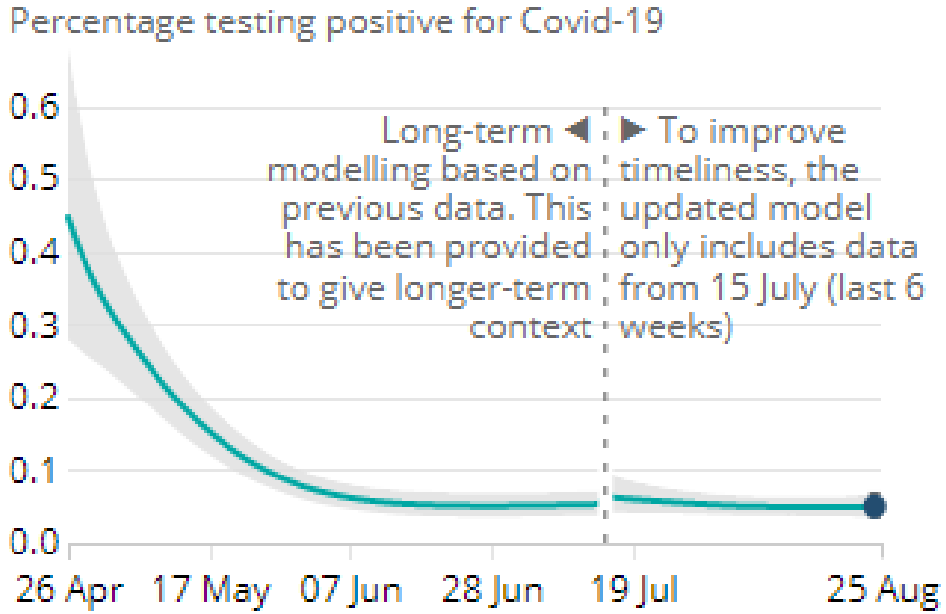
- During the most recent week (19 to 25 August 2020), ONS estimate there were around 0.36 (95% credible interval: 0.21 to 0.58) new COVID-19 infections for every 10,000 people per day in the community population in England,
- This equates to around 2,000 new cases per day (95% credible interval: 1,100 to 3,200) in England.
- **In Stockport this would equate to around 11 new cases per day** (credible interval 6-17).
- The ONS infection survey began at the end of April, and therefore does not include estimates about the trends in new cases through the first wave of the pandemic, however using the available trend data from the new cases per day data (see chart) we can estimate that **since 26th April there have been 2,300 new cases in Stockport** (see table)**.**
- There have been 1,175 cases diagnosed in Stockport since this point, so **around 50% of the total are now being diagnosed.**
- Since June the level of new cases per day at a national level has been reasonably stable, the survey is not necessarily sensitive enough to identify local increases and hot spots.
- Estimates from Imperial College estimate that at the peak of the pandemic in late March there were 100,000 new infections a day nationally, which would equate to around 500 a day in Stockport.

ONS National Estimate of New Infection Rate:



ONS figures applied to Stockport population:

Month	Estimated new cases ONS	Estimated new cases per day ONS	Actual diagnosed cases	Actual diagnosed new cases per day
26th–30th April	360	72.0	147	29.4
May	1,180	38.1	430	13.9
June	270	9.0	128	4.3
July	250	8.1	166	5.4
1st–25th August	240	9.6	190	7.6

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/latest

ONS & PHE National data shows:

Differences by age are the most significant disparities

- With risk of severe impact increasing significantly for older people

Differences by gender

- With men being more effected than women at all ages, working age males diagnosed with COVID-19 were twice as likely to die as females.

Differences by BAME groups

- People from minority ethnic are at greater risk of a coronavirus (COVID-19)-related death than the White population, after adjusting for age and other characteristics.
- Black males and females are nearly twice as likely as similar White people to experience a COVID-19 death

Differences by region and deprivation

- Local authorities with the highest diagnoses and death rates are mostly urban and follows a regional trend with London the highest, followed by the North West and East..
- People who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females. This is greater than the inequality seen in mortality rates in previous years, indicating greater inequality in death rates from COVID-19.

Differences by occupation

- Men and women working in social care – including care workers and home carers – had significantly higher rates of deaths involving COVID-19 compared with those of the same age and sex in the general population
- The highest rates of deaths involving COVID-19 were seen among male low-skilled workers such as security guards, followed by taxi drivers and chauffeurs bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants.
- Healthcare workers are among those most likely to be exposed to COVID-19 because of physical proximity and exposure to disease in general, though this may be mitigated by the use and availability of personal protective equipment (PPE).

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

COVID-19 Stockport – September 2020 – age profile of diagnosed cases

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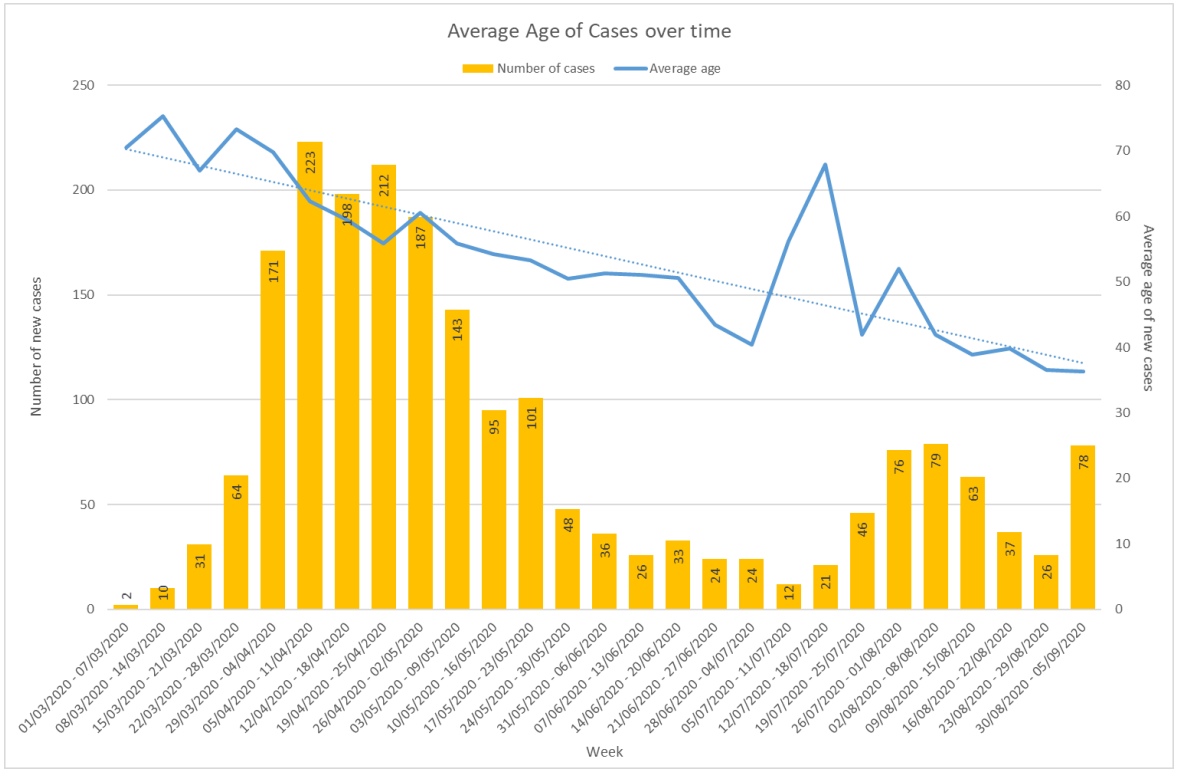
Analysis of the age profile of cases shows that over time the average age of diagnosis has fallen, from around 70 years in the very early stages to around 35 at the beginning of September.

In part this change is driven by testing policy, as in the early stages those in hospital (who tend to be older) and hospital staff (who are more likely to be females aged between 30 and 60) were the most likely to be tested.

As testing extended to all the average age fell to 50, however since then this decline has continued, in part driven by different occupational roles and behaviours amongst different age groups.

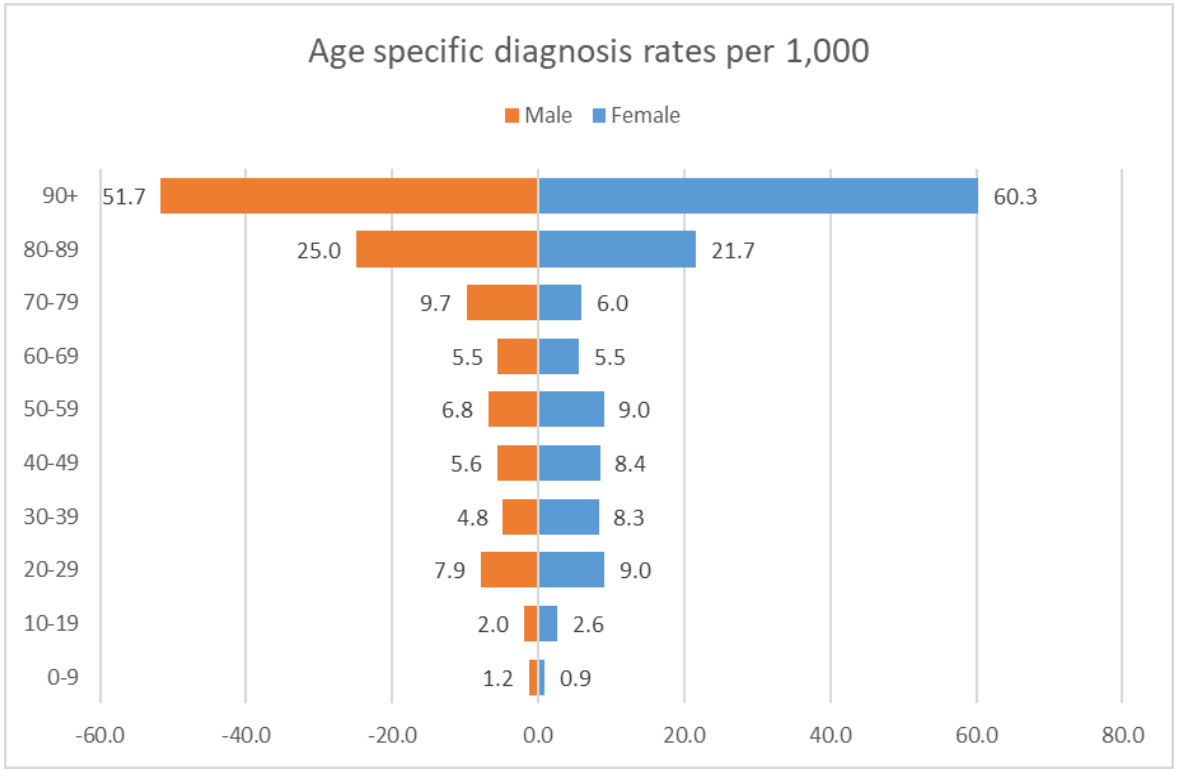
When case numbers were at their lowest the average age increased sharply, due to a hospital outbreak.



Around 5.7% of people aged 90+ in Stockport have been diagnosed with COVID-19 and around 2.3% of those aged 80-89, for all other age groups the rate is less than 1% and is especially low for children (under 0.3%). These rates again will be significantly impacted by the testing policy early in the pandemic.

Gender analysis again is effected by testing policy, as the hospital workforce is dominated by females, therefore increasing the proportion of females between 30 and 60 years diagnosed when compared to males.

For ages 70-89 more males have been diagnosed than females, for ages 70-79 the male diagnosis rate is almost 50% higher than the female rate.



COVID-19 Stockport – September 2020 – ethnicity of diagnosed cases

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National analysis has shown that people from all minority ethnic groups apart from Chinese and Mixed are at greater risk of a coronavirus (COVID-19).

In Stockport, although numbers are small this trend is evident, with the crude rate per 1,000 of diagnosed cases being more than double in Asain / Asian British, Black / Black British and other ethnic groups.

Due to population size the numbers of cases are highest for people from Indian or Pakistani ethnic groups.

There are still a significant number of cases where the ethnicity is not known, which could affect these rates.

Analysis by age and ethnic group show that children and younger adults diagnosed with COVID-19 are disproportionately more likely to come from a Black Asian or other Minority Ethnic Group (BAME) than those at older ages, this in part reflects the age profile of the BAME population.

As the BAME population of Stockport is geographically clustered these trends will particularly impact areas to the east of Stockport, including Heald Green, Gatley, Cheadle and Heaton Mersey.

