



Scrutiny Co-ordination Committee

Time and Date

11.00 am on Wednesday, 7th October, 2020

Place

This meeting will be held remotely. The meeting can be viewed live by pasting this link into your browser:

<https://www.youtube.com/watch?v=hdVXmObjC8U&feature=youtu.be>

Public Business**1. Apologies and Substitutions****2. Declarations of Interest****3. Minutes**

(a) To agree the minutes of the previous meeting held on 16 September 2020 (Pages 3 - 6)

(b) Matters Arising

4. Health Inequalities (Pages 7 - 290)

Briefing Note of the Director of Public Health and Wellbeing

Councillors K Caan and R Ali, Cabinet Member and Deputy Cabinet Member for Public Health and Sport, have been invited to the meeting for the consideration of this item

5. Scrutiny Co-ordination Committee Work Programme 2020/2021 and Outstanding Issues (Pages 291 - 294)

Report of the Director of Law and Governance

6. Any Other Items of Public Business

Any other items of public business which the Chair decides to take as a matter of urgency because of the special circumstances involved.

Private Business

Nil

Julie Newman, Director of Law and Governance Council House Coventry

Tuesday, 29 September 2020

- Notes:1) The person to contact about the agenda and documents for this meeting is Suzanne Bennett, Democratic Services, Council House, Coventry, telephone 76972299, alternatively E-mail: suzanne.bennett@coventry.gov.uk/liz.knight@coventry.gov.uk
- 2) Council Members who are not able to attend the meeting should notify Suzanne Bennett no later than 9.00 a.m. on the day of the meeting, giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.
 - 3) Scrutiny Board Members who have an interest in any report referred to this meeting, but who are not Members of this Committee, have been invited to notify the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors N Akhtar, A Andrews, R Brown (Chair), J Clifford, L Kelly (Deputy Chair), C Miks, G Ridley, K Sandhu and R Singh

By invitation Councillors R Ali and K Caan

Suzanne Bennett/Liz Knight, Governance Services - Telephone: 024 7697 2299/2644

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Coventry City Council
Minutes of the Meeting of Scrutiny Co-ordination Committee held at 11.00 am on
Wednesday, 16 September 2020

Present:

Members: Councillor R Brown (Chair)

Councillor N Akhtar
Councillor A Andrews
Councillor J Clifford
Councillor L Kelly
Councillor C Miks
Councillor G Ridley
Councillor K Sandhu
Councillor R Singh

Other Members Present:- Councillor J O'Boyle, Cabinet Member for Jobs and Regeneration

Employees: V Castree, Law and Governance
G Holmes, Law and Governance
D Hope, Economic Growth
J Kilgallon, Economic Growth
A Williams, Director of Business Investment and Culture

Apologies: Councillor G Duggins, Leader of Coventry City Council

Public Business

19. Declarations of Interest

There were no declarations of interest.

20. Minutes

The Minutes of the meeting held on 29 July, 2020 were agreed as a true record. There were no matters arising.

21. Jobs, Regeneration and Recovery

Jobs, Regeneration and Recovery

Cllr Brown introduced the item, outlining the effect that the pandemic had had on businesses and employment in the city. There had been various Government support available and the Committee wanted to ensure that the Council were using all of the tools available to them.

The Committee received a presentation which outlined the following;

- The contraction of the UK economy
- The growing jobs problem
- Coventry City Council actively supporting the economy
- Impacts of the support offered
- The continued regeneration of Coventry
- Changes to ways of working
- Future economic opportunities
- The need for inclusive growth
- Delivering the recovery

Councillor O'Boyle, Cabinet Member for Jobs and Regeneration, highlighted the fact that work on economic development had continued throughout the lockdown and that the City was in a good position despite the impact of Covid-19. There were two areas in particular that were emphasised- the green economy and Very Light Rail. There had been a One Coventry approach bringing together the Council, national, regional and sub-regional government, and private business to make things happen.

Following the presentation, Members raised a number of questions and issues, and received the following responses;

- Information about support to businesses had been shared on the Council website and social media, as well as via newsletters. Also, information had been shared through the Federation of Small Businesses and direct phone calls to businesses. All businesses who asked for support had been given it.
- Coventry had been a beneficiary of European funding over many years and the Council had been pursuing the Shared Prosperity fund which would replace it, but they needed to know how this would be delivered regionally and sub-regionally
- Officers had been looking at international partnerships and emerging markets and would look in detail at the trade deal with Japan.
- Future trade deal with the European Union would be important post-Brexit and officers had been supporting businesses to be post-Brexit ready.
- There were no figures locally on the impact of the furlough scheme but nationally the Office for Budget Responsibility predicted that 15% of jobs which had been furloughed would be lost.
- The Job Shop was working with employers with vacancies to match with those who needed work
- Officers were following all possible schemes to support those who become unemployed including the Kickstart scheme for young people.
- Partners across the region were working hard to make the argument for a battery Gigafactory to be located locally. The benefits would be the direct creation of 3000 jobs from highly skilled to semi-skilled, as well as the associated supply chain jobs.
- That an effective test track and trace system was important to building confidence for businesses and consumers alike. Officers were supporting employers and businesses to be covid-compliant; the main focus was on minimising the risk.
- Data on the location and sector of business who had been supported with grants was not available but could be forwarded to Members for their information.

- There had been unprecedented demand for support over the lockdown period which had meant that officers had not targeted support at any underrepresented groups in particular but recognised that there was more work to do to support women in employment, including childcare provision.
- Officers were supporting businesses on the digitalisation agenda.

RESOLVED:-

- 1) That the contents of the presentation be noted
- 2) That the following items be added to the Work Programme:-
 - i. Understanding the impact on BAME and women of Covid 19 on employment. To include reviewing whether suitable childcare is in place to support employment.
 - ii. Update on broadband access across the City, including the rollout of Fibre to be provided
- 3) That information be disseminated to Members regarding support available to businesses within their Wards

22. **Draft Scrutiny Annual Report to Council 2019-20**

The Committee considered the draft Scrutiny Annual Report to Council 2019-20.

RESOLVED that the draft report be approved.

23. **Scrutiny Co-ordination Committee Work Programme 2020/2021 and Outstanding Issues**

The Committee considered and noted their Work Programme for 2020/21.

24. **Any Other Items of Public Business**

There were no items of urgent public business.

(Meeting closed at 12.40 pm)

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Briefing note

To: Scrutiny Co-ordination Committee

Date: 7th October 2020

Subject: Health Inequalities

1 Purpose

- 1.1 This report provides an update to the Board on health inequalities; the impact of COVID19 and emerging work to address this. It provides Scrutiny Co-ordination Committee the opportunity to offer insight and support into the on-going work.

2 Recommendations

- 2.1 Scrutiny Co-ordination Committee are recommended to:
- 1) Support the inclusion of health inequalities considerations in everything that goes to Scrutiny Boards and Scrutiny Co-ordination Committee.
 - 2) To encourage the inclusion of health inequalities considerations at the beginning of new service or policy development or at the beginning of the review of existing services or policies.
 - 3) To endorse and support the Call to Action on health inequalities.

3 Information/Background

- 3.1 The COVID19 pandemic has shone a light on health inequalities, showing the stark reality that the circumstances you are born into, and in which you live your life, can have very real consequences for your health.
- 3.2 In Coventry, men in the most deprived areas can expect to live an average of 10.7 years less than men from the most affluent areas, with the gap for women being 8.3 years. National and regional evidence shows that COVID19 has and will continue to widen existing health inequalities, both through the direct impacts of the virus and the indirect impacts of the control measures imposed.¹
- 3.3 People who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. The mortality rates from COVID19 in the more deprived areas were more than double the least deprived areas, for both males and

¹ <https://www.wmca.org.uk/media/4122/regional-health-impact-of-covid19-v5.pdf> (Appendix A)

females. This is greater than the inequality seen in mortality rates in previous years, indicating greater inequality in death rates from COVID19².

- 3.4 National analysis has shown that people from most BAME groups have a higher risk of dying from COVID19 than those of white ethnicity.³ In statistical analyses, these risks were reduced when socio-economic, household and geographical characteristics and factors relating to occupation were accounted for, suggesting that some, but not all, of the increased risk of death is due to these. At the time of the 2011 Census, one in three Coventry residents (33%) were from BAME groups and among children attending Coventry schools in January 2020, 53% were from BAME groups⁴.

4 System-wide Responses

- 4.1 The **NHS** has also recognised the impact of COVID19 on health inequalities and are working collaboratively with communities and partners to address these. In response to COVID19 the eight urgent actions on inequalities that the NHS have identified are⁵:

- 1) Protect the most vulnerable from COVID19
- 2) Restore NHS services inclusively, so that they are used by those in greatest need
- 3) Develop digitally enabled care pathways in ways which increase inclusion
- 4) Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes
- 5) Particularly support those who suffer mental ill health
- 6) Strengthen leadership and accountability
- 7) Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities
- 8) Collaborate locally in planning and delivering action to address health inequalities

- 4.2 In addition, there is a consensus across partners in the Coventry and Warwickshire Health and Care Partnership about the need for a focus on health inequalities, as articulated in their shared system vision. The NHS Long Term Plan also directs systems that addressing inequalities should be a priority.

- 4.3 The Population Health and Prevention Enabling Delivery Group is overseeing work to understand the emerging population health needs and risks arising from the pandemic and to plan for mitigating the impact on population health in any second wave and post pandemic. This includes a specific emphasis on addressing

²

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 (Appendix B)

³ Office for National Statistics. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020

[\[https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyethnicgroupenglandandwales/2march2020to15may2020\]](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyethnicgroupenglandandwales/2march2020to15may2020). Accessed 2020 Jul 02.

⁴ Coventry Health and Wellbeing Board. *Coventry Joint Strategic Needs Assessment. Coventry Citywide Profile 2019*. Coventry; Coventry City Council; 2019; Department for Education, Schools, pupils and their characteristics 2020.

⁵ https://www.england.nhs.uk/wp-content/uploads/2020/08/C0716_Implementing-phase-3-v1.1.pdf (Appendix C)

inequalities and a Coventry and Warwickshire Health Inequalities Task and Finish Group is leading this work. They will make recommendations to the Population Health and Prevention Enabling Delivery Group about the longer-term system approach to inequalities and how this should be implemented.

4.4 The **WMCA** has established the Regional Health Impacts of COVID19 Task and Finish Group to focus on the relationship between disparities analysis from the PHE review and wider health inequalities in the region (see Appendix A). This will include:

- Coordinating work by partners and stakeholders around COVID19 and linking to the wider determinants of health
- Drawing on other streams of work around the region on COVID19 and health inequalities
- Sharing work across different organisations and synchronising use and outputs of work.
- Identifying a series of interventions that might be made in response to their findings
- Feeding into national level discussions about the health impact of COVID19

4.5 The **Marmot Partnership** work to date has been built on and mobilised quickly as a whole system to respond to COVID19. Following the Coventry Health and Wellbeing Board meeting on 27th July 2020, the following recommendations have been approved:

- The Marmot Partnership Group take the strategic lead on supporting the system to address health inequalities relating to COVID19.
- The work of the Marmot Partnership Group should include leading on implementing the recommendations developed by Public Health England (PHE) to reduce the disproportionate impact that COVID19 has had on people from Black, Asian and minority ethnic (BAME) groups⁶.
- The Marmot Partnership Group provides a progress update in 6 months to the Health and Wellbeing Board
- A Call to Action will act as an overall stimulus to reduce health inequalities in Coventry and focus on a range of areas, including BAME, Business and Skills Development and supporting communities.

4.6 **Businesses** have taken action to protect their workforces. They have utilised the range of support available for recruitment, grants, bespoke training offers, skills development, redundancy and help with staff wellbeing. Businesses have been articulating their needs in terms of additional support requirements to make adjustments and become COVID19 safe to Local Authorities, Chamber, Growth Hub and Federation of Small Businesses, amongst others. The local business support ecosystem has mobilised itself where possible, working collaboratively with

6

council, private and voluntary sectors, to strengthen this ecosystem and deliver such support.

4.7 **Coventry City Council** has been supporting businesses and the economy including with:

- Award of Government COVID19 grants. These include small businesses and retail and hospitality firms; business rate relief for 2020/21; discretionary grants to SMEs (Small and Medium sized Enterprises)
- Support with accessing other Government schemes. These include loan schemes and the coronavirus job retention scheme
- Coventry Employment and Skills Plan: response to COVID19. This plan has identified priority areas including supporting young people (16-24); helping those 50+; supporting BAME communities; rapid response to redundancy; long term unemployed; supporting those with complex barriers; enabling digital inclusion and mental wellbeing and social isolation
- Negotiation of Getting Building Fund for priority capital projects
- Webinars for Coventry City Council's SME support programmes and green recovery
- Job Shop continued operations
- Thrive at Work Wellbeing Award, which supports workplace wellbeing and the mental and physical health of employees

4.8 **Inclusive growth** is about a more deliberate and socially purposeful model of economic growth – important not only for growth, but also by how well it is shared across the whole population and place. Coventry City Council are working toward ensuring Coventry residents benefit from economic recovery. Employment and skills support schemes are now running until 2023, In addition, employment and skills and SME support offers are being integrated.

4.9 Coventry City Council had been working with communities prior to COVID19, however the pandemic has strengthened this work. The aim of the Community Resilience Team is to give people greater influence and control over what happens in their communities and the area that they live in. The Community Resilience Team does this by working with individuals, small or large voluntary organisations and communities to identify and build on already existing strengths and skills within neighbourhoods.

4.10 Via the **Community Network** (the extra staff deployed to it, the many community and voluntary groups in the city and the individual volunteers who came forward) the following were established:

- 5 new social supermarkets were set up (Stoke Aldermoor, Stoke Heath, Canley, Cheylesmore and Willenhall), and 10 emergency food hubs with 26,232 people supported by foodbank and social supermarkets April to September 2020. This

equates to twice the level of people receiving emergency food supplies in comparison to pre-COVID19.

- Service information and Public Health messages disseminated through the social supermarkets and food hubs
- Over 2,000 children supported with breakfast and activity packs over the 5 weeks of the school holidays. Each pack has contained 5 days of breakfasts and activities and approximately 1,500 of these were given out each week
- Community networks established consisting of local volunteers to support local people in their area
- 52 funding applications (£545,997) made to support the voluntary sector with £352,745 successfully awarded to date

4.11 Through strengthening support for communities, places of worship and **faith groups** have been able to adjust their religious practice and behaviours in light of COVID19.

4.12 **Migrant Health Champions** have been supporting their communities and disseminating messages alongside Public Health to help keep communities safe and well.

4.13 Moving forward, work with partners and communities to design culturally competent messages to reach into the heart of communities. To reach this goal, over 150 **Community Messengers** (number still rising) are in place to give out messages about COVID19 and other priority Public Health issues. These are people already in community organisations who will give general messaging and bring back local intelligence from communities. Their remit is to include harder to reach groups. This engagement and participation approach will be used as the blueprint for future engagement work.

4.14 **COVID19 Community Advisors** have been seconded from CCC departments such as libraries. They are going out into communities to support businesses and the community itself to be COVID19 safe. They can be allocated to specific areas in the city that are identified as hot spots. They respond to community concerns that may have been raised (either through the Community Messengers or directly to the council by the community). The Community Advisors signpost people to resources or provide resources where necessary and the Advisors feedback as necessary to the COVID19 mobilisation groups.

5 Next Steps

5.1 Strengthen and embed our focus on reducing health inequalities as a key theme across all of Coventry City Council's corporate priorities.

5.2 Implement local recommendations from the national PHE report and the recommendations from the Coventry and Warwickshire COVID19 Health Impact Assessment⁷.

⁷ <https://democracy.warwickshire.gov.uk/documents/s8449/Background%20Paper%20for%20COVID-19%20Health%20Impact%20Assessment.pdf> (Appendix D)

- 5.3 Launch a Call to Action to employers and organisations to ask them to consider what actions they can take to help reduce health inequalities, with a particular focus on businesses and communities and driving through actions around BAME, employment and skills, housing and families with 0-5 year olds. This work is being led by the Marmot Partnership Group.
- 5.4 Utilise the collective local knowledge and expertise from members of the Scrutiny co-ordinating committee to inform and support our approach.

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West Midlands Regional Health Impact of COVID-19 Task and Finish Group

Interim Report and Call for Evidence
August 2020



West Midlands
Combined Authority

This report has been prepared by the PHE Population Intelligence Hub for the West Midlands Regional Health Impact of COVID-19 Task & Finish Group. The Population Intelligence Hub is a virtual intelligence hub which was established by PHE and the WMCA and it is part of the WMCA's Inclusive Growth Unit to initiate and advocate for research, data systems and existing intelligence to result in actionable insight to improve outcomes and reduce health inequalities for the West Midlands population.

Introduction

National and regional evidence shows that COVID-19 has widened existing health inequalities, both through the direct impacts of the virus, and the indirect impacts of the control measures imposed. While underlying health conditions have increased the risk of serious consequences from infection, the economic and social response to COVID-19 has exacerbated inequalities in physical and mental health and the wider determinants of health: the conditions in which we are born, grow, live, work and age.

The pandemic has especially exposed and exacerbated longstanding inequalities affecting BAME groups in the UK including challenges faced through systemic discrimination.

This report acts as an interim to the Health of the Region Report due to be published later in 2020 which will reflect on the implications of

COVID-19 in relation to inequalities in health and wellbeing across the West Midlands region. The purpose of this report is to demonstrate and reflect on work and analysis of COVID-19 and health inequalities to date which has been carried out by PHE Population Intelligence Hub and stakeholder members of the West Midlands Regional Health Impact of COVID-19 Task and Finish Group. This Group has been convened with representation from the WMCA, PHE, local authorities, universities, community organisations and the NHS. The purpose of the group is to focus on the relationship between disparities analysis from the PHE review and wider health inequalities in the West Midlands region.

The report identifies stakeholder concerns around the upcoming challenges facing the West Midlands over the coming months, the unique opportunities that

the situation presents, and the next steps for the group's work. It includes a call for evidence as the group begins a short period of stakeholder engagement to inform its work.

The purpose and role of the Regional Health Impact of COVID-19 Task and Finish Group

To focus on the relationship between disparities analysis from the PHE review and wider health inequalities in the wider WMCA Region. This includes:

1. Coordinating work by Partners and Stakeholders around COVID-19 and linking to the wider determinants of health;
2. Drawing on other streams of work around the region on COVID-19 and health inequalities;
3. Sharing work across different organisations and synchronising use and outputs of work
4. Identifying a series of interventions that might be made in response to our findings;
5. Feeding into national level discussions about the health impact of COVID-19.

The group members

Name/role	Organisation
Ed Cox (Chair)	WMCA
Lola Abudu	PHE
Mark Axcell	Black Country Healthcare NHS Foundation Trust
Guy Daly	Coventry University
John Denley	DPH Wolverhampton
Claire Dhami	WMCA
Clare Gollop	Violence Reduction Unit
Chris Ham	Coventry & Warwickshire STP
Sue Ibbotson	PHE
Lina Martino	PHE
Paul Maubach	Black Country and West Birmingham CCG
Helen Paterson	Walsall MBC
Stephen Raybould	Birmingham Voluntary Service Council (BVSC)
Bec Riley	WMREDI
Dave Rosser	University Hospitals Birmingham
Sean Russell	WMCA
Grace Scrivens (Project Coordinator)	PHE
Jonathan Tew	Birmingham City Council
Alison Tonge	NHSE
Amrick Ubhi	Mayors Faith Network and Nishkam Centre
Joy Warmington	BRAP

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Background

On 2nd June 2020, Public Health England published **COVID-19: review of disparities in risks and outcomes**¹. The review confirmed that **the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them.**

The key points from the report are as follows:

1. **Age** remains the most important risk factor for death from COVID 19. People who were 80 or older were seventy times more likely to die than those under 40.
2. Risk of dying among those diagnosed with COVID-19 was also **higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups.**
3. The review also looked at excess all cause deaths during the same period. **This reports a high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes.**
4. People from **Black ethnic groups were most likely to be diagnosed with COVID in the hospital testing data,** however this did not take account of local population and distribution of cases in different geographies, or exposure risk from occupation.
5. **Death rates from COVID-19 were highest among people of Black and Asian ethnic groups.**

6. An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, shows that after accounting for the effect of sex, age, deprivation and region, people of **Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.** These analyses did not account for the effect of occupation, comorbidities or obesity.
7. Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned **diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates. Diabetes was reported on over 20% of death certificates for patients who died from COVID-19** and this was doubled in both Asian and Black ethnic groups.
8. The report included commentary on inclusion health groups such as the homeless and migrants and highlighted concerns about increased cases but acknowledges the numbers in NHS records are small.

The report was limited by the data it was able to access, focusing primarily on data from hospital testing and deaths which biases the findings to those who are most clinically unwell. The report also undertook very limited multi-variant analysis such as the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. It is hoped that this will be followed up through the research commissioned by the National Institute for Health Research. The report was unable to analyse some variables such as faith because there is no statutory requirement for this information to be included in death certificates and it is poorly recorded in NHS data.

On 16th June 2020, Public Health England published **Beyond the data: Understanding the impact of COVID-19 on BAME groups.**²

The report provided a descriptive summary of a rapid literature review to understand the social and structural determinants of health that may impact disparities in COVID-19 in BAME groups, and of stakeholder insights into the factors that may be influencing the impact of COVID-19 on BAME communities and strategies for addressing inequalities.

The key points from the literature review and stakeholder feedback are as follows:

- Risks associated with COVID-19 transmission, morbidity, and mortality can be **exacerbated by the housing challenges** faced by some members of BAME groups.
- **Ethnicity and income inequality are independently associated** with COVID-19 mortality.
- Individuals from BAME groups are more likely to work in occupations with a **higher risk of COVID-19 exposure** and they are more likely to use public transportation to travel to their essential work.
- **Systemic discrimination at work and poorer experiences of healthcare** may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk.

The report was limited due to timescales and more research needs to be undertaken to understand the literature on links between racism and health outcomes and of stakeholder insights.

The health impact of COVID-19 in the West Midlands

Birmingham City Council Public Health Division have explored COVID-19 related death rates and local area characteristics in the West Midlands. These findings are limited by the small number of local areas explored, therefore conclusions are broad and show an association rather than a statistical relationship.

1. Aggregated data for the WMCA show that on average, **local authority areas ranking higher for socioeconomic deprivation also have higher rates of COVID-19 related deaths.** This demonstrates that there is a broad correlation between area deprivation and COVID-19 related deaths, however there are outliers which reiterates the need to consider multivariate analysis.
2. Sub-national analysis of ethnicity and COVID-19 cases or deaths is not available and ethnicity data is not routinely collated by NHS. **A limited correlation between the % of ethnic minority population and the cumulative rate of COVID-19 related deaths in West Midlands Region has been identified.**
3. Analysis of the cumulative rate of **COVID-19 related deaths correlated with the proportion of the population over the age of 70yrs shows a downward trend with some outliers.** This has been seen nationally and may reflect reduced social interactions for more elderly populations.
4. Higher **cumulative rate of COVID-19 related deaths are associated with a lower rate of non-UK born residents.**

There remain significant unanswered questions about the higher death rates in ethnic minority communities and further research is urgently needed to understand this. The PHE Population Intelligence Hub has been exploring existing population vulnerabilities, risk factors and inequalities in West Midlands to understand population groups most likely to be disproportionately impacted by COVID-19. The aim of this analysis is to provide a starting point for identifying key areas of focus in mitigating the impact of COVID-19 on health inequalities in the region, including over the longer term. This approach helps to recognise the relationship between health and wealth and the need to address inequalities in education, skills and employment across the region and ensure that the inclusive growth agenda is truly delivering in ways that close the inequalities in employment and life changes.

Occupational inequalities

The national report identified a high increase in excess all cause deaths for those in caring occupations. The WMCA area³ has a slightly higher proportion of jobs within the health and social work sector (14%) compared with West Midlands Region (13.2%) or the national average (12.5%). Many jobs within this sector in WMCA area are in hospital activities (5.9%) which is

slightly more than national average (4.8%) and West Midlands Region (5%). The social work sector makes up 3.2% of jobs in the WMCA and is again slightly more than national average (2.8%) and West Midlands Region (2.9%). Sandwell has the highest proportion of jobs within WMCA area within social work at 3.9% followed by Birmingham and Dudley (3.5%). Dudley has the highest proportion of jobs in residential caring (3%) followed by Wolverhampton (2.9%); this is slightly higher than WMCA area (2.3%) but similar to West Midlands Region (2.9%) and national average (2.8%).

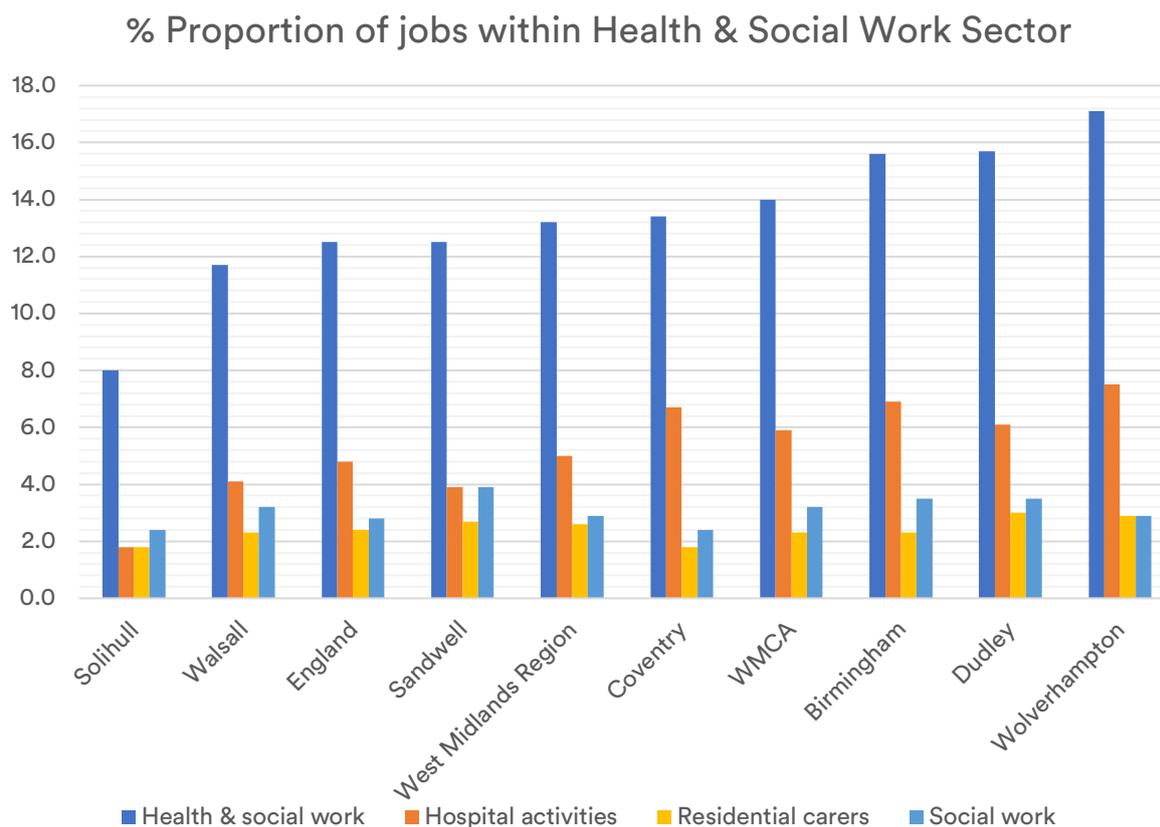


Figure 1

The national report identified that Black ethnic groups were most likely to be diagnosed with COVID-19 in the hospital testing data and that death rates from COVID-19 were highest among people of Black and Asian ethnic groups. Healthcare workers have the highest increased health risk due to exposure to infection and in the West Midlands Region⁴, Black ethnic group has the largest proportion of their population working in this sector (33.6%) followed by 'other Asian background' (18.9%). This is similar to national figures with Black ethnic group also having the largest proportion within its population working within this sector (26.9%) followed by 'other Asian background'⁵ (20.8%).

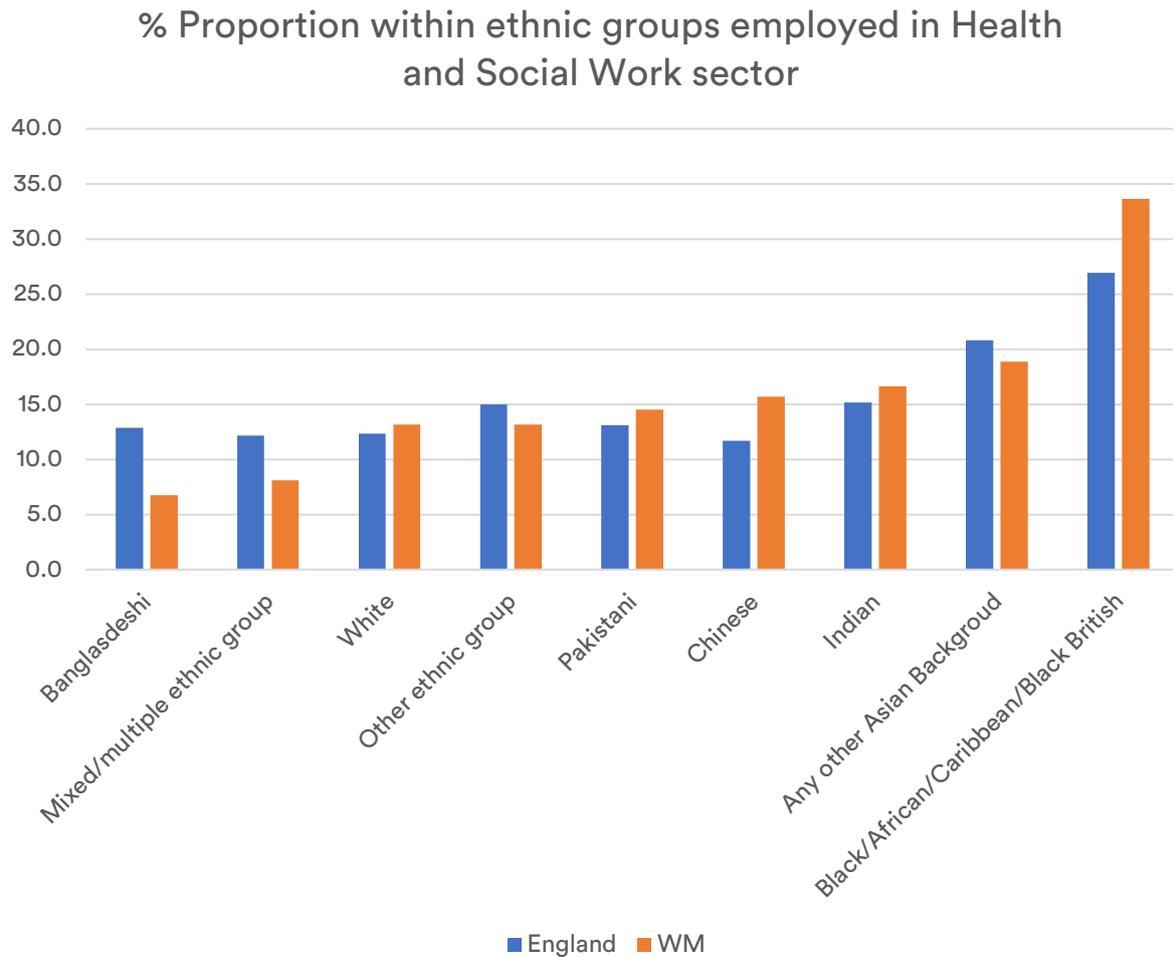


Figure 2

The national report also highlighted a high increase in excess all cause deaths for those who drive passengers in road vehicles for a living. We know that transport workers broadly have an increased exposure to infection and health risks due to increased contact with members of the general public. The WMCA area⁶ and West Midlands Region have a slightly higher proportion of jobs within the transport and storage sector (5.5%) compared with the national average (4.9%). Walsall has the highest proportion of jobs within

the WMCA area within this sector (9.2%) followed by Sandwell (7.9%) and Solihull (7.3%).

Limited analysis carried out in the national report found that people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Pakistani ethnicity had between 10 and 50% higher risk of death when compared to White British. In the West Midlands Region⁷, Pakistani ethnic group has the largest proportion within its population working within the transport and

storage sector (17.2%) followed by Bangladeshi ethnic group (15.5%) and therefore have a greater risk as population groups of being exposed to the infection. This is similar to national figures with Pakistani ethnic group also having the largest proportion within its population working in this sector (15.1%) followed by Bangladeshi ethnic group (10.6%).

Older age population

The national report concluded that age remains the most important risk factor for death from COVID-19, particularly for those 80 or older. An estimated⁸ 4.4% of the WMCA population is 80 or older which is slightly less than national average (4.9%) and West Midlands Region (5%). Solihull has the greatest proportion in this age bracket within WMCA area (6.1%), followed by Dudley (5.6%), and Birmingham has the lowest proportion (6.2%).

Underlying conditions

The national report identified that among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates. In WMCA area⁹, the estimated prevalence for each of these underlying conditions

is similar to the national picture. However, prevalence of diabetes in the WMCA area is notably higher at 8.2% than national average (6.8%). This is significant as diabetes was reported on over 20% of death certificates for patients who died from COVID-19.

Excess weight is recognised as a key health risk factor for complications or death from COVID-19.¹⁰ While this increased risk is present even after accounting for age, sex, ethnicity or other health conditions, it is important to note the intersection with social and economic factors. Obesity prevalence is highest amongst the most deprived groups in society, and children in the most deprived parts of the country are more than twice as likely to be obese as their peers living in the richest areas.¹¹ Within the WMCA, 11.4% of reception age children are obese and this rises to 25.5% in Year 6 – both are significantly higher than the national average (9.7% and 20.2% respectively).¹²

Other vulnerable groups

The national report recognised concerns around other vulnerable groups such as the homeless and migrants in increased cases, although data here is limited. We know that rough sleepers are a particularly vulnerable group and are unable in the ordinary course

of events to self-isolate. In the West Midlands Region¹³ there is an estimate of 319 people sleeping rough; Birmingham has the highest number of rough sleepers (52) followed by Coventry (23). The majority of the rough sleepers in West Midlands Region are male (83%), over age of 26 (83%) and UK-born (64%).

To summarise, existing risk factors and inequalities suggest that the risk associated with age – of those 80 or older – is lower in the WMCA area than the national average. However, this appears to be countered by other risk factors and inequalities. Firstly, occupation and ethnicity risk factors – the WMCA area has a higher proportion of jobs within sectors associated with a higher increase in excess all cause deaths and increased exposure to infection. In the West Midlands Region, jobs in these sectors are disproportionately held by ethnic groups associated with poorer COVID-19 health outcomes. Secondly, the prevalence of excess weight, diabetes and deprivation in WMCA area increases the prevalence of population groups more likely to be disproportionately impacted by COVID-19 due to an increased risk for complications or death from COVID-19.

The immediate consequences of COVID-19: worsening inequalities across the life course

Many stakeholders across the WMCA area are concerned about the effects that upcoming challenges facing the West Midlands over the coming months are likely to have on existing health inequalities. The economic consequences and the wider forms of response hold the risk of exacerbating problems at every stage of life.

It is important to consider these inequalities in the context of the relationship between health and wealth, and the wider determinants of health across the life course. Health inequalities in working age and older adults often reflect the impact of cumulative disadvantage from the early years and beyond. Approaches to mitigating the risks of COVID-19 should therefore be balanced against the potential harms of increasing inequalities in safeguarding, educational opportunities, access to employment, income, housing and healthcare, as well as wider community assets.

In addition, cross-cutting inequalities relating to ethnicity, gender, disability and vulnerability mean that particular groups of people may be disproportionately

affected throughout. An inclusive approach which seeks to actively engage seldom heard citizens is essential in supporting services and communities in responding to and recovering from COVID-19.

The following key areas of focus have been identified:



Social factors and systemic discrimination

Research on inequalities relating to ethnicity as a cross-cutting theme across the life course identify a range of social factors to explain the ethnic inequalities in relation to COVID-19. These include:

- socioeconomic deprivation due to the links between poor health and poverty and that particular ethnic groups are more likely to be on lower incomes, reside in deprived areas, and live in more crowded households;
- experiencing discrimination and racism on a daily basis which can affect physical and mental health and, experience and access to health services;
- living in more deprived areas with higher levels of pollution;
- poorer access to health services;

- different preferences and attitudes towards health promoting activities;
- impact of genetic factors (which is thought to be marginal).

These issues could mean that BAME children and young people are especially vulnerable to the impacts of COVID-19 and experience a disproportionate effect on children's best start in life, resulting in cumulative disadvantage throughout the life course.



Children and young people

Children and young people have been identified as a key population group for several reasons. Firstly, there is concern around the impact of disruption to education on existing educational inequalities as a result of home-schooling. In the West Midlands Region¹⁴, only 57.2% of children with free school meal status are achieving a good level of development at the end of reception year. Whilst this is similar to national average (56.5%), some areas within WMCA area are much lower, for example Dudley (48.2%) and Coventry (54.4%). Research shows an increase of 71% in young people in the Midlands¹⁵ feeling anxious about school or college in comparison to the previous year.¹⁶

There is concern that the wider impact of COVID-19 control measures is having a disproportionate effect on children's best start in life and particularly, on vulnerable children. Within the WMCA area¹⁷, all local authorities have an estimated prevalence of children eligible for free school meals that is higher than national average (15.2%). Birmingham has the highest estimated prevalence at 27.1% of children, followed by Wolverhampton (25.7%). Within the WMCA area¹⁸, all local authorities have an estimated prevalence of households with children claiming universal credit that is higher than national average (134.8 per 1000 households with children). Wolverhampton has the highest estimated (229.7 per 1000 households with children), followed by Birmingham (196.29 per 1000 households with children). With a higher proportion of vulnerable children living in low income households in WMCA area, there is an increased risk of a disproportionate direct and indirect impact of COVID-19 widening existing inequalities. For example, as an indirect result of control measures, low income families are put under increasing financial strain and local authority budgets may not be able to provide services and resources for the most vulnerable children.¹⁹

The West Midlands Region²⁰ has a total of 82 per 100,000 children looked after by local authority which is greater than national average (65). Sandwell has the greatest amount of looked after children with 109 per 100,000 children, followed by Wolverhampton (102). This group is identified as a particularly vulnerable group associated with poor outcomes and requiring additional support. Schools and early years education are key to addressing educational inequalities faced by this population group and the closing of schools is likely to exacerbate these inequalities further due to a lack of access to education.

Different experiences within the education system mean that some BAME groups are less likely to achieve required grades and more likely to be excluded.²¹ The conditions, such as these, of vulnerability that may lead a young person to be drawn into violence or unable to exit violent environments also affect their health and life outcomes in a range of ways. Evidence reviews of the youth justice system highlighted the over-representation of Black and Minority Ethnic (BAME) young people affected by criminality.²² This can have a cumulative impact across the lifecourse resulting in an under employment of young people from BAME groups.

Lockdown measures also increase risk for children living in households who experience abusive behaviour and domestic abuse. Educational settings were an opportunity for children's social care interventions and the impact of the lack of contact due to closure of these settings may be a significant increase in referrals.²³

However, the recent Ofsted ratings²⁴ for local authority children services found that all local authorities within WMCA, apart from Wolverhampton who were rated as "good", were rated as "requires improvement" and Sandwell were rated as "inadequate". This indicates that children's services may not be adequate to support vulnerable children in need of intervention.

Young people's mental health has been identified as a focus for concern in light of their employment prospects. For example, young people tend to be employed in vulnerable lockdown sectors or are struggling to find good employment following completion of higher education. This has a detrimental effect on sense of value and economic contribution. Disturbingly, research shows a 250% increase in young people in West Midlands and East reporting suicidal thoughts in comparison to the previous year.²⁵



Unemployment

Research²⁶ has shown that people who were already in lower socioeconomic brackets are more likely to face adverse experiences, including losing a job, having problems accessing food and being unable to pay bills. They are also more likely to worry about the risk of these adversities, with worry having the same negative effect on mental health as the actual experience. There is a known detrimental impact of longer term unemployment on mental health which further widens health inequalities as those further down the social gradient scale experience poorer mental health outcomes. The WMCA area²⁷ experienced a 3.6% increase in unemployment claimants between March 2020 and May 2020 which is similar to West Midlands Region (3.3%) and national average (3.4%). Wolverhampton saw the largest increase within the WMCA area (3.9%) followed by Walsall, Sandwell and Birmingham (3.8%). The WMCA area is facing a 4.3% rise in unemployment claimants in comparison to the previous year, which is slightly higher than the national average of 3.9%.

There is an estimated employment decrease of 9% by January 2021²⁸

in the West Midlands region and it is expected that the challenge of unemployment will be facing a new cohort of people who have been furloughed or self-employed and may be facing unemployment for the first time.



Sectors

Lockdown control measures have made several sectors vulnerable due to the negative economic effects of COVID-19 leading to insecure employment and job loss. These sectors include retail (excluding food retail), accommodation and food services and arts, entertainment & recreation services. Within the WMCA area²⁹ it is estimated that 14.8% of jobs may be within vulnerable sectors; this is less than national average (17.7%) and WM Region (15.5%). Solihull has the highest proportion within WMCA of jobs which may be vulnerable (16.2%) followed by Birmingham (15.2%). As these sectors start to reopen and consumer spend remains low, the consequence this will have on widening inequalities is concerning, as the jobs facing the most instability are more likely to be occupied by BAME groups and young population.³⁰

Workers in lockdown sectors face an increased risk of exposure to loss of income and in the West Midlands³¹, Pakistani ethnic group has the largest proportion of their population working in wholesale and retail trade whilst 'other Asian ethnic group'³² has the largest proportion of their population working in accommodation and food services. Within WMCA area, Pakistani ethnic group has the greatest employment rate gap between male and female at 41.6% followed by 'other ethnic group'³³ at 33.6%. Therefore, the income earner for households in these population groups are likely to have been employed within a vulnerable sector creating financial instability and exacerbating existing inequalities.

It is well documented that BAME groups face structural barriers and systemic discrimination in the workplace. For example, there is a disparity in outcomes between BAME professionals compared to their white counterparts, from underrepresentation in management and leadership positions to the ethnicity pay gap.³⁴ ³⁵ It is recognised that experiencing racism is likely to have a negative effect on overall health and mental health.³⁶



Housing

Where someone's home is not a place of safety, or when they do not have ready access to essentials such as food and medicine, being more isolated may place them at greater risk of harm. The WMCA area³⁷ has an aggregated 3.46 homeless households per 100,000 households which is significantly higher than the national average (1.49) and West Midlands Region (1.72); Dudley has the highest rate of 3 per 100,000 households. The WMCA has an aggregated 3.34 households in temporary accommodation per 100,000 households and 77.4% of these households are with children. This is just less than national average (3.74) but greater than West Midlands Region (1.91). Birmingham has the highest rate of 6.7 per 100,000 households and 81.7% of these households are with children, followed by Coventry (4.01 per 100,000 households and 56.9% with children).

Living in an overcrowded household is associated with worse health outcomes and is a potential route for transmission of infection. People in lower income households are more likely to be in overcrowded accommodation than those in higher income households

and are more likely to include an adult aged over 75 or someone with a health condition.³⁸ In the West Midlands³⁹, 2.8% of households experience overcrowding which is similar to the national figure (3%). Nationally figures show that rates of overcrowding tend to be much higher for Bangladeshi households (30%) in comparison to White British households (2%).



Mental health and additional support needs

Emerging evidence reveals a widening of pre-existing inequalities in mental health.⁴⁰ Recent research shows that nationally mental health and loneliness appear worse than before COVID-19 with young adults, people from low income households, people with mental illness and people from BAME groups disproportionately at risk.⁴¹ Compliance with government guidelines is directly related to mental health and the study found that looking after people's mental health is fundamental to the successful management of the pandemic. The WMCA area⁴² has an estimated prevalence of people with serious mental illness of 1%, which is slightly higher than national average and WM region (0.9%); this is highest in

Birmingham at 1.2%.

Social distancing and isolation is having a detrimental impact on mental health and wellbeing, including through harmful health behaviours and reducing access to services and support. Illness, bereavement and anxiety around contagion are also likely to contribute to poorer mental health during the pandemic. Population groups likely to be disproportionately affected in this way require support for additional needs. There is an estimated⁴³ 0.7% prevalence of dementia in the WMCA population, which is slightly less than national average and West Midlands Region (0.8%), but this is slightly higher in Dudley at 0.9%. The WMCA has the same estimated prevalence of people with learning disabilities as national average and West Midlands region (0.5%); this is slightly higher in Birmingham and Wolverhampton (0.6%).

People who misuse or are dependent on drugs and alcohol may be at increased risk of becoming infected, and infecting others, with coronavirus (COVID-19). They may also be more vulnerable to the impact of infection with the virus, due to underlying conditions. There is an estimated⁴⁴ 0.8% of WMCA population in treatment at drug or alcohol misuse services which is higher than

West Midlands Region (0.66%). Solihull has the greatest estimated proportion within this population group at 0.91% in WMCA area, followed by Birmingham (0.85%) and Walsall (0.81%).

There has been a growing concern about the effect that control measures, which have had to be taken by prisons, have had on inmates. The use of extended lock up has resulted in 23 hours a day isolation in cells for most inmates alongside no visits from family, friends or external therapists, which is likely to exacerbate feelings of loneliness and isolation. Planned medical procedures that involve leaving the estate for hospitals outside have not been able to take place due to combination of security and pandemic concerns and there has been limited continuation of rehabilitation activity, causing delays to accessing healthcare and rehabilitation services. The prison sector has also faced challenges in planning resettlement activity and finding appropriate move on support for inmates which has a detrimental effect on exiting the criminal justice system.



Access to healthcare

Inequality in healthcare provision has been identified as a cause for concern due to disparities in access to good quality healthcare, especially for poorly managed conditions in vulnerable groups. The NHS are dealing with a significant backlog of non-COVID related morbidity and it is likely that the effect of this will widen existing health inequalities and lead to avoidable cancer death as a result of diagnostic delays.⁴⁵ Across the UK it is estimated that 2.1 million people have missed out on screening, while 290,000 people with suspected symptoms have not been referred for hospital tests. This means that more than 23,000 cancers could have gone undiagnosed during lockdown.⁴⁶ The availability of ventilators to continue surgery and the delivery of endoscopy and colonoscopy diagnostic procedures, which are at a significant higher risk of COVID-19 transmission, could prove to be a challenge around ensuring access to urgent care diagnosis and treatment in the event of a second spike in the West Midlands. In addition, reduced capacity in primary care and reluctance to visit healthcare settings due to perceived risk may present barriers to routine management of long-term health conditions.



Social care and elder care

The region's older age group population remains an important consideration over the coming months due to the direct health risks and indirect impact of COVID-19 control measures. The largest group experiencing loneliness is older people; in the UK there are an estimated 1.2 million chronically lonely older people.⁴⁷ Intervening early to tackle loneliness and social isolation will help to prevent more costly health and care needs from developing.⁴⁸ The indirect impact of social distancing measures are likely to exacerbate existing loneliness and isolation in the older age population and there is a challenge for the region's social care sector to respond to the increase in demand for services to address isolation, whilst the region's adult residential care sector has been faced with considerable challenges due to COVID-19 outbreaks and deaths over the past weeks.

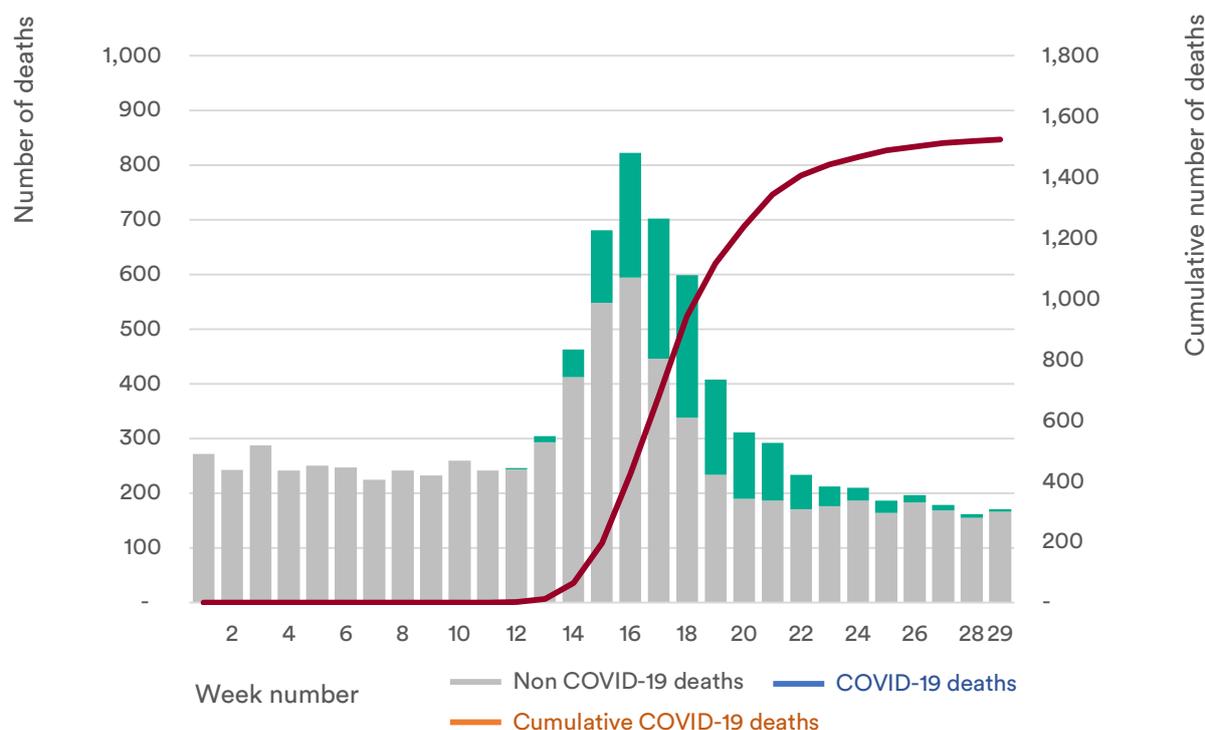


Figure 3 - Trend in numbers of deaths by cause and cumulative COVID-19 deaths, deaths that occurred up to 17 July 2020 but were registered up to the 25 July 2020, by week, where place of death was recorded as 'Care Home', West Midlands ONS region⁵⁰

Challenges to adult social care have been identified as reduced care capacity due to service closure and reduced support activities; pressures around hospital discharge flows due to delays and lack of appropriate support in place; impacts of COVID-19 hotspots in care homes (see figure 3); and challenges to telecare continuity and digital exclusion of residents and service users.⁴⁹

To summarise, economic consequences and the wider forms of response risk exacerbating problems at every stage of life. Children and young people have been identified as a key population group due to the disruptive impact of educational setting closures, disproportionate effects on early years development (best start in life), and lack of opportunity for children's social care interventions. Moreover, the indirect economic impact is likely to exacerbate young people's mental health challenges due to uncertainty in employment prospects. Health inequalities from the early years are likely to result in cumulative disadvantage in working age and older adults.

For working age adults, those already in lower socioeconomic brackets, BAME groups or young cohorts have been identified as key groups more likely to face adverse experiences, such as losing a job as a result of working in unstable and vulnerable sectors. For those living in unstable or overcrowded accommodation, the impact of lockdown measures is likely to exacerbate health risks faced by these population groups. Mental health and wellbeing have been negatively impacted by the pandemic and control measures, and there is evidence that existing mental health inequalities have widened. People with severe mental illness, older people and those with complex needs are likely to be at increased risk of these impacts, and to also have difficulty accessing the care they need.

Opportunities for change

Despite the negative impacts of the COVID-19 pandemic on the region, there are some ways in which responses during the crisis have created opportunities and prefigured new ways of working that could begin to address underlying concerns.

Alignment of economic recovery plans with existing priorities around inclusive growth, health inequalities and wellbeing will support the development of a regional approach to radical prevention, linking with national strategies and programmes for building community resilience, reducing inequalities and improving physical and mental health. Furthermore, rethinking how our health and care systems interact might create a significant opportunity to co-ordinate action across the system to improve the wider determinants of health, working in partnership with stakeholders across localities and sectors.

The Regional Health Impact of COVID-19 Task and Finish Group have identified a number of current opportunities to address some of the challenges on existing and exacerbated health inequalities. This is not an exhaustive list but aims to provide a commitment from the regional health system to the actions which will be identified in the Health of the Region Report due to be published in later in 2020.

These include:

1. New public focus on health inequalities and public health, including the recently launched national strategy for tackling obesity⁵¹
2. Increased public awareness of infection control
3. Reframing of physical activity as an opportunity to be outdoors, socialise, get around safely and improve wellbeing, rather than solely as a tool to promote healthy weight
4. New ways of working that maximise use of technology, enabling more flexibility and improving work-life balance as well as reducing environmental impact
5. Changes to local delivery models, for example the Black Country Healthcare Mental Health Trust is a new organisation rethinking the delivery model of mental health services to involve voluntary sector, service users and GPs
6. Role of communities, for example in driving a collaborative approach to population health management
7. Workstreams to ensure that BAME inequalities are considered in all aspects of response and recovery, for example the PHE West Midlands' Health & Wellbeing team

has set out a comprehensive programme of work focusing on health inequalities with a specific focus on BAME inequalities through COVID-19 recovery and beyond

8. Drawing down resources to help address structural inequalities, for example through a formal submission to the comprehensive spending review
9. Understanding lessons learnt from the first wave from a healthcare perspective
10. Pooling and sharing of intelligence and engagement resources and analysis as a regional health systems network.

Anecdotally, some people have noted that some of the changes we have seen during the crisis have promoted greater inclusion for people with disabilities, or those limited by family or caring roles. However, it is important to note that these benefits are not equally distributed, and that many others (e.g. those who are economically inactive) have felt even more isolated and excluded as a result of lockdown measures. Digital inclusion has been identified as a key issue and is often underpinned by the same factors as social and economic exclusion in general.

In developing strategies for inclusive and health-promoting economic recovery, it is important to maintain a balance between developing

a cohesive, regional approach and understanding the specific needs, assets and priorities of local communities. Local stakeholders, NHS and primary care providers will play the driving role in mobilising the health system response. This means being clear about where the WMCA can add value to local work, and where that role should focus on co-ordination and collaboration. Opportunities for action over the longer term include:

11. Developing a Health in all Policies approach to embed consideration of physical and mental health across all WMCA policy areas
12. Using the Thrive model to improve workforce health and wellbeing, and to address inequalities in education, skills and employment across the region in line with inclusive growth objectives
13. Maximising the potential of the 2022 Commonwealth Games to drive down inequalities and deliver a lasting legacy that undermines inequalities, especially in communities hit hardest by COVID-19
14. Supporting regional collaboration to tackling health inequalities, especially for groups such as the homeless and migrant populations
15. Working with communities, and local and national partners, to improve the recording and routine analysis of demographic data so that we are actively monitoring inequalities and demonstrating progress across the region (e.g. in relation to death certificates recording of details such as faith and ethnicity)
16. Supporting local governments in their ambitions to protect and improve the lives of local citizens and work with them to ensure adequate funding for the public health function that has been so important in responding to the current crisis
17. Devolution presents a significant opportunity to co-ordinate action across the system in local recovery to improve the wider determinants of health, working in partnership with stakeholders across localities and sectors

Stakeholder activities

We are now working with agencies and communities to explore these issues with a view to developing clear commitments for change in the region. Below we set out some of the activities which are being taken forward by individual stakeholders. Whilst this is not an exhaustive list it provides an understanding of some of the approaches being adopted across some of the approaches being adopted across the West Midlands Combined Authority area.

Examples of regional stakeholder activity in responding to COVID-19 as follows:

Public Health England

PHE Midlands and East Region are supporting the Region's local health system, for example the Directors of Public Health in the West Midlands in understanding inequalities exacerbated at local level and; are also working with NHSE on health inequality as a recovery theme and the significant backlog of non-COVID-19 morbidity in light of its effect which may widen existing inequalities. PHE are committed to supporting vulnerable health groups, for example those dealing with homelessness and the criminal justice system and this overlaps with the work of the Violence Reduction Unit. PHE West Midlands

Health and Wellbeing Team have a strong focus on BAME communities moving forward, as part of a wider programme of work focusing on health inequalities through COVID-19 recovery and beyond.

The WMCA Population Intelligence Hub is focusing on the existing inequalities in WMCA and WM Region and the implications of COVID-19 in relation to inequalities in health and wellbeing across the region. The Hub has produced analysis focused on population vulnerabilities, risk factors and inequalities, for example key sector and vulnerable sector jobs; older age population; groups requiring additional support such as those with mental health conditions, facing homelessness, drug or alcohol use and looked after children; BAME occupational profiles for West Midlands Region focused on occupational inequalities due to increased exposure to infection and loss of income; and West Midlands local vulnerability profile based on the Children's Commissioner Childhood Vulnerability Data. The Hub is planning an exploratory piece of analysis looking at area characteristics of localities which have experienced a high COVID-19 related mortality rate and a severe economic impact. The Hub has a proposed future research project to look at inequalities in mental health.

Councils

Walsall Council are using this as an opportunity for reset not just recovery. There is focus on mental health and broader communities, for example workforce and young people age 14 to 25 and their skills and sense of value and contribution. Building on work that has been carried out around shielding, there is a focus on the continued need for befriending due to isolation, lack of cohesion and connectivity in communities; the Council are focused on building confidence within its communities.

City of Wolverhampton Council are focusing on the longer-term impact of unemployment on mental health; children's disruption to education directed towards best start in life and vulnerable children; and inequality in healthcare provision working towards access to good quality healthcare, especially for poorly managed conditions in vulnerable groups and enabling and engaging those populations.

Birmingham City Council have focused on producing a comprehensive Cabinet report which was published in July 2020 and sets the frame for their work to understand impact over time, as well as sharing what they know now. The Council are increasingly building an emphasis around tackling inequalities into Council

strategies and delivery planning arrangements, and this will be taken forward by the Health and Wellbeing board sub-group; there are a number of facets to poverty for example, food, fuel, child, advice and welfare that need to be brought together to do this. The Council is also focused upon transparency with the public over the next stages, economy and schools, co-design and new demands for public services, for example mental health, domestic abuse and benefits system.

Walsall Council and other local authorities across WMCA will be undertaking deep dive community engagement pieces utilising existing various consultation groups to engage and consult, and Birmingham City Council is undertaking ethnographic research.

NHS

NHSE are delivering restoration and recovery through the System Transformation Recovery Board (STAR), building health inequalities into governance with STPs and clinical stewardship whilst also standing services back up. The approach is strongly supported by population health management by which clinicians are equipped with intelligence and decision making power and drives a collaborative structure between STPs, hospital, communities and primary care.

NHSE are also focusing on the adoption of digital delivery as a default option, workforce development of the whole clinical team contribution, and adoption of improvement science for productivity and reducing variation. Research being undertaken by NHSE is focused upon primary care looking at impact on services nationally and regionally, and the impact and challenges on pathway-based services such as cancer and heart disease in comparison to mental health services.

University Hospitals Birmingham Trust are focusing on the management of increasing emergency attendances and the flow of attendee clusters. The Trust is also focused on preparedness for a second wave. There is an attention to the nervousness of BAME community in presenting at hospital; over the next two years the Trust will concentrate on digital transformation through the use of technology and links into NHS England Improvement approach, and development of patient pathways linking nearby services to populations. The Trust has also been participating in national research trials on testing.

Black Country & West Birmingham CCG are focusing on deprived populations groups which have been most affected by the immediate and subsequent impact on physical

and mental health. Deprived communities are also experiencing a greater economic impact due to the effect of infection prevention and control measures. The CCG are also concentrating on urgent care and COVID-19 capacity forward planning for a second wave, preventative services in the community and public perception of service access. The CCG has carried out a study looking at the testing of all staff and residents in all care homes across Black Country & West Birmingham. There is also a mortality review underway along with analysis focusing on current impact on local populations in Birmingham, Solihull and Black Country.

Black Country Healthcare Mental Health Trust is implementing an approach of Reimagination as part of the NHS programme of 'Recovery and Restoration', and as a newly created Trust are undertaking a programme of working with stakeholders to develop a clinical strategy, embracing the learning and innovation from COVID-19. The Reimagination delivery model will involve the voluntary sector, service users and GPs. The Trust is a member of the MERIT – a partnership involving all of the mental health provider Trusts in the West Midlands area. The partnership, led by Midlands Partnership Trust FT, is developing a model which utilises learning

from other pandemics, natural disasters and emergency situations to predict the impact on mental health and subsequent demand for mental health services, with interesting potential for regional and local use.

Community and Voluntary Sector

Birmingham Voluntary and Community Sector are focusing on the crisis and recovery by accelerating STP transformation focus on prevention to reduce health inequalities and increase community capacity. BVSC is undertaking a voluntary sector survey which will be published in September 2020 and have been involved with Birmingham City Council Public Health Directorate research on impact of COVID-19 on BAME communities

Violence Reduction Unit

The West Midlands Violence Reduction Unit has supported its delivery partners to transition services to enable the delivery of detached youth work and remote intervention and support services. The unit is monitoring the effectiveness of this with a view to upscaling activity in the future, recognising the complexity of the digital divide and other inhibitors to equal access to services. VRU programmes include support for

the education system through guidance, advice, and a toolkit regarding reducing vulnerability; practical and financial support to commission interventions across the education system during the autumn and spring terms; and the delivery of a programme of activities for vulnerable young people. The VRU executive group is supporting member organisations to identify opportunities to improve approaches to community engagement and youth voice; alongside supporting youth engagement forums through a range of routes. The unit is delivering place-based support in seven communities across the region this year, layering initiatives from different organisations in order to reduce vulnerability. Each of these is steered by a committee which brings together community members and organisations that deliver services in those localities.

Universities

West Midlands Universities are balancing exiting lockdown in September to avoid a greater economic hit on the West Midlands Universities sector against the impact that young people moving into the region will have upon the system and perceptions in local places. The Universities are involved with the Midlands Engine funded Mental Health Productivity Pilot (MHPP), led

by Coventry University, and now includes looking at the impact that COVID-19 has had on small, medium and large enterprises. One of the workstreams of the MHPP project includes a large survey undertaken by Warwick University that looks at mental wellbeing of employers and employees.

WM-REDI and WMCA Office of Research & Data Analytics are focusing on the economic impacts of COVID-19 and concern around a recovery approach that favours big capital investment and does not result in local job creation, thus widening existing inequalities further. WM-REDI and ODA have been producing an on-going weekly economic monitor which includes the wider context of what is being seen in the West Midlands and reaches a wide audience. It focuses on the economic impact of sectors, furloughs, claimant count and consumer spend on low value jobs affecting young people and BAME populations . The State of Region Report which is being produced ties in with the impact of COVID-19 on health inequalities.

A call for evidence

This report has demonstrated how national and regional evidence indicates that the pandemic has widened existing inequalities in health in addition to creating new challenges. Feedback received through the PHE national community engagement exercise clearly and consistently emphasised the importance of explicitly considering ethnicity, racism and structural disadvantage in our responses to COVID-19 and tackling wider health inequalities.

The Regional Health Impact Group is working with partners and stakeholders across the region to build on this feedback and develop an approach to recovery from COVID-19 that takes into account the experiences, needs and priorities of our citizens.

As part of this process, the group is issuing a Call for Evidence. This will consolidate existing evidence, on-going research and analysis in relation to the health impact of COVID-19, particularly wider health inequalities and particular cohorts of the population from across the region.

It is important that the evidence used to inform the regional approach is representative of our communities, and that we recognise what has already been done to understand the impact

of COVID-19 in local areas. By consolidating existing evidence from across the region, we will be able to identify common themes as well as issues specific to localities. We will also be able to identify any gaps in the evidence and make plans to address them.

The Call for Evidence aims to hear from a wide range of public agencies involved in planning and delivering health and care services. From NHS trusts to local authorities to those on the frontline of primary care. The Group is also keen to hear from local services and community groups about community engagement activities carried out in relation to COVID-19 and its impacts. Finally, the Group hopes to hear from individuals who have additional thoughts or experiences they would like to share.

The evidence gathered will be reviewed and key themes will be drawn out, summarised and used to identify a set of priority areas for action. These will be fed back to contributors so that the priorities and concerns identified in communities are appropriately represented, and that there are opportunities to provide additional feedback before including in the final report.

Consultation questions

For individuals and households -

1. Is there anything you wish to share about your experiences of COVID-19 as an individual or household? We would especially like to hear about the services or support networks you have used, and what additional support you might find helpful.

For service providers/community groups:

2. How has COVID-19 affected your community? What have been the negative impacts and challenges? Are there any positives or opportunities we can build on?

For public agencies and other service providers:

3. What analysis have you carried out in relation to the impact of COVID-19 and its relationship with health inequalities? Do you have evidence of its disproportionate effect on BAME or other sections of the population?
4. Have you encountered any challenges or barriers in supporting service users and/or citizens and what have you done to try to overcome these?

5. Do you have any examples of good practice in making services or groups more accessible and/or inclusive during the pandemic?

6. How are you changing your approach / services / activities in order to tackle underlying health inequalities in the future and what changes / support do you need to achieve this effectively?

Please limit your responses to **no more than 2000 words**. We are particularly keen to receive any existing reports, presentations or to hear about on-going research and community engagement.

In addition, if you are holding any community engagement events or activities where you feel we may be able to have meaningful conversations about how COVID-19 has affected local communities, please let us know if we would be able to attend to listen or to facilitate a discussion.

The Call for Evidence closes on Monday 14 September 2020 and can be [submitted here](#).

If you are interested in contributing please contact Grace.Scrivens@phe.gov.uk or at 0121 232 9152 who will be able to provide you with more information.

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West Midlands
Combined Authority



Public Health
England

Protecting and improving the nation's health

Disparities in the risk and outcomes of COVID-19

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Executive summary

This is a descriptive review of data on disparities in the risk and outcomes from COVID-19. This review presents findings based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets. It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them. These results improve our understanding of the pandemic and will help in formulating the future public health response to it.

The largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity, but they do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.

When compared to previous years, we also found a particularly high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes. These analyses do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and could explain some of these differences.

When this data was analysed, the majority of testing had been offered to those in hospital with a medical need. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected. This is important because disparities between diagnoses rates may reflect differences in the risk of getting the infection, in presenting to hospital with a medical need and in the likelihood of being tested.

Some analyses outlined in this review are provisional and will continue to be improved. Further work is planned to obtain, link and analyse data that will complement these analyses.

The results of this review need to be widely discussed and considered by all those involved in and concerned with the national and local response to COVID-19. However, it is already clear that relevant guidance, certain aspects of recording and reporting of data, and key policies should be adapted to recognise and wherever possible mitigate or reduce the impact of COVID-19 on the population groups that are shown in this review to be more affected by the infection and its adverse outcomes.

As the numbers of new COVID-19 cases decrease, monitoring the infection among those most at risk will become increasingly important. It seems likely that it will be difficult to control the spread of COVID-19 unless these inequalities can be addressed.

Age and sex

COVID-19 diagnosis rates increased with age for both males and females. When compared to all cause mortality in previous years, deaths from COVID-19 have a slightly older age distribution, particularly for males.

Working age males diagnosed with COVID-19 were twice as likely to die as females. Among people with a positive test, when compared with those under 40, those who were 80 or older were seventy times more likely to die. These are the largest disparities found in this analysis and are consistent with what has been previously reported in the UK.

These disparities exist after taking ethnicity, deprivation and region into account, but they do not account for the effect of comorbidities or occupation, which may explain some of the differences.

Geography

The regional pattern in diagnoses rates and death rates in confirmed cases among males were similar. London had the highest rates followed by the North West, the North East and the West Midlands. The South West had the lowest. For females the North East and the North West had higher diagnosis rates than London, while London had the highest death rate.

Local authorities with the highest diagnoses and death rates are mostly urban. Death rates in London from COVID-19 were more than 3-times higher than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequalities in all cause mortality rates in previous years.

Deprivation

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.

High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes from COVID-19 infection in deprived areas remain after adjusting for age, sex, region and ethnicity, but the role of comorbidities requires further investigation.

Ethnicity

People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. This is the opposite of what is seen in previous years, when the mortality rates were lower in Asian and Black ethnic groups than White ethnic groups. Therefore, the disparity in COVID-19 mortality between ethnic groups is the opposite of that seen in previous years.

An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, shows that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced.

Occupation

A total of 10,841 COVID-19 cases were identified in nurses, midwives and nursing associates registered with the Nursing and Midwifery Council. Among those who are registered, this represents 4% of Asian ethnic groups, 3.1% of Other ethnic groups, 1.7% of White ethnic groups and 1.5% of both Black and Mixed ethnic groups. This analysis did not look at the possible reasons behind these differences, which may be driven by factors like geography or nature of individuals' roles.

ONS reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. Our analysis expands on this and shows that nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 to 2018. For many occupations, however, the number of deaths is too small to draw meaningful conclusions and further analysis will be required.

Inclusion health groups

When compared to previous years, there has been a larger increase in deaths among people born outside the UK and Ireland. The biggest relative increase was for people born in Central and Western Africa, the Caribbean, South East Asia, the Middle East and South and Eastern Africa. This may be one of the drivers behind the differences in mortality rates seen between ethnic groups.

There were 54 men and 13 women diagnosed with COVID-19 with no fixed abode, likely to be rough sleepers. We estimate that this represents 2% and 1.5% of the known population of women and men who experienced rough sleeping in 2019. Data is of poor quality, but this suggests a much higher diagnoses rate when compared to the general population.

People in care homes

Data from the Office for National Statistics (ONS) shows that deaths in care homes accounted for 27% of deaths from COVID-19 up to 8 May 2020. The number of deaths in care homes peaked later than those in hospital, in week ending 24 April.

Our analyses show that there have been 2.3 times the number of deaths in care homes than expected between 20 March and 7 May when compared to previous years, which equates to around 20,457 excess deaths. The number of COVID-19 deaths over this period is equivalent to 46.4% of the excess suggesting that there are many excess deaths from other causes or an under-reporting of deaths from COVID-19.

Comorbidities

Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This finding is consistent with other studies that have reported a higher risk of death from COVID-19 among patients with diabetes. This proportion was higher in all

BAME groups when compared to White ethnic groups and was 43% in the Asian group and 45% in the Black group. The same disparities were seen for hypertensive disease.

Several studies, although measuring the different outcomes from COVID-19, report an increased risk of adverse outcomes in obese or morbidly obese people.

Acknowledgements

All the analyses in this document were done by scientists working in the Epi cell, Surveillance cell and Health Intelligence team at Public Health England. A draft of this document was reviewed by the individuals and teams below, to whom we are extremely grateful:

- John Pullinger
- Professor Andrew Hayward
- Professor Keith Neal
- The Race Disparity Unit (Cabinet Office)
- PHE topic experts

1. Age and sex

1.1 Main messages

Diagnosis rates are higher among females under 60, and higher among males over 60. Despite making up 46% of diagnosed cases, men make up almost 60% of deaths from COVID-19 and 70% of admissions to intensive care units.

The rate of diagnosed cases increases with age, but the age profile is markedly different among those in critical care. The largest number of patients in critical care come from age groups between 50 and 70 for both males and females and only small numbers aged over 80.

When compared to all cause mortality in previous years, deaths from COVID-19 have a slightly older age distribution, particularly for males. Between the ages of 40 to 79, the age specific death rates from COVID-19 among males were around double the rates in females compared with 1.5 times for all cause mortality in previous years.

A survival analysis looked at people with a positive test, and those 80 or older, when compared with those under 40, were seventy times more likely to die. These are the largest disparities found in this analysis. Working age males diagnosed with COVID-19 were twice as likely to die as females.

The majority of excess deaths (75%) occurred in those aged 75 and over. COVID-19 deaths were equivalent to 80% of the excess in every age group, except the oldest age group where this proportion is lower. There have been fewer deaths than expected in children under 15 years of age.

These findings are consistent with what has been previously reported by ONS (1) and ICNARC (2).

1.2 Background

Male sex and increasing age are known factors associated with COVID-19-related mortality. This was apparent from early on in the pandemic among patients in Wuhan, China (3) and evidence has since accumulated from multiple other countries (4).

Data from the Intensive Care National Audit and Research Centre (ICNARC) has consistently reported that COVID-19 admissions to critical care are mostly among men, making up 71.0% of admissions reported as of 21 May (2). Similarly, ONS reported COVID-19 age-standardised mortality rate for males (781.9 deaths per 100,000) is

significantly higher than that for females (439.0 deaths per 100,000) (1). This difference in risk is also observed in the hospitalised population; data from 16,649 COVID-19 positive patients in 166 UK hospitals between February and April 2020 showed that even after controlling for age, comorbidities and obesity, female sex was associated with a reduced risk of death (HR=0.80 (95%CI 0.72-0.89)) compared to male sex (5).

COVID-19-related mortality rates reported by ONS also increase across age groups. For males the increase is significant from 35 to 39 years and above, and for females from 40 to 44 years and above (1). This increase in mortality by age is also observed among hospitalised patients; data from the same study of 16,649 COVID-19 positive patients showed that, even after adjusting for comorbidities, sex and obesity, the risk of dying among those over 80 was almost 14 times higher than those under 50 years old (5).

It is not yet fully clear what drives the differences in outcomes between males and females. Some could be driven by different risks of acquiring the infection – for example due to behavioural and occupational factors – and by differences in how women and men develop symptoms, access care and are diagnosed, or by biological and immune differences that put men at greater risk.

1.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

As of 13 May, there had been 63,661 cases in males (46.4%) and 73,529 cases in females (53.6%). Figure 1.1 shows the distribution of these cases by age groups and sex.

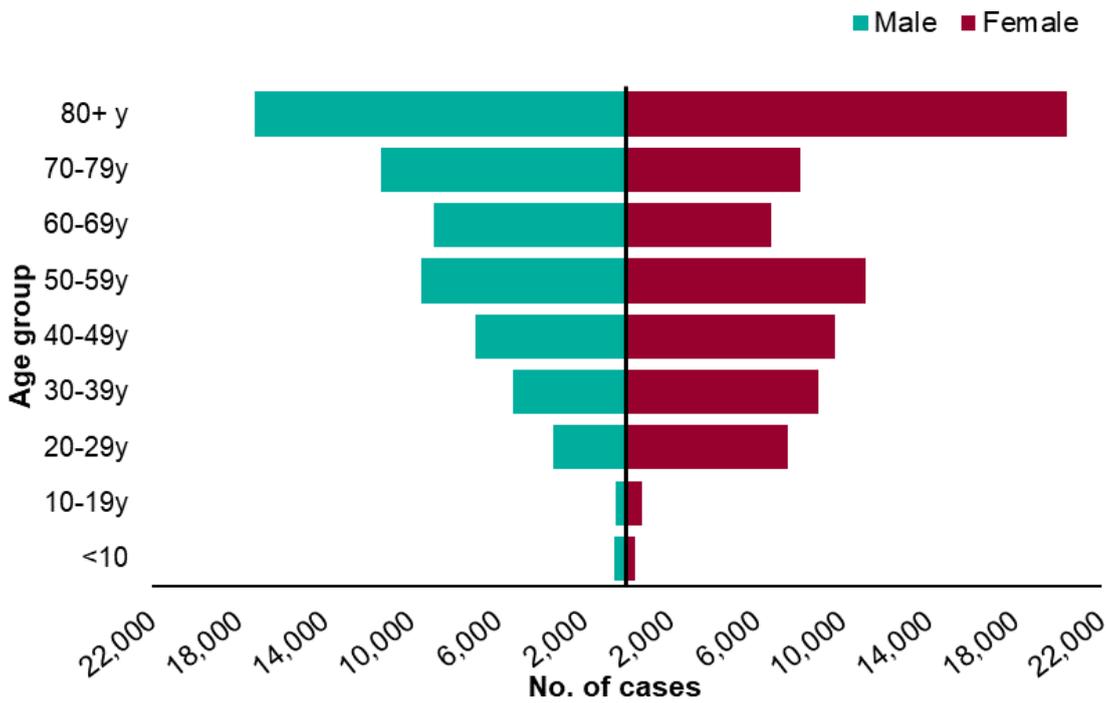


Figure 1.1. Age sex pyramid of laboratory confirmed COVID-19 cases as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

The age standardised diagnosis rates per 100,000 population were similar in males (256.0) and females (252.0). Among people under 60, diagnosis rates were higher in females than males, and among people aged 60 years and older, diagnosis rates were higher in males (Figure 1.2).

PHE has reported previously that among those who were tested, males were more likely to have a positive test (6). This may suggest that females were tested more often and possibly with milder disease. This could be a reflection of the higher number of females working in occupations that expose them to the infection and could explain higher diagnoses rates in working age females. Higher diagnosis rates among males over 60 may reflect worse clinical outcomes in this group.

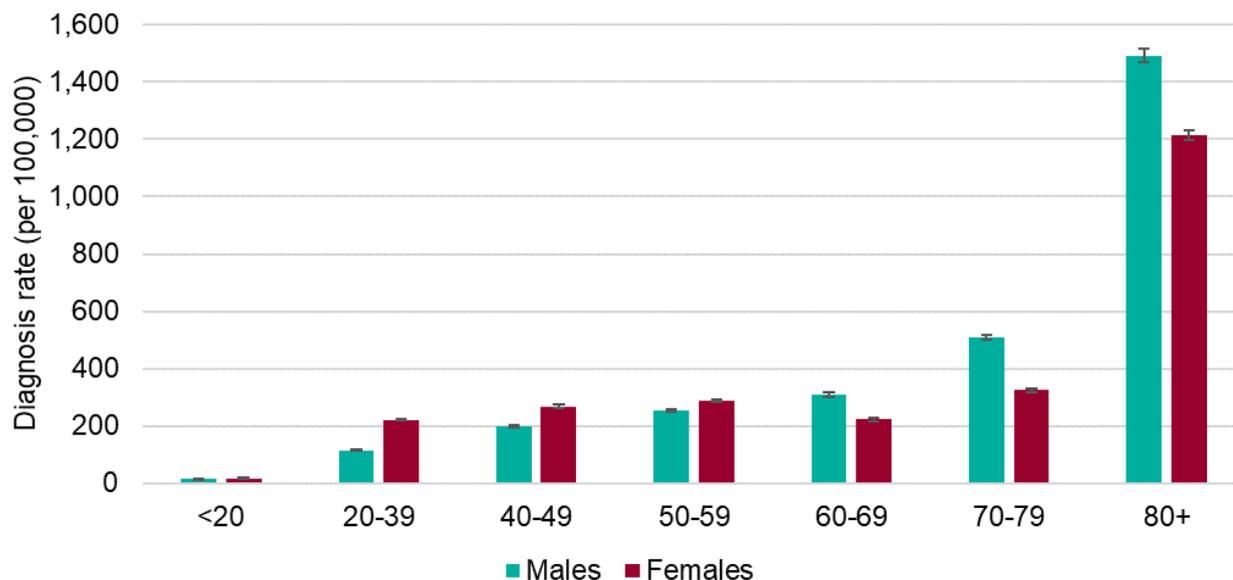


Figure 1.2. Diagnosis rates by sex and age as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

1.4 Hospitalisations

As of 19 of May, 42 trusts had reported lower level of care patients (defined as admission to any hospital ward, excluding intensive care units (ICU) or high dependency units (HDU)), and 94 trusts contributed ICU/HDU (critical care) patient data to the COVID-19 Hospitalisation in England Surveillance System (CHESS). Reporting varies by trusts and the majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the hospitalised cases. The data presented in this section have not been adjusted for this, which means findings must be interpreted with caution.