Ethnic Group	Number of Cases in Stockport	Estimated rate per 1,000
White / White British	1,622	6.2
Mixed/multiple	30	5.9
Asian / Asian British	221	16.1
Black / Black British	28	14.3
Other ethnic group	33	20.2

Age Group	White / White British	Mixed/ multiple	Asian / Asian British	Black / Black British	Other ethnic group	% from BAME group
0-9	20	<5	11		<5	41.2%
10-19	46	<5	15		<5	28.1%
20-29	177	9	34	<5	5	21.7%
30-39	164	5	37	<5	7	23.7%
40-49	164	<5	55	10	10	32.2%
50-59	247	6	40	8	6	19.5%
60-69	147	<5	14	<5	<5	12.5%
70-79	189	<5	7	<5		4.5%
80-89	305		7	<5		2.9%
90+	163	<5	<5	<5		1.8%

COVID-19 Stockport – September 2020 – inequalities in diagnosed cases

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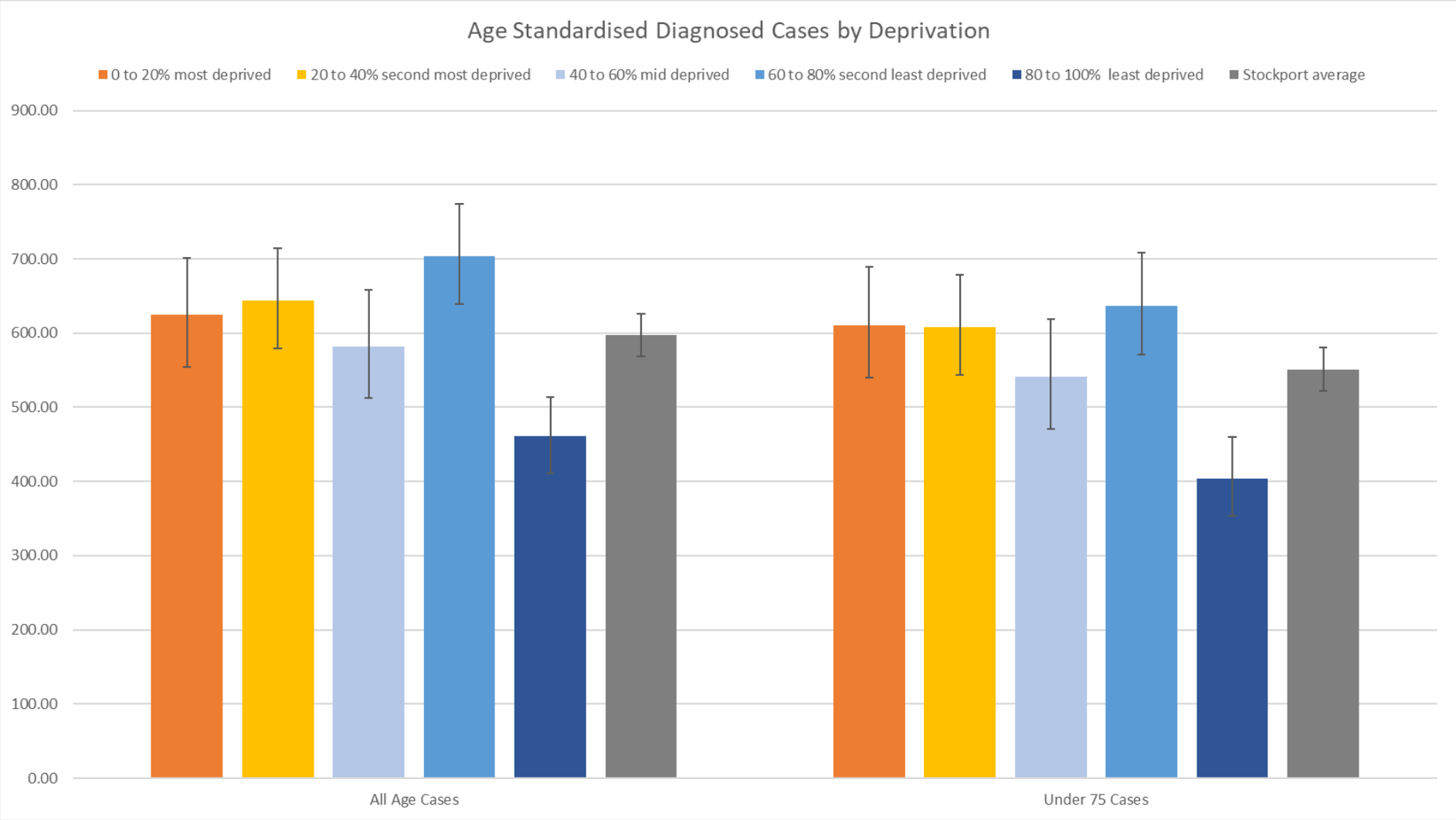
Age standardised analysis of diagnosed cases by deprivation shows that the rate of cases in the least deprived areas was significantly lower than in the other areas of Stockport, both at all ages and when focusing on those under 75.

There is, however, no significant difference in rates of diagnosed cases between the other deprivation quintiles, although the impact of severe COVID-19 and lockdown are likely to be felt more in areas of deprivation.



This analysis is based on the diagnosed cases identified for Stockport residents and therefore should be treated with caution as those not diagnosed may have different characteristic to those diagnosed.

Cases linked to care homes have been excluded from this analysis as they effect geographic analysis.

COVID-19 Stockport – September 2020 – wards of diagnosed cases

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The table below shows the count of positive cases by ward by week since March, grouped by Constituency. This data excludes 380 known cases linked to care homes (residents and staff) and 6 cases without a reported postcode. It includes cases linked to hospital or where a care home link was not clearly identified (for example care home staff before July). There have been cases in each ward, and wards with higher BAME populations and those closest to the hospital have had the highest counts. Since July wards with higher counts usually have multiple cases in households.

Ward Name	01/03 - 07/03	08/03 - 14/03	15/03 - 21/03	22/03 - 28/03	29/03 - 04/04	05/04 - 11/04	12/04 - 18/04	19/04 - 25/04	26/04 - 02/05	03/05 - 09/05	10/05 - 16/05	17/05 - 23/05	24/05 - 30/05	31/05 - 06/06	07/06 - 13/06	14/06 - 20/06	21/06 - 27/06	28/06 - 04/07	05/07 - 11/07	12/07 - 18/07	19/07 - 25/07	26/07 - 01/08	02/08 - 08/08	09/08 - 15/08	16/08 - 22/08	23/08- 30/08	31/08- 06/08	TOTAL
Bramhall North				<5	5	6	<5	8	<5	8	<5	<5	<5	<5		<5					<5	<5					<5	55
Bramhall South & Woodford			<5	<5	8	5	<5	<5	5	<5	<5	<5	<5							<5	<5		<5		<5		<5	49
Cheadle & Gatley	<5	<5	5	<5	17	13	15	8	5	7	8	7	5		<5		<5	<5	<5			<5	9	<5	<5	<5	9	134
Cheadle Hulme North			<5	<5	6	10	<5	9	5	5		<5	<5	<5	<5	5	<5		<5	<5	<5	<5			<5	<5	<5	72
Cheadle Hulme South			<5	<5	9	14	13	<5	5	<5	<5	<5		<5	<5	<5		<5			<5	<5	5	<5	<5	<5	<5	80
Heald Green			<5	<5	7	11	<5	9	7	11	<5	<5	<5		<5	<5	<5	<5	<5	<5	<5	<5	5	7	6	<5	<5	102
Stepping Hill		<5	<5	<5	<5	6	14	14	9	7	<5	<5				<5	<5		<5		<5	<5	<5	6	<5	<5		80
Bredbury & Woodley				<5	5	11	7	10	8	10	<5	<5	<5	<5			<5		<5		<5	<5	<5	<5	<5	<5	<5	81
Bredbury Green & Romiley				<5	<5	<5	7	5	7	<5	<5		<5	<5	<5		<5			<5		6	<5	<5		<5	<5	55
Hazel Grove			<5	<5	12	14	12	10	14	10	11	8	<5			<5		<5	<5		5	<5	<5			<5	<5	109
Marple North		<5	<5	<5	7	5	<5	8	<5	6	<5	<5	<5	<5	<5						<5	<5	<5		<5		<5	53
Marple South			<5	<5		<5	<5	<5	<5	6	<5	<5	<5		<5				<5	<5	<5	<5	<5	<5	<5			44
Offerton			<5	<5	6	14	8	6	9	11	<5	<5	<5	<5	<5	<5	<5	<5	<5	<5	5	<5	<5	<5	<5	<5		97
Brinnington & Central		<5	<5	<5	5	5	14	15	11	5	<5	10	<5			<5	<5				<5	<5	6	<5	<5	<5	<5	95
Davenport & Cale Green			<5	<5	5	8	13	15	10	6	<5	<5	<5	5	<5	<5	<5	<5	<5	<5	<5		<5	<5	<5	<5	7	100
Edgeley & Cheadle Heath				<5	7	9	5	7	6	<5	5	<5	<5	<5	<5	<5	<5	<5				<5	5	<5	6		<5	77
Heatons North					8	7	7	<5	<5	<5	7	<5	<5	6			<5	<5	<5	<5	<5	<5	8	<5	<5	<5	6	78
Heatons South			<5	<5	5	7	7	6	5	<5	9	<5	6	<5	<5	<5	5	<5			<5	<5	<5	7	<5	<5	9	94
Manor				<5	6	8	7	9	10	5	<5		<5	<5	<5	<5		<5		<5	5	8	<5	<5		<5	<5	80
Reddish North					<5	9	5	10	8	<5	5	5				<5		<5	<5			<5	<5	<5		<5	<5	73
Reddish South				<5	<5	7	8	<5	8	<5	<5	6	<5	<5	<5	<5	<5	<5		<5	<5	5	<5	<5		<5	6	74
STOCKPORT none care home	<5	<5	25	45	131	175	158	168	144	123	83	73	41	28	25	29	23	22	14	17	42	61	69	51	32	26	71	1682
Care home total		6	6	19	39	47	38	44	42	20	12	28	7	8	<5	<5		<5		<5	<5	15	10	12	5		7	380

COVID-19 Stockport – September 2020 – diagnosed cases in care homes

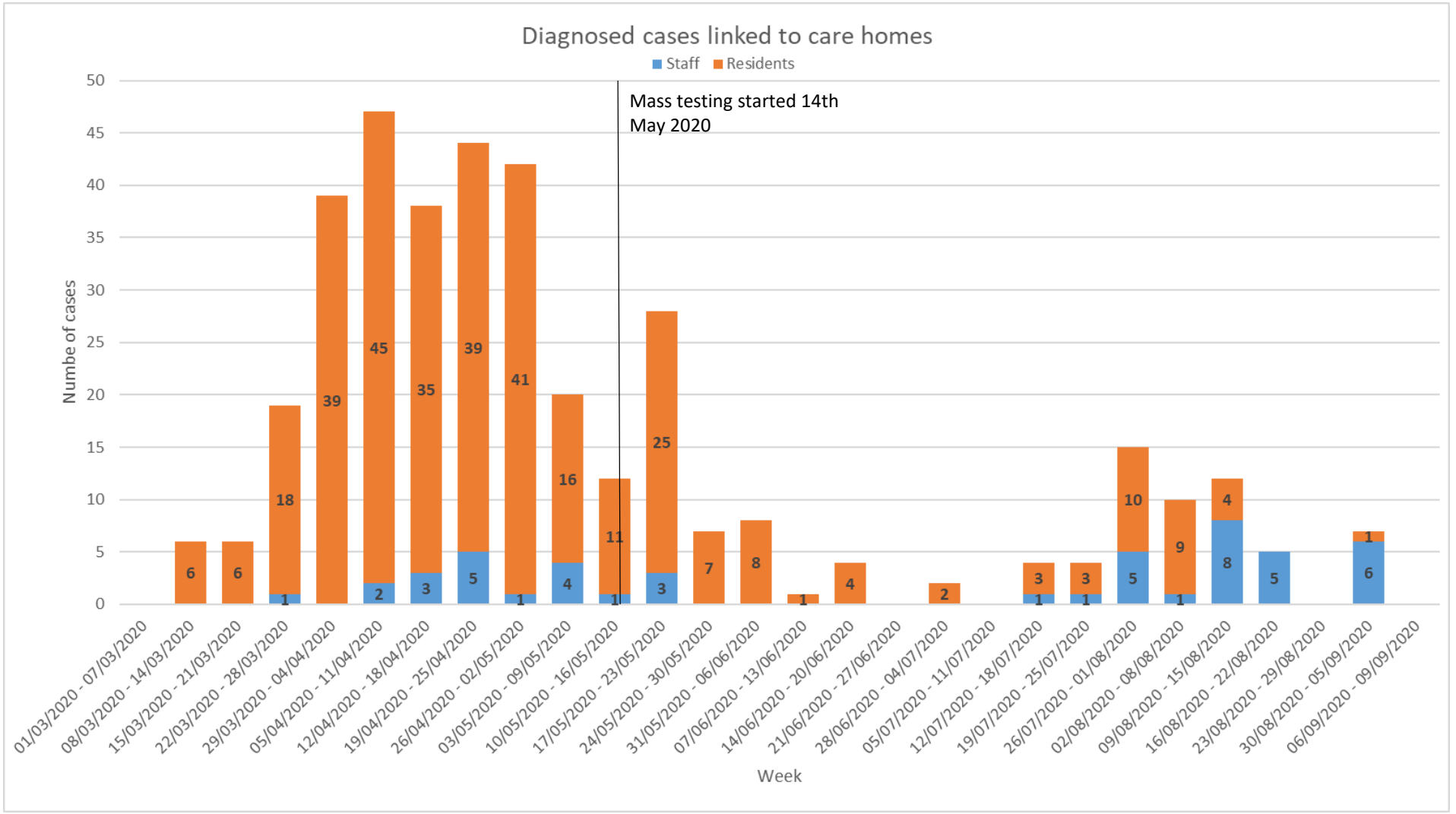
18% (380) of diagnosed cases have been linked to care homes, although this is a likely undercount*.