Figure 1.3 shows the age and sex distribution of COVID-19 confirmed cases in ‘lower level of care’ and in critical care. Males make up 54.4% of patients in lower level of care and 70.4% of patients in critical care.

For both sexes, the patient population is younger in critical care. Cases aged over 70 make up 65.5% and 67.6% of the patients in lower level of care among males and females, respectively; in critical care, those over 70 make up only 22.0% and 17.9% of the male and female patients, respectively. The overrepresentation of younger patients in critical care does not necessarily reflect increased severity in this group of patients alone but may also reflect critical care admission criteria.

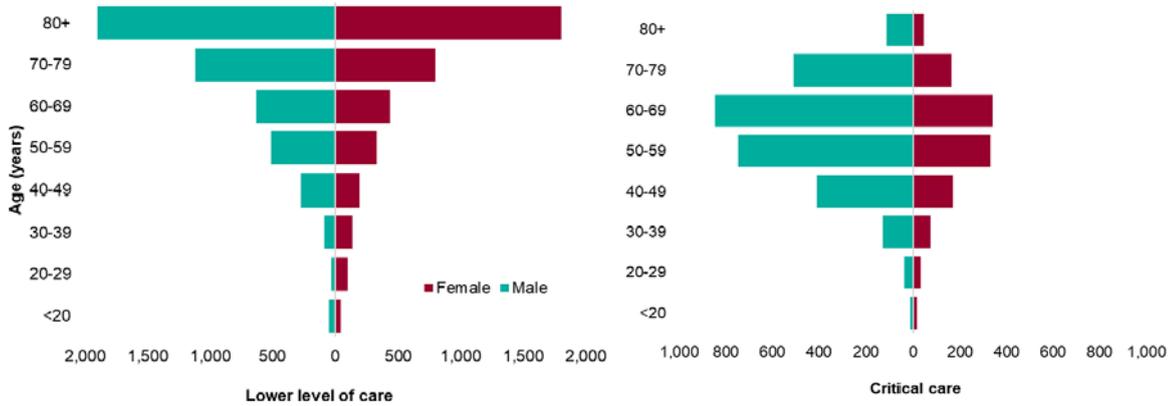


Figure 1.3. Age sex pyramids of admissions for laboratory confirmed COVID-19 to acute trusts, for lower level of care and critical care, as of 19 May 2020, England. Source: Public Health England COVID-19 Hospitalisations in England surveillance system (CHESS).

1.5 Deaths in confirmed cases

As of 13 May, there had been 17,598 deaths in confirmed cases among males (59.3%) and 12,075 in females (40.7%). 56.3% of deaths were among people 80 years and older. Figure 1.4 shows the distribution of deaths by age groups and sex.

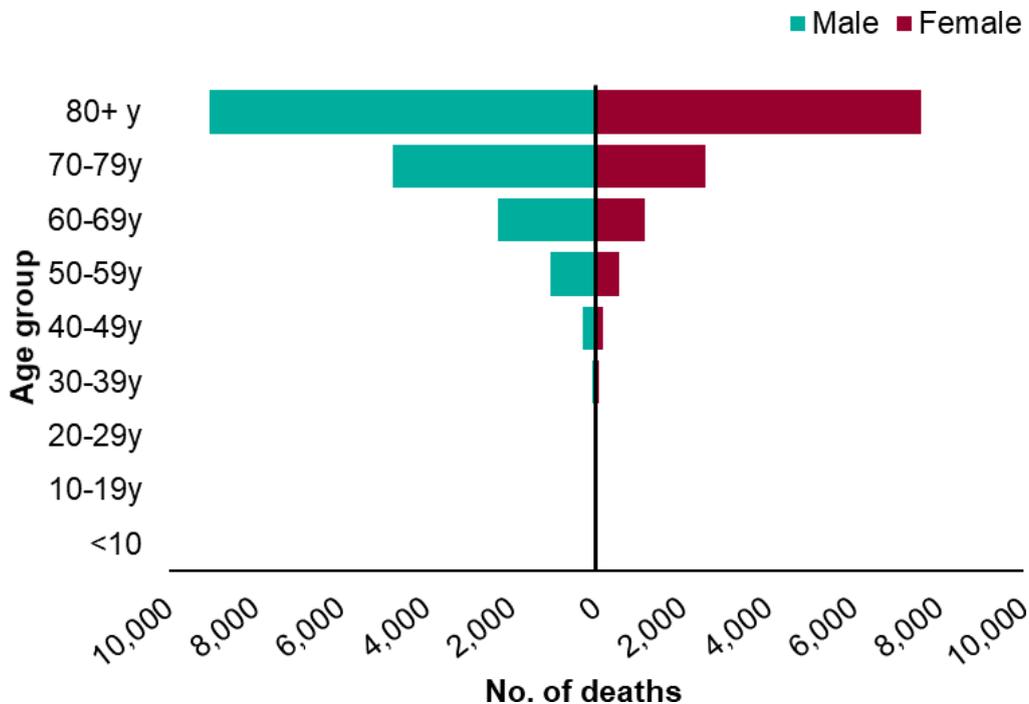


Figure 1.4. Age sex pyramid of laboratory confirmed COVID-19 deaths as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Overall, the mortality rates among confirmed cases per 100,000 population among males were 1.3 to 2.1 higher than among females for all age groups (Figure 1.5). Overall the age standardised mortality rate in males (76.1 per 100,000) was twice that of females (38.8 per 100,000).

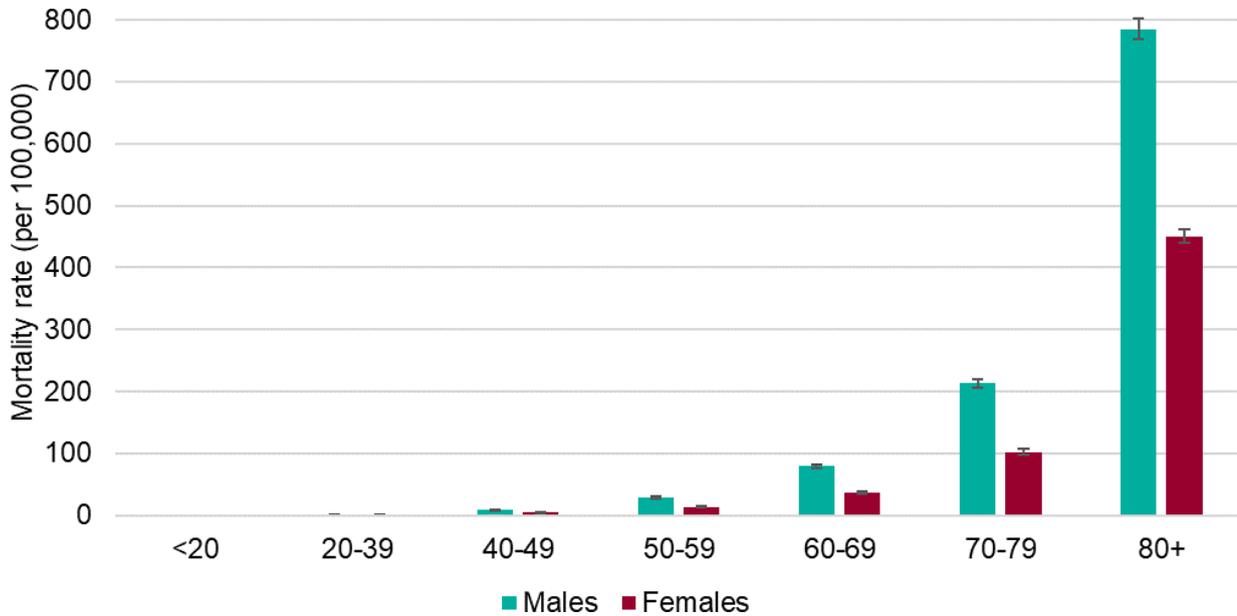


Figure 1.5. Crude mortality rates of laboratory confirmed COVID-19 deaths per 100,000 population by age group and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

An analysis of survival among people with confirmed COVID-19 adjusted for sex, ethnicity, deprivation and region, shows that, compared with people under 40, the probability of death was about 3-times higher among those aged 40 to 49, 9-times higher among those aged 50 to 59, 26 times higher among those aged 60 to 69, 50 times higher among those aged 70 to 79 and 70 times higher among those aged 80 and over. These are the largest disparities by far found in this analysis (Appendix A, table A1).

This analysis also showed that working age males diagnosed with COVID-19 were twice as likely to die than females (Appendix A, table A2). For older adults (65 and over) the disparity remains significant but is much lower, with males in this age group having approximately 50% higher risk of death when compared to females (Appendix A, table A3).

1.6 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates from COVID-19 between 21 March and 8 May 2020 with

inequalities in all cause death rates for previous years (the 'baseline all cause' figure). COVID-19 deaths in this section include all those where COVID-19 was mentioned on the death certificate. These can include cases where the doctor thought it likely that the person had COVID-19, even when there was no positive test result. The deaths reported by ONS will include deaths that are not included in the 'deaths in confirmed cases' because they did not have a positive test result confirmed by a PHE or NHS laboratory, and may not include all 'deaths in confirmed cases'.

There were 35,425 deaths registered between 21 March and 8 May 2020 that mentioned COVID-19 on the death certificate. This is equivalent to 31% of all deaths over this period.

Males accounted for 57% of deaths from COVID-19 and females 43%, while the baseline all cause figures were 49% and 51%. This indicates that males make up a larger percentage of COVID-19 deaths than all causes.

Among males, 54% of COVID-19 deaths were in those aged 80+ compared with 67% of deaths among females. This compares with 48% and 64% for the baseline all cause deaths respectively. 8% of deaths from COVID-19 among males were in those under 60 years of age compared with 6% of females. This compares with 13% and 8% for baseline all cause deaths respectively.

Figures 1.6A and 1.6B show age specific mortality rates for all causes of death and for deaths mentioning COVID-19 between 21 March 2020 and 8 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018.

Between the ages of 40 to 79, the age specific death rates among males were around double the rates in females, compared with 1.5 times for baseline all causes (Figure 1.6A and 1.6B).

Age specific death rates from COVID-19 increase with age and were highest in those aged 80+ where they were 4.0 times higher than in those aged 70 to 79 in males and 5.1 times higher in females. This ratio is slightly higher than the baseline all cause data for 2014 to 2018 (3.7 and 4.8 in males and females respectively) (Figure 1.6A and 1.6B). Deaths from COVID-19 have a slightly older age distribution than baseline all cause deaths, particularly for males.

The age and sex distribution of ONS deaths from COVID-19 and deaths in confirmed cases were also broadly similar, but ONS deaths had a slightly higher proportion in older ages.

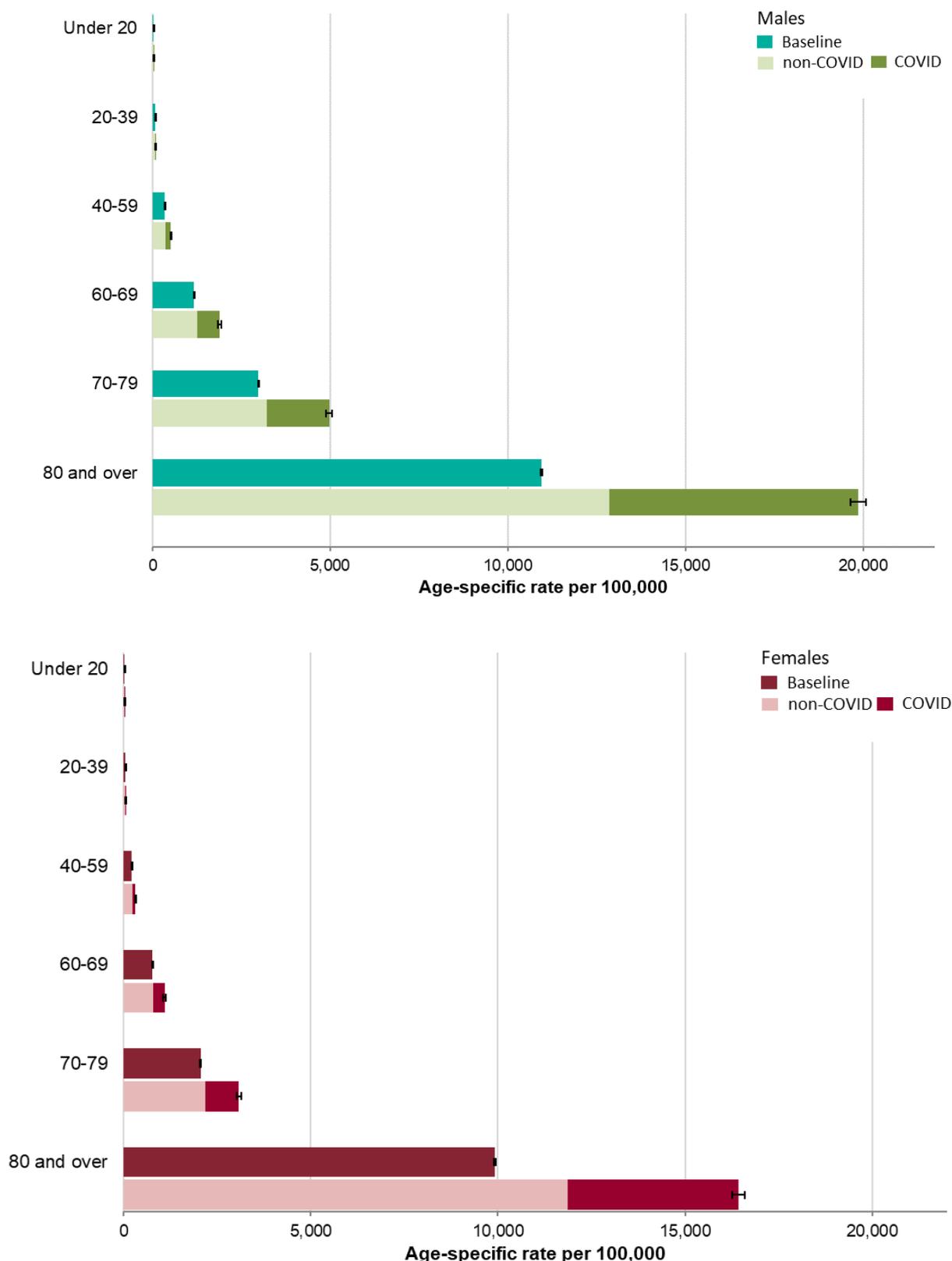


Figure 1.6A and 1.6B. Age specific death rates for all cause deaths and deaths mentioning COVID-19, compared with baseline, by sex, 21 March to 8 May 2020, England. Source: Public Health England analysis of ONS death registration data

1.7 Excess mortality

PHE has developed a model to estimate all cause excess mortality in the population. Figure 1.7 shows the number of excess deaths by age and sex in the period 20 March to 7 May against the number of deaths that would be expected for corresponding dates in 2015 to 2019. It also illustrates how many deaths have COVID-19 mentioned on the death certificate.

The model suggests there have been 46,056 excess deaths between 20 March 2020 and 7 May 2020, 24,731 in males and 21,324 in females. This is similar to the number of excess deaths reported by ONS for England and Wales up until 8 May 2020 (7). ONS compared deaths in 2020 with the simple average for the years 2015 to 2019. However, this will not adjust for ageing of the population or the effect of Easter or bank holidays on the number of deaths registered. The PHE model does adjust for this. More details are provided in the data sources and methodologies section.

The majority of excess deaths have occurred in those aged 75 and over, with 20,841 (45%) in those aged 85+ and 13,921 (30%) in those aged 75 to 84.

There have been fewer deaths than expected in children under 15 years of age. Accidents are a leading cause of death in children and these may have reduced over this period, following social distancing measures, or there could be a delay in the registration of these deaths. Among those age groups where there were excess deaths, the number of deaths with COVID-19 mentioned on the death certificate is equivalent to more than 80% of all excess deaths in each age group, except those aged 85+ where this proportion is lower.

Disparities in the risk and outcomes from COVID-19

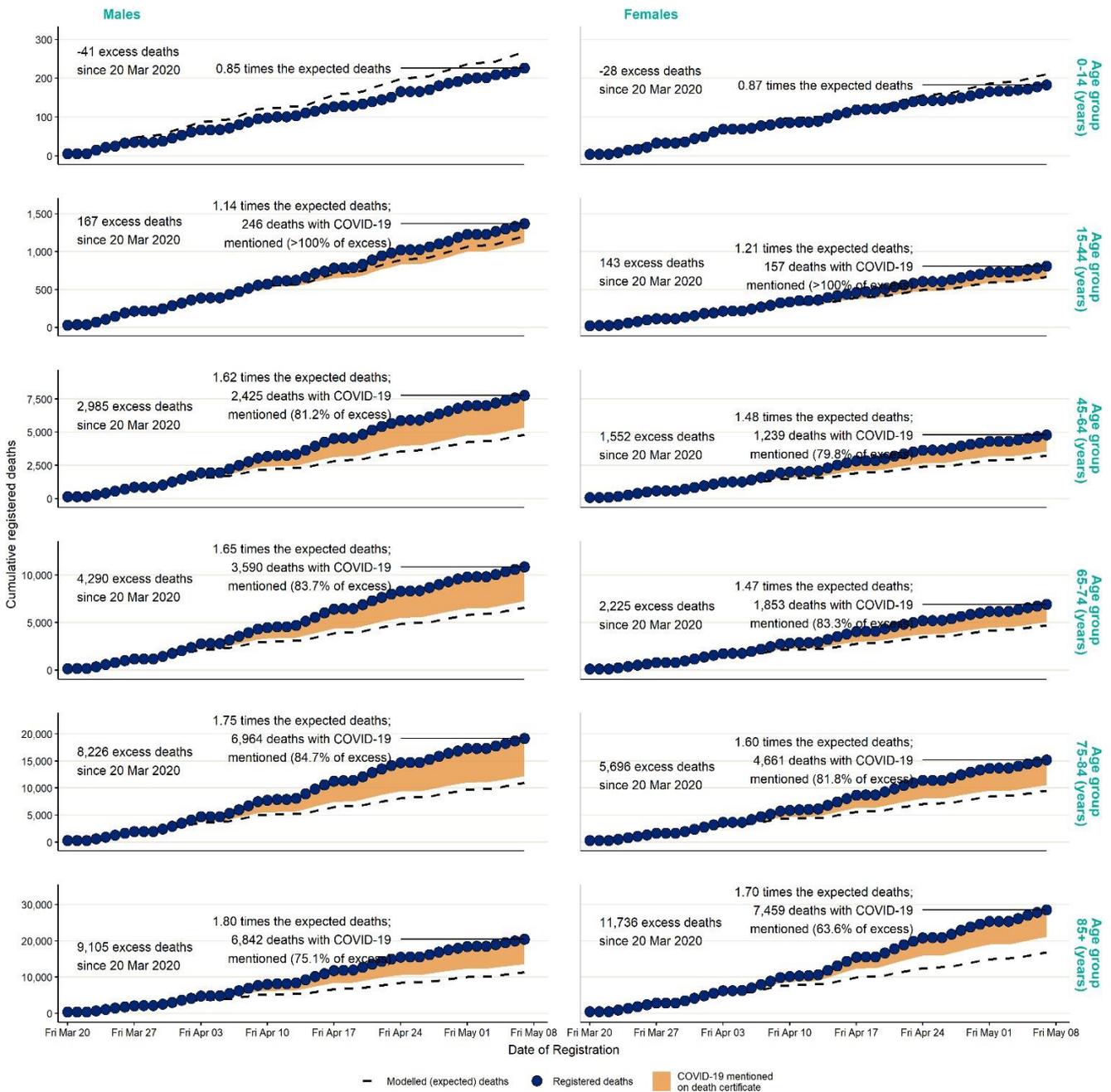


Figure 1.7. Cumulative all cause deaths by date of registration by age and sex, 20 March to 7 May 2020, England. Source: Public Health England excess mortality model based on ONS death registration data.

2. Geography

2.1 Main messages

At 13 May 2020, the regional pattern in diagnosis rates and death rates in confirmed cases among males were similar. London had the highest rates followed by the North West, the North East and the West Midlands. The South West had the lowest.

For females the North East and the North West had higher diagnosis rates than London while London had the highest death rate in confirmed cases.

Diagnosis rates by local authority were highly clustered. Authorities, which are mostly urban, in London, the North West, the West Midlands and the North East had the highest rates. A similar geographic pattern is seen for death rates.

The peak in the number of diagnosed cases happened first in London, the East Midlands and the West Midlands in week ending 4 April. Diagnosed cases peaked latest in South East and Yorkshire and Humber in week ending 18 April. The number of deaths in confirmed cases peaked in week ending 11 April in all regions except North West and Yorkshire and Humber, where it peaked in week ending 18 April.

Death rates in London from COVID-19 were more than 3-times higher than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequality between all cause mortality rates in previous years.

The excess mortality model suggests there have been 9,035 excess deaths in London between 20 March and 7 May, compared with 2,900 in the South West.

2.2 Background

The burden of disease and mortality from COVID-19 is not evenly spread in the population. The UK coronavirus dashboard (8) presents data on the number of cases and deaths in people who have tested positive for SARS-CoV-2 and shows considerable variation in the number of cases by region across the UK. As at 21 May 2020, the number of cases was highest in London and lowest in the South West. The PHE weekly COVID-19 surveillance report as at 13 May 2020 shows the North East and North West regions to have the highest diagnosis rates per 100,000 population, however, London had the highest crude mortality rate in confirmed cases (6).

ONS analysis shows that between 1 March and 17 April 2020, local authorities in London had the highest mortality rates from COVID-19 in England when the age structure of the population was taken into account (9).

Findings from other studies have demonstrated that people living in urban areas versus rural areas have increased odds of testing positive for COVID-19 (10). At the local authority level in England, population density, deprivation and other factors associated with urban areas such as an ethnically diverse population may also be associated with higher mortality from COVID-19 (11).

2.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

Data reported to PHE up to 13 May 2020 shows that London had the highest number of diagnosed cases (26,024) and the South West the lowest (7,155) and that there was considerable variation among local authorities in England (Table 2a in the data pack).

The highest weekly number of diagnosed cases was reported in week ending 4 April in the East Midlands, London and West Midlands; in week ending 11 April in the East of England, North East, North West and South West; and in week ending 18 April in the South East and Yorkshire and Humber (Figure 2.1).

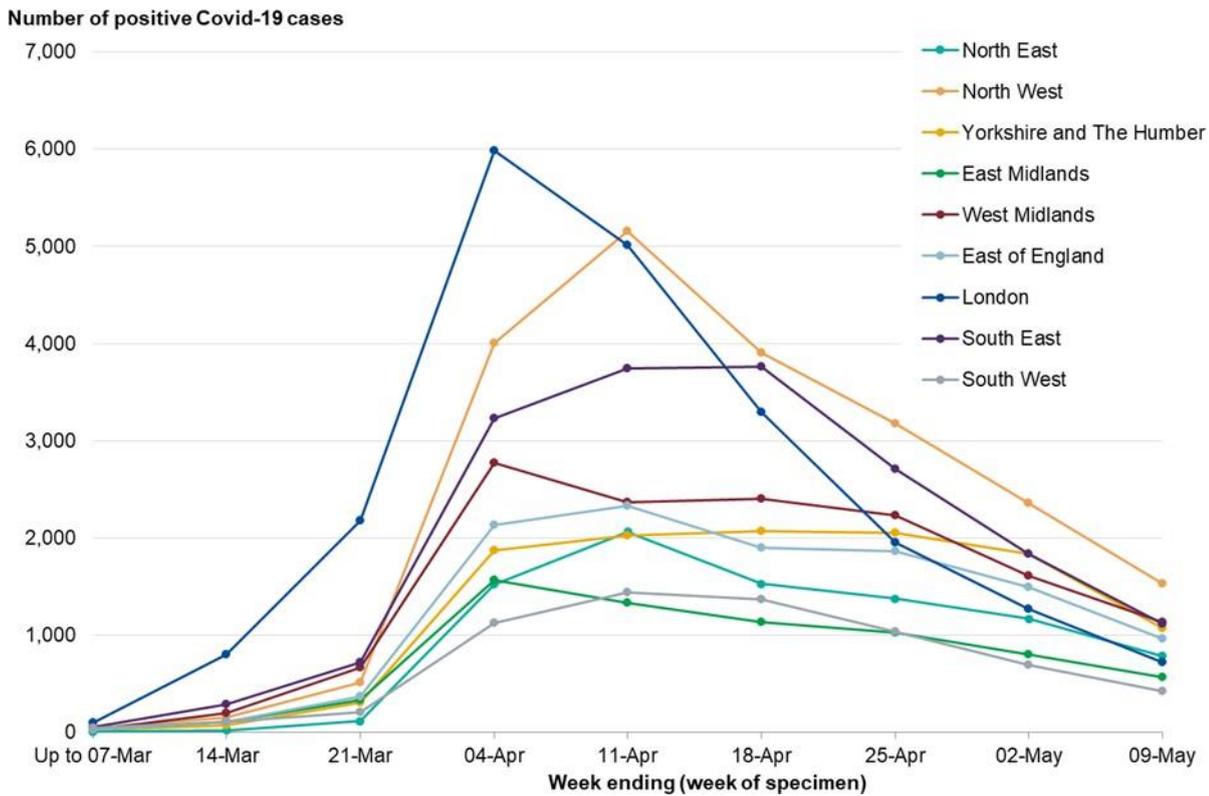


Figure 2.1. Number of positive cases by week by region, as of 9 May 2020, England. Source: Public Health England Second Generation Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The age standardised diagnosis rates (which are adjusted for the population size of the areas and to account for the difference in their age structure) were highest in London (423.9 per 100,000 population) followed by the North West (307.7) and the North East (294.7) for males. For females the rate was highest in the North East (405.0) followed by the North West (335.3) and London (318.5) (Figure 2.2). The South West region had the lowest standardised diagnosis rate for both males and females.

In the North East, North West, Yorkshire and the Humber, and the South East the female diagnosis rates were higher than males, whereas in the East Midlands, East of England and London the opposite was true. In England as a whole the rates were broadly similar for males and females.

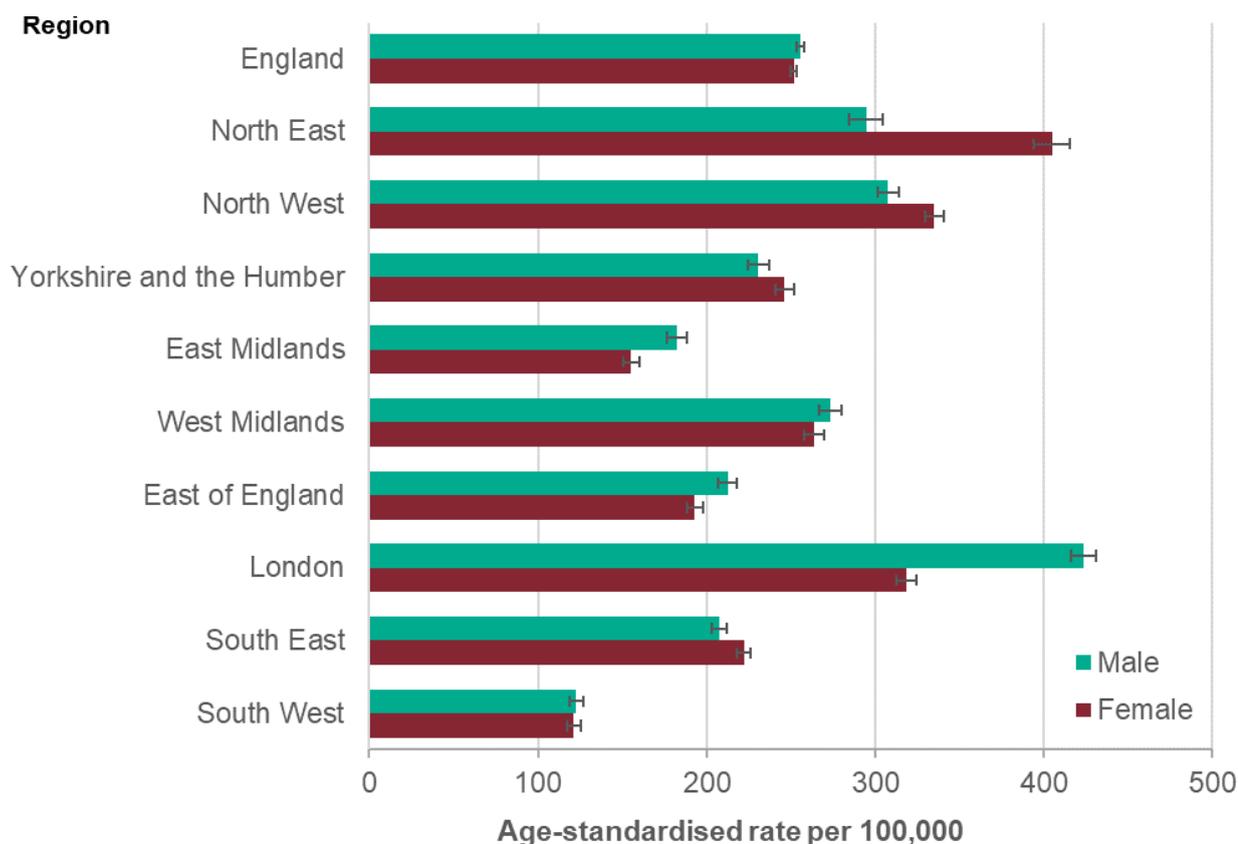
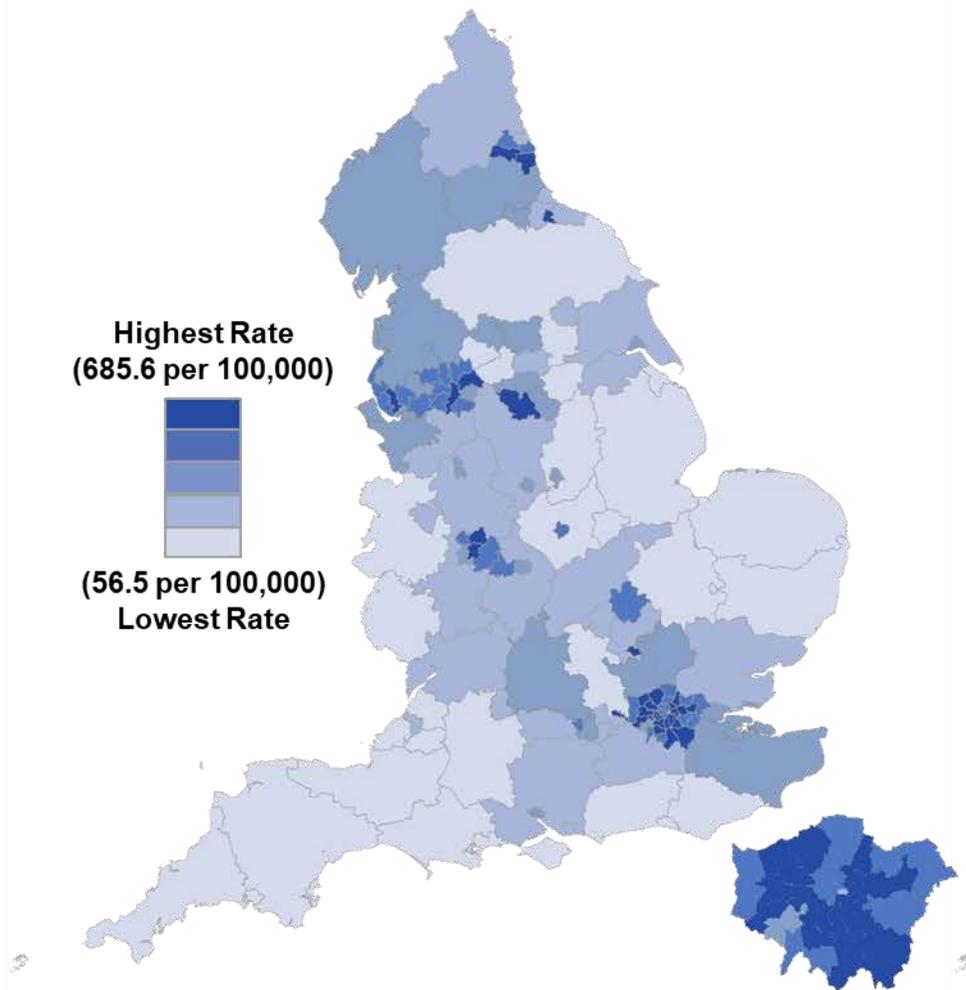


Figure 2.2. Age standardised diagnosis rates by region and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

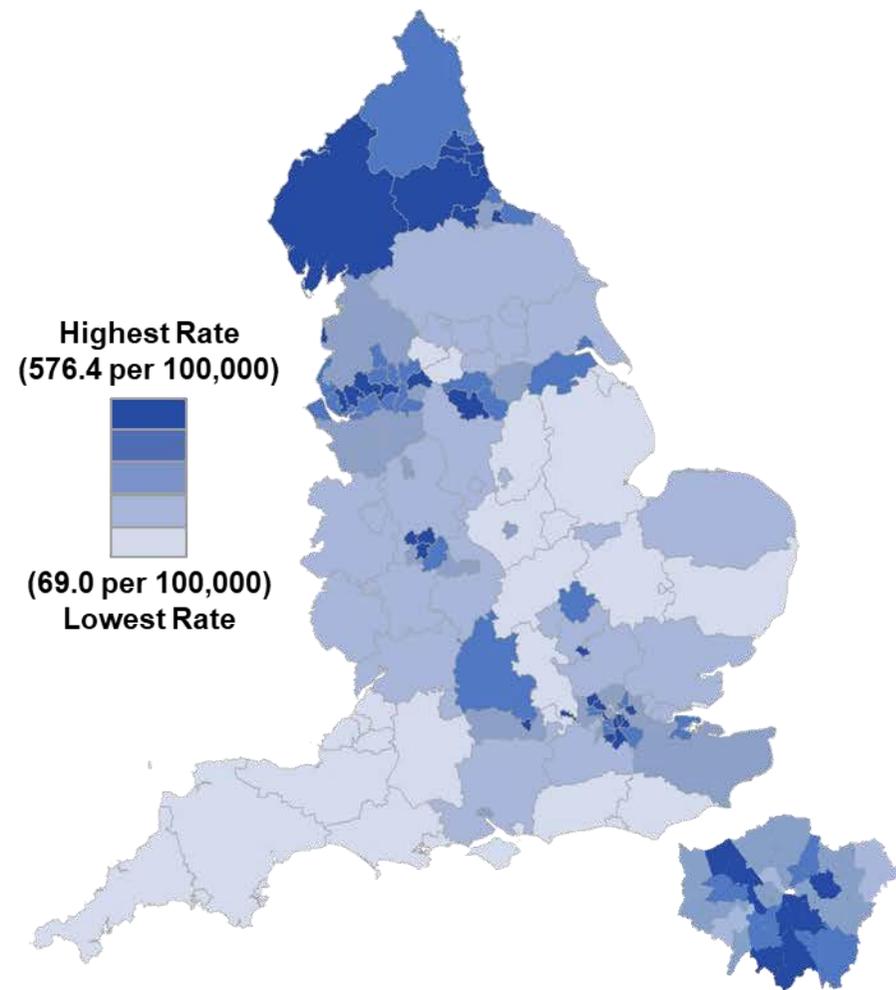
Maps 2.1A and 2.1B show age standardised diagnosis rates by upper-tier local authority in England. Among males there is a 12-fold difference in the rates between local authorities and an 8-fold difference in the rates among females. Variation in diagnosis rates will be partly influenced by variation in testing practices between areas.

The maps show diagnosis rates are highly clustered. Authorities which are mostly urban areas, in London, the North West, the West Midlands and the North East had the highest rates. For males, the ten local authorities with the highest diagnosis rates are in London. For females, Cumbria has the sixth highest rate which is a predominately rural area in the North West. These data are also presented in the data pack in Table 2a.

Males



Females



Map 2.1A and 2.1B. Age standardised diagnosis rates by local authority and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

2.4 Hospitalisations

This section presents data reported to the COVID-19 Hospitalisations in England surveillance system (CHES). Reporting varies by trusts and the majority of trusts in London do not consistently report to CHES which will impact on the representativeness of the hospitalised cases. Therefore, rather than providing number of hospitalised patients, daily rates are reported in this section and are analysed using the reporting trusts' catchment area population (rather than regional population denominator) to account for this issue.

Figure 2.3 shows the 3 day moving average rate of hospital admissions to all levels of care (critical and lower level of care) for laboratory confirmed COVID-19 between 15 March and 19 May 2020 by NHS region. The highest rate of hospital admissions occurred between 3 and 9 of April for all regions.

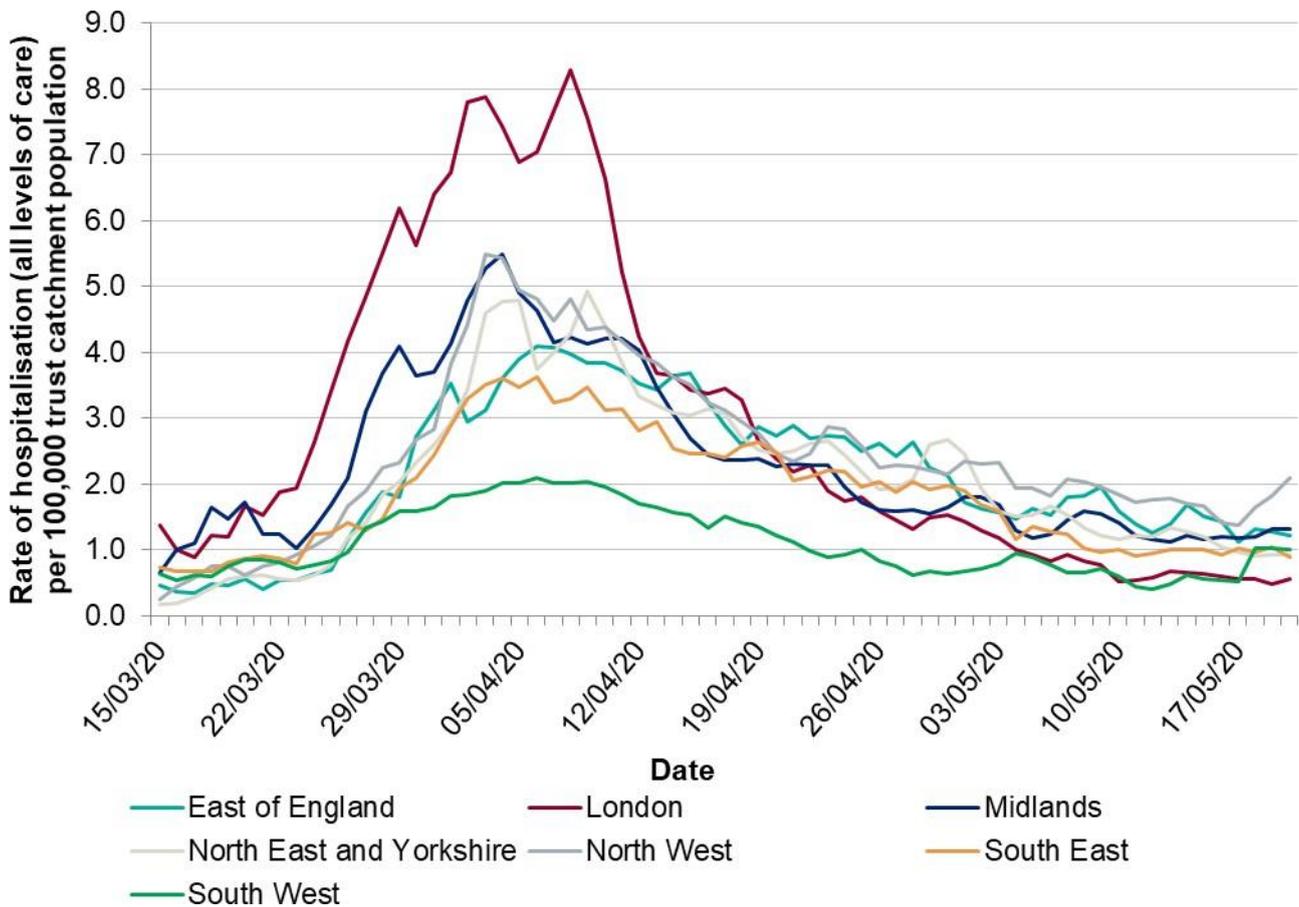


Figure 2.3. 3-day moving average rate of hospital admission to all levels of care for laboratory confirmed COVID-19, by NHS region, as of 19 May 2020, England. Source: Public Health England COVID-19 Hospitalisations in England surveillance system (CHES).