44 care homes have reported outbreaks and a further 8 have reported issues relating to COVID-19 since March 2019; equating 81.3% of care homes in Stockport.

This proportion ranks 5th in Greater Manchester and similar to the GM average.

Mass testing is now occurring regularly in care homes meaning many of the more recent cases have been asymptomatic and identified via this route, although outbreaks are still occurring, 93 positive tests have been identified by mass testing.

Work is underway to improve our understanding of how the first wave of the pandemic was felt by care homes, to help preventative strategies for any future wave.



*Identifying cases linked care homes is not an exact science, especially identifying staff whose test details may be linked to their home address rather than the care home. Reporting has improved but a significant number of staff cases from earlier in the pandemic maybe missing from this analysis.

The Academy of Medical Science have prepared an analysis of a reasonable worse case scenarios to inform government planning for winter, focusing on what a possible resurgence of COVID-19, which might be greater than that seen in the spring, could look like when combined with other pressures.

The need for health and social care regularly undergoes large seasonal fluctuations, peaking in the winter. The NHS and social care systems typically operate at maximal capacity in the winter months, with bed occupancy regularly exceeding 95% in recent years. Four additional challenges have great potential to exacerbate winter 2020/21 pressures on the health and social care system, by increasing demand on usual care as well as limiting surge capacity:

1. **A large resurgence of COVID-19 nationally,** with local or regional epidemics. Modelling of reasonable worst-case scenario – in which the effective reproduction rate of SARS-CoV-2 (Rt) rises to 1.7 from September 2020 onwards – suggests a peak in hospital admissions and deaths in January/February 2021 of a similar magnitude to that of the first wave in spring 2020, coinciding with a period of peak demand on the NHS. We are already seeing local outbreaks.

2. **Disruption of the health and social care systems** due to reconfigurations to respond to and reduce transmission of COVID-19 with a knock-on effect on the ability of the NHS to deal with non-COVID-19 care. The remobilisation of resources for COVID-19 (staff and facilities) that occurred during the first wave of COVID-19 is unlikely to be possible this winter, due to other winter pressures, urgent delayed care, and a likely increase in staff sickness absence, among others.

3. **A backlog of non-COVID-19 care** following the suspension of routine clinical care that is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity (which needs to be quantified). Estimates suggest that the overall waiting list in England could increase from 4.2 million (pre-COVID-19) to approximately 10 million by the end of the year. Reducing the backlog of care will be hampered by reduced operational capacity across NHS organisations designed to prevent nosocomial transmission of COVID-19.

4. **A possible influenza epidemic that will be additive to the challenges above**. The size and severity of the influenza epidemic in winter 2020/21 will be particularly difficult to estimate, but the most recent significant influenza season in winter 2017/18 coincided with a colder winter; led to over 17,000 excess respiratory deaths; and caused NHS Trusts to cancel all elective surgery in January 2018, resulting in 22,800 fewer elective hospital admissions when compared to the previous year. A generalised increase in respiratory infections over the winter could also rapidly overwhelm test and trace capacity.

https://acmedsci.ac.uk/file-download/51353957

The following section sets out what we know about the those who have experienced COVID-19 severely enough to required hospital admissions.

Key Findings

Stockport residents have had 500 admissions as a result of COVID-19.

The average length of stay was 11.5 days, 25% of patients were in hospital for at least 2 weeks and 10% more than 4 weeks.

Demographic trends were different to those for diagnosed cases:

- Those admitted had an older profile
- Those admitted were more likely to be from a white ethnic background.
- Those admitted were more likely to be care home residents.

At least 270 people have been discharged from hospital to the community after receiving care for COVID-19.

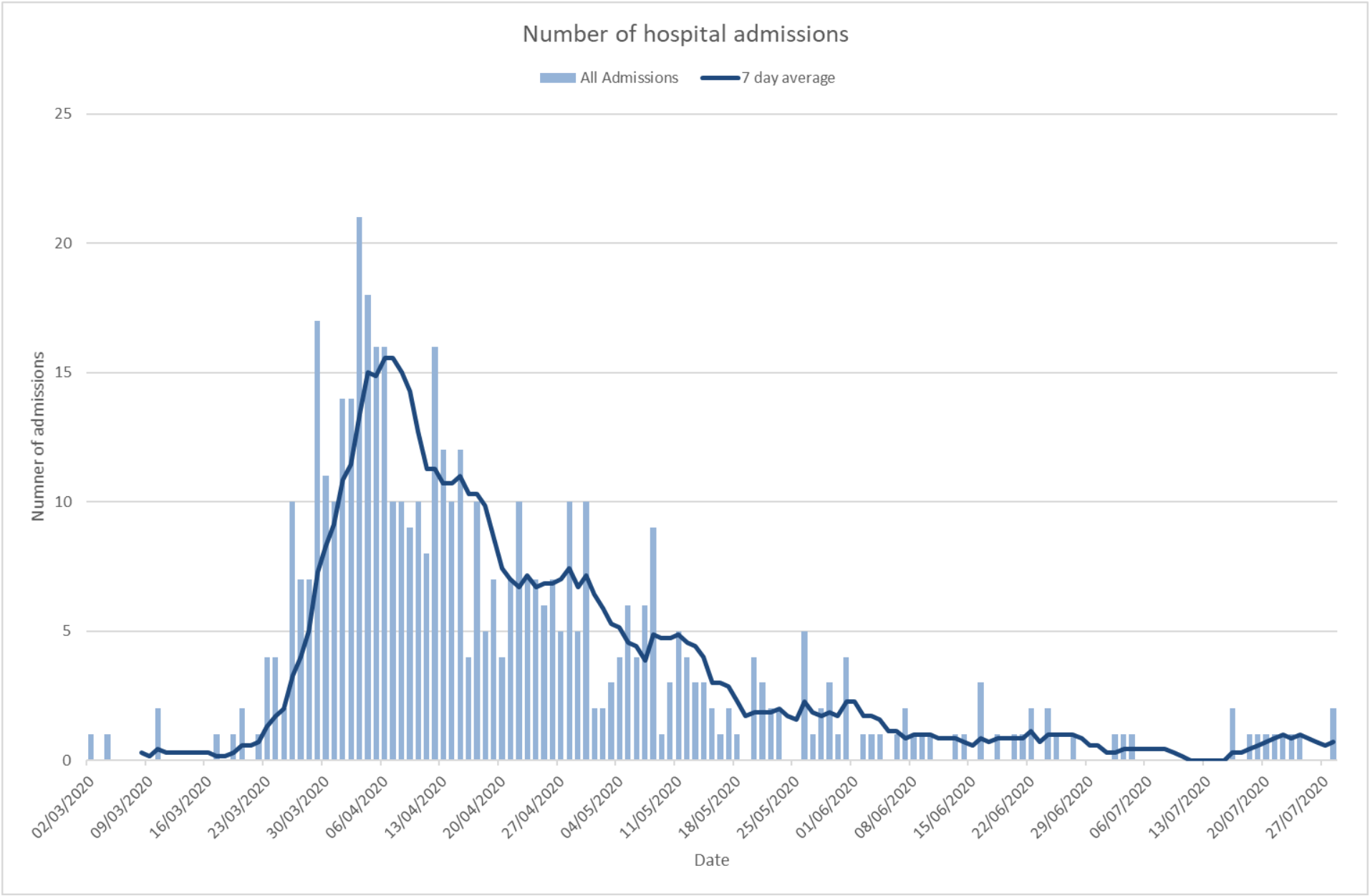
What we need to understand more about

There is sill more to understand about the long term impact of COVID-19 on those who have been discharged, evidences is emerging about the need for support for:

- Repository health care
- Chronic fatigue
- Diabetes, and more rapid progression from pre-diabetes to diabetes
- Mental Wellbeing

What is not known is the duration of these effects, or the full extent of the level of increased need in Stockport.

COVID-19 Stockport – September 2020 – hospital admissions over time



500 Stockport residents had been admitted and discharged by 31st July, with a primary diagnosis of COVID-19.

The number of admissions peaked at the beginning of April with an average of over 15 admissions a day, since June the average number of admissions has been under 1 a day.

The average length of stay was 11.5 days, 25% of patients were in hospital for at least 2 weeks and 10% more than 4 weeks.

80% of Stockport resident admissions were at Stockport NHS foundation Trust and 15% at Manchester University Foundations Trust.

Data for Stockport NHS Foundation Trust (for all patients) shows that the maximum number of patients in hospital at any one time with COVID-19 was 137, of whom 19 were in high dependency unit.

COVID-19 Stockport – September 2020 – hospital admissions by age and gender and ethnicity

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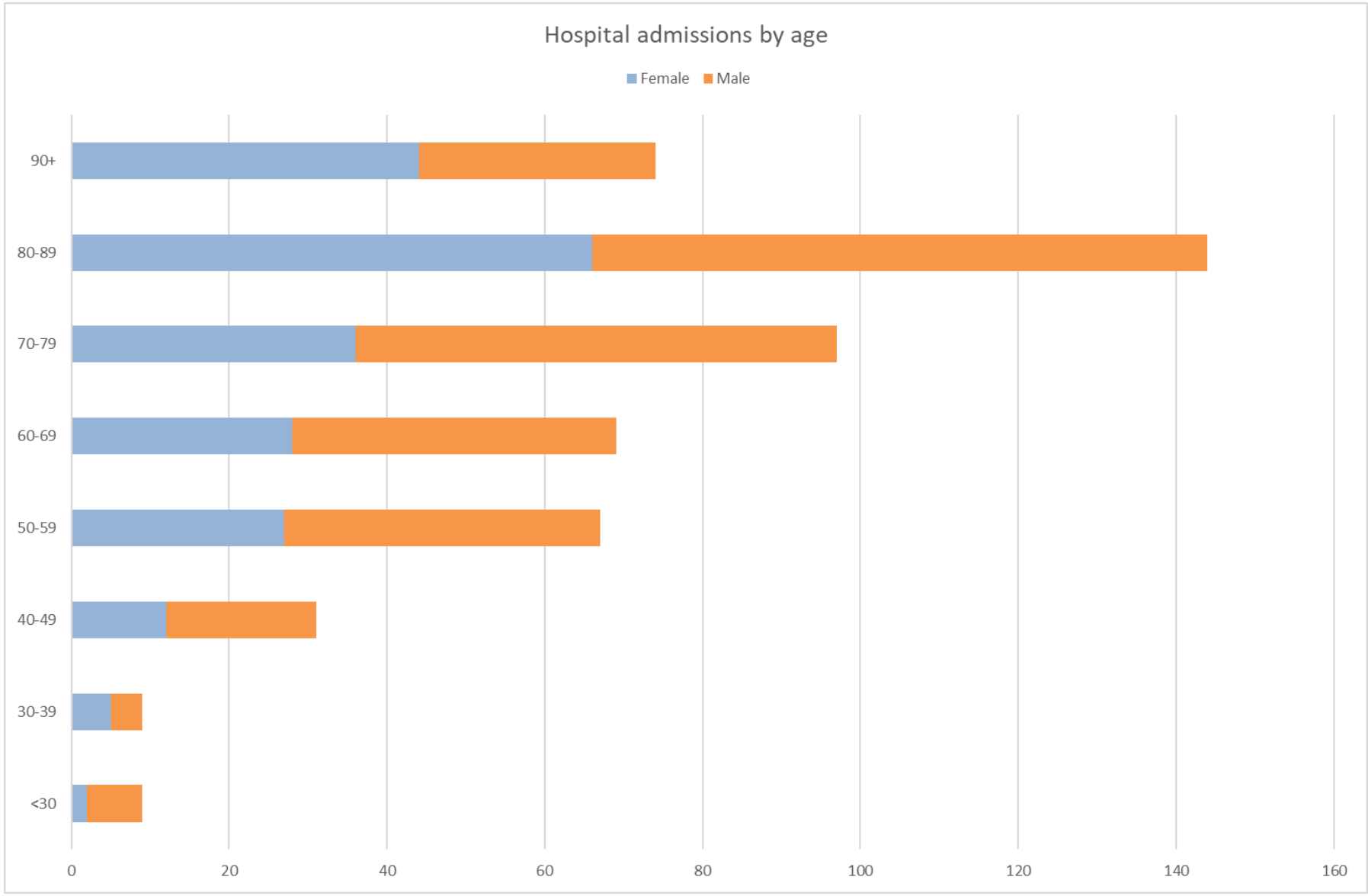
90% of these 500 admissions were for those aged 50 or more, and 63% of admissions were for those aged 70 or more, an older age profile than the diagnosed cases

56% of admissions were for males.

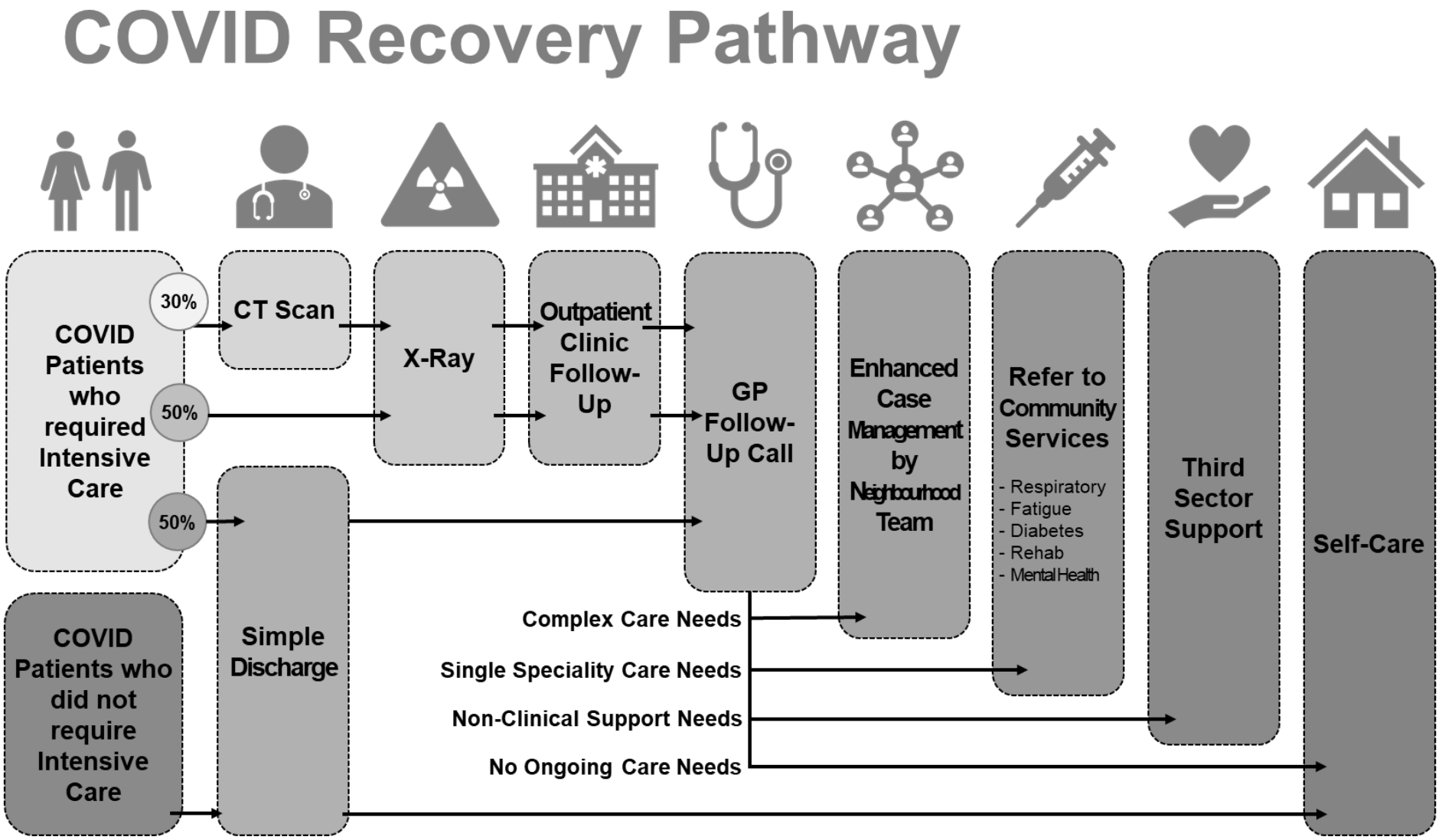
94% of admissions were for people from a White ethnic group, and 3.5% from an Asain group, a trend that more closely follows the demographics than the diagnosed cases.

25% of admissions were for residents of care homes, a higher proportion than the overall diagnosed cases.



Around 230 people have died in hospital as a result of COVID-19, meaning at least 270 people who have been discharged out of hospital after receiving care for COVID-19.

Health and care services in Stockport have developed a recovery pathway (see left) and a national COVID-19 "You COVID recovery" service has been implemented in August. Analysis will be undertaken on the number of people accessing these services.



A number of hospitalised cases reported continuing symptoms for 8 or more weeks following discharge. Persistent health problems reported following acute COVID-19 disease include:

- respiratory symptoms and conditions such as chronic cough, shortness of breath, lung inflammation and fibrosis, and pulmonary vascular disease
- mental health problems including depression, anxiety and cognitive difficulties
- fatigue, weakness and sleeplessness
- cardiovascular symptoms and disease such as chest tightness, acute myocarditis and heart failure
- protracted loss or change of smell and taste
- inflammatory disorders
- gastrointestinal disturbance with diarrhoea
- continuing headaches
- liver and kidney dysfunction
- clotting disorders and thrombosis
- lymphadenopathy
- skin rashes
- Increased speed of progression from pre-diabetes to type 2 diabetes.

Research to evaluate the long-term health and psychosocial effects of COVID-19 is continuing. Major studies include the Post-Hospitalisation COVID-19 study (PHOSP-COVID) in the UK and the International Severe Acute Respiratory and emerging Infection Consortium (ISARIC) global COVID-19 long-term follow-up study.

Work is underway in Stockport to quantify the likely level of increase need due to the long term impacts of COVID-19 for those who have been discharged.

https://www.gov.uk/government/publications/covid-19-long-term-health-effects/covid-19-long-term-health-effects

The following section sets out what we know about the those who have sadly died as a result of COVID-19.

Key Findings

There have been around 360 deaths due to COVID-19 so far, and around 19% more deaths in 2020 so far than would have been expected (excess mortality).

There are significant inequalities evident in mortality rates that are not evident in the diagnosed cases, showing that COVID-19 has disproportionally effected the health of people in deprived areas.

Following national trends mortality rates for those under 65 are low, and then increase at each age.

For all age groups the mortality rates for males are higher than for females.

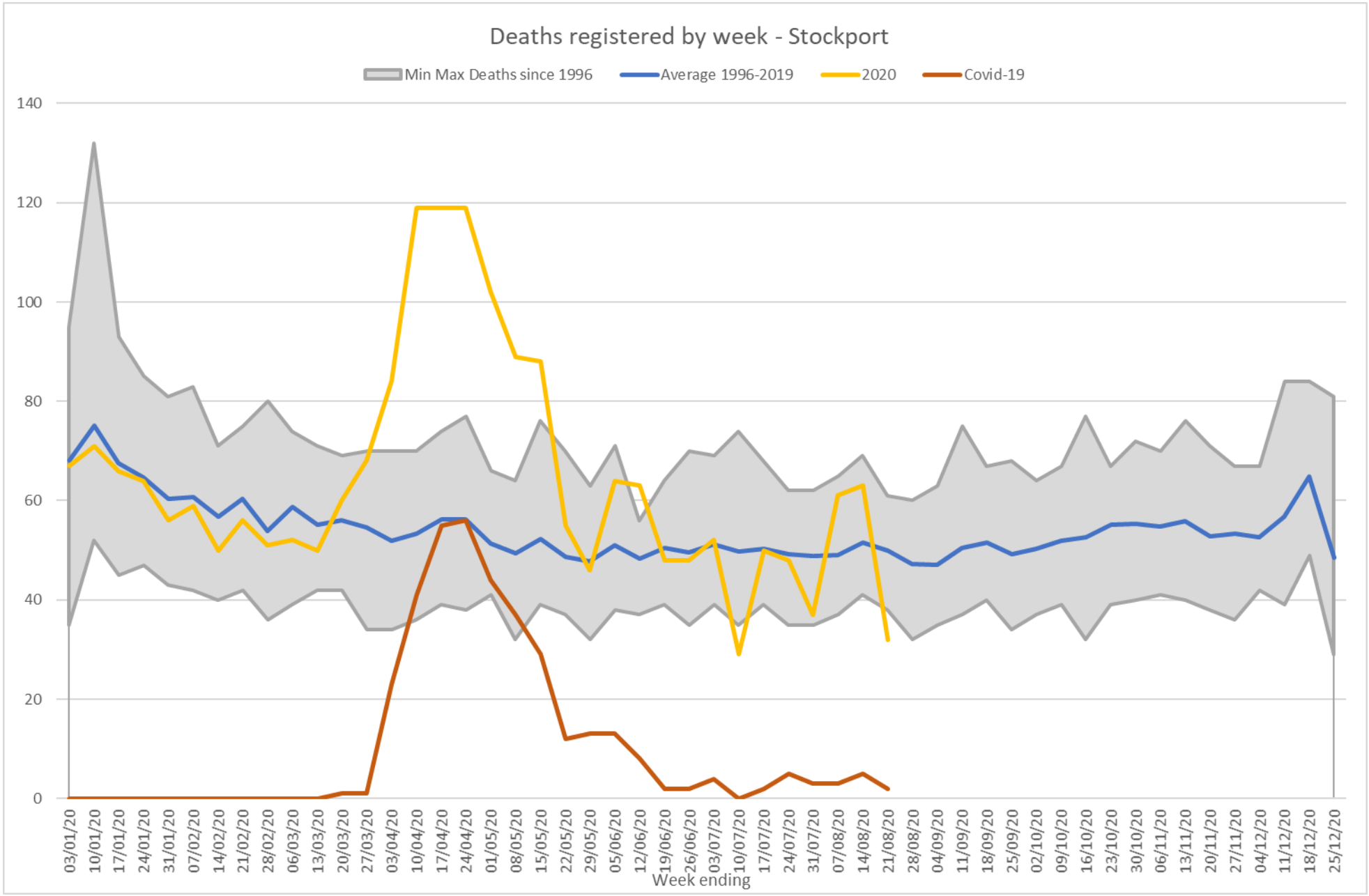
44% of COVID-19 deaths were care home residents, and mortality levels in care homes in 2020 are 50% higher than average.

What we need to understand more about

Local mortality data does not include data about ethnicity, national trends show that mortality rates for those from BAME groups are higher than for those from White groups.

It is not known what will happen to the volume of deaths in the future, ONS have set out a number of reasons why deaths may either reduce for the rest of the year, stay stable, or increase (either due to a future wave of COVID-19 or due increase mortality due to delays in health care).

COVID-19 Stockport – September 2020 – 2020 excess mortality



Up to week ending 21st August 2,186 deaths from all causes have been registered for Stockport in 2020.