2.5 Deaths in confirmed cases

The trend in the number of deaths in confirmed cases by week in each region shows that London had the highest number of deaths every week up until week ending 18 April after which the North West had the highest number of deaths. The highest weekly number of deaths in confirmed cases was reported in week ending 11 April in all regions except the North West and Yorkshire and Humber, where it was reported in week ending 18 April (Figure 2.4).

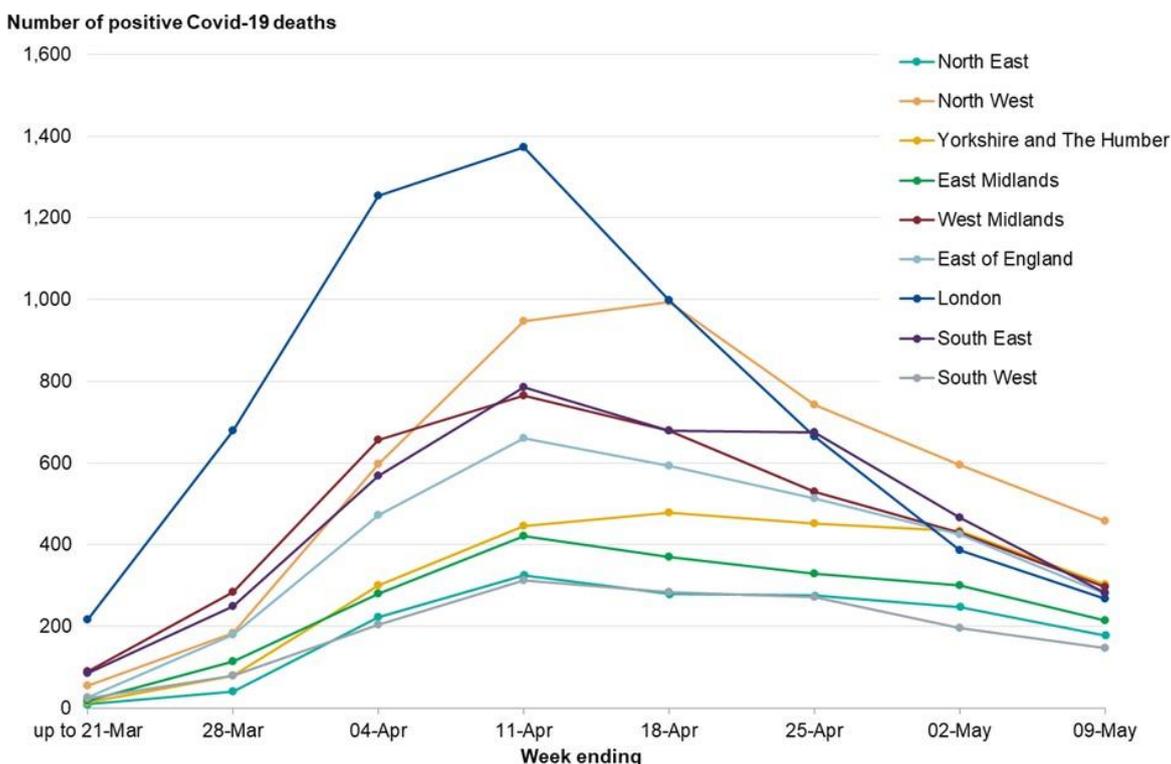


Figure 2.4. Number of deaths in laboratory confirmed COVID-19 cases by region and week, as of 9 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System. Note: The last week of data was removed as it was an incomplete week.

Up to 13 May 2020, the age standardised death rate among confirmed cases, per 100,000 population, was highest in London for both males (140.3) and females (66.8) (Figure 2.5) and were also high in the North East, North West and West Midlands. The South West had the lowest standardised death rate among confirmed cases for both males and females. In all regions the death rate in males was higher than females.

Among males, the regional pattern in diagnoses rates and death rates in confirmed cases were similar. However, for females the North East and the North West had the highest diagnosis rates while London had the highest death rate in confirmed cases. This may be explained by different testing strategies and capacity at different times of the pandemic.

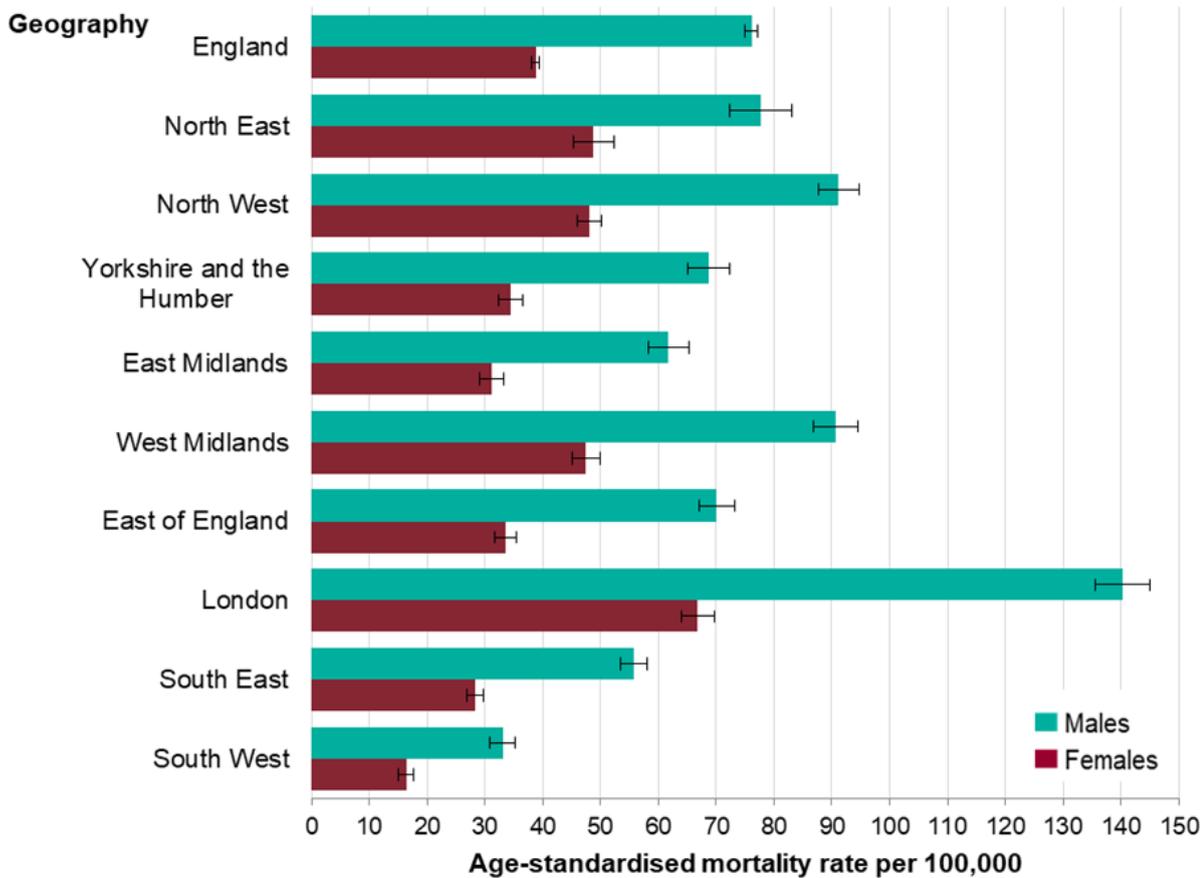
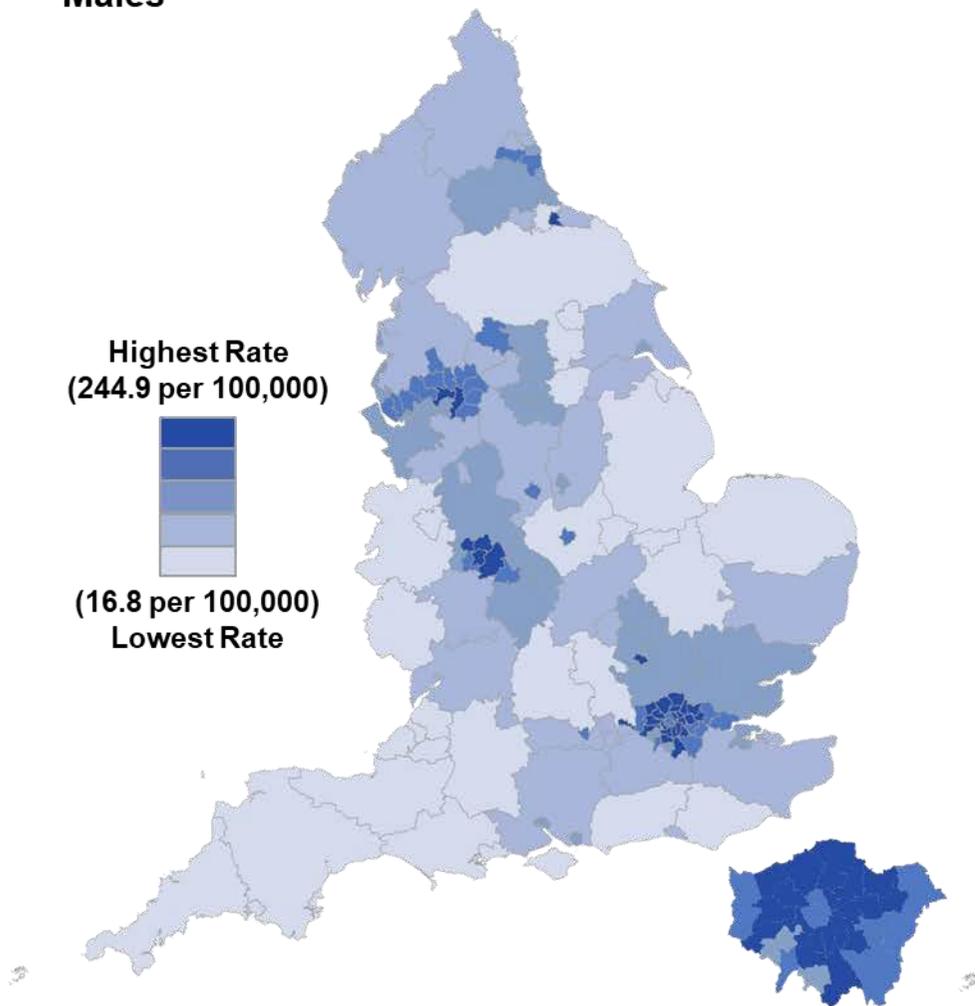


Figure 2.5. Age standardised death rates in laboratory confirmed COVID-19 cases, per 100,000 population, by region and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

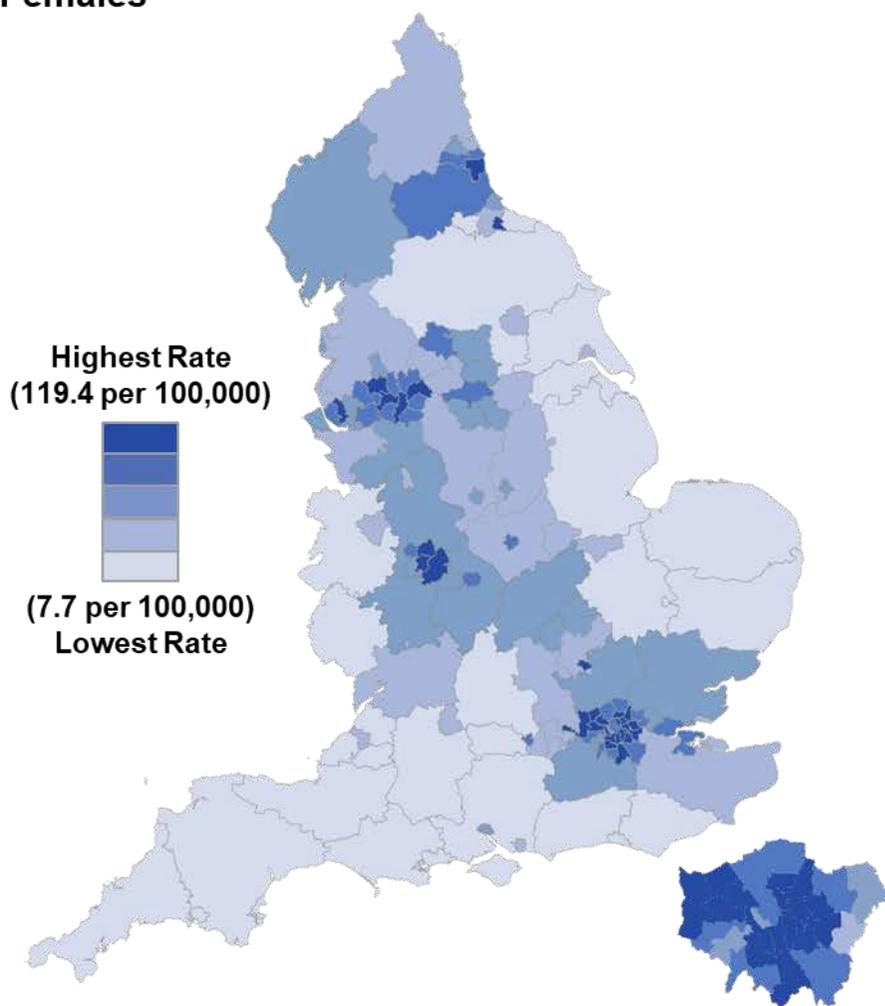
Maps 2.2A and 2.2B show age standardised death rates among confirmed cases, per 100,000 population, by upper-tier local authority in England. The maps show that death rates were highly clustered. Authorities, which are largely urban areas, in London, the North West, the West Midlands and the North East had the highest death rates. For males, the 8 authorities with the highest death rates among confirmed cases are in London. (Table 2b in the data pack).

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, showed that among people of working age (aged 20 to 64) those living outside of London had a slightly lower risk of death, except for East Midlands and the East of England where the risk was similar. In older ages (65 and over) people living in the North East had a slightly lower risk of death while those in the East of England a higher risk of death compared with London. (Appendix A, tables A2 and A3). However, the magnitude of these inequalities was not as great as that seen for population based death rates for confirmed cases.

Males



Females

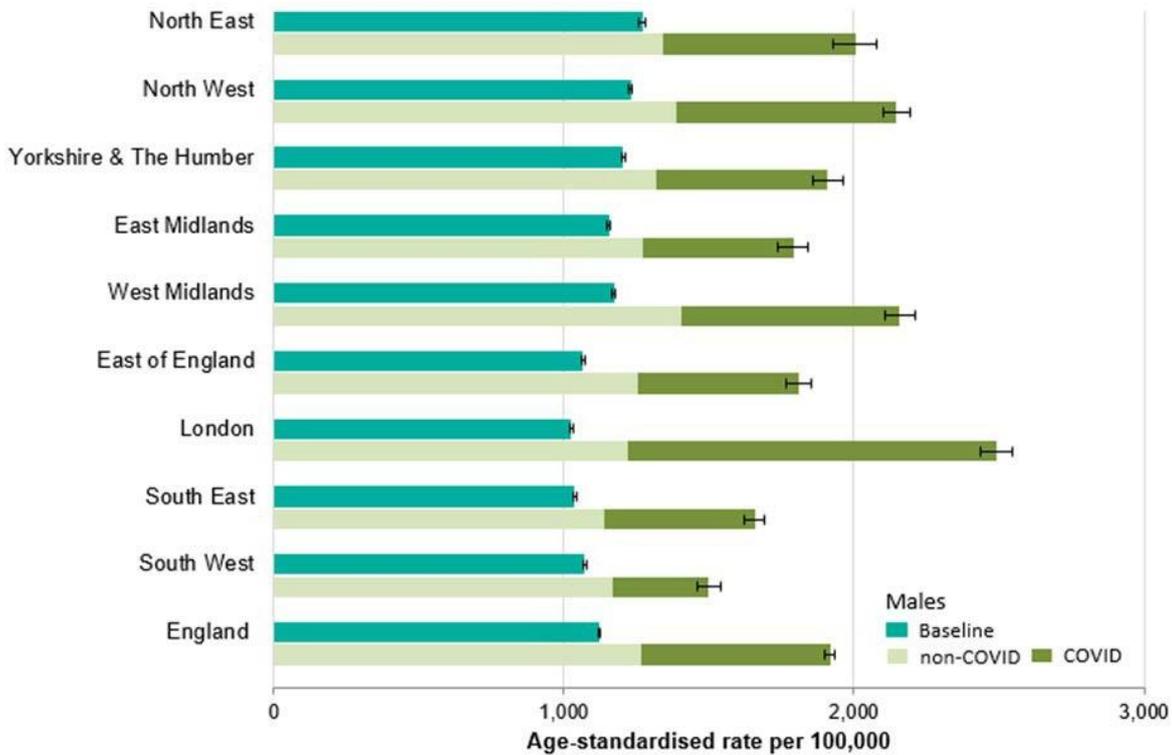


Map 2.2A and 2.2B. Age standardised death rates in laboratory confirmed COVID-19 cases, per 100,000 population, by local authority and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

2.6 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates from COVID-19 between 21 March and 8 May 2020 with inequalities in all cause death rates for previous years (the ‘baseline all cause’ figure).

Figures 2.6A and 2.6B show age standardised mortality rates for all causes of death and for deaths mentioning COVID-19 by region between 21 March 2020 and 8 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018. The same information is presented by local authority in Table 2c in the data pack.



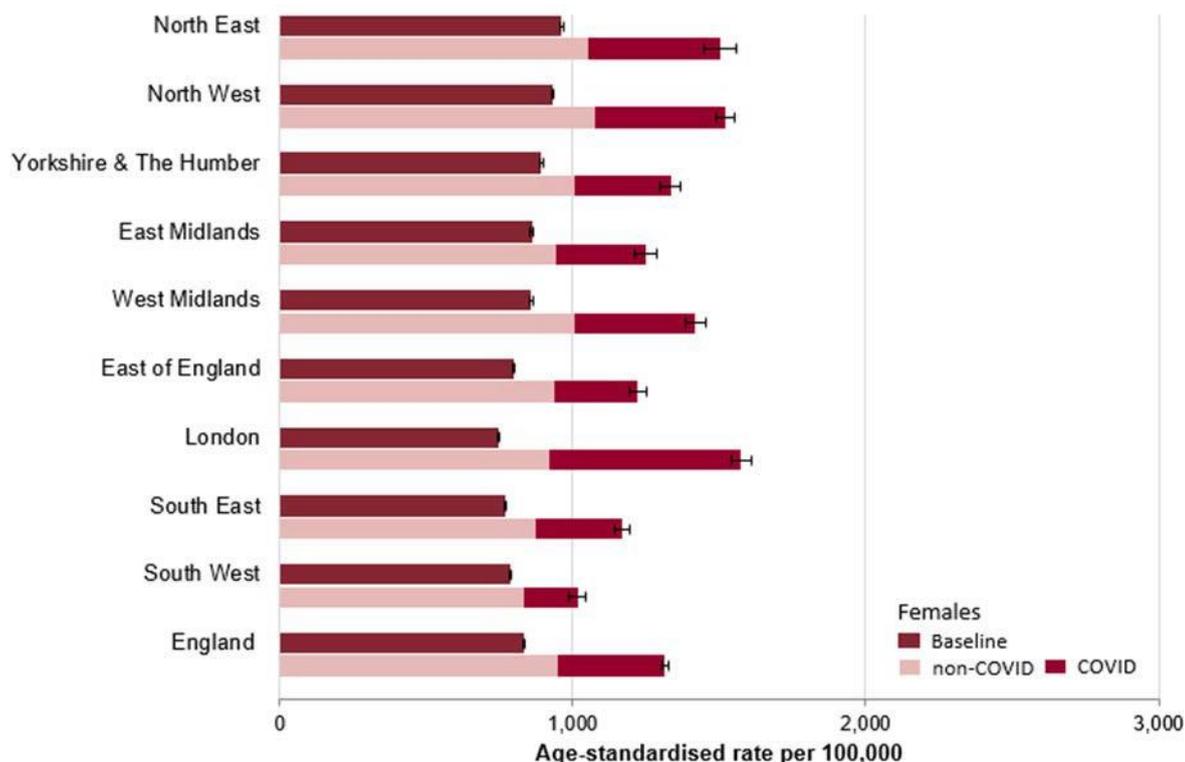


Figure 2.6A and 2.6B. Age standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 8 May 2020, compared with baseline mortality rates (2014 to 2018), by region and sex, England. Source: PHE analysis of ONS death registration data

The age standardised death rates from COVID-19 were highest in London for both males and females but were lowest in the South West (Figure 2.6A and 2.6B). This is consistent with the pattern seen for deaths in confirmed cases. The ratio of these rates for males was 3.8 and for females 3.5, indicating that mortality in London from COVID-19 was more than 3-times higher than the South West.

The baseline all cause mortality rates were highest in the North East and were 1.2 times higher in males and 1.3 times higher in females than London, the region with the lowest rates. Therefore, regional inequalities in COVID-19 mortality are greater than those seen previously for all cause mortality and the geographic gradient is different. London had the highest COVID-19 mortality rates, but the lowest baseline all cause mortality rates.

2.7 Excess mortality

PHE has developed a model to estimate all cause excess mortality in the population. Table 2.1 shows results from the excess mortality model and includes the number of excess deaths by sex and region in the period 20 March to 7 May against the number of

deaths that would be expected for corresponding dates in 2015 to 2019. It also highlights how many deaths have COVID-19 mentioned on the death certificate.

Overall the model suggests deaths in London have been 2.3 times higher than expected in this period, compared with 1.4 times higher in the South West.

Table 2.1. Cumulative all cause deaths by date of registration and region, 20 March to 7 May 2020 England. Source: Public Health England excess mortality model based on ONS death registration data

	Observed deaths	Expected deaths	Ratio observed/expected	Excess deaths	COVID-19 deaths	COVID-19 deaths as % excess
North East	6196	3932	1.6	2264	1906	84.2%
North West	17133	10050	1.7	7083	5460	77.1%
Yorkshire and The Humber	11346	7321	1.5	4025	3086	76.7%
East Midlands	9659	6394	1.5	3265	2531	77.5%
West Midlands	13548	7731	1.8	5817	4293	73.8%
East of England	13170	8133	1.6	5037	3513	69.7%
London	16073	7038	2.3	9035	7383	81.7%
South East	18205	11575	1.6	6630	5079	76.6%
South West	10939	8039	1.4	2900	2188	75.4%
Total	116269	70213	1.7	46056	35439	76.9%

3. Deprivation

3.1 Main messages

The trend in the number of diagnosed cases by deprivation quintile shows that cases in the least deprived group peaked earlier and lower than other groups and at 13 May, the cumulative number of cases and diagnosis rate was highest in the most deprived quintile.

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 ratio for all cause mortality between 2014 to 2018 indicating greater inequality in death rates from COVID-19 than all causes.

Survival among confirmed cases, after adjusting for sex, age group, ethnicity and region was lower in the most deprived areas, particularly among those of working age where the risk of death was almost double the least deprived areas.

In summary, people in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas. High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation.

3.2 Background

Evidence from previous analysis suggests that there is some association between area based deprivation levels and incidence and mortality from COVID-19. However, this may be weaker once other factors such as ethnicity are taken into consideration (11) (12).

Deprivation is classified using the Index of Multiple Deprivation and encompasses a wide range of aspects of an individual's living conditions including income, employment, education, health, crime, housing and the living environment (13). Deprived areas can be found in both urban and rural areas of England.

ONS analysis shows that between 1 March and 17 April 2020 the deprived areas in England had more than double the mortality rate from COVID-19 than the least deprived areas (9). Other sources have shown that people living in more deprived areas were more likely to test positive for COVID-19 (10) and to have higher mortality rates (14).

The latest report from the Intensive Care National Audit and Research Centre (ICNARC) used data up to 21 May 2020 and showed that a larger proportion of patients critically ill in intensive care units (ICU) with COVID-19 were from the most deprived quintile of areas (25.0%) than the least deprived (14.7%), however, this pattern was similar to the pattern seen previously among patients admitted for viral pneumonia between 2017 and 2019 (2). Patient outcomes from COVID-19 across deprivation categories were similar.

3.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

The trend in the number of diagnosed cases by deprivation quintile shows that cases in the least deprived group (quintile 5) peaked earlier and lower than other groups (Figure 3.1). As of 13 May the cumulative number of cases was highest in the most deprived quintile (quintile 1). Deprivation quintiles are roughly equal in population size and are defined in section 10.

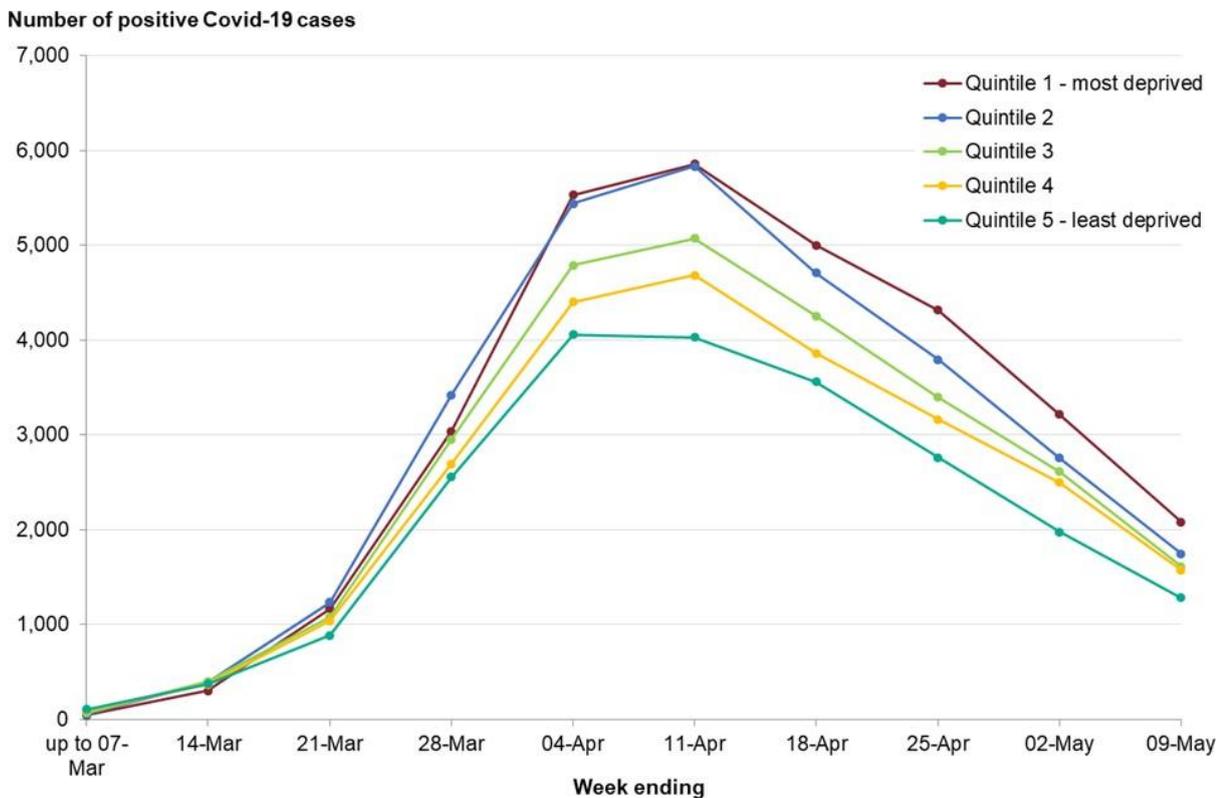


Figure 3.1. Number of positive confirmed cases by deprivation quintile and week, as of 9 May 2020, England. Source: Public Health England Second Generation Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The age standardised diagnosis rates were highest in the most deprived quintile in both males and females, and lowest in the least deprived quintile. The rate in the most deprived quintile was 1.9 times the rate in the least deprived quintile among males and 1.7 times among females. In quintiles 1 and 2 (the most deprived) the male diagnosis rates were significantly higher than females, whereas in all other quintiles the rates in the sexes were very similar (Figure 3.2).

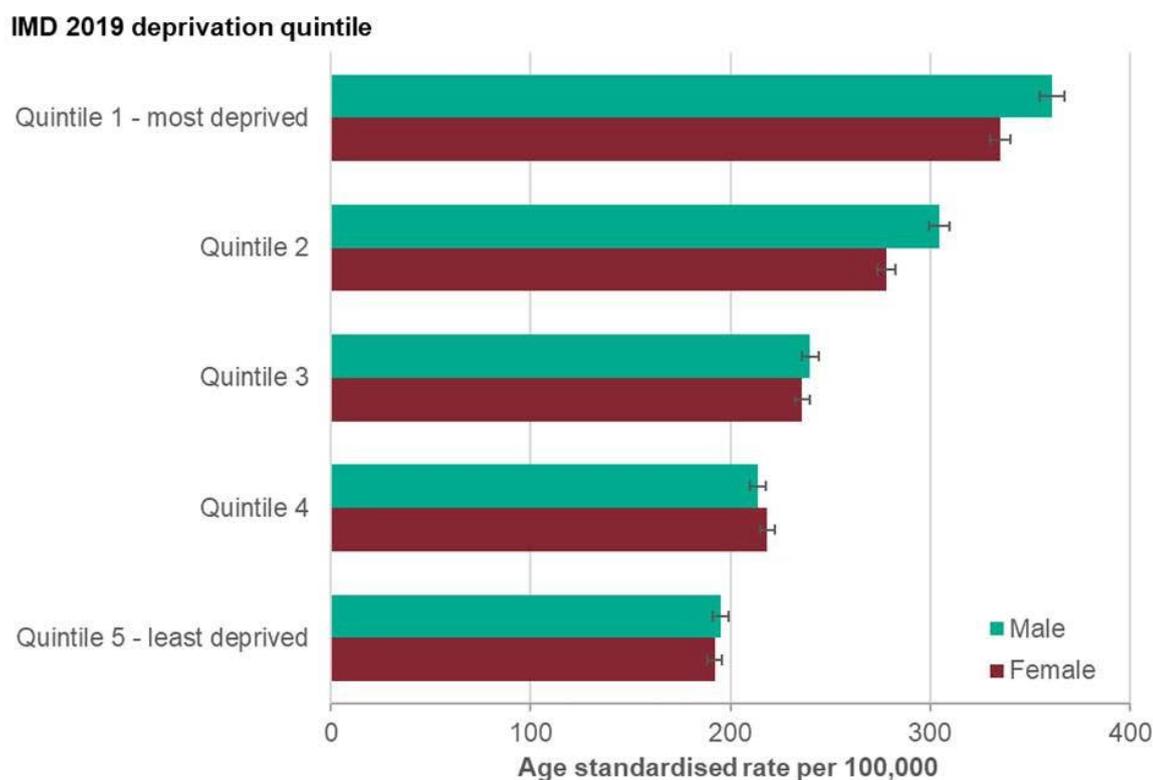


Figure 3.2. Age standardised diagnosis rates by deprivation quintile and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

3.4 Deaths in confirmed cases

The trend in the number of deaths in confirmed cases by week in each quintile shows that by week ending 11 April the number of weekly deaths was highest in the most deprived quintile (quintile 1) and remained so for every following week. For all quintiles, the week with the peak number of deaths in confirmed cases was week ending 11 April 2020 (Figure 3.3). By 13 May the cumulative number of deaths was highest in the most deprived quintile (quintile 1) (6,894) and lowest in the least deprived (quintile 5) (4,672).

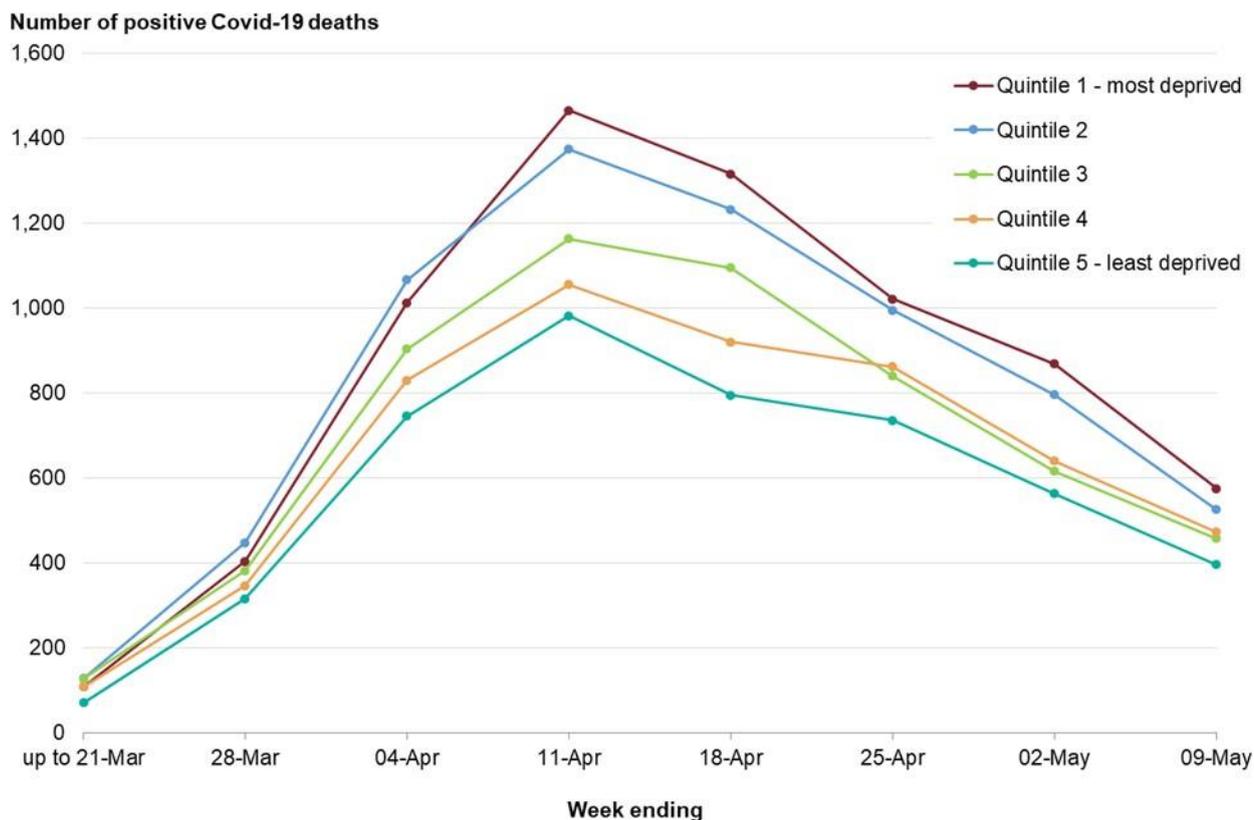


Figure 3.3. Number of deaths in laboratory confirmed COVID-19 cases by deprivation quintile and week, as of 9 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The age standardised death rates in confirmed cases, per 100,000 population, were highest in the most deprived quintile in both males and females, and lowest in the least deprived quintile. The rate in the most deprived quintile was 2.3 times the rate in the least deprived quintile among males and 2.4 times among females. In all quintiles the male death rates were significantly higher than females (Figure 3.4).

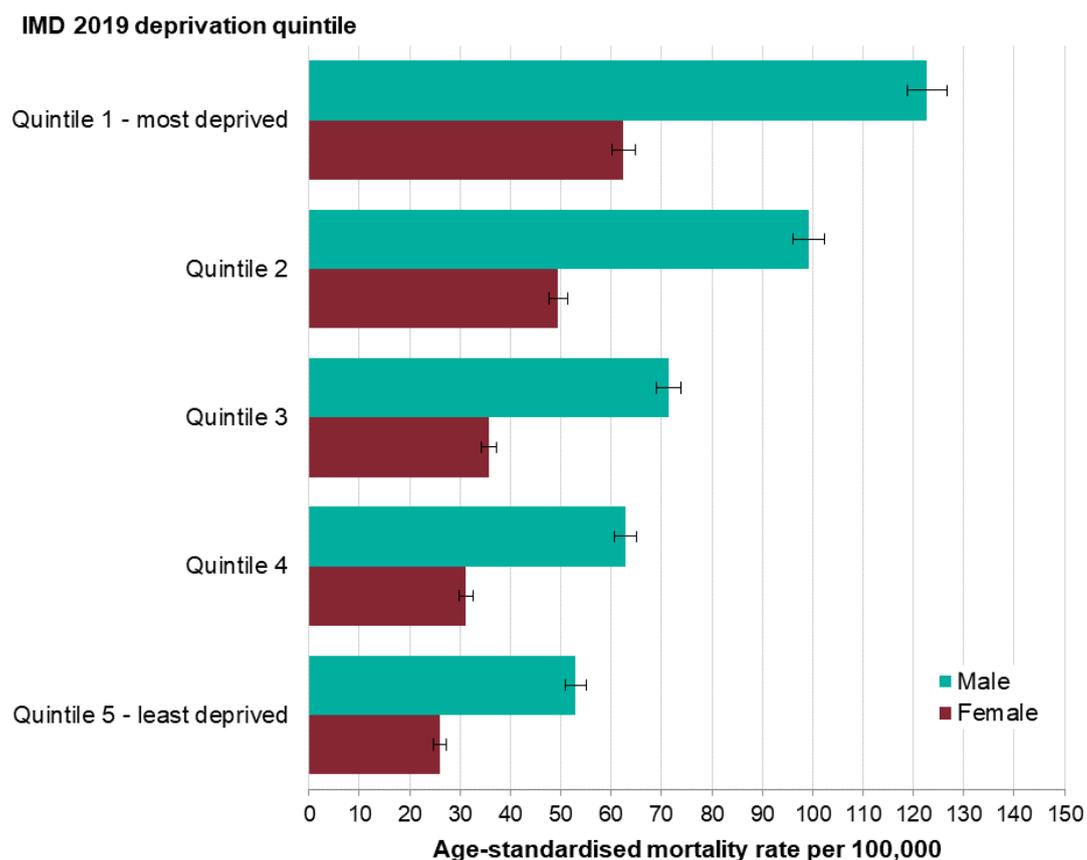


Figure 3.4. Age standardised death rates in laboratory confirmed COVID-19 cases by deprivation quintile and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, showed that, among people of working age (20 to 64), people living in the most deprived areas of the country were almost twice as likely to die than those living in the least deprived (Appendix A, table A2). For older adults (65 and over) the disparity remains significant but is much lower, with people in the most deprived areas having approximately 9% higher risk of death when compared to people in the least deprived areas (Appendix A, table A3).