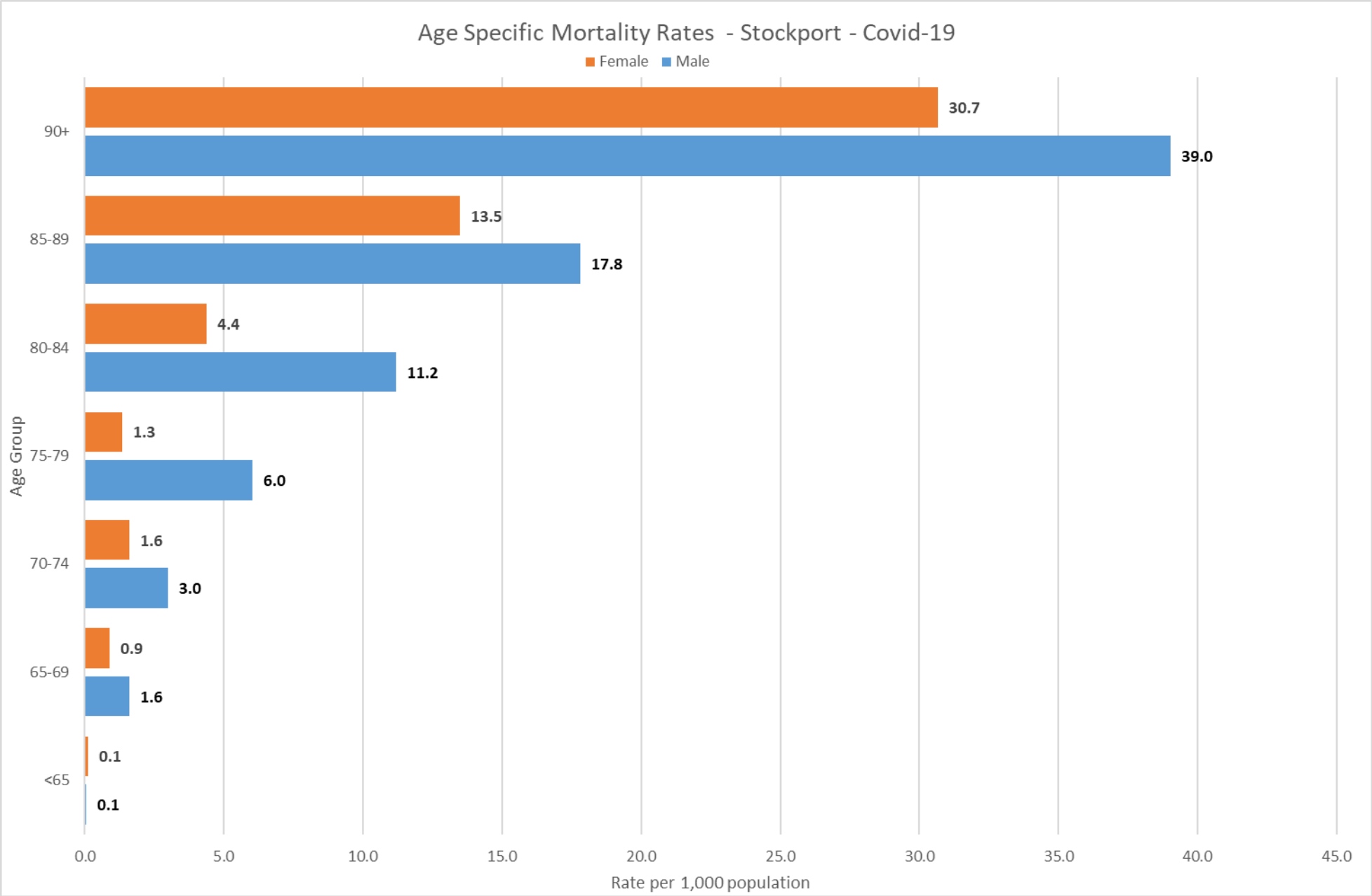
361 of these deaths have been directly attributed to COVID-19 (16.5%).

The 5 year average 2015-2019 number of deaths registered for the same period was 1,842; meaning there have been **around 344 excess deaths** (18.7%).

Across England there have been 15.7% more deaths registered in 2020 than to the same point in 2015-2019, this varies by regions, being highest in London at 27.3%. The North West average is 17.3%.

Approximately 44% of COVID-19 deaths in Stockport either occurred in care homes or for care home residents who died in hospital.

COVID-19 Stockport – September 2020 – age and gender differences in mortality



For those who have died as a result of COVID-19 the age and gender patterns in Stockport are similar to those seen nationally with a low rate of mortality below 65, which rises to over 30 per 1000 by the age of 90.

It should be noted however that 20 people aged under 65 have died in Stockport.

For all age groups the mortality rates for males are higher than for females, and are more than double for ages 70-84 years.

COVID-19 Stockport – September 2020 – inequalities in mortality

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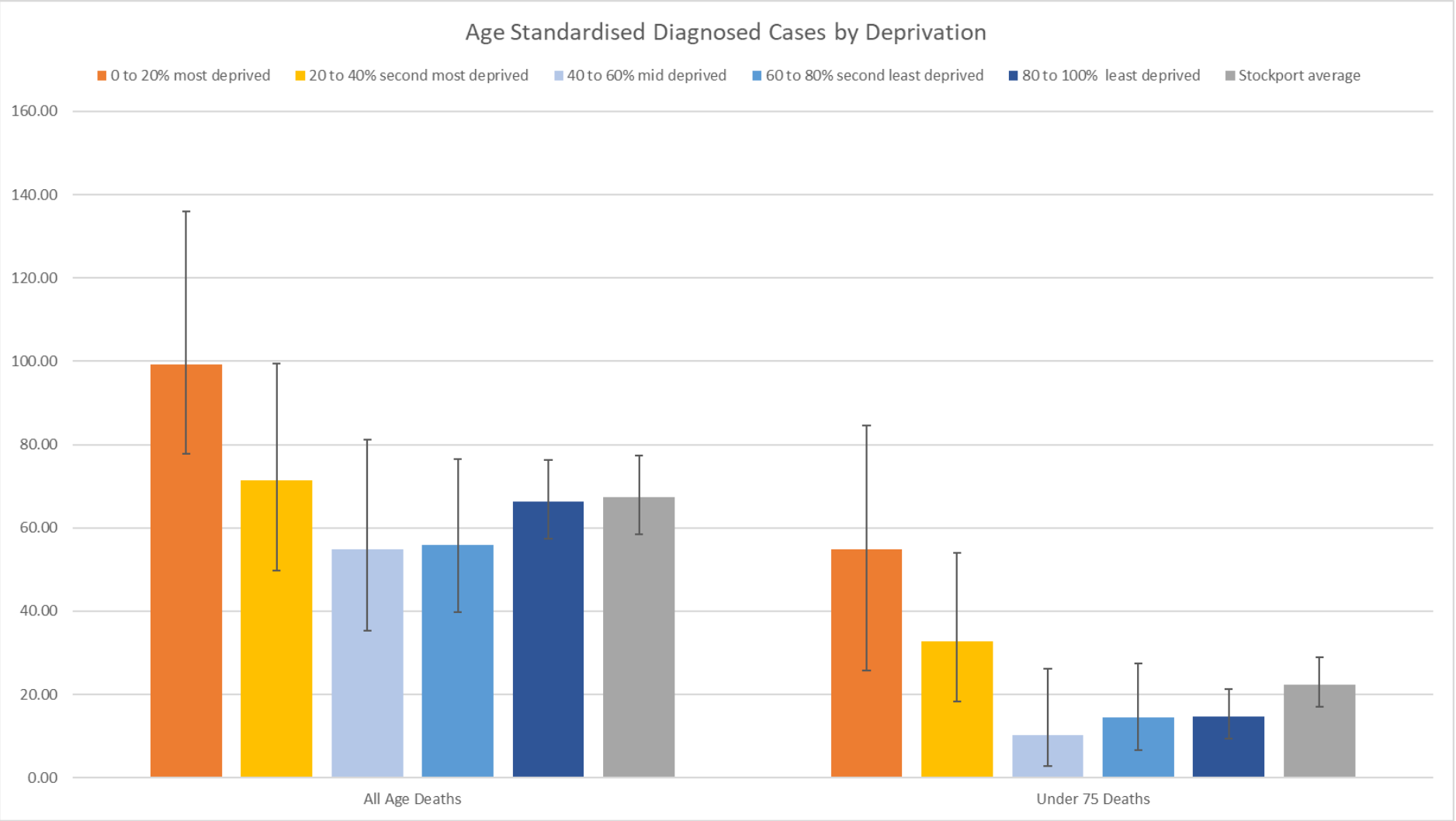
Age standardised analysis of mortality rates from COVID-19 by deprivation shows that there are significant inequalities effecting the most deprived quintile, and in particular adults aged under 75.

A third of all deaths under 75 were for people who live in the most deprived quintile, where around 17% of the population live, mortality rates in these are double the average.

These inequality patterns are different to those seen in diagnosed cases showing that people in deprived areas are more likely to COVID-19 severely.



Deaths that occurred in care homes have been excluded from this analysis as they effect geographic analysis.

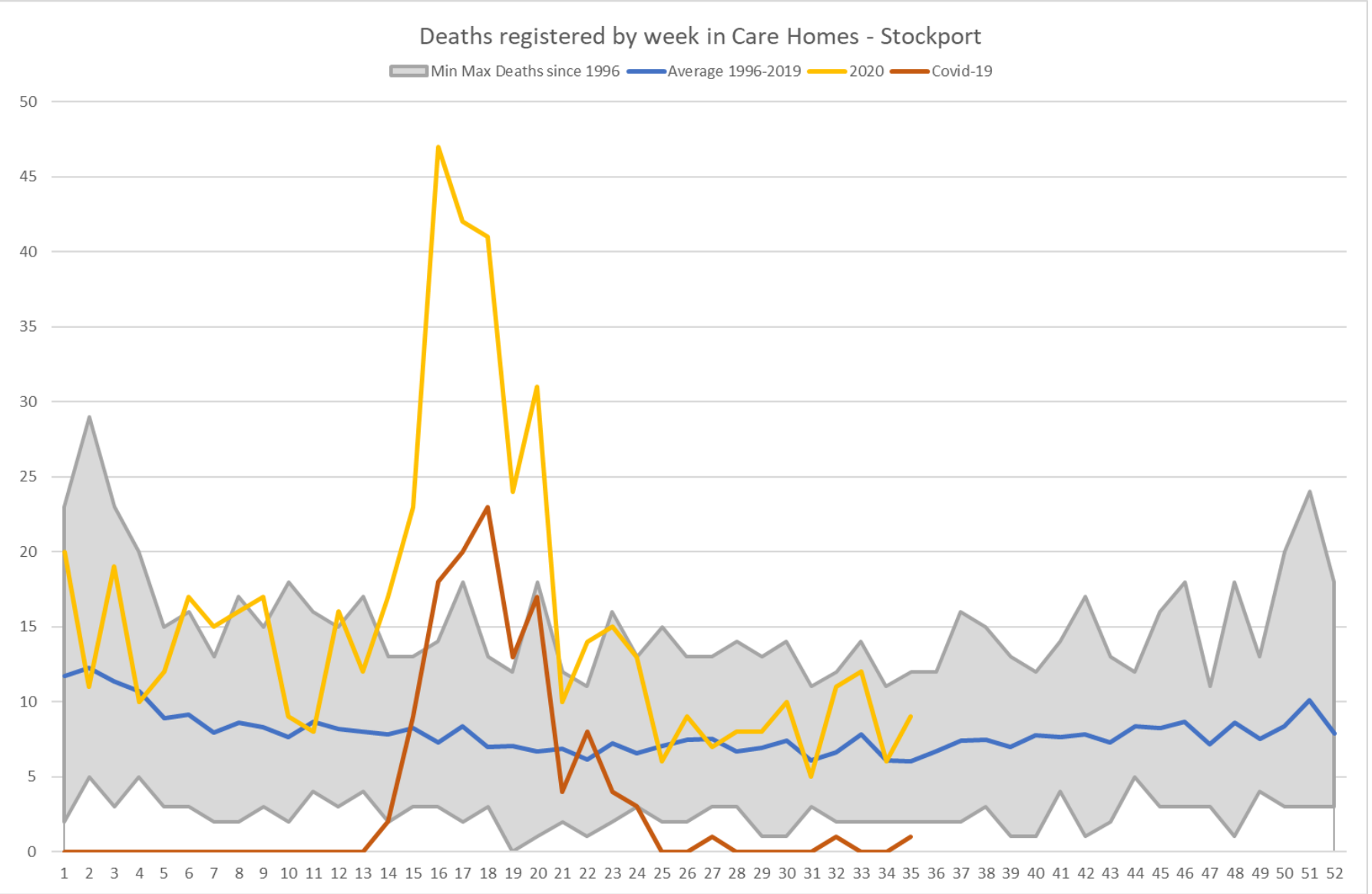
COVID-19 Stockport – September 2020 – mortality in care home

ONS data shows that 124 deaths directly related to COVID-19 have been registered as occurring in care homes. This represents 34.0% of total registered COVID-19 deaths in Stockport.