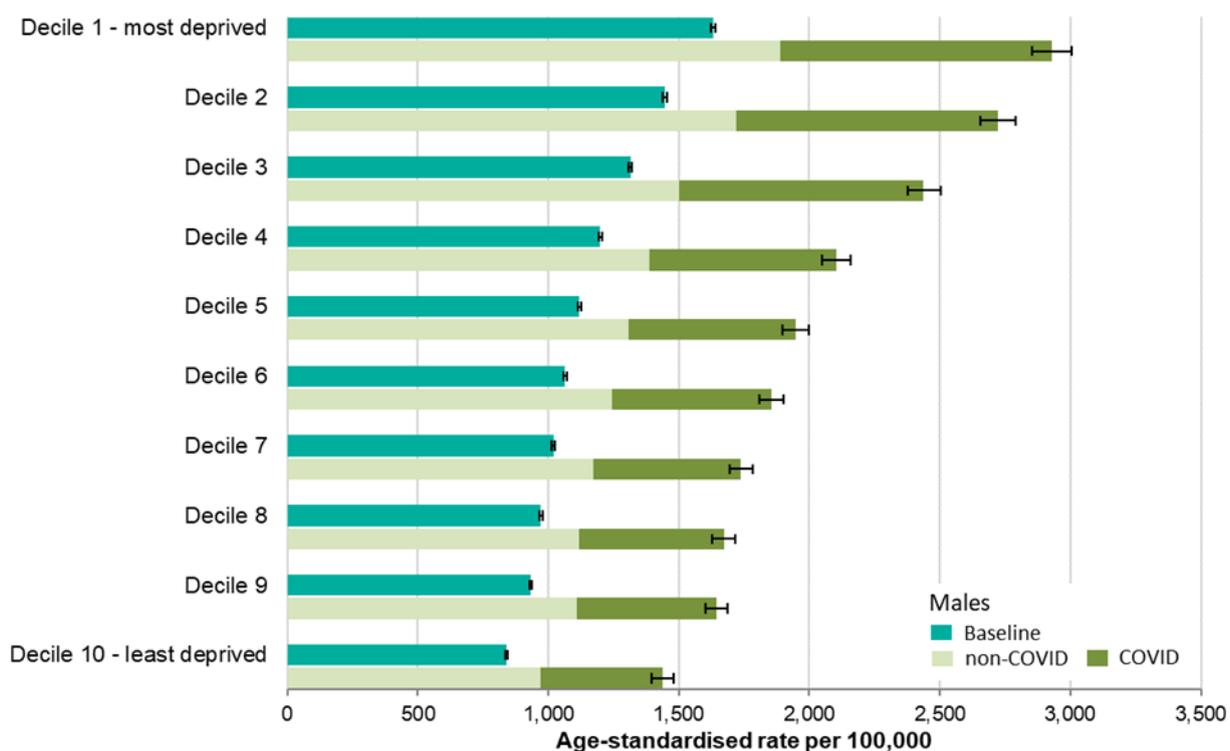
3.5 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates mentioning COVID-19 on the death certificate with inequalities in all cause death rates for previous years (the ‘baseline all cause’ figure).

Figure 3.5A and 3.5B show age standardised mortality rates for all causes of death and for deaths mentioning COVID-19 by deprivation decile between 21 March 2020 and 8 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018.

The age standardised death rate from COVID-19 was highest in the most deprived decile in males, but in the second most deprived decile in females (Figure 3.5A and 3.5B). The rate in the most deprived decile was 2.2 times the rate in the least deprived decile among males and females. In all deciles the male death rates were significantly higher than females. This analysis is consistent with the analysis by ONS (9).

From 2014 to 2018 the baseline all cause mortality rate in the most deprived decile was 1.9 times that in the least deprived decile in both males and females. This is smaller than the ratio for COVID-19 mortality rates indicating that the level of inequality in COVID-19 mortality rates is greater than that for all cause mortality in previous years.



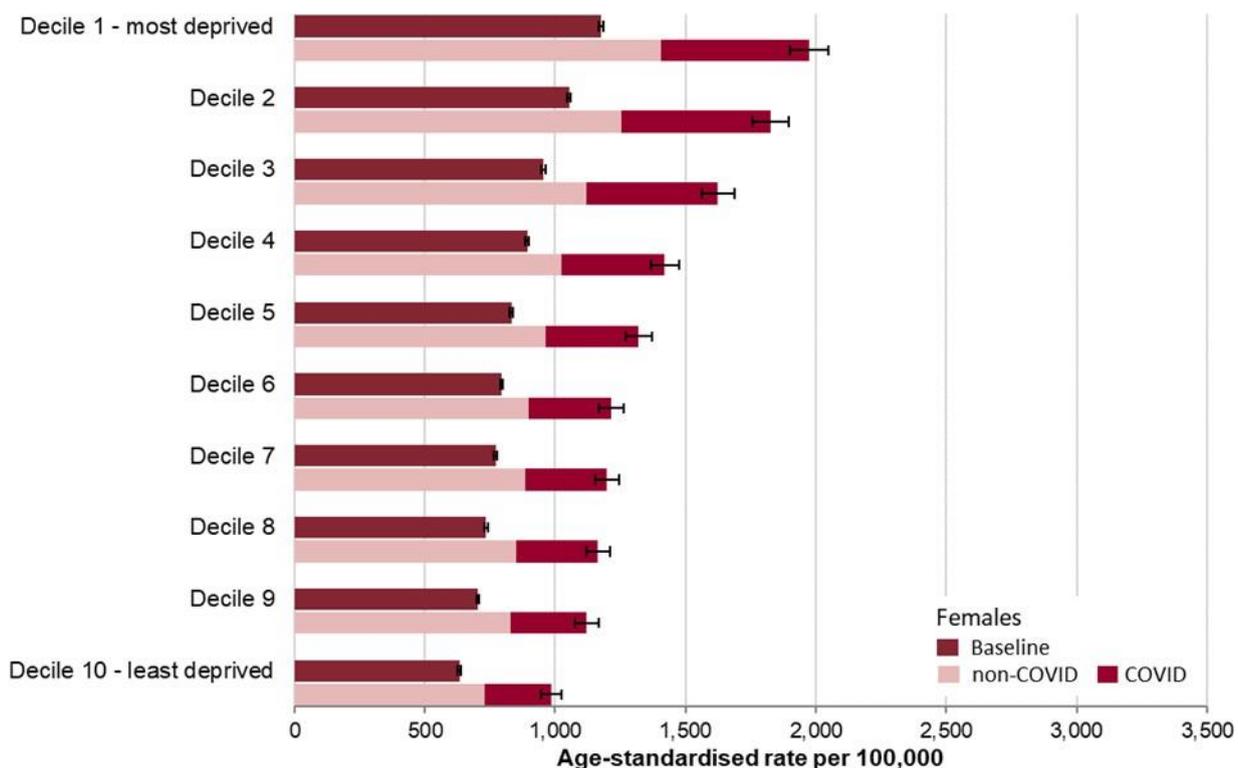


Figure 3.5A and 3.5B. Age-standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 8 May 2020, compared with baseline mortality rates (2014 to 2018), by deprivation decile and sex, England. Source: Public Health England analysis of ONS death registration data

3.6 Excess mortality

The PHE excess mortality model shows that between 20 March and 7 May 2020, there was excess mortality among all 5 deprivation quintiles. The crude number of excess deaths ranges from 10,678 in the most deprived quintile areas to 8,621 in the least deprived. This is a slightly larger relative increase in the most deprived quintile. The number of deaths with COVID-19 mentioned as a percentage of these excess deaths ranges from 72-77% across the quintiles.

4. Ethnicity

4.1 Main messages

The highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

An analysis of survival among confirmed COVID-19 cases shows that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all cause mortality rates were lower in Asian and Black ethnic groups. Therefore, the inequality in COVID-19 mortality between ethnic groups is the opposite of that seen for all causes of death in previous years.

Comparing to previous years, all cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

These analyses were not able to include the effect of occupation. This is an important shortcoming because occupation is associated with risk of being exposed to COVID-19 and we know some key occupations have a high proportion of workers from BAME groups.

These analyses were also not able to include the effect of comorbidities or obesity. These are also important factors because they are associated with the risk of death and are more commonly seen in some BAME groups. Other evidence has shown that when these are included, the difference in risk of death among hospitalised patients is greatly reduced.

4.2 Background

Evidence suggests that COVID-19 may have a disproportionate impact on people from Black, Asian and minority ethnic (BAME) groups. The Intensive Care National Audit and

Research Centre (ICNARC) report published on 22 May found that Black and Asian patients were over-represented among those critically ill with confirmed COVID-19 receiving advanced respiratory support. The report found that 15.2% and 9.7% of critically ill patients were from Asian and Black ethnic groups respectively (2).

Some evidence also suggests the risk of death from COVID-19 is higher among people of BAME groups (15) and an ONS analysis showed that, when taking age into account, Black males were 4.2 times more likely to die from a COVID-19-related death than White males (16). The risk was also increased for people of Bangladeshi and Pakistani, Indian and Mixed ethnic groups. However, an analysis of over 10,000 patients with COVID-19 admitted to intensive care in UK hospitals suggests that, once age, sex, obesity and comorbidities are taken into account, there is no difference in the likelihood of being admitted to intensive care or of dying between ethnic groups (17).

The relationship between ethnicity and health is complex and likely to be the result of a combination of factors. Firstly, people of BAME communities are likely to be at increased risk of acquiring the infection. This is because BAME people are more likely to live in urban areas (18), in overcrowded households (19), in deprived areas (20), and have jobs that expose them to higher risk (21). People of BAME groups are also more likely than people of White British ethnicity to be born abroad (22), which means they may face additional barriers in accessing services that are created by, for example, cultural and language differences.

Secondly, people of BAME communities are also likely to be at increased risk of poorer outcomes once they acquire the infection. For example, some co-morbidities which increase the risk of poorer outcomes from COVID-19 are more common among certain ethnic groups. People of Bangladeshi and Pakistani background have higher rates of cardiovascular disease than people from White British ethnicity (23), and people of Black Caribbean and Black African ethnicity have higher rates of hypertension compared with other ethnic groups (24). Data from the National Diabetes Audit suggests that type II diabetes prevalence is higher in people from BAME communities (25).

Most analyses in this section of the review look at 5 broad ethnic groups: White / White British, Black / Black British, Asian / Asian British, Mixed / Multiple Ethnic groups and Other ethnic groups. The survival analysis looks at sixteen smaller ethnic groups. These are based on the data available from different sources. Appendix B and the data sources and methodologies section outline these groups and how they were collapsed.

4.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well

as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

It was possible to assign ethnicity to 127,821 (91.9%) of the 139,086 individuals who had tested positive for SARS-CoV-2 by 13 May 2020. Figure 4.1 shows the weekly number of positive cases by ethnic group since the start of the pandemic. For Black and Other ethnic groups, the highest weekly number of cases was reported in week ending 4 April and for all other ethnic groups the highest weekly number of cases was reported in week ending 11 April.

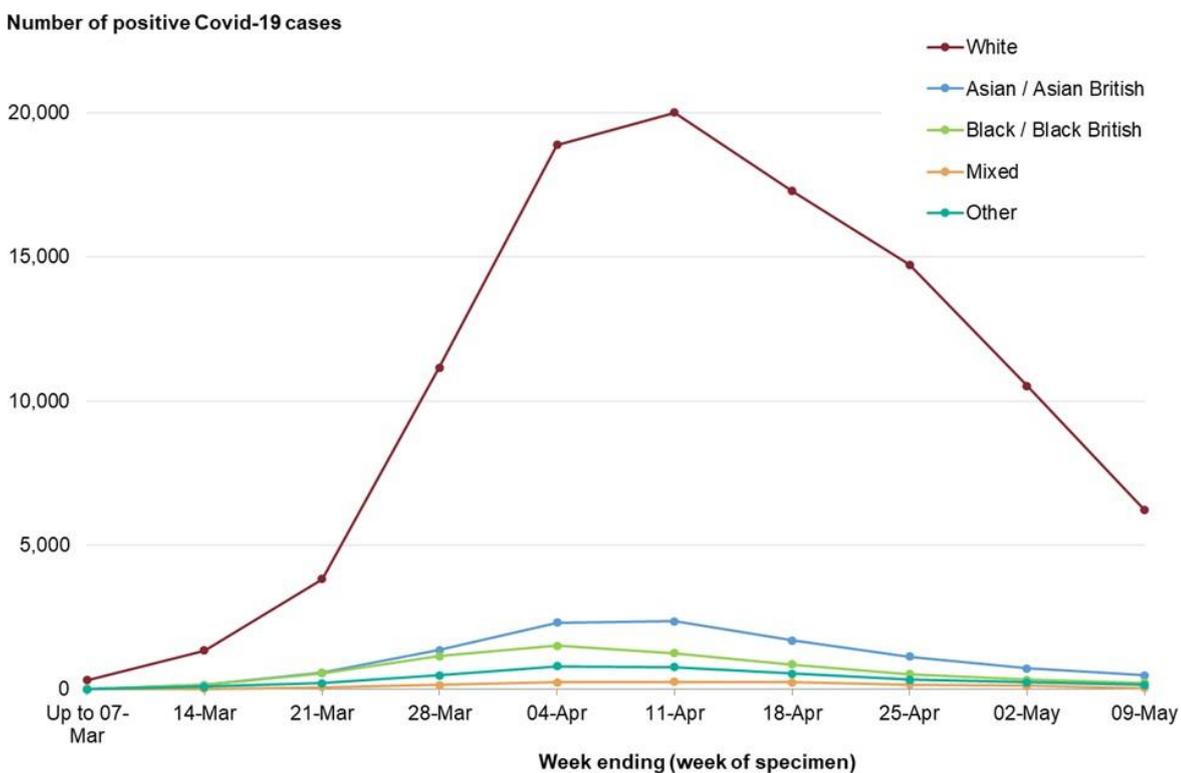


Figure 4.1. Number of positive confirmed cases by ethnic group and week, as of 9 May 2020, England. Source: Public Health England Second Generation Surveillance System. Note: The last week of data was removed as it was an incomplete week.

Figure 4.2 shows the age standardised diagnoses rates by ethnic group. After adjustment by age, the highest diagnosis rates of COVID-19 per 100,000 population were in people of Other ethnic groups (1,076 in women and 1,101 in men) followed by people of Black ethnic groups (486 in females and 649 in males). This compared to 220 per 100,000 among White females and 224 among White males.

These results are not adjusted for some factors that may influence the likelihood of becoming infected, such as geographical location. The rates in the Other ethnic group

are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases data and the population data used to calculate the rates.

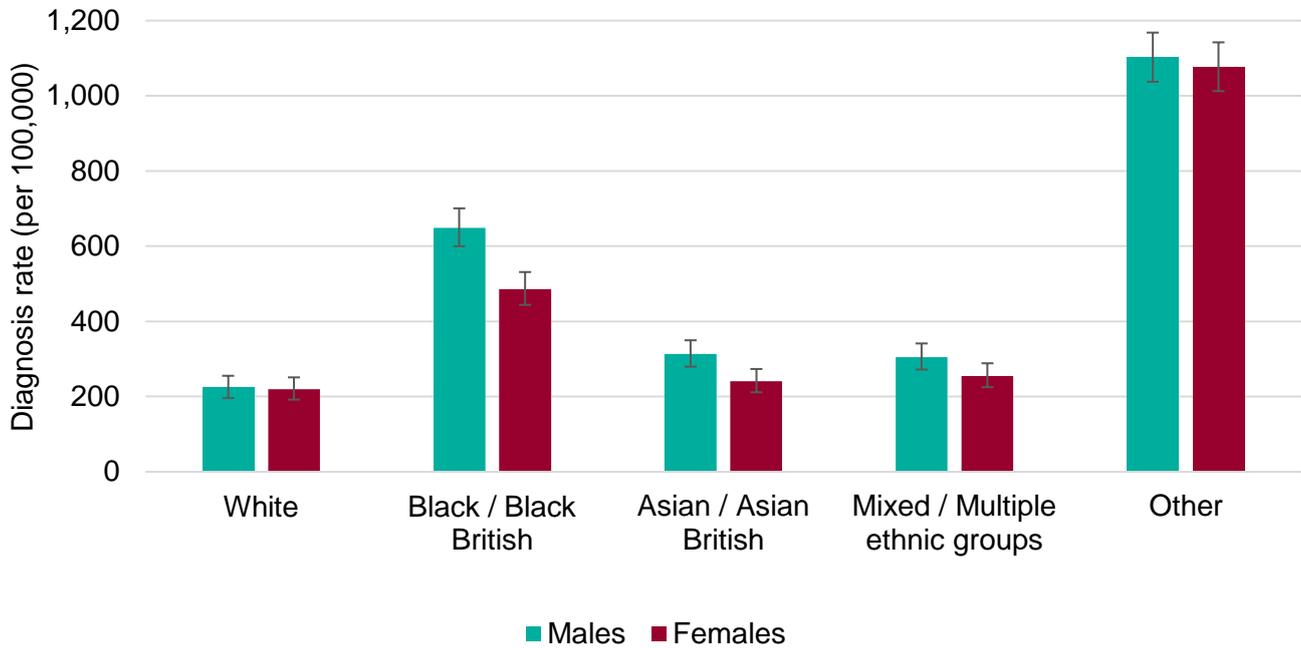


Figure 4.2. Age standardised diagnosis rates by ethnicity and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

4.4 Hospitalisations

As of 19 May, 42 trusts had reported lower level of care patients (defined as admission to any hospital ward, excluding ICU or HDU), and 94 trusts contributed ICU/HDU (critical care) patient data to the COVID-19 Hospitalisations in England surveillance system (CHESS). Reporting varies by trusts and the majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the hospitalised cases. The data presented in this section have not been adjusted for this, which means findings must be interpreted with caution.

The lower level of care subset contained 8,508 cases of which 7,617 (89.5%) could be linked to Hospital Episode Statistics (HES) to assign ethnicity. The critical care subset contained 3,978 cases of which 3,219 (80.9%) could be linked to HES to assign ethnicity.

Among cases hospitalised in lower level of care, 11% were of Black, Asian and other Minority Ethnic (BAME) groups; however, this proportion was 36% of those admitted to critical care (Figure 4.3). Confirmed cases among BAME groups tend to be younger than White ethnic groups, which is likely to explain some of this difference, as might other factors such as comorbidities.

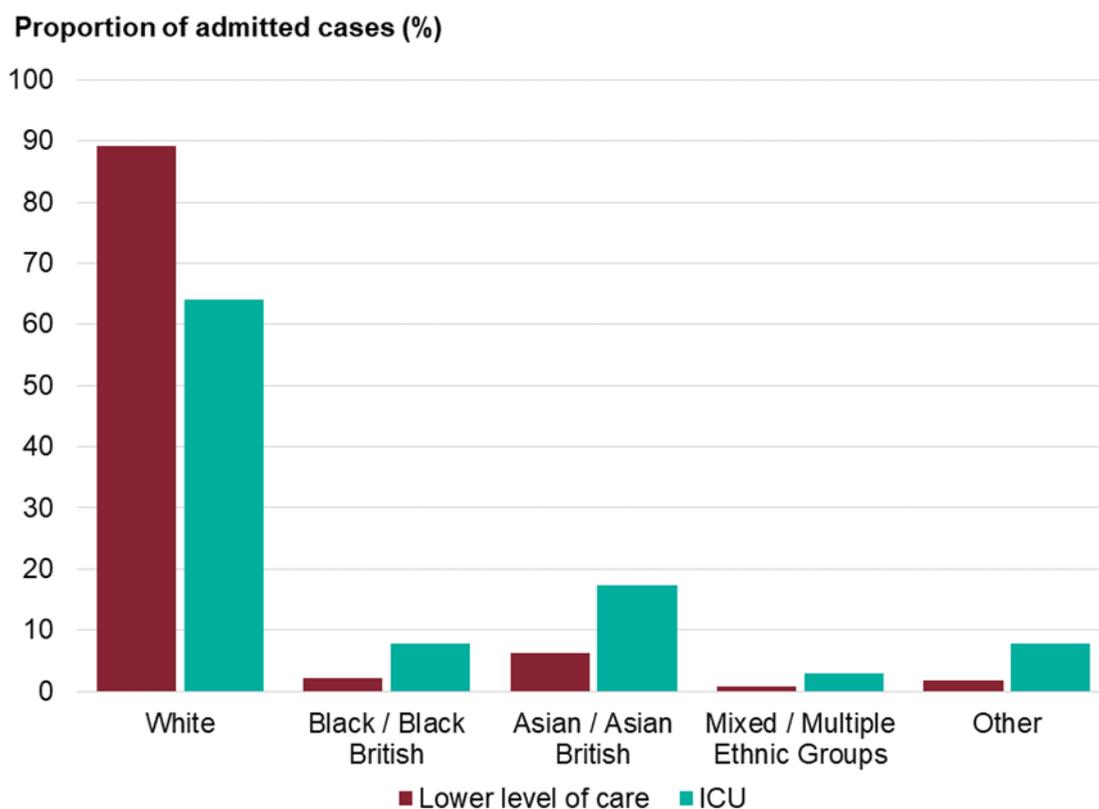


Figure 4.3. Laboratory confirmed admissions for COVID-19 to acute trusts, by level of care and ethnicity, England, as of 19 May 2020. Source: Public Health England COVID-19 Hospitalisations in England surveillance system (CHESS).

4.5 Deaths in confirmed cases

There were 29,673 deaths reported to PHE by 13 May 2020 of which it was possible to obtain ethnicity for 29,500 (99.4%). For all ethnic groups, the highest weekly number of deaths was recorded on week ending 11 April, except for Mixed / Multiple ethnic groups who had an equally high number on week ending 18 April (Figure 4.4).

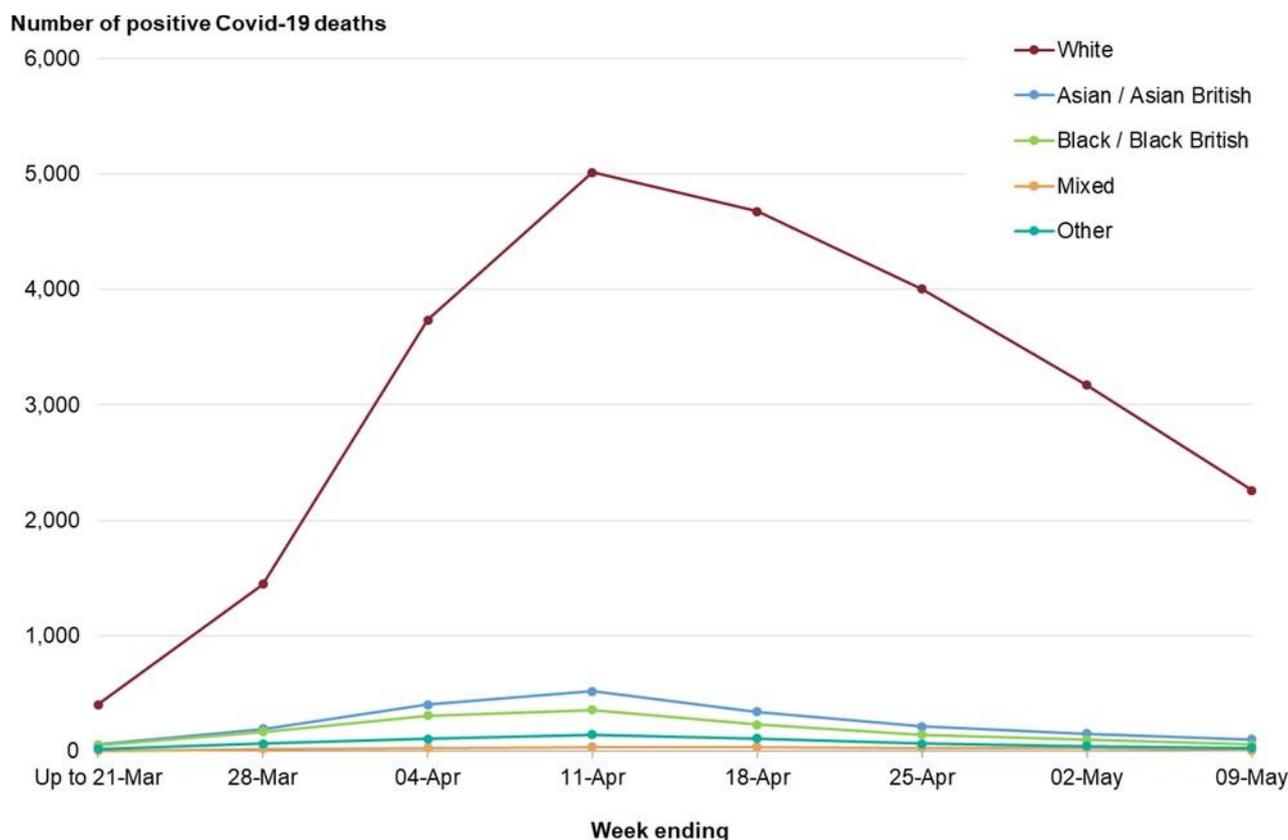


Figure 4.4. Number of deaths in laboratory confirmed COVID-19 cases by ethnicity and week, as of 9 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The highest age standardised deaths rates in confirmed cases per 100,000 population were among people of Other ethnic groups (234 in females and 427 in males) followed by people of Black ethnic groups (119 in females and 257 in males), Asian ethnic groups (78 in females and 163 in males), Mixed ethnic groups (58 in females and 116 in males) and White ethnic groups (36 in females and 70 in males) (Figure 4.5).

The rates in the Other ethnic group are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases/mortality data and the population data used to calculate the rates.

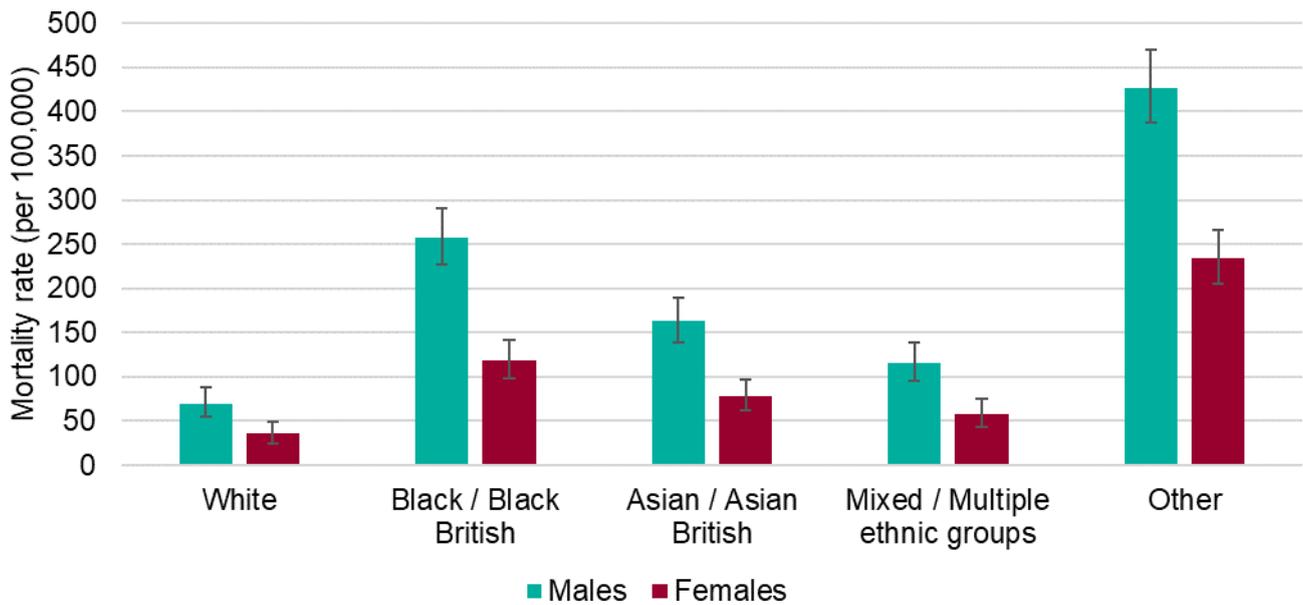


Figure 4.5. Age standardised mortality rates in laboratory confirmed COVID-19 cases by ethnicity and sex, as of 13 May, England. Source: Public Health England: COVID-19 Specific Mortality Surveillance System.

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, shows that, after taking these factors into account, some ethnic groups still had a higher risk of death than others (Appendix A). This analysis looked at 16 ethnicity categories and found that, when compared to White British ethnicity, people of Bangladeshi ethnicity had twice the risk of death. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British (Appendix A, table A1).

When looking only at the working age population (between 20 and 64 years old), the increased risk of death is seen among people of Bangladeshi ethnicity (80% higher risk than White British ethnicity), Black Other ethnicity, Pakistani ethnicity (both 50% higher) and Black Caribbean ethnicity (30% higher) (Appendix A, table A2).

While this analysis adjusts for many important factors such as age and deprivation, it does not adjust for factors such as comorbidities and obesity, which are likely to have an important impact on the different risk of dying between ethnic groups.

4.6 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates mentioning COVID-19 on the death certificate with inequalities in all cause death rates for previous years (the ‘baseline all cause’ figure). Ethnicity is not recorded at death registration, so this information was obtained through

linkage to Hospital Episode Statistics. It was possible to obtain ethnicity information for 97% of all cause deaths.

Figures 4.6A and 4.6B show age standardised mortality rates for all causes of death and for deaths mentioning COVID-19 by ethnic group between 21 March 2020 and 1 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018.

Death rates from COVID-19 were higher in people of Asian, Black, Mixed and Other ethnic groups than White ethnic groups (Figure 4.6A and 4.6B). Black males were 3.9 times more likely to die than the White group, compared with 2.5 times in Asian males. Among females, death rates were 3.3 times higher in the Black ethnic group, and 2.3 times higher in the Asian ethnic group than the White group. These inequalities are broadly consistent with the pattern of deaths in confirmed cases and the findings from ONS before adjustment for other factors (16).

However, the baseline all cause rates show lower mortality in Asian and Black ethnic groups than the White group, therefore the inequality in COVID-19 mortality between these groups is the opposite of that seen for all causes of death in previous years.

The Other ethnic group also had higher mortality rates from both all causes and COVID-19 than the White group. The rates in the Other ethnic group are likely to be an overestimate due to the difference in the source of allocating ethnicity codes to the mortality data and the population data used to calculate the rates. This may explain the high mortality rates in the Other group, which cannot be interpreted and requires further investigation.

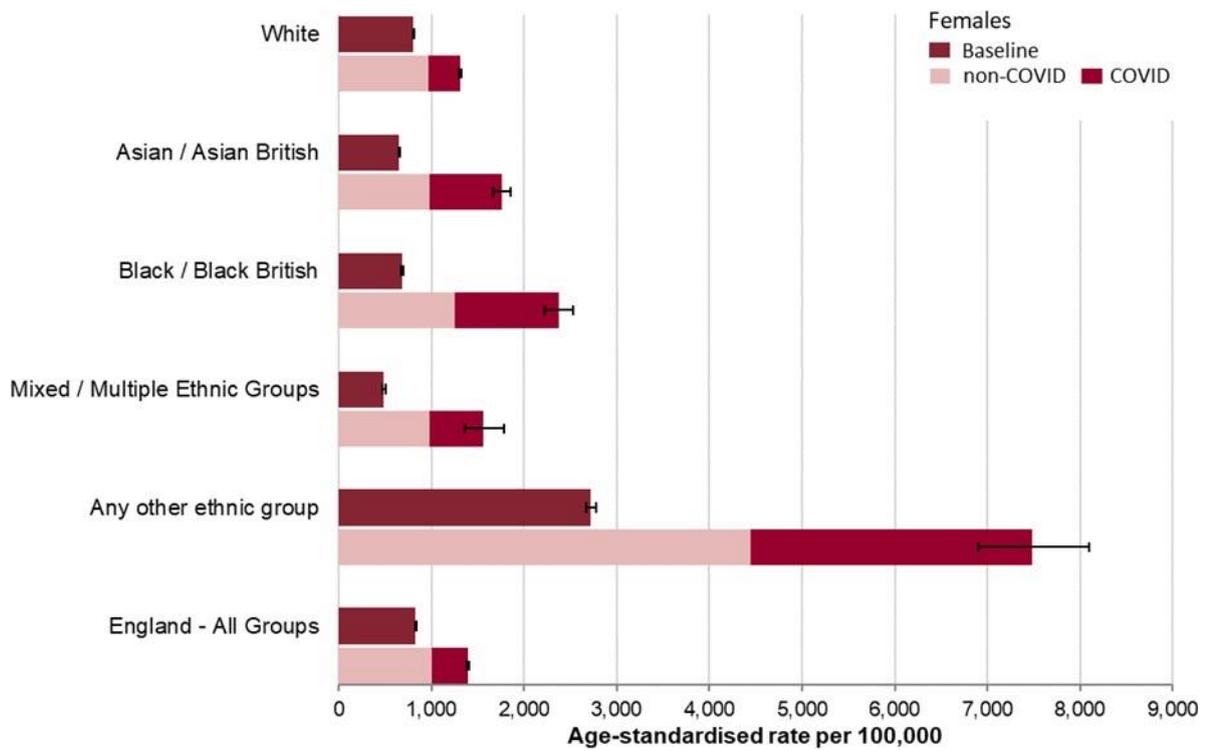
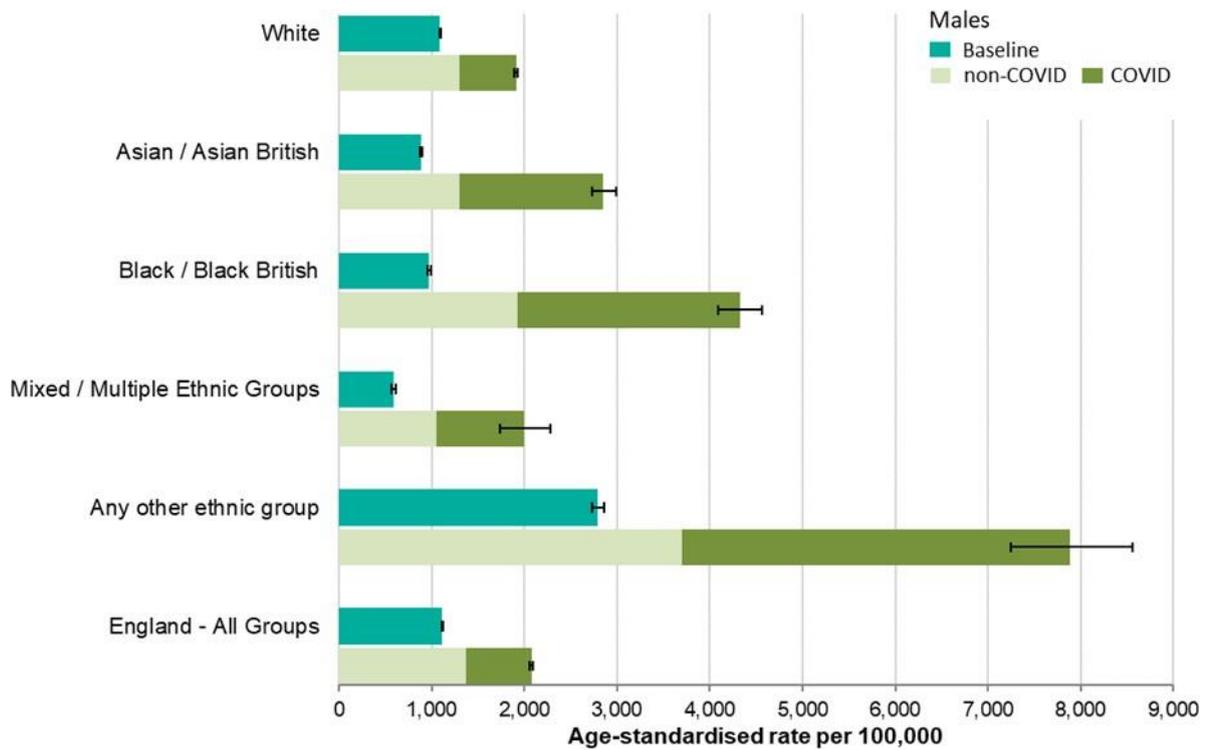


Figure 4.6A and 4.6B. Age-standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 1 May 2020, compared with baseline mortality rates (2014 to 2018), by ethnicity and sex, England. Source: Public Health England analysis of ONS death registration data.

4.7 Excess mortality

The excess mortality model shows the number of excess deaths by sex and ethnic group in the period 20 March to 7 May against the number of deaths that would be expected for corresponding dates in 2014 to 2018 (Figure 4.7). It also quantifies how many deaths had COVID-19 mentioned on the death certificate.

Overall, the model suggests there have been 43,941 excess deaths among the White group, 2,301 Black, 3,083 Asian, 385 Mixed and 1,038 in the Other ethnic group. Deaths in Black males were 3.9 times higher than expected in this period, compared with 2.9 times higher in Asian males and 1.7 times higher in White males. Among females, deaths were between 2.7-2.8 times higher in Black, Mixed and Other ethnic groups in this period, compared with 2.4 in Asian and 1.6 in White females.

The percentage of these excess deaths for which COVID-19 is mentioned is highest in males in the Other ethnic group (94.0%) and Asian males (80.9%), and lowest in Mixed females (58.2%) and females in the Other ethnic group (62.8%).

Disparities in the risk and outcomes from COVID-19

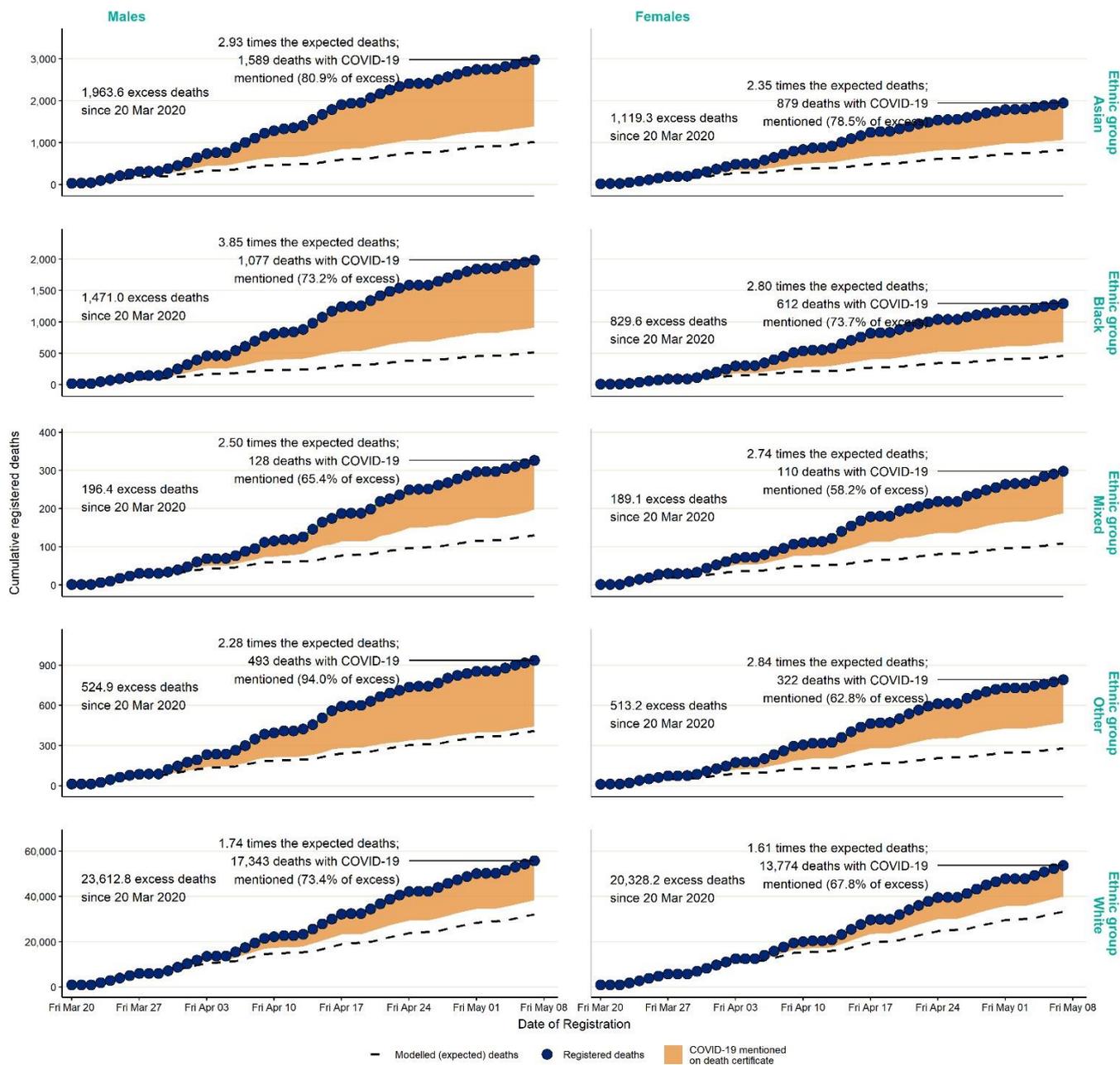


Figure 4.7. Cumulative all cause deaths by date of registration by ethnicity, 20 March to 7 May 2020, England. Source: Public Health England excess mortality model based on ONS death registration data.

5. Occupation

5.1 Main messages

A total of 10,841 COVID-19 cases were identified in nurses, midwives and nursing associates, representing 1.9% of the health professionals who are registered with the Nursing and Midwifery Council (NMC). By ethnic group, this represents 3.9% of nurses, midwives and nursing associates of Asian ethnic groups, 3.1% of Other ethnic groups, 1.7% of White ethnic groups and 1.5% of both Black and Mixed ethnic groups. This analysis did not look at the possible reasons behind these differences, which may be driven by factors like geography or nature of individuals' roles.

ONS reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. Our analysis expands on this and shows that nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 to 2018. For many occupations, however, the number of deaths is too small to draw meaningful conclusions and further analysis will be required.

5.2 Background

Some occupations require close or frequent contact with other individuals, which leads to an increased risk of COVID-19 infection. Early reports suggest that occupational exposure accounts for some infections (26), with healthcare workers (HCW) being particularly at risk of infection, but also individuals working in other people-facing occupations such as retail, hospitality, transport and security. Epidemiological data from European countries suggest that HCW may account for 9% to 26% of those infected (27).

ONS created an estimate of exposure to disease and physical proximity for UK occupations, which provides an indication of which roles may be more likely to come into contact with people with COVID-19 (21). HCW are exposed to disease on a daily basis and require close contact with others. Other occupations, such as those working in the emergency services (police, fire, ambulance), social care and educators, and other occupations such as bar staff and hairdressers, also have close contact with others but are less likely to be exposed to people with the disease when compared to HCW.

For some people in these occupations, social distancing measures have substantially reduced their physical proximity to others. Among workers in occupations that are more

likely to be in frequent contact with people and exposed to disease, 3 in 4 are women and one in 5 are from BAME groups (21). An analysis of 119 deaths of NHS staff showed a disproportionately high number of BAME staff among those who had died (28).

Despite the differences in likelihood of exposure, the ONS Coronavirus (COVID-19) Infection Survey for England found no evidence of a difference between the proportions testing positive for patient-facing healthcare or resident-facing social care roles and people not working in these roles (29). These are provisional results and there is a high level of uncertainty about this estimate.

ONS has recently reported that men working in low skilled occupations had the highest rate of death involving COVID-19 up to 20 April 2020 (52). Men working in some specific occupations had significantly raised rates of death involving COVID-19, including security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, and lower skilled occupations in construction and processing plants. Men and women working in social care were also reported to have had significantly raised rates of death involving COVID-19. HCW were not found by ONS to have higher rates of COVID-19-related death when compared with those of the same age and sex in the general population.

5.3 Cases in nurses, midwives and nursing associates

This section presents laboratory confirmed cases that were matched to the professionals on the Nursing and Midwifery Council (NMC) register on 14 May 2020. The cases were identified under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

A total of 10,841 diagnosed COVID-19 cases in nurses, midwives and nursing associates were identified, 9,385 of whom were in females. This represents 1.9% of the professionals on NMC register. The median age of cases was 45.5 and 45.1 for males and females, respectively.

Figure 5.1 shows the proportion of COVID-19 cases among registered nurses, midwives and nursing associates by ethnic group. This proportion was highest among those of Asian ethnic groups (3.9%), followed by Other ethnic groups (3.1%), White ethnic groups (1.7%) and Black and Mixed ethnic groups (both with 1.5%).

These results are not adjusted for factors that may influence the likelihood of becoming infected, such as age, sex, geographical location or nature of individuals' professional roles.

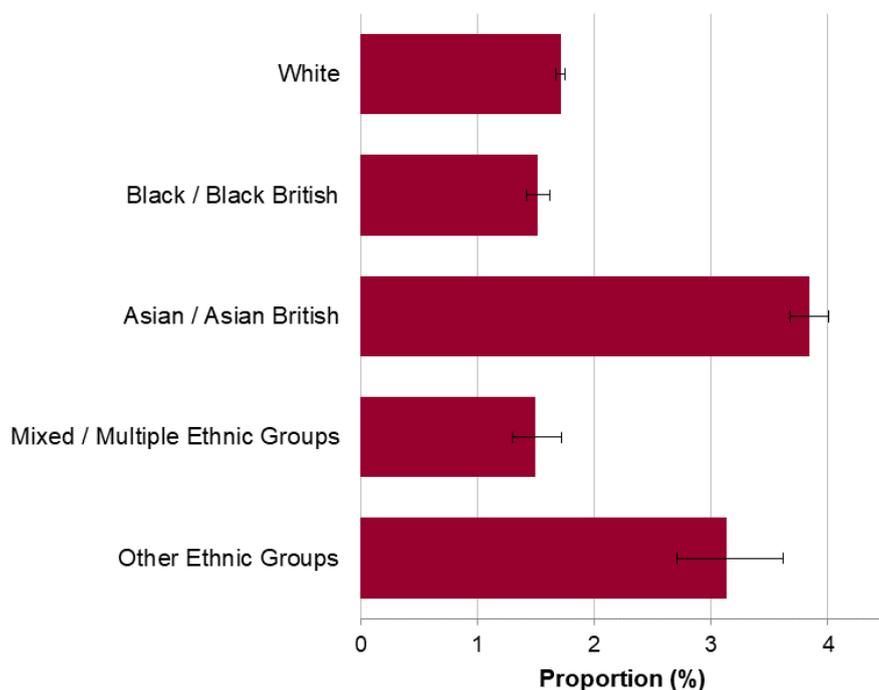


Figure 5.1. Proportion of registered nurses, midwives and nursing associates with laboratory confirmed COVID-19 by ethnic group, as of 18 May 2020, England. Source: NMC register and Public Health England Second Generation Surveillance System.

5.4 Mortality by occupation

This section examines the relative increase in all cause death registrations by occupation in the period 21 March to 8 May 2020, compared with the average for the same period in the years 2014 to 2018. Deaths in people aged 20 to 64 in 2020 were 1.5 times higher than average.

For 3 occupations the relative increase in deaths in 2020 was significantly higher than the average of 1.5: Caring Personal Services, Elementary Security Occupations, and Road Transport Drivers (Table 5.1). Of these groups, the biggest increase was for Elementary Security Occupations, where deaths were 2.3 times higher in 2020 than in the same period in 2014 to 2018. Workers in these groups were also identified in the ONS analysis as having high rates of death involving COVID-19.

Within these groups, there were 3 occupational ‘unit groups’ where the increase in deaths in 2020 was significantly higher than the increase for everyone aged 20 to 64. These were nursing auxiliaries and assistants, security guards and related occupations, and taxi and cab drivers and chauffeurs.

Table 5.1. Relative increase in all cause deaths registered between 21 March and 8 May 2014 to 2018 and 2020, for people aged 20-64, by occupational groups, England.*
Source: Public Health England analysis of ONS death registration data

Occupation	Deaths 2014-18 average all causes	Deaths 2020 all causes	Relative increase between 2014-18 and 2020	Lower 95% confidence interval	Upper 95% confidence interval
Caring Personal Services	414	760	1.8	1.6	2.1
Nursing auxiliaries and assistants	52	128	2.5	1.8	3.4
Elementary Security Occupations	117	267	2.3	1.8	2.8
Security guards and related occupations	80	209	2.6	2.0	3.4
Road Transport Drivers	384	694	1.8	1.6	2.0
Taxi and cab drivers and chauffeurs	87	217	2.5	1.9	3.2
All people aged 20-64	9,440	14,409	1.5	1.5	1.6

*Occupations are only listed where the relative increase was significantly higher than the average for all persons. Results for all occupational groups can be found in the Table 5a and 5b in the data pack.

Although only these small number of occupations had a significant relative increase in deaths in 2020, other occupations have seen a large increase in their absolute number of deaths since the start of the pandemic. These are listed in Table 5a and 5b in the data pack. These tables also include the number of deaths in 2020 where COVID-19 was recorded on the death certificate, and the percentage of the excess deaths in 2020 which were due to COVID-19.

The largest absolute increase was for workers in Caring Personal Services. There were 760 deaths from all causes among these workers in the period 21 March to 8 May 2020 for people aged 20 to 64. This is 346 more than in the same period in 2014 to 2018 and 74% had COVID-19 recorded as a cause of death.

For workers in Construction and Building Trades, the number of deaths related to COVID-19 was slightly higher than the number of excess deaths. This indicates that deaths from other causes have gone down which may be due to a reduced risk of occupational related injuries over this time period.

As noted above, ONS did not find that healthcare workers had higher rates of death involving COVID-19 compared with the general population. The ONS definition of HCW includes people in 26 different occupational groups, who are likely to have had different levels of contact with individuals, particularly during the pandemic. Table 5b in the data pack shows that the relative increase in the number of deaths registered for medical practitioners was 2.5 times higher than in 2014 to 2018. This is a larger increase than the average for all people aged 20-64 (1.5) but is not statistically significant. The relative increase for nurses was 1.7. This was also not significantly higher than average, but nurses are one of the occupations with the highest absolute increase in deaths between 2014 to 2018 and 2020 (from 133 to 233).

6. Inclusion health groups

6.1 Main messages

For people born outside of the UK and Ireland, the relative increase in deaths in 21 March to 8 May 2020 was higher than the average. The biggest relative increase was for people born in Central and Western Africa (which includes Nigeria, Ghana and Somalia), the Caribbean, South East Asia (which includes Malaysia, the Philippines and Vietnam), the Middle East and South and Eastern Africa (which includes South Africa, Zimbabwe and Kenya).

There were 54 men and 13 women diagnosed with COVID-19 with no fixed abode, likely to be rough sleepers. We estimate that this represents 2% and 1.5% of the known population of women and men who experienced rough sleeping in 2019.

6.2 Introduction

Populations who are socially excluded, such as people who experience homelessness and vulnerable migrants, tend to have the poorest health outcomes, putting them at the extreme end of the gradient of health inequalities (30). This is a consequence of being exposed to multiple, overlapping risk factors, such as facing barriers in access to services, stigma and discrimination.

Notably, people who are socially excluded are not consistently recorded in electronic records, often making them effectively invisible for policy and service planning purposes (31). Nevertheless, there is strong evidence that inclusion health groups have very high levels of morbidity and mortality, often with multiple and complex needs including overlapping mental and physical ill-health, and substance dependency (32). This puts these populations at increased risk from the consequences of emergencies, such as pandemics.

A recent modelling exercise, for example, estimated that in a “do nothing” scenario, 34% of people living in hostels and sleeping rough would be infected with COVID-19, leading to over 4,000 hospital admissions (33). Other countries have reported outbreaks in homeless shelters (34) and among migrant workers (35).

6.3 Mortality in Migrants

This section uses deaths reported by ONS to compare deaths between 21 March and 8 May 2020 with deaths in previous years by country of birth. Being born outside of the UK does not necessarily mean a person is a vulnerable migrant, but migration is a

factor that impacts on people’s health. In the UK resident population, there is some association between ethnicity and being born abroad.

In the period 21 March to 8 May 2020, the number of death registrations from all causes for people in England was 1.7 times higher than in the same period for the average of the years 2014 to 2018. For people born in England, Scotland, Wales, Northern Ireland, and Ireland, the relative increase was similar to this (Figure 6.1). For all other groups of countries, the relative increase was higher than the average and in almost all cases this increase was significantly higher.

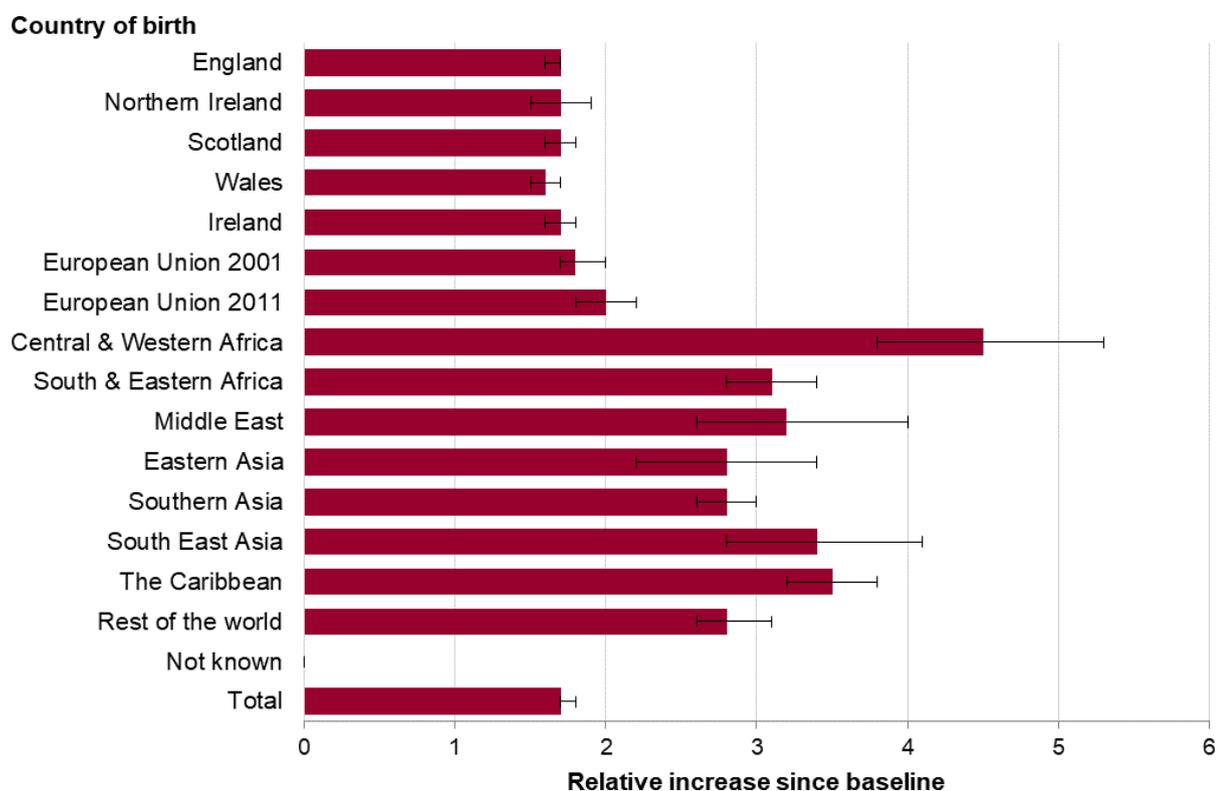


Figure 6.1. Relative increase in total deaths registered in England in 2020 compared to the average for 2014 to 2018, 21 March to 8 May, by country of birth.* Source: Public Health England analysis of ONS death registration data.

(*The numbers of deaths in each of the country groupings can be found in Table 6a in the data pack. The list of countries in each of the groups can be found in Table 6b in the data pack.)

The biggest relative increase was for people born in Central and Western Africa (4.5 times higher in 2020 than in 2014 to 2018). This group of countries includes Nigeria, Ghana and Somalia. For people born in 4 other groups of countries, deaths in 2020 were more than 3 times higher than the equivalent period in 2014 to 2018: the Caribbean (3.5), South East Asia, which includes Malaysia, the Philippines and Vietnam (3.4), the Middle East (3.2) and South and Eastern Africa, which includes South Africa, Zimbabwe and Kenya (3.1).

For people born in the European Union 2001, the relative increase was 1.8 times higher, and this was the only group of countries not significantly higher than the average for England. This group includes all countries which were EU members in 2001. Countries which joined the EU between 2001 and 2011 (such as Poland and the 9 other countries which joined in 2004) are included in the European Union 2011 group, for which the relative increase was 2.0.

6.4 People with no fixed abode

Overall, there were 67 diagnoses of COVID-19 among people assigned a 'no fixed abode' (NFA) code. Of these, 54 (80.6%) were men.

Taking into account the estimated number of people sleeping rough in England in Autumn 2019, this represents 1.6% of the rough sleeping population. This is lower for men (1.5%) than women (2.1%) (Figure 6.2).

These figures are subject to uncertainty and should be treated as estimates.

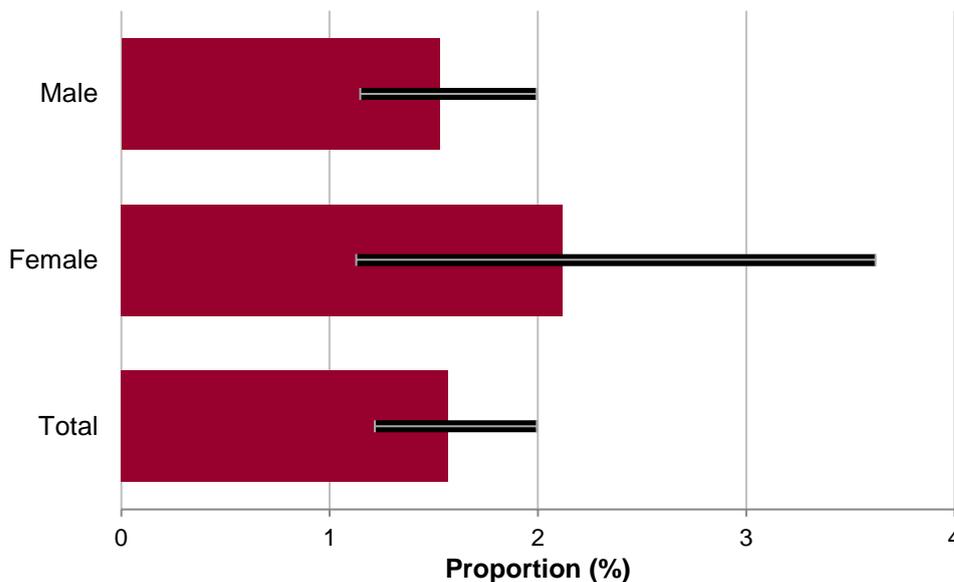


Figure 6.2. Proportion of cases assigned a no fixed abode code per 100 population of rough sleepers by sex and in total as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System and Ministry of Housing, Communities and Local Government.

7. Deaths in care homes

7.1 Main messages

By the 10 April 2020, deaths in care homes accounted for 10% of all deaths from COVID-19 in England. However, this percentage has increased over time and in the week ending 8 May care homes accounted for a much greater proportion (43%). The number of deaths from COVID-19 in hospitals peaked in the week ending 17 April, but the number in care homes peaked a week later.

The excess mortality model suggests that there have been 2.3 times the number of deaths in care homes than expected between 20 March and 7 May which equates to around 20,457 excess deaths. The number of COVID-19 deaths over this period is equivalent to 46.4% of the excess, suggesting that there were many excess deaths from other causes or an under-reporting of deaths from COVID-19.

7.2 Background

Between 9 March and 17 May 2020 there were 5,887 outbreaks of COVID-19 reported in care homes in England (36). There are 15,514 care homes in England, so this indicates that 38% had experienced an outbreak.

Many countries have seen a significant proportion of COVID-19 deaths in care homes or in care home residents and this proportion seems to be higher in countries where there have been a larger number of deaths (37).

7.3 Death registrations

Data reported by ONS show that 9,492 deaths mentioning COVID-19 on the death certificate that occurred in care homes were registered up until 8 May 2020. This is 27% of all COVID-19 deaths (7). This figure will not include all deaths of care home residents who may die elsewhere.

The number of deaths from COVID-19 in hospitals has been greater than the number in care homes each week between week ending 27 March and 8 May (Figure 7.1). The number of deaths from COVID-19 in hospitals peaked in the week ending 17 April, but the number in care homes peaked a week later.

By the 10 April 2020, deaths in care homes accounted for 10% of all deaths from COVID-19 in England. However, this percentage has increased over time and in week

ending 8 May 2020 deaths in care homes accounted for a much greater proportion (43%), compared with 50% for hospitals.

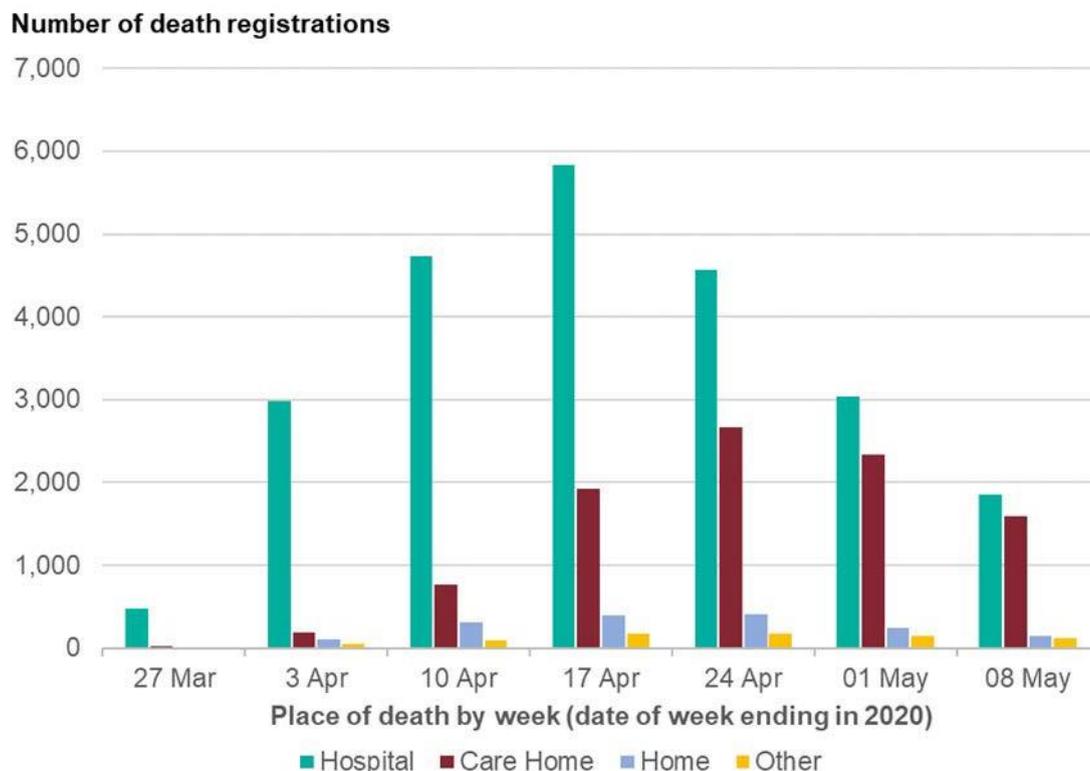


Figure 7.1. Weekly provisional death registrations for deaths where COVID-19 was mentioned on the death certificate, by place of occurrence, data up to 8 May 2020, England. Source: Public Health England analysis of ONS death registration data.

The Care Quality Commission report on deaths of care home residents, regardless of where the death took place. Between 11 April and 8 May 2020, there were 27,817 deaths of care home residents (38). This is 3,024 more than the number of deaths occurring in care homes reported by ONS during the same period (24,793). During this period, 73% of care home residents died in care homes, 13% died in hospital and for the majority of the remainder information on place of death was not available.

7.4 Excess mortality

Table 7.1 shows results from the excess mortality model and includes the number of excess deaths by place of death in the period 20 March to 7 May against the number of deaths that would be expected for corresponding dates in 2015 to 2019. It also quantifies how many deaths have COVID-19 mentioned on the death certificate.

Table 7.1. Cumulative all cause deaths by date of registration and place of death, 20 March to 7 May 2020, England. Source: Public Health England excess mortality model based on ONS death registration data.*

	Observed deaths	Expected deaths	Ratio observed/expected	Excess deaths	COVID-19 deaths	COVID-19 deaths as % excess
Home	26400	16858	1.6	9542	1630	17.1%
Care home	35933	15476	2.3	20457	9496	46.4%
Hospital	47913	31897	1.5	16016	23569	>100%
Hospice	3617	4006	0.9	-389	453	No excess deaths
Other places	2406	1674	1.4	732	291	39.8%
Total	116269	69911	1.7	46358	35439	76.4%

*Note that the model for place of death is slightly different from other models and therefore the number of excess deaths is slightly different.

Overall the model suggests that there have been 20,457 excess deaths in care homes between 20 March and 7 May 2020 and 16,016 in hospitals. The care home finding is consistent with the finding reported in section 1, that 75% of excess deaths are in people aged 75 and over. It is not possible to say whether these excess deaths in care homes have been concentrated in a few with outbreaks or distributed among many. There have been no excess deaths in hospices.

The number of COVID-19 deaths in hospitals is greater than the estimated number of excess deaths. This suggests that deaths in hospitals from causes other than COVID-19 have reduced over this period or that COVID-19 has also contributed to deaths from other causes.

In care homes the number of COVID-19 deaths is equivalent to 46.4% of the excess. This is consistent with figures reported by ONS (39) and suggests that there has been an increase in deaths from other causes over this period in care homes or an under-reporting of COVID-19 on death certificates. Deaths in care homes were around 2.3 times the number expected in this period.

8. Comorbidities

8.1 Main messages

Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This finding is consistent with other studies that have noticed a higher risk of death from COVID-19 among patients with diabetes. By age, the percentage was highest in males aged 60 to 69, was higher in all BAME groups than the White group and was 43% in the Asian group and 45% in the Black group. The same inequalities were seen for hypertensive disease.

Several studies, although measuring the different outcomes from COVID-19, report an increased risk of adverse outcomes in obese or morbidly obese people.

PHE is seeking to obtain and link additional datasets that measure body mass index (BMI), a more comprehensive range of comorbidities and other sociodemographic characteristics such as ethnicity to understand the combination of these risks further.

8.2 Introduction

People with underlying health conditions or other recognised risk factors for severe outcomes from respiratory infections appear to be at a higher risk of poor outcomes from COVID-19 than people without these conditions. One review suggested the most commonly reported conditions associated with poor outcomes were diabetes mellitus, chronic lung disease and cardiovascular disease (40). Persons with certain underlying conditions are classed as 'extremely clinically vulnerable' or 'clinically vulnerable' to COVID-19 (41).

Emerging evidence has established a need to better understand the association between obesity and COVID-19 particularly as 28% of adults in England in 2018 were obese (Body Mass Index (BMI) of 30kg/m² or more) and 3% were morbidly obese (BMI of 40kg/m² or more) as indicated by the Health Survey for England (42). In addition, patients living with obesity may not be equally exposed to COVID-19 or may have other underlying conditions, such as those mentioned above, which influence their outcome from COVID-19.

The prevalence of obesity and underlying health conditions such as diabetes also varies by ethnic group. Data from the National Diabetes Audit suggests that type II diabetes

prevalence is higher in people from BAME communities (25). The latest data from the Health Survey for England indicates that obesity prevalence rises to 54% in Black females but was as low as 16% in Asian males (42).

However, there are limitations in the availability of appropriately linked data to understand the relationship between obesity, underlying health conditions, socioeconomic characteristics including ethnicity and risk of adverse outcomes from COVID-19. For example, some datasets are limited to inpatient data or patients admitted to ICU, so they will not include all cases or deaths from COVID-19. This section summarises the available data to date.

8.3 Obesity

The latest report from the Intensive Care National Audit and Research Centre (ICNARC) used data up to 21 May 2020 and showed that 7.7% of patients critically ill in intensive care units (ICU) with confirmed COVID-19 were morbidly obese compared with 2.9% of the general population (after adjusting for age and sex) (2). This disparity was also seen when looking at white and non-white patients separately.

The report also showed a relationship between BMI and death from COVID-19 in BMI over 30 kg/m². This analysis controlled for other demographics and health conditions but is restricted to those patients admitted to ICU from 289 participating trusts.

A study using data from over 400,000 patients aged 40 to 69 from UK Biobank linked to COVID-19 test data from PHE found that higher BMI was associated with a positive COVID-19 diagnosis (43). Compared with non-overweight people (BMI < 25 kg/m²), the odds ratios¹ were 1.26 (confidence interval of 1.01-1.56) for those who were overweight, 1.37 (1.06-1.76) for those in obese class I and 2.04 (1.50-2.77) for those in obese classes II and III combined².

A study by the OpenSAFELY collaborative used a dataset of 17 million adult primary care electronic health records linked to deaths data from the COVID-19 Patient Notification System (CPNS) up to 25 April 2020 (44). This found a relationship between death from COVID-19 and BMI when controlling for demographics and other health

¹ The odds of an event occurring is the probability of an event occurring divided by the probability of an event not occurring.

The odds ratio is the odds of one event occurring divided by the odds of another event occurring. In this case, the odds ratio divides the odds of a person having COVID-19 in a particular overweight or obese BMI group by the odds of a patient having COVID-19 in the control group which is those people who were not overweight (BMI < 25 kg/m²).

² Overweight is 25-29.9 kg/m², obese class I is 30-34.9 kg/m², obese class II is 35-39.9kg/m² and obese class III is 40 kg/m² or more and is also sometimes referred to as being morbidly obese.

conditions. The hazard ratio³ compared to those who were not obese increased as BMI increased and was 1.27 (1.18-1.36) for those in obese class I, 1.56 (1.41-1.73) for those in obese class II and 2.27 (1.99 to 2.58) for those in obese class III (morbidly obese).

Although measuring the different outcomes of dying from COVID-19 once in ICU, contracting COVID-19 and dying from COVID-19, all 3 studies have shown a relationship between COVID-19 and increasing BMI. Of the studies mentioned, the study by the OpenSAFELY collaborative covers the broadest cohort of patients.

These findings are also consistent with studies from other countries. A study based on 383 COVID-19 patients admitted to the Third People's Hospital of Shenzhen in China found that obesity, especially in men, significantly increases the risk of developing severe pneumonia in COVID-19 patients (45). In France, a study of 124 patients admitted to intensive care in a hospital in Lille found the proportion of patients who required invasive mechanical ventilation increased with increasing BMI category (46).

NHS England have also looked at the relationship between BMI and diabetes and the risk of death from COVID-19 (47). The study linked data from the National Diabetes Audit, Hospital Episode Statistics and deaths from COVID-19 for around 265,000 people with type I diabetes and 2.9m people with type II diabetes. The analysis adjusted for demographics and other health conditions and showed the hazard ratio was highest for those with low and high BMI. For those with a BMI < 20 kg/m², the hazard ratio was 2.11 (1.32-3.38) for type I diabetes and 2.26 (2.04-2.50) for type II, and for those who were morbidly obese it was 2.15 (1.37-3.36) for type I and 1.64 (1.50-1.79) for type II.

8.4 Other conditions mentioned on death certificates

This section examines other conditions which have been mentioned on death certificates where COVID-19 is mentioned. The conditions included relate to people who are classed as 'clinically vulnerable' (41). Dementia has also been analysed since it is the leading cause of death among older people in England.

As this section only looks at death certificates, it will be an underestimate of the number of people who die from COVID-19 who have underlying health conditions as not all will be mentioned on the certificate.

³The hazard ratio is a comparison between the probability of events in a treatment group, compared to the probability of events in a control group.

In this case, it is a comparison of the probability of dying from COVID-19 for people in a particular obese BMI group compared to the probability of dying for people who were not obese (BMI < 30 kg/m²)

All of the conditions examined were more likely to be mentioned on a death certificate when COVID-19 was also mentioned, than they were for deaths overall. However, for cardiovascular disease, the difference was very small (Table 8.1).

The largest difference was for diabetes, which includes type I and type II. Diabetes was mentioned on 15% of all death certificates between 21 March and 1 May. However, it was mentioned on 21% of death certificates where COVID-19 was also mentioned.

Data from NHS England suggests that 26% of those who died in hospital and have tested positive for COVID-19 up to 19 May 2020 had diabetes as a pre-existing condition (48). A study using data from the National Diabetes Audit reports that death rates in those with diabetes have doubled during the pandemic (47).

Table 8.1. Percentage of all deaths, and percentage of COVID-19 deaths where one of the conditions were mentioned, 21 March to 1 May 2020, England. Source: Public Health England analysis of ONS death registration data.

Condition	Percentage of all deaths where condition is mentioned	Percentage of COVID-19 deaths where condition is mentioned
Cardiovascular disease	44.1	44.5
Diabetes	14.6	21.1
Hypertensive diseases	14.5	19.6
Chronic Kidney Disease	8.5	10.8
Chronic Obstructive Pulmonary Disease	10.6	11.5
Dementia	23.8	25.7

More detailed breakdowns of the data for each of the conditions can be found in Table 8a, 8b and 8c in the data pack.

Diabetes

The proportion of COVID-19 deaths where diabetes is also mentioned was higher among males than females (24% compared with 18%), and by age was highest among males aged 60 to 69 (31%).

Diabetes was more likely to be mentioned on the death certificate in more deprived areas. In the most deprived areas, 26% of COVID-19 deaths also mentioned diabetes. This is significantly higher than in the least deprived areas (16%) (Figure 8.1). The proportion of COVID-19 deaths where diabetes is mentioned ranged from 18% in the White ethnic group, 43% in the Asian group to 45% in the Black group.

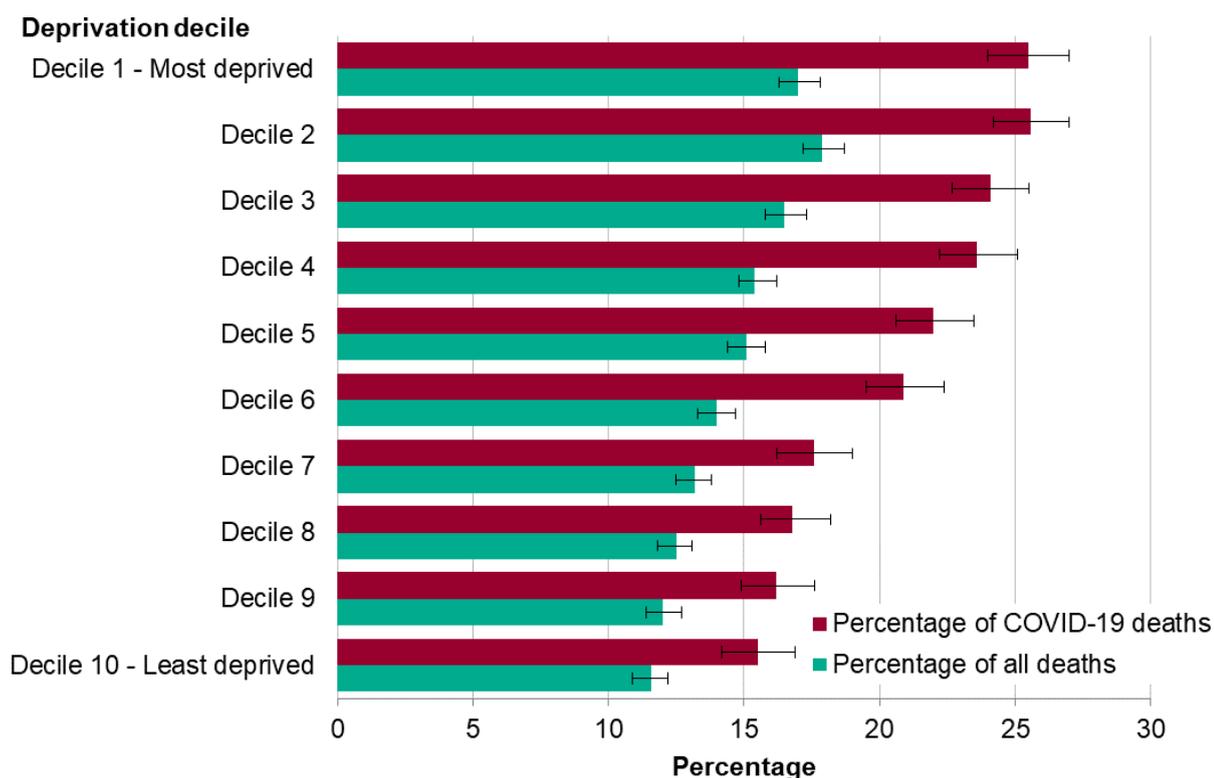


Figure 8.1. Percentage of COVID-19 deaths where diabetes was also mentioned on the death certificate, by deprivation decile, 21 March and 1 May 2020, England. Source: Public Health England analysis of ONS death registration data.

Hypertensive disease

The proportion of COVID-19 deaths where hypertensive disease is also mentioned is higher among males than females (21% compared with 18%), and by age highest among males aged 60 to 69 (26%). The proportion of COVID-19 deaths where hypertensive disease is mentioned ranged from 17% in the White ethnic group to 40% in the Black group but is also high in the Asian and Mixed groups (Figure 8.2).