In addition to the 124 COVID-19 deaths in care homes a further 32 COVID-19 deaths that occurred in hospital were for care home residents, meaning 156 deaths are associated with care homes, 44% of the total.

There have been 550 deaths registered as occurring in care homes in 2020, which is almost double the average for previous years, deaths in the early part of the year were also higher than average in care homes.

Comparisons to our nearest statistical neighbours for all deaths in care homes shows that the increase in Stockport is similar to that seen elsewhere.



The truth is, we don't know what will happen for the remainder of the year, there are a number of scenarios based on previous years which ONS have outlined:

Possibility 1: the number of deaths continues to fall below the five-year average

- COVID-19 has had a large impact on the number of deaths registered over the spring and is the main reason for deaths increasing above what is expected. The disease has had a larger impact on those most vulnerable; for example, those who already suffer from a medical condition, those at older ages and those in care homes. Some of these people probably would have died this year due to these other vulnerabilities, but their death occurred earlier due to the coronavirus. Due to these deaths occurring earlier than expected, we could see a lower number of death registrations throughout the later part of the year.
- It has also been suggested that there could be some beneficial health effects of the lockdown period, for example from reduced air pollution and accidents which may reduce mortality from some causes.

Possibility 2: the number of deaths could rise again to above the five-year average

- In 1918/19, the 'Spanish flu' had three separate waves, of which the second wave peaked much higher than the first. **Multiple waves of COVID-19** could cause the number of death registrations to rise back above the five-year average. It is too early to tell if there will be another wave of COVID-19, and if there is another wave, whether this will be in winter months of 2020-21 or later.
- Another issue to be considered is the **effect of the lockdown period on health for the rest of 2020**, and into next year. We have already seen some signs of increased mortality that are potentially caused by delayed access to healthcare services. There could also be increases in mortality which have already occurred but the deaths have not yet been registered, as some causes of death take longer to confirm than others. Examples of these are deaths due to suicide, substance abuse and domestic violence, all of which may have been expected to increase during lockdown.
- In the longer term, the economic downturn is also likely to have health effects, with loss of income and employment.

Possibility 3: the number of deaths continues to remain around average

- Starting the year with a lower than average number of deaths could possibly have contributed to the increase in deaths seen during the coronavirus. For example, those most vulnerable who possibly would have died earlier in the year if the winter weather or circulating influenza had been more severe, could have then died during the coronavirus pandemic. This means we may not see as big an impact as we would usually see during similar situations, such as during the heatwaves last year where large increases in deaths occurred on the hottest day, but this was followed by a period of decreased mortality.

The following section sets out what we know about the wider impact of COVID-19 on the health and wellbeing of Stockport residents so far, these affects are wide ranging and not fully clear as yet.

Key Findings

11,203 people in Stockport had been advised to shield, and national evidence suggests that 63% of these people will have followed this advice completely. Family contact, and food and medication delivery have been the most valued support mechanisms.

The impact on routine health and care services through April and May was significant and work is now underway to remobilise these services in a planned way, and way which has capacity to respond to and future waves of the pandemic.

ONS modelling suggests that there will be both positive and negative effects on health from pandemic and the control measures, such as improvements in health due to lower air pollution but deterioration due to mental wellbeing and economic consequences. Modelling suggests that these impacts are smaller than the consequences of letting the pandemic running its course without any control.

Almost one in five adults (19.2%) were likely to be experiencing some form of depression during the coronavirus (COVID-19) pandemic; rates which are double those pre pandemic. Younger adults, females and those on lower incomes were most likely to be affected,

What we need to understand more about

The impacts of the changes in health service availability and demand and lockdown have still to be seen in local data about the health and wellbeing of the population in Stockport, monitoring future rates of hospital activity, diagnosis of cancer, depression and mortality rates from other causes over the next few months will be key to understanding the long term impacts.

COVID-19 Stockport – September 2020 – shielded population

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Clinically extremely vulnerable people were advised to take extra precautions during the peak of the pandemic in England, this was known as 'shielding'.

11,203 people in Stockport (as at 3rd Sept) had been advised to shield:

- 5% of these were aged 18 or under, 52% aged 19-65, 43% aged 70+
- 38% of these people were already known to Adult Social Care teams, and 9% were current ASC service
- 6% flagged as vulnerable by Stockport Homes

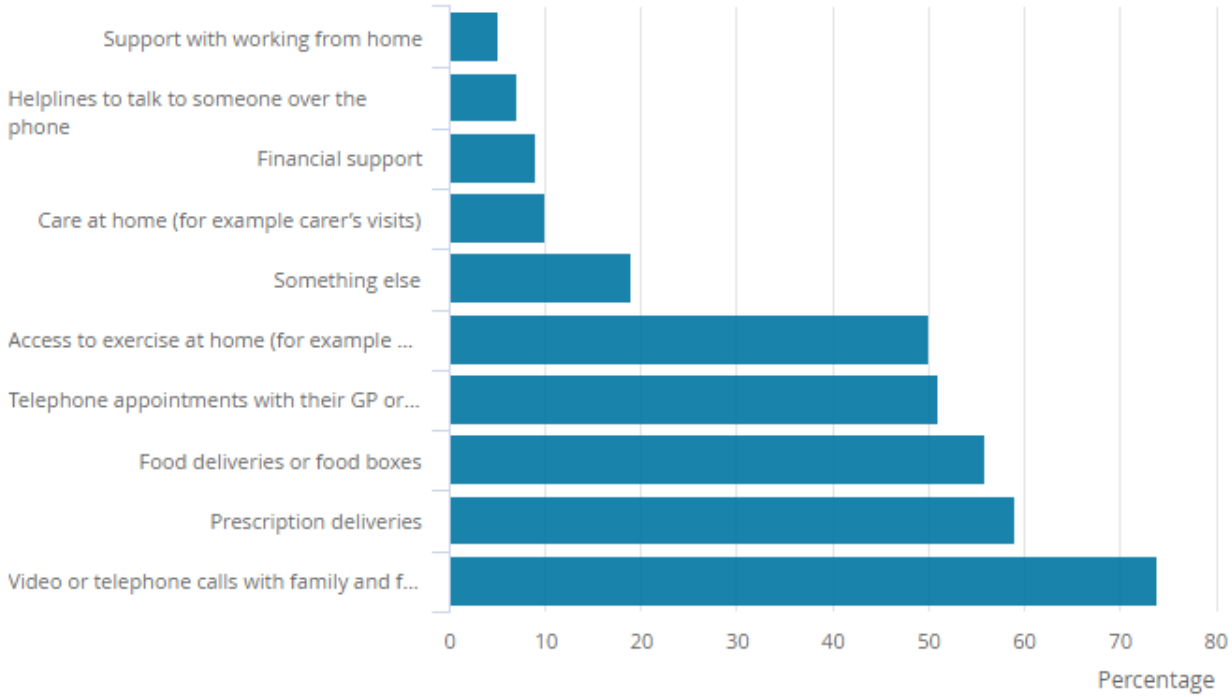
ONS surveys found that of the 2.2 million clinically extremely vulnerable (CEV) people, 63% reported completely following shielding guidance.

The government, as well as 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%),
- prescription deliveries (59%)
- food deliveries or food boxes (56%).

CEV people who are currently or have previously received treatment for their mental health were more likely to report a worsening in their mental health since being advised to shield (68% and 56% respectively). Females were more likely to report a worsening in their mental health than males, irrespective of age group.

Percentage of those who have not left home since receiving shielding advice or in the last seven days, by the type of support that has enabled them to stay at home, England, 9 to 18 June 2020



The advice to shield is currently lifted, though further periods of shielding are possible as measures to control the spread of COVID-19 are changed. Work is ongoing in Stockport to improve our understanding of these people who are also likely to be vulnerable in possible future waves of the pandemic.

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland/9juneto18june2020

COVID-19 Stockport – September 2020 – humanitarian response

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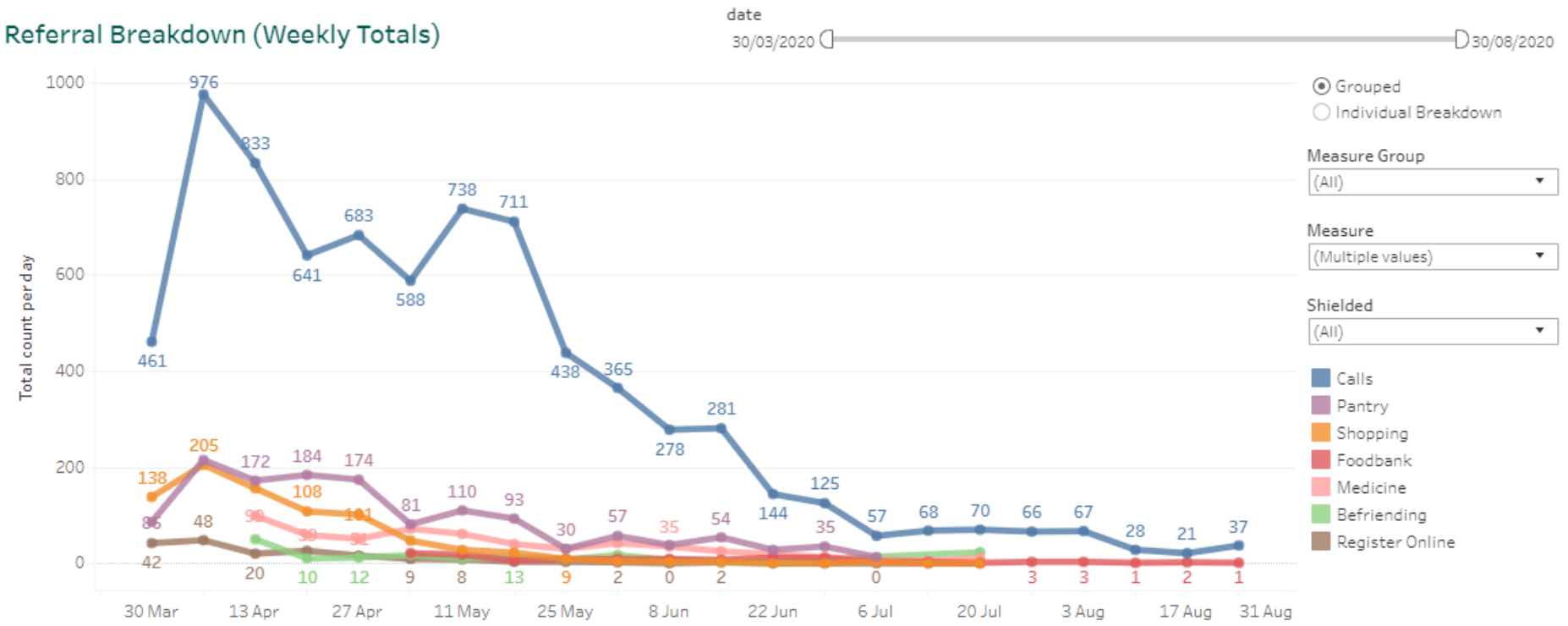
In response to the lockdown and advice to shield agencies across Stockport quickly mobilised to co-ordinate a humanitarian response, with a total of 8,403 calls being handled by the new helpline from the end of March. Call volumes following the pattern of new diagnosis.

Referrals were made for direct food supply, or support shopping, medicine collection and to support social isolation.