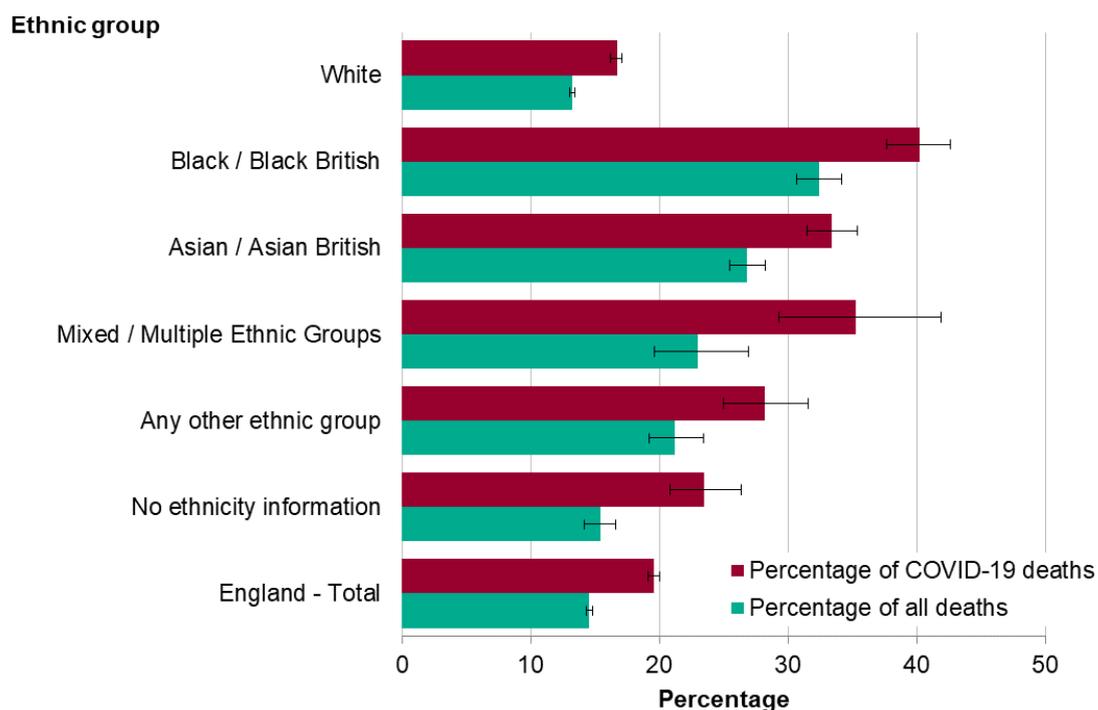


Figure 8.2. Percentage of COVID-19 deaths where hypertensive disease was also mentioned on the death certificate, by broad ethnic group, 21 March to 1 May 2020, England. Source: Public Health England analysis of ONS death registration data

9. Limitations

The analyses presented in this review use data available to PHE through multiple surveillance systems. These analyses are mostly descriptive and compare disparities in diagnosis and death from COVID-19 across a range of data sources. The descriptive nature of the analysis therefore limits the conclusions that can be drawn about the reasons for the disparities shown. In addition, there are other important limitations that must be considered when interpreting their findings.

Laboratory confirmed cases analysed in this report refer to Pillar 1 testing only. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease only, rather than all of those who get infected. This has important implications when considering, for example, the proportion of deaths among confirmed cases, which will be high as confirmed cases are mostly people with severe disease.

In addition, the numbers of cases and diagnosis rates are likely to be strongly influenced by case definition and testing policy, both of which have changed since the first cases were identified, may vary between geographical areas, and must be interpreted under that light. For example, when case definition included travel history, this may have made it more likely to test people of specific ethnic groups.

As of 19 May, 42 trusts had reported lower level of care patients (defined as admission to any hospital ward, excluding ICU or HDU), and 94 trusts contributed ICU/HDU (critical care) patient data to the COVID-19 Hospitalisation in England Surveillance System (CHESS).

Reporting to CHESS varies by trusts and the majority of trusts in London do not consistently report which will impact on the representativeness of the hospitalised cases. To account for variation in Trusts reporting within regions (and batch reporting), rather than providing daily number of hospitalised patients by region, daily rates are reported as 3 days moving averages using only the reporting trusts' catchment area populations (rather than regional population denominator). The demographic data presented here has not been adjusted for Trust underreporting as we cannot confidently assume and impute the missing demographic profiles of hospitalised patients for Trusts who have not reported. Because demographic composition of the population is considerably different in London from the rest of the country, the hospitalisation data must be interpreted with caution. Further analyses of the CHESS dataset have not been presented in this report because of its current limitations.

The analyses of ONS mortality data are based on records which have been provided to PHE very shortly after they have been registered. These records will have passed a series of automatic validation processes but will not have been subject to all the procedures which ONS undertake to ensure the quality and completeness of mortality data. These data are therefore provisional and small changes will be likely after data have been finalised. However, these changes are unlikely to affect the conclusions drawn from the data.

Ethnicity information for cases and deaths was derived through linkage to hospital records. Ethnicity information for the population denominators used to calculate the rates was derived from the 2011 Census. This creates a mismatch between the 2 sources and it is possible that there are proportionally more people assigned to the Other ethnic group in the hospital data than there are in the census data. This may explain the high diagnosis and mortality rates in the Other group, which requires further investigation and no firm conclusions can be drawn about this group.

However, this mismatch described above will not be apparent in the survival analysis presented as population denominators are not used for that analysis. In addition, it should not affect the comparisons of inequality with data for previous years as data for all time periods will be subject to a similar bias.

It was not possible to obtain ethnicity information for some records, although the proportion with missing ethnicity was low for most data sources (see data and methods section). CHESS data had the largest percentage with missing ethnicity data, particularly for ICU data, and therefore these findings should be given less weight. People with missing ethnicity data have been excluded from the analysis by ethnic group. This may have introduced some bias by excluding people who are less likely to have a hospital record or ethnicity recorded in their records.

The linked datasets used do not currently include all data that would be useful to understand disparities across all groups. They don't include, for example, information about household composition or genetic factors, which may explain some of the findings.

Information on vulnerable groups is lacking. Very few surveillance systems accurately capture groups of the population who are known to have the poorest health outcomes such as vulnerable migrants, sex workers or people experiencing homelessness or rough sleeping. These analyses therefore do not allow us to accurately assess the impact of COVID-19 on the most vulnerable groups of the population.

Occupational data is not currently available for all diagnosed cases. Robust data are available for those who have died and have been included in this report. Analysis of diagnosed cases has currently only been undertaken for nurses, midwives and nursing

assistants registered with the NMC. This data will continue to be analysed and further work of other healthcare workers is being planned.

The analysis of comorbidities presented in this report is currently limited to an analysis of death certificates and other published sources of data on obesity. Very few datasets available for analysis by PHE contain information on height and weight to calculate BMI and link to diagnosed cases and deaths.

A more thorough analysis is required to fully understand the relationships between comorbidities including obesity, sociodemographic characteristics such as ethnicity and occupation and the risk of diagnosis and death to understand these disparities further.

Comparisons have been made against the most appropriate baseline or group available at the time of analysis. This has created some complexities in interpretation and it may be possible to improve this when other data become available.

Some of the papers referenced in this report are early publication papers and have not been peer reviewed and should therefore be interpreted with some caution. However, many are authored by academics from multiple institutions which may give more confidence in the approach taken and conclusions drawn.

10. Data sources and methodologies

10.1 Testing and laboratory confirmed cases

Respiratory Datamart and the Second Generation Surveillance System (SGSS) were used for information about all samples tested and their results (positive and negative) from public health, NHS and private laboratories that report to PHE.

SGSS is an application that stores and manages data on laboratory isolates and notifications and is the preferred method for capturing routine laboratory surveillance data on infectious diseases and antimicrobial resistance from laboratories across England. Respiratory datamart is a laboratory-based surveillance system for influenza and other respiratory viruses in England.

The same individual can receive multiple tests. These were deduplicated so that a laboratory confirmed case of COVID-19 is any individual who has received a positive test result for the SARS-CoV-2 virus.

The majority of testing to date has been offered to those in hospital with a medical need. Laboratory confirmed cases therefore are likely to represent the typical population of people with severe disease, rather than all of those who get infected.

10.2 Hospitalised cases

New patients admitted to hospital with COVID-19 are reported daily to the COVID-19 Hospitalisations in England surveillance system (CHESS) by acute NHS trusts in England through a secure web portal. There are 2 subsets of data within CHESS: COVID-19 cases admitted to a lower level of care (defined as admission to any hospital ward, excluding ICU or HDU); COVID-19 cases admitted to ICU/HDU (critical care). Trusts report aggregate numbers by age group of all new hospital admissions with COVID-19 or acute respiratory illness. All acute trusts are asked to report individual level data on all new ICU/HDU admissions with COVID-19 and a sentinel network of Trusts report individual level data on all new hospital admissions at any level of care. All data are cleaned and analysed daily.

Reporting varies by trusts and not all trusts report daily; as of 19 of May, 42 trusts had reported lower level of care, and 94 trusts contributed critical care patient data to CHESS. The majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the demographic profile of hospitalised cases, including those in critical care.

Checking the validity of CHES aggregate data has been done by comparing CHES data with NHS England data for fields common to both datasets where trusts did report to both systems and there is good agreement via scatter plot and Bland–Altman plots. Nevertheless, further analyses of the CHES dataset have not been presented in this report because of its current limitations.

10.3 Mortality

Public Health England receives reports of death from 3 sources:

1. NHS England (NHSE) line listing of deaths reported by NHS trusts in the COVID-19 Patient Notification System (CPNS).
2. Health protection teams (HPTs) reporting deaths notified to them (primarily non-hospital settings).
3. The Demographic Batch Service (DBS) traced data, which takes a complete record level list of all individuals with a positive test in SGSS and links that to the central NHS Digital patient record of all deaths.

Data from each source are merged and duplicates removed in order to retain only one record per individual. Cleaned data sets are sent to DBS for tracing of missing information and then merged to form the final dataset.

This dataset only includes deaths in which the deceased has had a positive test result. More detail about the PHE data series on deaths in people with COVID-19 is available here: <https://www.gov.uk/government/publications/phe-data-series-on-deaths-in-people-with-covid-19-technical-summary>.

10.4 ONS registered deaths

Death registration data supplied by the Office for National Statistics over the period 24 March to 8 May 2020 was obtained and used for this analysis.

10.5 Data linkage to assign ethnicity

Completeness of ethnicity recording in the above datasets is low; this is common among similar systems. To mitigate this, data was linked with Hospital Episode Statistics (HES) data to assign ethnicity information. HES is a database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England. HES use ethnic categories as classified by the 2001 ONS census (49).

Ethnicity was assigned to all datasets by linking, using NHS number and date of birth, to the latest recording of ethnicity in the Outpatient Hospital Episode Statistics (HES) or the HES Admitted Patient Care data set.

Records that could not be linked to HES, either because there was not a record to link to within HES or because information on date of birth and/or NHS number was inconsistent or missing, were excluded from the ethnicity analyses in this report. People from certain ethnic backgrounds may be less likely to have an NHS number or full date of birth than those from other ethnic groups and consideration needs to be given to this in the interpretation of the findings within this report.

It was possible to obtain ethnicity for:

- 91.9% of COVID-19 cases
- 89.5% of cases in the lower level of care subset and 80.9% of cases in the ICU subset (for hospitalised cases)
- 99.4% of the deaths in laboratory confirmed COVID-19 patients
- 97% of all cause deaths

For the excess mortality model any unknown or not stated ethnicities were imputed using direct imputation methodology.

10.6 Population data

The denominators used to calculate rates by ethnic group are from the ONS 2018 'aged-on' population for ethnic groups, based on the 2011 Census, which uses the Harmonised Classification of Ethnic Groups. For ethnicity categories to match between HES and ONS denominators, the following were merged:

- in ONS data, the "Gypsy or Irish Traveller" category was merged into "Any other White background"
- in HES data, the "Chinese" category was moved to the "Asian or Asian British" grouping
- in both datasets, the "Arab" category was included in "Any Other Ethnic Group"

Appendix B provides a comparison of the ONS and HES ethnic categories.

ONS 2019 mid-year populations for Government Office Regions were used for population denominators by region and Upper Tier Local Authority (UTLA). ONS 2018 population estimates by LSOA were grouped into deprivation quintiles and deciles and used for population denominators.

10.7 Assigning deprivation quintiles and deciles

Deprivation quintiles and deciles have been constructed using Index of Multiple Deprivation scores at lower super output area (LSOA) level. LSOAs are small geographic areas produced by ONS to enable reporting of small area statistics in England and Wales. There are 32,844 LSOAs in England, each having a population of approximately 1,500.

LSOAs within England were ranked from most to least deprived and then divided into ten categories (deciles) or 5 categories (quintiles) with approximately equal numbers of LSOAs in each. The deprivation index used was the Index of Multiple Deprivation 2019 (IMD2019) scores from the English Indices of Deprivation 2019, released by the Ministry of Housing, Communities & Local Government (13).

10.8 Age standardisation

Age-standardised rates adjust for differences in the age structure of populations and allow comparisons to be made between geographical areas and through time, allowing identification of any underlying change in mortality rates. The direct method uses the age-standardised rate for a particular condition which would have occurred if the observed age-specific rates for the condition had applied in a given standard population. The standard used throughout this report is the European Standard Population 2013. Death rates calculated using ONS registered deaths were annualised to enable comparisons with previous years and with ONS analysis.

10.9 Cox regression

COVID-19 laboratory confirmed cases were matched to reported deaths by NHS number. Records that contained the linking field were included in the final analysis dataset ($n = 130,101$ cases, $n = 28,246$ deaths). Cox proportional hazards regression models were used (presented in Appendix A) to model survival time between date of positive specimen and date of death or survival to 13 May 2020 among people with confirmed COVID-19 by age, sex, ethnicity, region and deprivation (IMD quintile). Interaction between variables was assessed; since there are interactions between age and some of the other variables, models were stratified by age in sub-models: an all ages model, one for working age patients (20-64 years of age) and one for older patients (65+ years of age). All 3 models included all variables. The proportional hazards assumption was tested using Schoenfeld residuals and only sex was significant. However, sex was not adjusted for as a time varying covariate due to the nature of the stability of this factor. Hazard ratios from the crude and fully adjusted models are shown in Appendix A with 95% confidence intervals.

10.10 Nurses, midwives and nursing assistants

The data referring to the cases and deaths among Nurses and Midwives used the Nursing and Midwifery Council (NMC) register data of currently eligible to work nurses, midwives and nursing associates. The register data does not include temporary registrants who may have re-joined the temporary register recently to work in the COVID-19 response.

The NMC register was obtained on 14 May. This was linked to laboratory confirmed cases of COVID-19 as of 19 May. Linking was done using surname, first name, sex, date of birth and postcode. The linking process excluded cases for which information did not match, which means it will not identify some professionals.

A match with a confirmed COVID-19 case and being on the NMC register does not imply that the infection was acquired occupationally.

10.11 People with no fixed abode

The data for homelessness are based on the no fixed abode (NFA) code through the residential address ascribed in SGSS. NFA codes are subject to underreporting or misclassification, as well as changes in reporting over time.

Population (denominator) figures to calculate rates are based on estimates of the number of people sleeping rough in England in autumn 2019 (50). People sleeping rough are defined as “People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or ‘bashes’ which are makeshift shelters, often comprised of cardboard boxes)”. These figures are subject to some uncertainty and should be treated as estimates of the number of people sleeping rough on a single night and an indication of trends over time.

10.12 Excess mortality model

Excess deaths

Total cumulative excess mortality is estimated by calculating the cumulative deaths between March 20 and 7 May 2020 and subtracting the expected cumulative deaths in this period. Expected deaths are modelled using the previous 5 years of data, except when modelling for ethnicity, where the period 2014 to 2018 was used.

ONS compared deaths in 2020 with the simple average for the years 2015 to 2019. However, this will not adjust for ageing of the population or the effect of Easter or bank holidays on the number of deaths registered. The PHE model does adjust for this.

Daily registered deaths

We present daily ONS registered deaths from March 20 to 7 May 2020. To maximise correspondence with the pattern of death registrations in the baseline data (expected deaths), all weekend and public holiday death registrations were reassigned to the nearest working day.

Modelled expected deaths

Models to develop baseline estimates of the expected number of deaths on a given working day of the year were constructed using a combination of deaths and population-denominator data from 2015 to 2019. Because historically deaths were registered on working days, the few deaths registered on weekends or bank holidays were assigned to the nearest working day.

Data structure and covariates

Independent variables included day of week, whether a day was a bank holiday, and time of year allowing for seasonal effects. The model also includes specific adjustments for registrations around bank holidays, a linear trend by year and covariates allowing for the effect of age, gender, deprivation, ethnicity and geographical region. In addition, we include an interaction term between age and sex to allow sex to modify the effect of age on death.

The model structures are hierarchical with population denominators and counts of death each being fully disaggregated to demographic sub-groups. England, and region models contain variables for age, sex, and upper tier local authority (UTLA). Ethnicity and deprivation models were built separately from the England model because, by including UTLA in these models, the datafile became too large to model. Ethnicity and deprivation models therefore each contain age, sex and region.

To avoid competing risk, for place of death analyses, each outcome (e.g. death at home) was modelled separately. These models are currently built with no demographic structure and no denominators.

Statistical modelling

The models are Quasi-Poisson regression models, on the logarithmic scale (a 'log link') which account for over dispersion. The models for all causes, by age, sex, ethnicity and deprivation contained the set of covariates outlined in the section above and an offset reflecting the log-population-size in each population subset. Data were analysed using the glm function in R. In calculating the expected total number of deaths in a given population subgroup (e.g. males aged 85+ years in the Middlesbrough UTLA) on a given date in 2020, we added up the number of deaths expected in that specific subgroup taking appropriate account of the (gradually increasing) size of that sub-population size between 2015 and 2019.

COVID-19 deaths

Among cumulative death charts we added an orange 'ribbon' to represent deaths with a mention of COVID-19 on the death certificate. Even though it is well recognised that many people dying of COVID-19 had other significant co-morbidities, the majority (96%) of COVID-associated deaths are recorded as having COVID as the underlying cause of death.

Occupational classification

Mortality has been analysed according to the Standard Occupational Classification 2010 (SOC 2010) 'minor groups' and 'unit groups', the lowest level of the classification (51).

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Appendices

Appendix A: Multivariate analyses

COVID-19 laboratory confirmed cases were matched to reported deaths by NHS number. Records that contained the linking field were included in the final analysis dataset (n = 130,101 cases, n = 28,246 deaths). Missing data excluded from regression: sex, n=10; age group, n=38; ethnic group, n=2,024; region, n=446; deprivation quintile, n=639.

Cox proportional hazards regression models were used to model survival time between date of positive specimen and date of death or survival to 13 May 2020 among people with confirmed COVID-19 by age, sex, ethnicity, region and deprivation (IMD quintile). Interaction between variables was assessed; since there are interactions between age and some of the other variables, models were stratified by age in sub-models: an all ages model, one for working age patients (20-64 years of age) and one for older patients (65+ years of age). All 3 models included all variables. The proportional hazards assumption was tested using Schoenfeld residuals and only sex was significant. However, sex was not adjusted for as a time varying covariate due to the nature of the stability of this factor. Hazard ratios from the crude and fully adjusted models are shown in Appendix A with 95% confidence intervals.

In all 3 models, men had a significantly higher probability of death compared to women (adjusted hazard ratio (aHR)=1.54 (95%CI 1.50-1.57)) (Table A1). The increased risk was higher for working age adults (aHR=1.99 (95%CI 1.85-2.14)) than for older adults (aHR=1.47 (95%CI=1.44-1.51)).

Compared to the youngest age group of patients (<20), the probability of death significantly increased with age up to approximately 70-fold for those aged 80 and over (aHR=70.26 (95%CI 43.66-113.07)).

Those living in the most deprived areas had a higher probability of death when compared to those living in the least deprived (aHR for the most deprived quintile was 1.16 (95%CI 1.12-1.21) when compared to the least deprived quintile (Table A1). The risk was higher for working age patients (aHR=1.93 (95%CI 1.70-2.19)) (Annex A, Table A2) than for older patients (aHR=1.09 (95%CI 1.04-1.13)) (Table A3).

Regional differences were observed, with probability of death being higher as compared to London in East of England (aHR=1.10 (95%CI 1.05 - 1.15)) and lower as compared to London in North East (aHR=0.82 (95%CI 0.77 - 0.87)), North West (aHR=0.92

(95%CI 0.88 - 0.96)), South East (aHR=0.92 (95%CI 0.88 - 0.96)), South West (aHR=0.89 (95%CI 0.84 - 0.94)), West Midlands (aHR=0.93 (95%CI 0.89 - 0.98)) and Yorkshire and Humber (aHR=0.92 (95%CI 0.88 - 0.97)). The increased probability in East of England compared to London was observed in older age groups only (Table A3), whereas the lower probability in other regions as compared to London was primarily observed in the working age group (Table A2).

Six ethnic groups had significantly higher probability of death when compared to White British ethnicity in the model with all ages: Bangladeshi (aHR=2.02 (95% CI 1.74-2.35)), Pakistani (aHR=1.44 (95% CI 1.31-1.58)), other Black (aHR=1.35 (95% CI 1.18-1.55)), Chinese (aHR=1.28 (95%CI 1.04-1.58)), Indian (aHR=1.22 (95% CI 1.13-1.32)), other Asian (aHR=1.13 (95% CI 1.02-1.25)) and Black Caribbean (aHR=1.10 (95% CI 1.02-1.19)) (Table A1). People of White Irish ethnicity had lower probability of death when compared to White British ethnicity (aHR=0.88 (95% CI 0.79-0.99)).

These results were replicated in both age groups for people of Bangladeshi, Pakistani, Black Caribbean and Black other ethnic groups. For older age groups, the probability of death was also higher among people of Chinese, Indian and Other Asian ethnic groups (Tables A2 and A3).

Table A1. Multivariable hazard ratios for death among those with laboratory confirmed COVID-19. Data up to 13 May, England. Source: Public Health England Second Generation Surveillance System.

	number died	number total	Univariable			Multivariable			
			HR	95% CI	p-value	aHR	95% CI	p-value	
Sex									
Female	11,470	69,558	1.00 (ref)			1.00 (ref)			
Male	16,776	60,533	1.74	(1.69-1.78)	<0.001	1.54	(1.50 - 1.57)	<0.001	
Age group									
<20	19	2,004	1.00 (ref)			1.00 (ref)			
20-39	190	22,267	0.89	(0.54-1.47)	0.65	0.97	(0.59 - 1.59)	0.90	
40-49	455	15,349	3.20	(1.97-5.20)	<0.001	3.27	(2.01 - 5.31)	<0.001	
50-59	1,507	19,217	8.98	(5.57-14.49)	<0.001	9.03	(5.60 - 14.56)	<0.001	
60-69	3,226	15,002	26.77	(16.62-43.12)	<0.001	25.50	(15.83 - 41.08)	<0.001	
70-79	6,937	19,060	51.42	(31.95-82.77)	<0.001	50.18	(31.17 - 80.79)	<0.001	
80+	15,912	37,164	66.92	(41.59-107.68)	<0.001	70.26	(43.66 - 113.07)	<0.001	
Ethnic group									
White - British	22,880	99,098	1.00 (ref)			1.00 (ref)			
Asian / Asian British - Bangladeshi	182	708	1.10	(0.95-1.27)	0.21	2.02	(1.74 - 2.35)	<0.001	
Asian / Asian British - Chinese	92	470	0.78	(0.64-0.96)	0.02	1.28	(1.04 - 1.58)	0.02	
Asian / Asian British - Indian	746	4,149	0.75	(0.69-0.81)	<0.001	1.22	(1.13 - 1.32)	<0.001	
Asian / Asian British - Other	412	3,233	0.51	(0.46-0.56)	<0.001	1.13	(1.02 - 1.25)	0.02	
Asian / Asian British - Pakistani	483	2,353	0.86	(0.78-0.94)	0.001	1.44	(1.31 - 1.58)	<0.001	
Black / Black British - African	430	3,157	0.53	(0.48-0.58)	<0.001	1.06	(0.96 - 1.18)	0.24	
Black / Black British - Caribbean	713	2,367	1.30	(1.21-1.40)	<0.001	1.10	(1.02 - 1.19)	0.01	
Black / Black British - Other	229	1,167	0.79	(0.69-0.91)	<0.001	1.35	(1.18 - 1.55)	<0.001	
Mixed - Other	97	629	0.63	(0.51-0.77)	<0.001	1.04	(0.85 - 1.28)	0.68	
Mixed - White and Asian	30	285	0.43	(0.30-0.61)	<0.001	1.20	(0.84 - 1.72)	0.32	
Mixed - White and Black African	22	201	0.42	(0.28-0.65)	<0.001	0.79	(0.50 - 1.24)	0.30	

Mixed - White and Black Caribbean	46	248	0.77	(0.57-1.02)	0.07	1.18	(0.88 - 1.57)	0.28
Other - Any other ethnic group	574	3,725	0.62	(0.57-0.67)	<0.001	1.02	(0.94 - 1.12)	0.60
White - Irish	293	1,072	1.20	(1.07-1.35)	0.002	0.88	(0.79 - 0.99)	0.04
White - Other	951	5,215	0.76	(0.71-0.81)	<0.001	0.98	(0.92 - 1.05)	0.62
Region								
London	5,666	24,797	1.00 (ref)			1.00 (ref)		
East Midlands	2,038	7,828	1.22	(1.16-1.29)	<0.001	0.97	(0.92 - 1.03)	0.35
East of England	3,061	12,426	1.16	(1.11-1.21)	<0.001	1.10	(1.05 - 1.15)	<0.001
North East	1,562	8,987	0.79	(0.74-0.83)	<0.001	0.82	(0.77 - 0.87)	<0.001
North West	4,603	22,258	0.94	(0.91-0.98)	0.004	0.92	(0.88 - 0.96)	<0.001
South East	3,667	19,117	0.85	(0.82-0.89)	<0.001	0.92	(0.88 - 0.96)	<0.001
South West	1,490	7,023	0.96	(0.91-1.02)	0.21	0.89	(0.84 - 0.94)	<0.001
West Midlands	3,617	14,887	1.14	(1.10-1.20)	<0.001	0.93	(0.89 - 0.98)	0.003
Yorkshire and Humber	2,492	12,332	0.94	(0.90-0.99)	0.01	0.92	(0.88 - 0.97)	0.002
Deprivation quintile								
1 - most deprived	6,748	30,040	1.08	(1.04-1.13)	<0.001	1.16	(1.12 - 1.21)	<0.001
2	6,250	28,724	1.03	(1.00-1.07)	0.09	1.10	(1.05 - 1.14)	<0.001
3	5,372	25,584	1.00	(0.96-1.04)	0.98	1.04	(1.00 - 1.09)	0.04
4	5,175	23,791	1.04	(0.10-1.08)	0.07	1.04	(1.00 - 1.08)	0.06
5 - least deprived	4,531	21,323	1.00 (ref)			1.00 (ref)		

Table A2. Multivariable hazard ratios for death among those with laboratory confirmed COVID-19 and between 20 and 64 years of age. Data up to 13 May, England. Source: Public Health England Second Generation Surveillance System.

	number died	number total	Univariable			Multivariable		
			HR	95% CI	p-value	aHR	95% CI	p-value
Sex								
Female	1,202	37,677	1.00 (ref)			1.00 (ref)		
Male	2,346	27,284	2.68	(2.49 - 2.87)	<0.001	1.99	(1.85 - 2.14)	<0.001
Age group								
20-39	190	22,267	1.00 (ref)			1.00 (ref)		
40-49	455	15,349	3.59	(3.01 - 4.30)	<0.001	3.33	(2.79 - 3.99)	<0.001
50-59	1,507	19,217	10.08	(8.59 - 11.82)	<0.001	8.94	(7.61 - 10.50)	<0.001
60-64	1,396	8,129	23.36	(19.91 - 27.41)	<0.001	19.01	(16.18 - 22.35)	<0.001
Ethnic group								
White - British	2,255	44,588	1.00 (ref)			1.00 (ref)		
Asian / Asian British - Bangladeshi	59	474	2.48	(1.90 - 3.22)	<0.001	1.81	(1.38 - 2.37)	<0.001
Asian / Asian British - Chinese	19	310	1.24	(0.79 - 1.94)	0.36	1.12	(0.71 - 1.77)	0.61
Asian / Asian British - Indian	164	2,734	1.21	(1.03 - 1.42)	0.02	1.06	(0.90 - 1.25)	0.50
Asian / Asian British - Other	122	2,468	1.00	(0.83 - 1.20)	0.99	0.92	(0.77 - 1.12)	0.42
Asian / Asian British - Pakistani	142	1,563	1.86	(1.57 - 2.21)	<0.001	1.48	(1.24 - 1.76)	<0.001
Black / Black British - African	197	2,461	1.57	(1.36 - 1.82)	<0.001	1.04	(0.89 - 1.22)	0.59
Black / Black British - Caribbean	127	1,050	2.44	(2.03 - 2.92)	<0.001	1.31	(1.09 - 1.58)	0.005
Black / Black British - Other	96	834	2.31	(1.88 - 2.85)	<0.001	1.50	(1.21 - 1.86)	<0.001

Mixed - Other	22	409	1.11	(0.73 - 1.70)	0.61	1.18	(0.78 - 1.80)	0.43
Mixed - White and Asian	8	224	0.74	(0.37 - 1.49)	0.40	0.87	(0.43 - 1.74)	0.70
Mixed - White and Black African	6	140	0.87	(0.39 - 1.93)	0.73	0.72	(0.32 - 1.60)	0.42
Mixed - White and Black Caribbean	12	161	1.56	(0.89 - 2.76)	0.12	1.50	(0.85 - 2.66)	0.16
Other - Any other ethnic group	156	2,614	1.19	(1.01 - 1.41)	0.04	0.92	(0.77 - 1.09)	0.34
White - Irish	19	324	1.23	(0.78 - 1.93)	0.37	0.96	(0.60 - 1.53)	0.87
White - Other	132	3,059	0.88	(0.74 - 1.05)	0.17	0.80	(0.66 - 0.96)	0.01
Region								
London	1,092	13,436	1.00 (ref)			1.00 (ref)		
East Midlands	227	3,063	0.95	(0.82 - 1.10)	0.50	1.00	(0.86 - 1.16)	0.98
East of England	355	5,828	0.76	(0.67 - 0.86)	<0.001	0.96	(0.84 - 1.09)	0.52
North East	133	4,787	0.34	(0.29 - 0.41)	<0.001	0.44	(0.37 - 0.54)	<0.001
North West	499	11,311	0.55	(0.50 - 0.62)	<0.001	0.64	(0.57 - 0.72)	<0.001
South East	416	10,291	0.50	(0.44 - 0.56)	<0.001	0.70	(0.62 - 0.80)	<0.001
South West	139	3,350	0.51	(0.43 - 0.62)	<0.001	0.63	(0.52 - 0.76)	<0.001
West Midlands	412	6,276	0.85	(0.76 - 0.96)	0.007	0.87	(0.77 - 0.98)	0.03
Yorkshire and Humber	268	6,313	0.54	(0.47 - 0.62)	<0.001	0.64	(0.55 - 0.74)	<0.001
Deprivation quintile								
1 - most deprived	1,050	15,199	2.01	(1.78 - 2.27)	<0.001	1.93	(1.70 - 2.19)	<0.001
2	933	14,759	1.80	(1.59 - 2.03)	<0.001	1.65	(1.46 - 1.88)	<0.001
3	638	12,894	1.40	(1.23 - 1.60)	<0.001	1.38	(1.21 - 1.57)	<0.001
4	520	11,424	1.29	(1.13 - 1.48)	<0.001	1.32	(1.15 - 1.52)	<0.001
5 - least deprived	381	10,302	1.00 (ref)			1.00 (ref)		

	number died	number total	Univariable			Multivariable		
			HR	95% CI	p-value	aHR	95% CI	p-value
Sex								
Female	10,262	30,817	1.00 (ref)			1.00 (ref)		
Male	14,417	32,277	1.40	(1.36 - 1.43)	<0.001	1.47	(1.44 - 1.51)	<0.001
Age group								
65-69	1,830	6,873	1.00 (ref)			1.00 (ref)		
70-79	6,937	19,060	1.50	(1.43 - 1.58)	<0.001	1.55	(1.47 - 1.64)	<0.001
80+	15,912	37,164	1.95	(1.86 - 2.05)	<0.001	2.15	(2.05 - 2.26)	<0.001
Ethnic group								
White – British	20,617	53,291	1.00 (ref)			1.00 (ref)		
Asian / Asian British - Bangladeshi	122	203	1.95	(1.63 - 2.34)	<0.001	2.02	(1.68 - 2.42)	<0.001
Asian / Asian British - Chinese	73	153	1.21	(0.96 - 1.54)	0.11	1.32	(1.04 - 1.67)	0.02
Asian / Asian British - Indian	580	1,300	1.19	(1.10 - 1.29)	<0.001	1.28	(1.18 - 1.39)	<0.001
Asian / Asian British - Other	288	671	1.08	(0.96 - 1.22)	0.18	1.22	(1.08 - 1.38)	0.001
Asian / Asian British - Pakistani	339	723	1.26	(1.13 - 1.41)	<0.001	1.38	(1.24 - 1.54)	<0.001
Black / Black British - African	230	608	0.90	(0.79 - 1.03)	0.13	0.98	(0.86 - 1.13)	0.83
Black / Black British - Caribbean	586	1,305	1.14	(1.05 - 1.24)	0.002	1.09	(1.00 - 1.19)	0.05
Black / Black British - Other	132	305	1.10	(0.93 - 1.31)	0.27	1.19	(1.00 - 1.42)	0.05
Mixed – Other	75	180	1.07	(0.85 - 1.34)	0.58	1.01	(0.80 - 1.27)	0.92
Mixed - White and Asian	22	48	1.23	(0.81 - 1.87)	0.33	1.37	(0.90 - 2.09)	0.14
Mixed - White and Black African	16	45	0.86	(0.52 - 1.42)	0.55	0.82	(0.47 - 1.41)	0.47
Mixed - White and Black Caribbean	34	76	1.11	(0.80 - 1.56)	0.53	1.11	(0.79 - 1.55)	0.56
Other - Any other ethnic group	418	1,028	1.02	(0.92 - 1.12)	0.74	1.05	(0.95 - 1.16)	0.36

Disparities in the risk and outcomes from COVID-19

White – Irish	274	745	0.90	(0.80 - 1.02)	0.09	0.89	(0.79 - 1.00)	0.06
White – Other	819	2,050	1.01	(0.94 - 1.08)	0.76	1.02	(0.95 - 1.10)	0.60
Region								
London	4,564	10,981	1.00 (ref)		1.00 (ref)			
East Midlands	1,811	4,642	0.97	(0.92 - 1.02)	0.28	0.99	(0.94 - 1.05)	0.83
East of England	2,704	6,401	1.10	(1.05 - 1.16)	<0.001	1.14	(1.08 - 1.20)	<0.001
North East	1,429	4,113	0.89	(0.84 - 0.94)	<0.001	0.91	(0.85 - 0.97)	0.004
North West	4,103	10,687	0.96	(0.92 - 1.00)	0.07	0.99	(0.94 - 1.04)	0.64
South East	3,249	8,398	0.94	(0.90 - 0.98)	0.008	0.97	(0.93 - 1.02)	0.28
South West	1,351	3,554	0.92	(0.86 - 0.98)	0.006	0.94	(0.89 - 1.01)	0.08
West Midlands	3,202	8,373	0.95	(0.91 - 0.99)	0.03	0.96	(0.92 - 1.01)	0.12
Yorkshire and Humber	2,223	5,843	0.96	(0.92 - 1.01)	0.16	0.99	(0.94 - 1.04)	0.66
Deprivation quintile								
1 - most deprived	5,695	14,383	1.05	(1.00 - 1.09)	0.03	1.09	(1.04 - 1.13)	<0.001
2	5,312	13,528	1.03	(0.98 - 1.07)	0.24	1.04	(1.00 - 1.09)	0.05
3	4,727	12,294	1.00	(0.96 - 1.05)	0.87	1.02	(0.97 - 1.06)	0.48
4	4,652	11,993	1.01	(0.97 - 1.05)	0.62	1.02	(0.97 - 1.06)	0.47
5 - least deprived	4,149	10,682	1.00 (ref)		1.00 (ref)			

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Appendix B: Ethnicity classification in Hospital Episode Statistics (HES) data and in Office for National Statistics (ONS) data

HES ethnicity classification	ONS ethnicity classification
White A British B Irish C Any other White background	White <ul style="list-style-type: none"> • English / Welsh / Scottish / Northern Irish / British • Irish • Gypsy or Irish Traveller • Any other White background
Mixed D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background	Mixed / Multiple ethnic groups <ul style="list-style-type: none"> • White and Black Caribbean • White and Black African • White and Asian • Any other Mixed / Multiple ethnic background
Asian or Asian British H Indian J Pakistani K Bangladeshi L Any other Asian background	Asian / Asian British <ul style="list-style-type: none"> • Indian • Pakistani • Bangladeshi • Chinese • Any other Asian background
Black or Black British M Caribbean N African P Any other Black background	Black / African / Caribbean / Black British <ul style="list-style-type: none"> • African • Caribbean • Any other Black / African / Caribbean background
Other Ethnic Groups R Chinese S Any other ethnic group	Other ethnic group <ul style="list-style-type: none"> • Arab • Any other ethnic group

Appendix C: updates and corrections

Updates and corrections to the report

Correction made on 10 June 2020

Page 54

Corrected to list Somalia in in South and Eastern Africa rather than Central and Western Africa.

Corrections made on 11 August 2020

Page 15

The first paragraph said “Overall, the mortality rates among confirmed cases per 100,000 population among males were 1.3 to 2.1 higher than among females for all age groups (Figure 1.5). Overall the age standardised mortality rate in males (74.0 per 100,000) was twice that of females (38.0 per 100,000).”

The age standardised rates quoted here were based on analysis by ethnic group which used a different population to the analysis by age and sex. Figures have been corrected to 76.1 for males and 38.8 for females.

Page 15

The second paragraph said “An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, shows that, compared with people under 40, the probability of death was about 3-times higher among those aged 40 to 49, 9-times higher among those aged 50 to 59, 27-times higher among those aged 60 to 69, fifty times higher among those aged 70 to 79 and seventy times higher among those aged 80 and over.”

Two corrections as follows:

- For the 60-69 age group this was corrected to 26 times higher, rather than 27.
- The first sentence was reworded to say: “An analysis of survival among people with confirmed COVID-19 adjusted for sex, ethnicity, deprivation and region...”

Page 16

The third paragraph said “Males accounted for 57% of deaths from COVID-19 and females 43%, while the baseline all cause figures were 51% and 49%. This indicates that males make up a larger percentage of COVID-19 deaths than all causes.”

The baseline figures were corrected to 49% for males and 51% for females.

Page 16

The fourth paragraph said “8% of deaths from COVID-19 among males were in those under 60 years of age compared with 6% of females. This compares with 14% and 9% for baseline all cause deaths respectively.”

The baseline figures were corrected to 13% for males and 8% for females.

Page 17

The label on the x axis for Figure 1.6A and 1.6B was corrected from ‘Age-standardised rate per 100,000’ to “Age-specific rate per 100,000”.

Page 39 and page 45

Both pages corrected to say ‘Black Caribbean’ rather than just ‘Caribbean’.

Page 71

Section 10.6 corrected to say that the denominators used to calculate rates by ethnic group are from “the ONS 2018 ‘aged-on’ population for ethnic groups, based on the 2011 Census” rather than “the ONS 2018 mid-year populations for England”.

Implementing phase 3 of the NHS response to the COVID-19 pandemic

7 August 2020

Further to [the letter](#) of 31 July 2020 about the third phase of the NHS response to COVID-19, this document provides a range of supplementary materials to support implementation.

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1. Urgent actions to address inequalities in NHS provision and outcomes

Summary

COVID-19 has further exposed some of the health and wider inequalities that persist in our society. We are therefore asking you to work collaboratively with your local communities and partners to take the following eight urgent actions:

1. Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.
2. Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.
3. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.
5. Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.
6. Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.

7. Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.
8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

Introduction

COVID-19 has shone harsh light on some of the health and wider inequalities that persist in our society. Like nearly every health condition, it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations.¹ COVID-19 risks further compounding inequalities which had already been widening.²

Please take urgent action, in collaboration with local communities and partners, to increase the scale and pace of progress in reducing health inequalities, and regularly assess progress.

It is an integral part of the third phase of the NHS response to COVID-19, as set out [in the letter to the NHS on 31 July](#). As such, the actions set out here focus on the immediate tasks of continuing to protect those at greatest risk of COVID-19, restoring services inclusively and accelerating targeted prevention programmes, underpinned by improvements in leadership and accountability, data and insight and collaborative planning.