Referrals by Group per week (week start): *hover over measure group or dates to expand*

	30/03	06/04	13/04	20/04	27/04	04/05	11/05	18/05	25/05	01/06	08/06	15/06	22/06	29/06	06/07	13/07	20/07	27/07	03/08	10/08	17/08	24/08	G..
Calls	461	976	833	641	1,196	802	738	711	438	365	278	281	144	125	57	68	70	66	67	28	21	37	8,403
Pantry	86	215	172	184	174	81	110	93	30	57	38	54	28	35	13								1,370
Shopping	138	205	156	108	101	47	28	22	9	4	3	3	0	0	3	0	0						827
Medicine			99	59	51	72	61	40	30	42	35	25	19	13	7	5	11						569
Register Online	42	48	20	26	16	9	8	3	3	2	0	2	0	0	0	0	0						179
Befriending			50	10	12	17	10	13	8	17	7	4	4				23						175
Foodbank						21	18	6	9	9	9	7	12	11	4	3	1	3	3	1	2	1	120
Grand Total	727	1,444	1,330	1,028	1,550	1,049	973	888	527	496	370	376	207	184	84	76	105	69	70	29	23	38	11,643

COVID-19 Stockport – September 2020 – impact on NHS Health services

The impact of COVID-19 on the health and care system has also been significant:

Stockport's Health and Wellbeing Recovery Plan shows that in April and May 2020:

- Calls to NHS 111 reduced by 36% and of those call made, significantly fewer people were sent to A&E
- Ambulance services saw a significant increase in the number of patients treated on the phone (up 60%) or in person (up 38%) and a subsequent reduction in the number of people taken to A&E (down 18%)
- The number of people attending A&E reduced by 41%, with particular dips in those attendances that require no investigation or treatment
- Most GP appointments were by phone or video conference (280% increase), with most patients seen on the same day. Face-to-face appointments were down by 62% and home visits by 47%.
- GP referrals into the hospital have reduced by 56%, with particular reductions in the specialties of orthopedics, gastrointestinal (GI) and ear, nose and throat (ENT)
- First outpatient attendances in hospital were down by 36% and the hospital has significantly increased the use of virtual appointments
- Referrals into community services also changed, with a 70% increase in referrals to the respiratory medicine team and a 67% reduction in referrals to advanced nurse practitioners as this team was redeployed to support crisis responses
- Community service activity has changed significantly, with a 44% increase in palliative care services, a 41% increase in COPD nursing and all other activity reducing
- Cancer screening programmes were paused with 900 appointments missed a week.

Many of these services are now remobilising and activity levels are recovering, with significant amounts of work being undertaken by the NHS in Stockport to plan for a sustained recovery by year end.

The impacts of these changes in service availability and demand however have still to be seen in local data about the health and wellbeing of the population in Stockport, monitoring future rates of hospital activity, diagnosis of cancer and mortality rates from other causes over the next few months will be key to understanding some of the knock on effects of service change. ONS have however started to estimate these impacts (see over).

COVID-19 Stockport – September 2020 – modelled estimate of the long term impact on health

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The ONS report Direct and Indirect Impacts of COVID-19 on Excess Deaths and Morbidity estimates the number of excess deaths in England from COVID-19, changes to the healthcare system, and lockdown measures. These estimates are based on a scenario of weekly COVID-19 deaths continuing at approximately the same level as observed in mid-July, and the impacts of a two-month lockdown; they are not a forecast.

- Direct COVID-19 deaths account for the majority of all excess deaths; approximately 65,000 excess deaths are estimated as a result of contracting COVID-19 between March 2020 and March 2021.
- There are no deaths of COVID-19 patients estimated to be the result of receiving lower quality care because of NHS critical care capacity being breached; this is because it is judged that critical care capacity has not been breached to date.
- Approximately 16,000 excess deaths are estimated because of changes in emergency care and social care within a year from March 2020 – the majority of these are deaths in care homes; changes to elective care, primary, and community care are not expected to result in deaths in the short term in this scenario.
- Between March 2020 and March 2021, the wider impacts of social distancing measures are estimated to reduce mortality, resulting in 7,000 fewer deaths than expected; the main cause of this change is less air pollution early in the outbreak, though the results of that improvement to air quality are not expected to actually occur over the longer term.
- Over the whole period presented from March 2020 to more than five years from now, there are approximately 25,000 excess deaths resulting from social distancing and economic impacts in the chosen scenario.
- The negative health impacts of social distancing amount to a loss of 88,000 Quality Adjusted Life Years (QLAYs) up to March 2021, so **mortality improves over this period but health worsens – the main causes of this are increases in: depression; musculoskeletal disorders, resulting from more people working from home without suitable equipment; and domestic abuse.**
- Socio-economic effects are estimated to have the greatest impact on quality of life of all categories investigated, over the short and long term combined; from March 2020 to more than five years from now, the impacts of lockdown and a resulting recession are estimated to reduce England's health by over 970,000 QALYs – the health impacts of contracting COVID-19 are still unclear in the long term, but between March 2020 and March 2021, these represent 570,000 lost QALYs.
- While these negative health impacts of lockdown exceed the impacts of COVID-19 directly, they are much smaller than the negative impacts estimated for a scenario in which these measures are not in place; without these mitigations, the impact of direct COVID-19 deaths alone on both mortality and morbidity would be much higher – an estimated 439,000 excess deaths resulting from COVID-19, and 3,000,000 QALYs lost.

Monitoring local changes to conditions such as depression and musculoskeletal disorders and reported levels of domestic abuse and suicide along with socio-economic trends will be vital over the coming months to understand some of the broader impacts of COVID-19.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907616/s0650-direct-indirect-impacts-covid-19-excess-deaths-morbidity-sage-48.pdf

COVID-19 Stockport – September 2020 – impact on mental wellbeing national findings

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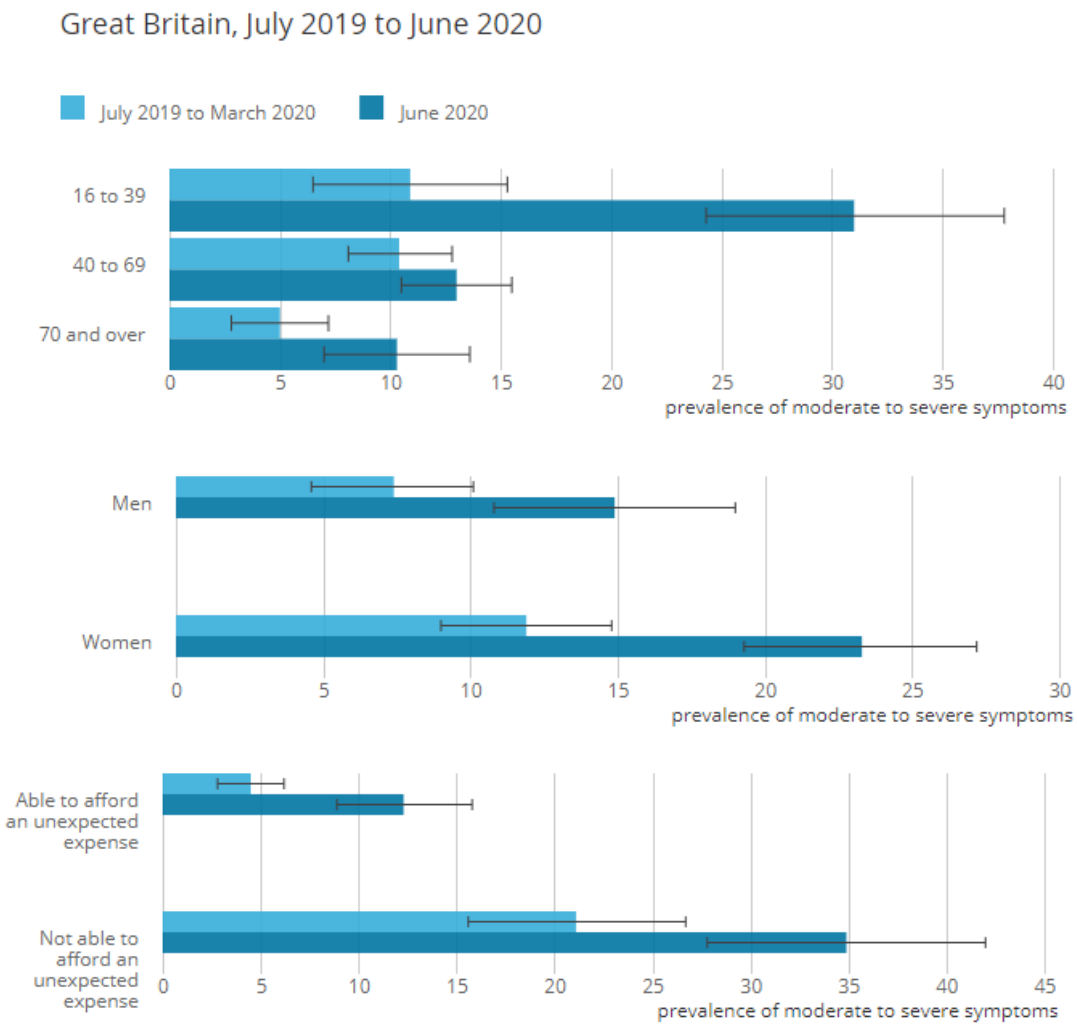
As well as the impact on physical health research in now emerging to quantify the a expected increase in levels of mental distress in adults during the coronavirus pandemic, compared with before the pandemic

- Almost one in five adults (19.2%) were likely to be experiencing some form of depression during the coronavirus (COVID-19) pandemic in June 2020; this had **almost doubled from** around 1 in 10 (9.7%) before the pandemic (July 2019 to March 2020).
- **One in eight adults (12.9%) developed moderate to severe depressive symptoms during the pandemic**, while a further 6.2% of the population continued to experience this level of depressive symptoms; around 1 in 25 adults (3.5%) saw an improvement over this period.
- Adults who were aged 16 to 39 years old (31.0%, up from 10.9%), female (23.2% up from 11.9%), unable to afford an unexpected expense (34.9% up from 21.1%), or disabled (34.8%) were the most likely to experience some form of depression during the pandemic.
- **Feeling stressed or anxious** was the most common way adults experiencing some form of depression felt their well-being was being affected, with 84.9% stating this.
- Over two in five (42.2%) adults experiencing some form of depression during the pandemic said their **relationships were being affected**, compared with one in five (20.7%) adults with no or mild depressive symptoms.



- Adults who were aged 16 to 39 years old were the most likely to have seen a deterioration in their mental wellbeing,
- Females were more likely to have seen a deterioration in their mental wellbeing
- Those unable to afford an unexpected expense were more likely to have seen a deterioration in their mental wellbeing

https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/june2020

Greater Manchester Health and Social Care Partnerships have undertaken rapid review of to inform recovery plans for Mental Health services.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

The COVID-19 crisis period has led to:

- Significant changes to Mental Health service provision across Greater Manchester
- Significant challenges faced by people and communities because of changes:
    - to the socio-economic environment and economy,
    - bereavement as a direct or indirect consequence of the pandemic
    - restrictions during lockdown

Which is leading to more people experiencing mental health issues in the general population, most who will not meet clinical mental health thresholds and who will present with social needs**,** much of this demand is likely to initially present through the VCSE sector.

COVID-19 has exacerbated existing inequalities, the specific groups who are more likely to be exposed and are susceptible to the virus, are often the groups who may not have sufficient protective factors or resilience to maintain their mental wellbeing during this time. These characteristics are often interlinked, therefore multiplying vulnerability to mental ill-health. The demographics within Greater Manchester mean that COVID-19 is anticipated to have a greater impact here than in other areas of the country, exacerbating existing inequalities further.

The following section sets out what we know about the wider impact of COVID-19 on the wider determinants of health and the impacts on different communities.

Key Findings

What we need to understand more about

THIS REPORT IS STILL IN DRAFT FORMAT AND A REVISED VERSION WILL BE SUBMITTED THE HEALTH AND WELLBEING BOARD WITH FURTHER DETAILS ADDED TO THIS FINAL SECTION AND A SUMMARY / CONTENTS AT THE START

In August 2020, Best Beginnings, Home-Start UK and Parent-Infant Foundation, all leading organisations advocating for parents and babies, commissioned Critical Research to work with them to gain insights into the impact COVID-19 is having on babies and their parents of all backgrounds from across the UK.

Babies in Lockdown found that:

- COVID-19 has affected parents, babies and services in diverse ways
- Families already at risk of poorer outcomes have suffered the most
- The pandemic will case a long shadow
- A third (34%) of respondents believed that their baby's interaction with them had changed during the lockdown period.
- One quarter (25%) of parents reported concern about their relationship with their baby, and one third (35%) of these would like to get help with this.
- Almost half (47%) of parents reported that their baby had become more clingy.
- One quarter (26%) reported their baby crying more than usual.
- The numbers of those reporting increases in babies crying, having tantrums and being more clingy than usual was twice as high amongst those on the lowest incomes than those on the highest. More parents aged 25 and under reported babies crying and being more clingy than usual.
- Almost 9 in 10 (87%) parents were more anxious as a result of COVID-19 and the lockdown. There was a notable variation amongst respondents who reported feeling "a lot" more anxious: White (42%), Black/Black British (46%), Asian/Asian British (50%), Parents 25 years old or under (54%) and parents with a household income of less than £16k (55%).
- It has been isolating and lonely for many, buy some expectant and new parents have found a silver lining at this time with more time at home together.
- Over a third (34%) of those who gave birth during lockdown stated that care at birth was not as planned.
- Just 1 in 10 (11%) parents of under twos have seen a health visitor face-to-face.
- Whilst some respondents valued digital health appointments, they left others feeling exposed and humiliated.

https://babiesinlockdown.info/download-our-report/

THIS REPORT IS STILL IN DRAFT FORMAT AND A REVISED VERSION WILL BE SUBMITTED THE HEALTH AND WELLBEING BOARD WITH FURTHER DETAILS ADDED TO THE FINAL SECTION AND A SUMMARY / CONTENTS AT THE START

Coronavirus Job Retention Scheme (CJRS) statistics show that 31% of Stockport's workforce have been furloughed at some point between March and June 2020.

- Nationally 9.6 million jobs have been furloughed through CJRS (32% of those eligible) for at least part of the period between March to June.
- The number of jobs furloughed peaked at 8.9 million on 8th May, then reduced to 6.8 million by 30 June. This peak is lower than the 9.6 million mentioned above since furloughed staff have been furloughed for different periods (and not all at the same time)

- Accommodation and food services sector has had the highest furlough rate of 77%, followed by arts, entertainment, recreation and other services at 76%. Over two-fifths of wholesale and retain jobs where furloughed (42%) at some point. Not all sectors have seen as high rates of furloughing, with the education and health sectors and finance and insurance sector having furlough rates of 10% and 7% respectively

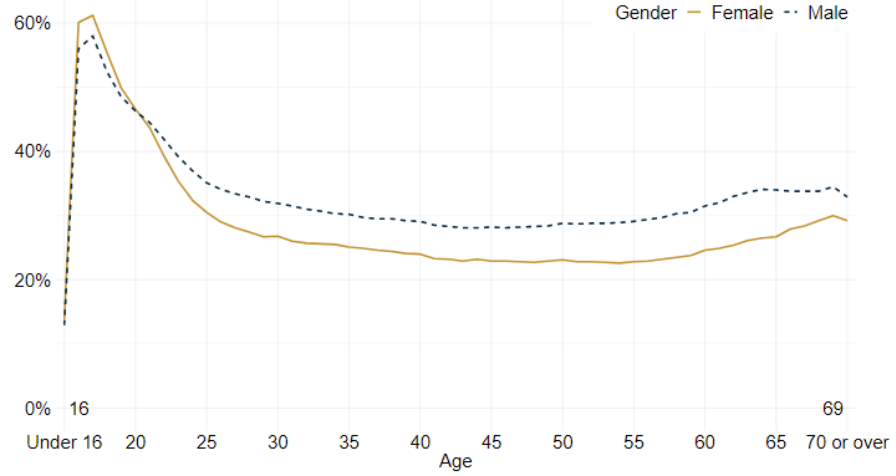
- Men have been furloughed at a higher rate than women: 34% and 29% respectively
- Employees aged under 25 years were the most likely to be furloughed, peaking at almost 60% of those aged 17 years, those in their 60s and above were more likely to be furloughed than those in their 40s and 50s

- Employees of small and micro-sized employers were more likely to have been furloughed than those working for medium-sized and large employers: 57% of jobs at employers with 2 to 9 employees had been furloughed against just 21% at employers with 250 or more employees
- 61% of eligible employers have claimed under the scheme

42,200 jobs furloughed in Stockport

Parliamentary Constituency	Jobs furloughed	Take-up rate
Cheadle	12,700	29%
Hazel Grove	11,200	31%
Denton and Reddish*	14,200	33%
Stockport	13,600	31%

National CJRS uptake by age and gender



Source: HMRC CJRS and PAYE Real Time Information

https://www.gov.uk/government/publications/coronavirus-job-retention-scheme-statistics-august-2020/coronavirus-job-retention-scheme-statistics-august-2020

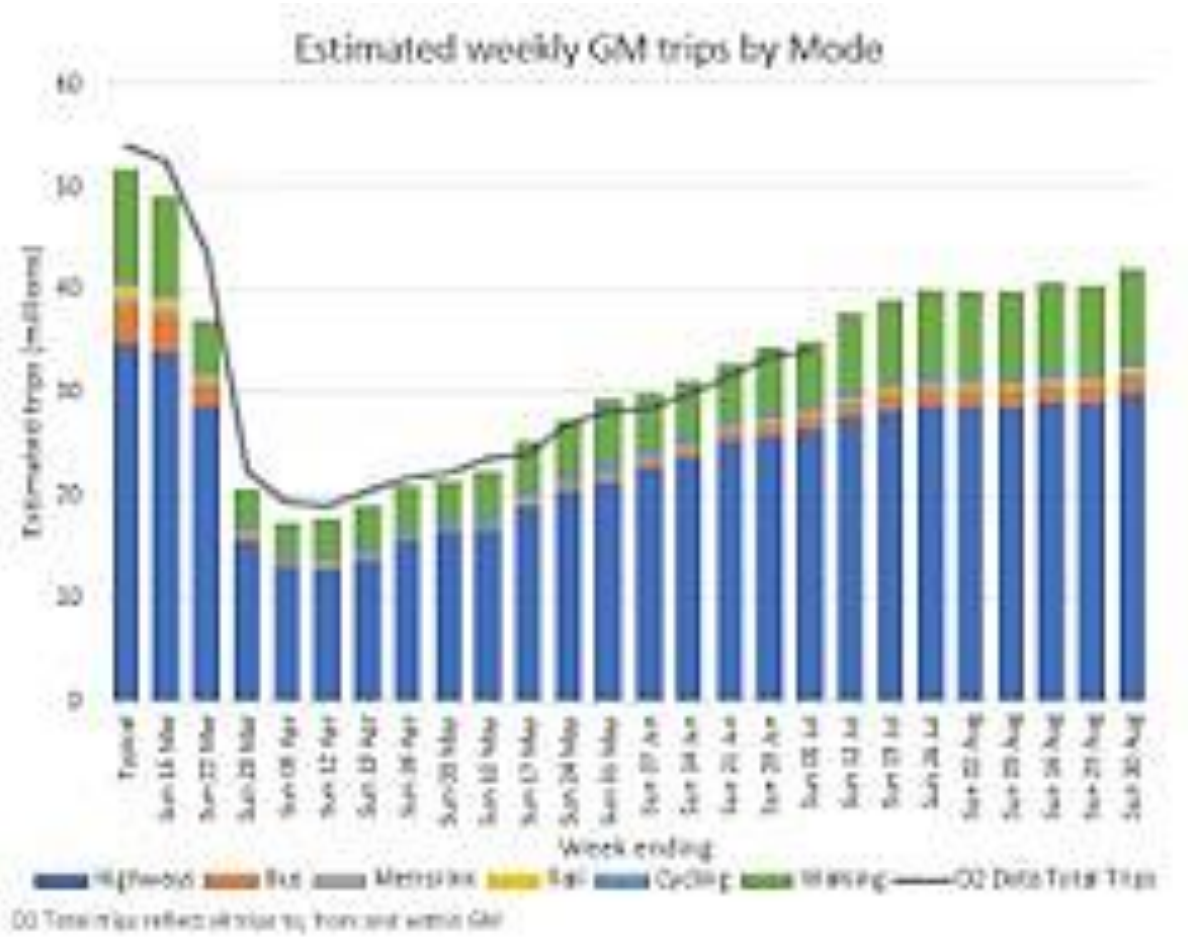
Analysis from TfGM shows how patterns of travel have changed over the course of the year, there was a significant reduction in travel at the start of lockdown with all trips down by almost 60% and public transport use in particular being minimal.

Levels have recovered, though they are still 20% lower than usual. Highways, walking and cycling levels are all 15% lower than expected while public transport is 54-64% lower than expected.

The resulting improvement in air pollution is expected to have a positive impact on health.

Main Mode	Typical Week		Week ending 30 Aug		Change
	Trips	%	Trips	%	
Highways	34,841,000	67%	29,947,000	71%	-14%
Bus	3,581,000	7%	1,677,000	4%	-54%
Metrolink	849,000	2%	303,000	1%	-64%
Train	1,121,000	2%	448,000	1%	-60%
Bicycle	857,000	2%	729,000	2%	-15%
Walk	10,438,000	20%	9,013,000	20%	-14%
Total	51,687,000		42,116,000		-19%

CHART REQUESTED IN CLEARER FORMAT



In May 2020, the LGBT Foundation published findings from the largest and most substantive research into the impact of the COVID-19 pandemic on LGBT communities in the United Kingdom to date. This research has uncovered some of the wide-ranging and profound effects the pandemic has had on the lives of LGBT people in areas such as mental health; isolation; substance misuse; eating disorders; living in unsafe environments; financial impact; homelessness; access to healthcare; and access to support.

Hidden Figures: The Impact of the Covid-19 Pandemic on LGBT Communities is a culmination of the findings from our online survey, existing research on LGBT health inequalities, and our own unpublished service user data. Our survey found that of LGBT people who responded:

- 42% would like to access support for their mental health at this time
- 8% do not feel safe where they are currently staying
- 18% are concerned that this situation is going to lead to substance or alcohol misuse or trigger a relapse
- 64% said that they would rather receive support during this time from an LGBT specific organisation
- 16% had been unable to access healthcare for non-COVID related issues
- 34% of people have had a medical appointment cancelled
- 23% were unable to access medication or were worried that they might not be able to access medication

https://lgbt.foundation/coronavirus/hiddenfigures

PHE have conducted engagement with a stakeholders who have a broad range of interests in BAME issues, these groups expressed deep dismay, anger, loss and fear in their communities about the emerging data and realities of BAME groups being harder hit by the pandemic than others, exacerbating existing inequalities. Nearly all are experiencing the impact of the disease on their communities with the significant social, physical and mental health impacts and complications.

Stakeholders acknowledged that while actions are already being undertaken, the results of the PHE review and other studies should be used to strengthen and accelerate efforts moving forward. Clear, visible and tangible actions, provided at scale were called for now with a commitment to address the underlying factors:

Longstanding inequalities exacerbated by COVID-19 It is clear from discussions with stakeholders that COVID-19 in their view did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK. A wide variety of explanations for these have been examined, ranging from upstream social and economic factors to downstream biological factors.

Increased risk of exposure to and acquisition of COVID-19 The results of the PHE data review suggest that people of Black, Asian and other minority ethnic groups may be more exposed to COVID-19, and therefore are more likely to be diagnosed. This could be the result of factors associated with ethnicity such as occupation, population density, use of public transport, household composition and housing conditions. Stakeholders highlighted the high proportion of BAME groups that were key workers.

Increased risk of complications and death from COVID-19 Once infected, many of the pre-existing health conditions that increase the risk of having severe infection (such as having underlying conditions like diabetes and obesity) are more common in BAME groups and many of these conditions are socioeconomically patterned. Stakeholders called for further efforts to strengthen health promotion programmes and improve early diagnosis and clinical management of chronic diseases as a strategy to improve overall health, increase resilience and reduce the risk of adverse COVID-19. The role of severe mental illness as a risk factor for COVID-19 disease severity and death was mentioned repeatedly and identified as an area that was at risk of being overlooked in the current response.

Racism, discrimination, stigma, fear and trust Stakeholders pointed to racism and discrimination experienced by communities and more specifically by BAME key workers as a root cause affecting health, and exposure risk and disease progression risk. Racial discrimination affects people's life chances and the stress associated with being discriminated against based on race/ethnicity affects mental and physical health. Fear of diagnosis and death from COVID-19 was identified as negatively impacting how BAME groups took up opportunities to get tested and their likelihood of presenting early for treatment and care. For many BAME groups lack of trust of NHS services and health care treatment resulted in their reluctance to seek care on a timely basis.

Forward / NEXSUS in Stockport are currently running a survey to understand how COVID-19 is affecting our local BAME communities. The answers will help to shape current and future services:
https://www.surveymonkey.co.uk/r/7HNFNYK

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

The PHE report concluded with 7 recommendations to be implemented to improve the lives and experiences of BAME communities.

Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

- https://analytics.phe.gov.uk/apps/covid-19-indirect-effects
- Domestic Abuse and Safeguarding
- Homeless
- Learning Disability
- Carers
- Long term income
- Life course analysis
- Change in demand for social care
- Community connectedness
- Changes in population lifestyle behaviour

THIS REPORT IS STILL IN DRAFT FORMAT AND A REVISED VERSION WILL BE SUBMITTED THE HEALTH AND WELLBEING BOARD WITH FURTHER DETAILS ADDED TO THE FINAL SECTION AND A SUMMARY / CONTENTS AT THE START