¹ For example, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

² See Chapter 5 <https://www.gov.uk/government/publications/health-profile-for-england-2019>

These measures will help lay the foundations for further action, particularly to enhance prevention and contribute to the concerted cross-governmental and societal effort needed to address the wider determinants of health; building on the strategy set out in the NHS Long Term Plan and the NHS's legal duties with regards to equality and health inequalities.

Action 1: Protect the most vulnerable from COVID-19

Systems (integrated care systems/sustainability and transformation partnerships), working with local authorities and other partners, should regularly update plans for protecting people at greatest risk during the pandemic. This includes ensuring that people who may be clinically extremely vulnerable to COVID-19 infection³ are identified and supported to follow specific measures – such as shielding – when advised, and to access restored health and care services when required.

As part of these plans, systems are asked to explicitly consider risks associated with people's relevant protected characteristics,⁴ and wider socio-economic, cultural and occupational risk factors in the local area. Plans should set out how insight into different types of risk and wider vulnerability within their communities will be improved, including through population health management and risk stratification approaches and deeper engagement with those at risk of exclusion, including carers. They should also ensure information on risks and prevention is accessible to all communities and reflects the need for culturally competent prevention campaigns.

Alongside these system plans, protection of NHS staff against COVID-19 also remains a key priority. NHS employing organisations have been completing COVID-19 risk assessments of staff by the end of July and taking subsequent action.

³ Specific groups of people have been defined by Government as clinically extremely vulnerable to COVID-19, based on expert advice and the earliest available clinical evidence. Clinicians have also been able to identify individuals as clinically extremely vulnerable based on their professional judgement and add them to the Shielded Patient List. As evidence regarding the impact of the virus increases, a new predictive risk model is being developed on behalf of the Department of Health and Social Care, that reflects a wider range of factors such as demographics alongside long-term health conditions, to better understand cumulative risk of serious illness for individuals if they catch COVID-19. Options for applying this model across a variety of health and care settings, including developing a tool to support conversations between patients and clinicians on individual risk, are being considered. More information will be provided over the summer as this work progresses.

⁴ See full list of protected characteristics at <https://www.equalityhumanrights.com/en/equality-act/protected-characteristics>

Action 2: Restore NHS services inclusively

The third phase of the NHS response to COVID-19 focuses on accelerating the return to near-normal levels of non-COVID health services. As part of that, and as the letter on 31 July highlights, specific actions may be needed to support any groups of patients who might have unequal access to diagnosis and treatment, including proactively reaching out to these patients.

To monitor this objective of an inclusive restoration of services, monthly NHS reporting will in future include measures of performance in relation to patients from the 20% most deprived neighbourhoods (nationally and locally, using the Index of Multiple Deprivation), as well as those from Black and Asian communities where data is available.

Monitoring will compare service use and outcomes across emergency, outpatient and elective care, including cancer referrals and waiting time activity. Over time, we will develop key metrics on clinical needs, activity and outcomes, including end of life care, mental health, children's health services, and primary care. We will also consider how to expand the approach to established performance standards and seek to improve data and insights on service performance experienced by people with a disability. All local NHS organisations should adhere to this approach in their internal and public performance reports, and swift action should be taken to rectify inequalities which are identified.

Our national and regional teams will also undertake specific reviews of the scope for specialised services to further address health inequalities. This will include monitoring the restoration of services to improve identification and engagement across all patient groups, assessing the scope for improving outcomes for those experiencing the greatest inequalities, and improving underlying recording of ethnicity and other relevant protected characteristics in datasets relevant to specialised services, including clinical databases, registries and audits. Specialised commissioning will require mandatory recording of ethnicity in clinical databases cited in specialised services service specifications by 31 March 2021.

These indicators should be considered alongside wider sources of community-based insight and the measurement of commitments set out in the NHS Long Term Plan. By

31 October 2020, we will further refine analysis of local inequality to support this wider work.⁵

Action 3: Develop digitally enabled care pathways in ways which increase inclusion

During the response to COVID-19, the health and care system has seen unprecedented levels of uptake of digital tools and services, helping keep patients, carers, friends, relatives and clinicians safe and ensuring that essential care can continue. Digitally enabled services provide an opportunity to create a more inclusive health and care system, creating more flexible services and opening up access for people who might otherwise find it hard to access in person, for example due to employment or stigmatisation.

The shift needs to be carefully designed to ensure it does not affect health inequalities for others, due to barriers such as access, connectivity, confidence or skills. All NHS organisations are therefore asked to ensure that no matter how people choose to interact with services, they should receive the same levels of access, consistent advice and the same outcomes of care. To monitor this, new care pathways should be tested for achieving a positive impact on health inequalities, starting with four: 111 First; total triage in general practice; digitally enabled mental health; and virtual outpatients. For each, systems should assess empirically how the blend of different 'channels' of engagement (face-to-face, telephone, digital) has affected different population groups, including those who may find any particular channel more difficult to access, and put in place mitigations to address any issues. System reviews, with agreed actions, should be published on all four by 31 March 2021.

Action 4: Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes

Some of the most significant, specific contributions the NHS can make to reduce health inequalities are to improve preventative services, maternity services and services for children and young people, including immunisation. The best approaches use an integrated and personalised model of care that takes account of wellbeing and

⁵ This analysis will also benefit from the work of the new NHS Race and Health Observatory <https://www.england.nhs.uk/2020/05/nhs-england-and-nhs-confederation-launch-expert-research-centre-on-health-inequalities/>

wider social and economic needs. Local NHS systems will need to address local priorities, in collaboration with partners. At the same time, we expect consistent national progress on the following four areas:

- Improving uptake of the flu vaccination in underrepresented 'at risk' groups: This coming winter, we may be faced with co-circulation of COVID-19 and flu. It is therefore essential to increase flu vaccination levels for those who are living in the most deprived 20% of neighbourhoods, those from BAME communities and people with a learning disability, and significantly reduce the gap in uptake compared with the population as a whole. We recognise this may be challenging given the expansion of the flu programme and the constraints of infection prevention and control for this winter. It will therefore require high quality, dedicated and culturally competent engagement with local communities, employers and faith groups.
- General practice, working with analytical teams and wider system partners, including social care and voluntary sector organisations, should use the capacity released through the [modified QOF requirements for 2020/21](#) to develop priority lists for preventative support and long-term condition management, such as for obesity management and hypertension. These should reflect how health needs and care may have been exacerbated during the COVID-19 pandemic. Priority groups for programmes such as obesity prevention, smoking cessation, and alcohol misuse, cardiovascular, hypertension, diabetes and respiratory disease prevention and long-term condition management should be engaged proactively, recognising the extra barriers to engagement which COVID-19 has brought, reflecting the wider strategy for restoring primary care services. For example, local areas should focus on generating referrals into the NHS Diabetes Prevention Programme on individuals of South Asian, Black African and Black Caribbean ethnicity and those from the most deprived communities.
- As set out in the Phase 3 letter of 31 July, GP practices should ensure that everyone with a learning disability is identified on their register and that annual health checks are completed. As a minimum, by 31 March systems should aim to ensure that primary care practices reach an annual rate of seeing at least 67% of people on their learning disability register through higher quality health checks, accelerating progress towards the NHS Long Term Plan target of 75% by 2023/24. This approach is backed by a £140 per person fee, a primary care network incentive, and quality improvement tools.

We expect every system to monitor and achieve this goal. To improve their GP learning disability register, it is particularly important to ensure people with a learning disability from a BAME background are known and included.

There is also a fundamental need to improve the provision of comprehensive physical health checks and follow-up interventions for people with severe mental illnesses (SMIs). At present, there is good completion rates of some of the individual elements of the comprehensive check. However, at a national level we are falling short of our ambition to provide this check for 60% of people with SMI. Given the very significant health inequalities faced by those with SMI, of reduced life expectancy of 15-20 years, further rapid progress is needed. We will also review incentives to improve completion rates from 2021/22.

- In maternity care, implementing continuity of carer for at least 35% of women by March 2021, with the number of women receiving continuity of carer growing demonstrably towards meeting the goal of most women. As part of this, by March, systems should ensure that the proportion of Black and Asian women and those from the most deprived neighbourhoods on continuity of carer pathways meets and preferably exceeds the proportion in the population as a whole. This is in line with the NHS Long Term Plan commitment that by 2024 75% of women from these groups will receive continuity of carer, and is more urgent in light of the increased risk facing Black and Asian women of both poor maternity outcomes and outcomes from COVID-19.

Action 5: Particularly support those who suffer mental ill-health

Mental ill-health is a significant contributor to long-term health inequalities, and the immediate and longer-term social and economic impacts of COVID-19 have the potential to contribute to or exacerbate mental health problems.

In response, systems have been asked to validate their plans to deliver the mental health transformation and expansion programme over the next eight months. These plans should pay particular attention to advancing equalities in access, experience and outcomes for groups facing inequalities across different mental health pathways, such as BAME communities, LGBT+ communities, children and young people with neurodevelopmental disorders, and older people. To underpin this, providers and

systems should improve the quality and flow of mental health data to allow more robust monitoring of disproportionalities in access and experience and take action where problems are identified. Building on the monitoring of IAPT, by 31 December providers must enhance the overall quality and completeness of ethnicity and other protected characteristics data provided to the national Mental Health Services Data Set.

The Advancing Mental Health Equalities Taskforce will set out further advice and support by 31 October.⁶

Action 6: Strengthen leadership and accountability

These actions and wider measures to increase the pace and scale of progress to reduce inequalities rest on clear and accountable leadership. All systems and every NHS organisation should therefore identify, before October, a named executive board-level lead for tackling inequalities. Primary care networks should also nominate their clinical director or an alternative lead to champion health equality.

As outlined in the NHS [People Plan](#) published on 30 July, addressing health inequalities will be enhanced by ensuring that we reflect the diverse communities we serve. We are committed to strengthening the culture of belonging and trust which enables this. Each NHS board has therefore been asked to publish an action plan showing how over the next five years its board and senior staffing will, in percentage terms at least, match the overall BAME composition of its overall workforce, or its local community, whichever is the higher. We are ourselves committed to ensuring that at least 19% of our people come from a Black, Asian or minority ethnic background at every level, including director level, by 2025.

Action 7: Ensure datasets are complete and timely

Given the importance of data and insight to understanding need and monitoring progress, all NHS organisations must review the quality and accuracy of their data on patient ethnicity, as recommended by the Public Health England report [Understanding the impact of COVID-19 on BAME groups](#),⁷ and ensure these characteristics are recorded for all patients by 31 December 2020. As part of these measures,

⁶ Advice is also already available from <https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality>

⁷ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

retrospectively updating and completing the COVID-19 Hospital Episode Surveillance System (CHESS) is essential.

Specific action is needed to improve the recording of ethnicity within general practice. We expect that to start, by no later than 1 September, through seeking to confirm the ethnicity of the adults who are eligible for flu vaccination; groups who are also typically likely to be at risk of COVID-19. By the end of September, we will aim to have developed a joint plan with primary care partners to extend that to all patients as quickly as possible. It will also be important to improve GP registration for those without proof of identity or address.

The use of data on protected characteristics to improve care and planning will be enhanced by combining with better recording of wider risks, using risk prediction tools. Action is also needed locally to improve the understanding of the needs of inclusion health groups, such as people who are homeless and refugees, and of the impact of intersectionality.⁸

Action 8: Collaborate locally in planning and delivering action

Systems (integrated care systems and sustainability and transformation partnerships) will need to support and oversee delivery of these actions, understanding population needs and building partnerships to address health inequalities. By 21 September 2020, system plans to restore critical NHS services should take account of all the actions set out above. Systems should assess progress regularly and provide an overall account of delivery against the actions in this note by 31 March 2021. They should also look to strengthen accountability to their local population and listen to their concerns, particularly those at risk of health inequalities. Data should be regularly published at the lowest meaningful geographical level possible to support this.

Areas with the greatest inequalities have received additional funding through the CCG allocation formula. These resources should be targeted at the areas of greatest deprivation and used to support these actions and local priorities for addressing

⁸ People are often disadvantaged by multiple sources of disadvantage and discrimination which can compound each other

inequality. Systems will be asked to review how resources have been used to address health inequalities over the financial year by 31 March 2021.

The collaboration seen during COVID-19 with local government and the voluntary, community and social enterprise sector, and the population health management approaches deployed, should be used to inform the development of longer-term plans to address the underlying causes of health inequality from 2021/22. Plans are likely to particularly benefit from bolstering the primary care workforce, especially in deprived areas, including ensuring primary care networks make full use of the Additional Roles and Reimbursement Scheme and help increase the number of GPs in under-doctored areas. Systems should also support NHS organisations seeking to serve as effective 'anchor' institutions, learning from the new NHS England and NHS Improvement/Health Foundation network.

Putting these actions into practice is a shared endeavour. We will seek rapid feedback on areas of action where national collaboration and learning may be valuable alongside the local work of systems, places and neighbourhoods.

Task and finish group on accelerating NHS progress on tackling health inequalities during the next stage of COVID-19 recovery

Dr Owen Williams OBE (Chair) – CEO Calderdale and Huddersfield NHS Foundation Trust

Evelyn Asante-Mensah OBE – Chair, Pennine Care NHS Foundation Trust

Charlotte Augst – CEO, National Voices

Nicola Bailey – Chief Officer, NHS County Durham CCG

Linda Charles-Ozuzu – Regional Director of Commissioning, NHS England and NHS Improvement

Samantha Clark – CEO, Learning Disability England

Dr Kiren Collison – Clinical Chair, Oxford CCG

Dr Vin Diwakar – Regional Medical Director, NHS England and NHS Improvement

Amanda Doyle – Chief Clinical Officer for West Lancashire CCG, Blackpool CCG and Fylde and Wyre CCG, and ICS Lead for Lancashire and South Cumbria

Professor Kevin Fenton – Regional Director, Public Health England

Donna Hall CBE – Chair, New Local Government Network

Jacob Lant – Head of Policy and Public Affairs, Healthwatch England

Patricia Miller – CEO, Dorset County Hospital NHS Foundation Trust

Patrick Nyarumbu – Regional Director of Nursing Leadership and Quality, NHS England and NHS Improvement

Jagtar Singh – Chair of Coventry and Warwickshire Partnership NHS Trust

Robin Tuddenham – Chief Executive, Calderdale Council

We are also grateful to members of the Health and Wellbeing Alliance, and other partners and colleagues in providers, commissioners and systems who have helped inform and develop the actions.

2. Mental health planning

Here we outline the steps we are taking to support the next phase of our COVID-19 response, in which mental health needs may increase significantly. It continues to be a requirement that the Mental Health Investment Standard (MHIS) is met in every CCG in 2020/21. We will be repeating the independent audits of the MHIS and we expect to see historic underinvestment in Mental Health addressed in every CCG.

As with the rest of the NHS the Phase 3 Mental Health planning process closes on 21 September, with an interim submission on 1 September, allowing us to allocate the additional funding required to meet the MHIS. The national mental health team will work closely with your teams over the coming weeks to support this planning process. We need to grow services, recruit staff and make the necessary changes to ensure we still meet the ambitions outlined in the NHS Long Term Plan (LTP).

STPs / ICSs should continue to strive to achieve the specific deliverables for 2020/21 set out in the [NHS Mental Health Implementation Plan 19/20–23/24](#) to the best of their abilities, recognising that COVID-related practical constraints (including staff absence, social distancing or disruption to referral pathways) may restrict what they are able to deliver in practice and use of technology enabled support will need to continue. We need to make sure our trajectories for 2020/21 are a realistic reflection of the context we are in. Mental health providers should organise themselves at STP/ICS level (including identifying a lead mental health provider), and work with their STP/ICS to ensure that plans are adequate to meet the activity requirements in 2020/21. To support moving towards a “System by Default” way of working from April 2021, ICS/STP leads and a lead Mental Health Provider will be asked to sign off on their Phase 3 Mental Health plans, confirming that the MHIS investment covers all the priority areas for the programme. Where a Provider Collaborative exists, it may be that existing partnership arrangements can support this way of working, as well as other local partnerships.

Our priority is to maintain momentum and continue to deliver the LTP. The LTP is a solid foundation to address the impact of COVID-19, which will improve the quality of mental health services and expand access to 2 million more people each year by 2023/24. We can confirm that the total annual allocations for all SDF (Transformation

Funding) programmes in 2020/21 remain in place and sites should proceed with delivery. The mechanism for flowing funding will be confirmed shortly.

Our partners find themselves operating in an increasingly challenging environment. The partnerships we have created in recent months with local authorities, the third sector and other parts of the health system are central to successful delivery of the programme and need to be maintained. We must make sure that over the next few months we work with patients, staff and families, by ensuring that they play a central and meaningful role in our decision making and reshaping of services. The NHS-commissioned [Working Well Together toolkit](#) provides practical steps on how to do this. NHS-Led Provider Collaboratives offer a model for achieving and strengthening these local partnerships and their implementation this year is critical.

We are beginning to see increased acuity in presentations to our services. To ready ourselves for winter and a potential second wave, we must use the Phase 3 planning process to ensure we invest across the entire health pathway, and not just in beds. This means continuing our investment in 24/7 crisis lines and alternatives to admission, as well as strengthening and investing in community services to help people to stay well and avoid escalations where possible. This is how we will transform the quality and reach of mental health care in this country.

Workforce growth remains the key enabler but also constraint to our ambition. When systems come to sign off investment plans for 2020/21, they should do so with the confidence that they have triangulated activity, finance and workforce trajectories and produced a plan that is feasible.

Evaluating the role of digital transformation must also be a central feature of this planning exercise as it offers a major opportunity to modernise care. However, in many cases, it should not be a replacement for face-to-face support. Systems are encouraged to review the impact of digital transformation in their area before moving into this next phase.

Local services should do all they can to meet the dementia diagnosis target, but our shared commitment to older adults goes beyond that, and we must also focus on ensuring that access to talking therapies, community mental health care and 24/7 crisis support meets the needs of older adults.

Addressing health inequalities remains a priority for our work on mental health. The [Advancing Mental Health Equality Resource](#) and IAPT Positive Practice Guides for [Older People](#) and [BAME communities](#) should be used to the best of their advantage.

We can now bring about the eradication of dormitories in mental health settings, supported by extra capital of £250 million in 2020/21 with a further sum next year. We ask mental health providers with dormitory provision to work with regional finance and estates colleagues to identify schemes that can proceed immediately, to ensure that we deliver this clear patient benefit without delay.

We will discuss 2020/21 plans during our upcoming Q1 Deep Dive round. As of Q2 2020/21, national assurance activity and data collections will resume with performance being discussed in the quarterly deep dives.

Areas of focus for the rest of 2020/21

The expansion of **Improving Access to Psychological Therapies (IAPT) services** should be at the forefront of this next phase as they provide NICE recommended treatment for the most common mental health problems and accept self-referral. The specialised support IAPT can offer to those with PTSD, anxiety, depression or to those who have spent lengthy time in an ICU, are all the more vital in the context of COVID-19. For this reason, we must use this year to grow and bring in more trainees to the service. Money is available to augment salary replacement costs to help with the expected, significant, surge in demand for IAPT services. Where regions did not achieve IAPT targets last year, recovery trajectories must be provided as part of the planning process.

Services should conduct proactive reviews for all patients on **community Mental Health teams'** caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community. In 2020/21, the year-on-year baseline funding uplift for community-based services for people with SMI, including EIP services and Physical Health Checks for People with SMI, is £162 million. The cumulative baseline uplift since 2018/19 is now £251 million. This is a significant component of CCG baseline funding increases and we encourage services to invest this as soon as possible to increase staffing to required levels. Services should also use this funding to promote and prioritise physical health for people with SMI, and accelerate LTP transformation where possible, including for adult eating disorders, mental health rehabilitation, and

'personality disorders' services. The ambition to eliminate inappropriate out of area placements for adult acute care by April 2021 stands and good community care is an important facet to delivering this ambition.

Children and young people have been significantly impacted by COVID-19, through the disruption to multi-agency support and through the closure of schools and colleges. As schools prepare to welcome children and young people back, services should ensure that local access to pathways, consultation and advice is clearly advertised. They should continue to expand provision, focusing on the needs of the most vulnerable such as those with autism or neurodisability, making full use of the £47 million year-on-year uplift in 2020/21 CCG baseline funding for CYP mental health services (including crisis and eating disorders). The baseline funding uplift since 2018/19 is now £83 million. The National Quality Improvement Taskforce for children and young people's mental health, learning disability and autism inpatient services has resumed its work and will be getting in touch with providers in the coming weeks. Community and inpatient services should continue working to improve pathways of care across their services.

This year will be the largest flu vaccination programme and we must do all we can to protect our staff and patients. We are already engaging with the vaccination programme team to make sure the specific needs of the mental health sector are considered and will be working closely with regional colleagues.

Support for NHS staff

We have launched a health and wellbeing offer for all NHS staff, which includes a telephone and text helpline and access to support for issues such as debt, bereavement, stress, domestic violence etc.

We are aware that many systems are putting in place local offers to support health and social care frontline staff. As signalled in the Winter Wellbeing plan, we are supporting a number of pilot sites across the country, testing an approach to improving staff mental health by establishing resilience hubs working in partnership with Occupational Health programmes. These pilots will undertake proactive outreach and assessment, and coordinate referrals access to prompt and evidence-based treatment and support for a range of needs, with a view to making the case for further roll out in future years.

The direct and indirect effects of COVID-19 will probably have psychological and social impacts that will have an effect on mental health and planning for some years to come. We will continue to address the impact of COVID-19 for the rest of this year, and beyond. Services should continue to ensure delivery of safe care in appropriate settings, addressing risks to both the mental and physical health of patients and staff in line with published guidance.

3. Restoration of adult and older people's community health services

This guidance on the restoration of adult and older people's community health services supersedes the prioritisation guidance for community health services first published on 20 March 2020 and updated on 2 April 2020, which is withdrawn.

All the service areas listed in the 20 March 2020 and 2 April 2020 guidance should now be fully reinstated, including where needed home visits for vulnerable adults, subject to appropriate infection control protections in line with Public Health England advice, and any other relevant NHS England guidance.

4. Using patient initiated follow-ups as part of the NHS COVID-19 recovery

Introduction

This section provides practical information about implementing patient initiated follow-up (PIFU) processes in secondary care. This guidance has been informed by the experience of providers and specialties that implemented PIFU as part of their COVID-19 response or before the pandemic, and guidance published by the [national cancer programme](#).

In line with the [personalised care](#) agenda, PIFU can play a key role in enabling shared decision-making and supporting patients with self-management, by helping them know when and how to access the right clinical input. Used alongside clinical waiting list reviews, remote consultations and a 'digital first' approach, it is a useful tool for provider recovery.

Benefits of patient initiated follow-up

Benefits to patients	Benefits to clinicians	Benefits to organisations and systems
<ul style="list-style-type: none"> • Together with remote appointments, encourages patients to attend appointments, as they know they will not need to go to an NHS site unless clinically necessary • Improves patients' engagement with their health • Empowers patients by allowing them to book appointments when they most need them (eg during a flare-up) • Services are more responsive due to improved management of waiting lists • Time and cost savings due to not having to travel to appointments without clinical need^{9,10} • Improved patient satisfaction¹¹ and reduction in anxiety 	<ul style="list-style-type: none"> • Ensures clinicians know that they are seeing the patients who need it the most • Provides a mechanism for the clinician to jointly develop plans and 'what if' scenarios with patients, and share the clinical risk • Helps clinicians to manage their caseloads and waiting lists • Gives clinicians confidence that patients know how to contact services if they need to 	<ul style="list-style-type: none"> • Reduction in waiting times and waiting lists due to net reduction in follow-up appointments^{9,10,11} • Reduction in service costs⁹ • Reduction in did not attend (DNAs) and improved use of clinical resources • Reduction in unmet need and clinical risk from patients being on waiting lists for follow-up appointments • Enabler to reducing outpatient appointments

When to use patient initiated follow-ups

Individual services should develop their own guidance, criteria and protocols on when to use PIFUs. PIFU pathways can be used for patients of any age, provided the patient and their clinician agree that it is right for them. In some cases, it may be appropriate for the patient to share the responsibility with a carer or guardian. Some general guidance is given below.

⁹ [Coleridge S, Morrison J. Patient-initiated follow-up after treatment for low risk endometrial cancer: a prospective audit of outcomes and cost benefits. *Int J Gynecol Cancer* Published Online First: 5 May 2020.](#)

¹⁰ [Wickham-Joseph R, Lugman I, Cooper N, et al. P166 Patient-initiated follow-up for low-risk endometrial cancer: an economic evaluation. *Int J Gynecol Cancer* 2019; 29: A160.](#)

¹¹ [Hewlett S, et al. Patient initiated outpatient follow up in rheumatoid arthritis: six year randomised controlled trial. *BMJ* 2005; 330: 171.](#)

For PIFU to be suitable for a patient, they should meet the following conditions:

- at low risk of urgent follow-up care and satisfies criteria established by the specialty¹²
- is confident and able to take responsibility for their care for the time they will be on the PIFU pathway, eg they do not have rapidly progressing dementia, severe memory loss or a severe learning disability¹³
- understands which changes in their symptoms or indicators mean they should get in touch with the service, and how to do so
- has the tools to understand the status of their condition (eg devices, leaflets, apps) and understands how to use them
- has the health literacy and knowledge, skills and confidence to manage their follow-up care (patient activation); if they do not, the patient may benefit from support to improve these areas in line with the personalised care approach
- understands how to book their follow-up appointments directly with the service, and how long they will be responsible for doing this; for some patients who are unable to book their appointments directly, administrative staff at their care home or GP surgery may be able to help.

If any of the following conditions are met, the appropriateness of PIFU for the patient needs to be carefully considered:

- the patient's health issues are particularly complex
- there are clinical requirements to see the patient on a fixed timescale (timed follow-ups), although it is important to note that a blend of PIFU and timed follow-ups can also be offered (eg for cancer pathways)
- the clinician has concerns about safeguarding for the patient
- the patient takes medicines that require regular and robust monitoring in secondary care
- the patient is not able to contact the service easily (eg lack of access to a telephone¹⁴).

¹² [Whear R, et al. Patient initiated clinics for patients with chronic or recurrent conditions managed in secondary care: a systematic review of patient reported outcomes and patient and clinician satisfaction. *BMC Health Serv Res* 2013; 13: 501.](#)

¹³ [Batehup L, et al. Follow-up after curative treatment for colorectal cancer: longitudinal evaluation of patient initiated follow-up in the first 12 months. *Support Care Cancer* 2017; 25: 2063–73.](#)

¹⁴ [Goodwin VA, et al. Implementing a patient-initiated review system for people with rheumatoid arthritis: a prospective, comparative service evaluation. *J Eval Clin Practice* 2016; 22\(3\): 439-445.](#)

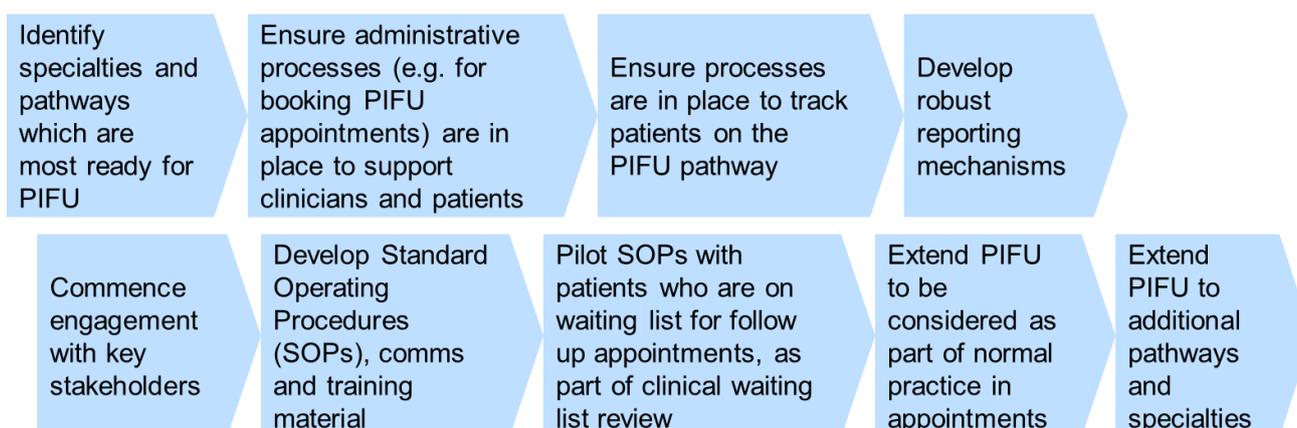
Clinical specialties most suited for patient initiated follow-ups

PIFU can be used in a wide variety of clinical specialties, both medical and surgical:

- cardiology
- colorectal surgery
- dermatology
- diabetes
- disablement services
- ear, nose and throat
- endocrinology
- gastroenterology
- general surgery
- geriatric medicine
- gynaecology
- hepatology
- mental health
- neurology
- oncology
- ophthalmology
- orthopaedics and trauma
- orthoptics
- paediatrics, including dermatology, ENT, epilepsy, gastroenterology, neurology, ophthalmology, orthopaedics, plastic surgery and rheumatology
- pain management
- palliative medicine
- physiotherapy
- plastic surgery
- rehabilitation
- renal medicine
- respiratory medicine
- rheumatology
- thoracic medicine
- urology
- vascular surgery

Implementing patient initiated follow-ups

Example high-level plan for implementing PIFU



Example implementation checklist adapted from work by Somerset CCG.

 <p>Strong clinical leadership and engagement</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Identify the specialties and pathways most ready for PIFU, by considering the following: <ul style="list-style-type: none"> • clinical buy-in • proportion of appointments that are follow-up appointments • number of patients with long-term conditions • number of patients who do not need to be seen for extended periods of time • case studies from elsewhere • academic studies. <input type="checkbox"/> Arrange workshops and give clinicians protected time to plan and design their own PIFU processes. <input type="checkbox"/> Arrange communication to ensure everyone is sighted on the new process. <input type="checkbox"/> Collect feedback from clinicians on what is working well and how implementation can be improved. <input type="checkbox"/> Share learning and good news stories to increase engagement across the organisation.
 <p>Effective planning and programme management</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Identify service managers responsible for delivering PIFU. <input type="checkbox"/> Set regular meetings of service managers to discuss emerging barriers. <input type="checkbox"/> Identify stakeholders, eg: <ul style="list-style-type: none"> • patient groups • clinicians • managers • admin staff • IT team • informatics team • information governance team • primary care • local clinical networks, eg cancer alliances. <input type="checkbox"/> Develop engagement plan. <input type="checkbox"/> Set clear implementation milestones and PIFU targets. <input type="checkbox"/> Plan staff training. <input type="checkbox"/> Make plans early for evaluation and data collection.
 <p>A simple patient narrative</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Keep the story simple, consistent and focused on benefits, including the opportunity to empower patients. <input type="checkbox"/> Develop patient information leaflets and a method for their distribution (eg via post, email, text message). <input type="checkbox"/> Communicate clearly to patients about symptoms to watch out for and how to book an appointment. <input type="checkbox"/> Engage with patient groups and adapt rollout strategy as necessary. <input type="checkbox"/> Gather feedback from patients to enable continuous improvement.

 <p>Locally determined eligibility criteria and protocols</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Clinical leads define the PIFUs for their own specialty, follow-up periods and appropriate patients. <input type="checkbox"/> Work with admin and IT teams to define how patients will be reflected on booking systems and clinic outcomes. <input type="checkbox"/> Identify staff resources required to take calls from patients requesting PIFU appointments. <input type="checkbox"/> Work with IT to integrate clinic outcomes for PIFU patients into electronic medical records. <input type="checkbox"/> Integrate PIFU with patients' personalised care and support plans. <input type="checkbox"/> Carry out a desk review of patients on the waiting list for each specialty or pathway, and adapt approach as necessary: <ul style="list-style-type: none"> • review practice for scheduling follow-ups for the most common pathways • define the conditions under which it would be safe to share the responsibility for booking follow-ups with patients • review a sample of case notes from patients waiting for a follow-up appointment to test how PIFU would have affected those cases • team member to speak to any patient for whom PIFU may be suitable (eg by video appointment), and if PIFU is right for them, move them to a PIFU pathway. <input type="checkbox"/> Embed consideration of PIFU in normal practice for patient appointments. <input type="checkbox"/> Encourage sharing of peer learning to support accelerated local uptake of PIFU.
 <p>Accurate reporting systems for tracking PIFU activity</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Understand how best to record a patient as being on the PIFU pathway locally. <input type="checkbox"/> Analyse baseline activity and performance. <input type="checkbox"/> Estimate the impact of PIFU on service appointments and waiting list, and set up processes to monitor this regularly. <input type="checkbox"/> Set up performance reporting for the service (see section on data collection). <input type="checkbox"/> Have a system for recording discharges at the end of defined follow-up time period.
 <p>Flexible clinic systems</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Create flexible clinic capacity to accommodate PIFU appointments. <input type="checkbox"/> Set up a user-friendly system for patients to book follow-ups. <input type="checkbox"/> Switch off default follow-up letters for patients on the PIFU pathway.

Data collection

Implementing PIFU may create challenges for recording and reporting activity, therefore you may wish to consider implementing local reporting measures that provide insight into the following for each service.

Headline metrics

- Total number and proportion of patients on the PIFU pathway.
- Patient outcomes, eg recovery rates, relapse rates.
- Waiting times.
- DNA rates.

Process measures

- Number and proportion of patients who are:
 - put on a PIFU pathway following an appointment
 - discharged to primary care from PIFU pathway
 - discharged to primary care without being put on a PIFU pathway
 - taken off the PIFU pathway and put back on the routine follow-up pathway.
- Average time between an individual patient's appointments at different stages of treatment.
- Number of patients on the PIFU pathway who:
 - made contact with the service and had an appointment booked
 - made contact with the service but had their issues resolved without requiring an appointment.
- Patient demographics and numbers of patients for whom specific conditions are being managed.

Other outcomes and experience measures

- Patient and staff experience measures.
- Changes in patients' knowledge, skills and confidence (activation) using Patient Activation Measure or similar measures.
- Workforce productivity measures.

Case studies and other resources

General resources

[Personalised care](#) resources and policy documents

Letter to GPs about PIFU: [Cambridge University Hospitals NHS Foundation Trust](#)

Patient-facing information: [The Mid Yorkshire Hospitals NHS Trust](#); [The Royal Free London NHS Foundation Trust](#)

Equality Impact Assessment, [Guildford and Waverley CCG](#)

Specialty or condition-specific resources

Cancer:

- Living with and beyond cancer: [handbook for implementing personalised stratified follow-up pathways](#)
- Personalised care and support tools: [Cheshire & Merseyside Cancer Alliance](#)
- Patient centred follow-up video for breast cancer: [East of England Cancer Alliance](#)
- Breast cancer patient leaflet: [Sandwell and West Birmingham Hospitals NHS Trust](#)
- Gynaecological cancers recommendations and guidance on PIFU: [British Gynaecological Cancer Society](#)

Ear, nose and throat services guidance and case study: [Transforming elective care services: ENT](#), pp27-29.

Gynaecology services guidance and case study: [Transforming elective care services: Gynaecology](#), pp 29-32.

Inflammatory bowel disease case study: [Outpatients: The future - Adding value through sustainability](#), pp 11-14.

Orthopaedics case study: [Transforming musculoskeletal and orthopaedic elective care services](#), pp 31-32.

Rheumatology case study: [University Hospitals of Morecambe Bay NHS Foundation Trust](#) and rheumatology patient leaflet, [Royal Berkshire NHS Foundation Trust](#).

5. 2020/21 Phase 3 planning submission guidance

1. Introduction

This section outlines the submission process for the activity, performance, and workforce planning returns as we plan for the remainder of 2020/21. It includes the list of activity and performance metrics (Appendix 1) and links to the technical definitions for activity, performance and workforce measures.

1.1 Background

The [third phase of NHS response to COVID-19](#) letter from Sir Simon Stevens and Amanda Pritchard issued 31 July 2020 recognises that working across Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) has been essential for dealing with the pandemic and the same is true in recovery. We are asking systems to now plan and deliver the goals set out for Phase 3. The planning metrics reflect this by focusing on service demand as reflected in referrals, acute and diagnostic activity, acute bed capacity, and associated ambitions for elective care, cancer, mental health, and learning disabilities and autism.

1.2 Overview

A fundamental principle of this Phase 3 implementation process is that it will be STP/ICS led.

The process for submission of a small number of core metrics will be as follows:

- Draft numerical submission by 1 September submitted through Strategic Data Collection Service (SDCS) by STPs/ICSs. The accompanying short plan commentary should be submitted by email to the relevant regional planning mailbox (see Section 7).

- Final submission to be made by 21 September. Submissions will again be submitted via SDCS and the relevant regional planning mailbox.
- Submission of system level 'Local People Plans', as requested in '[We are the NHS: People Plan 2020/21 - action for us all](#)', also to be made by 21 September as a key enabler of Phase 3 STP/ICS plans. Plans should also be submitted by email to the relevant regional planning mailbox (see Section 7) alongside the plan commentary as set out above.

STPs/ICSs are expected to work across their partner organisations to produce plans that consider alignment between CCGs and providers, and correlation between activity and workforce.

1.3 Timetable

Key tasks	Date
Phase 3 letter issued	31 July
Guidance and template issued	7 August
Draft submission of the STP/ICS activity/performance and workforce templates. Draft submission of the associated STP/ ICS activity/performance/workforce narrative commentary	1 September
Final submission of the STP/ICS activity/ performance and workforce templates. Final submission of the associated STP/ICS activity/performance/workforce narrative commentary. Submission of system level 'Local People Plans'	21 September

2. STP/ICS plan collection

2.1 Activity and Performance

The set of planning metrics has been reduced to align with the priorities outlined in the 'third phase of NHS response to COVID-19' letter, and can be found at Appendix 1.

Systems are asked to provide a provide a brief commentary on the key strategic actions and assumptions that underpin the activity metrics within the STP/ICS plan template (see Section 5).

STPs/ICSs are asked to provide forecasts of activity and performance measures to cover the last 7 months of the 2020/21 financial year.

The measures being requested in Phase 3 are a subset of those requested as part of previous operational planning rounds, with a few additional amendments.

- Additional outpatient categories to capture face to face and telephone/video attendances separately
- Additional COVID/Non-COVID split for 1+ day non elective attendances
- Cancer data is requested as a count of activity rather than performance measures around waiting times,

2.2 Workforce

[We are the NHS: People Plan 2020/21 - action for us all](#) has been published in parallel. It asks that, in response, all systems should develop a Local People Plan. The submission of these Local People Plans is being aligned to the final submission of STP/ICS Phase 3 plans, and they should reinforce and expand on the workforce element of the STP/ICS planning template (see Section 5).

This submission is intended to collect STP/ICS workforce plans for the last 7 months of the 2020/21 financial year. For 2020/21 the workforce plan is profiled for each month, including 2020/21 forecast outturn values.

The sections in the provider input workforce tab of the template are as follows:

- WTE- Substantive, bank and agency WTE forecasts by staff group and by professions, in post.
- Validations: Summary of any errors highlighted, to be cleared before final submission.

2.3 Support available

Support materials will be made available on the NHS Planning FutureNHS collaboration platform as they become available. Regional leads will be the primary link to STPs/ICSs throughout the preparation, review and assurance of operational plans.

3. Detailed guidance

3.1 Commissioner assignment

For the outpatient, admitted patient care and A&E data sets, the Prescribed Specialised Services Identification Rules (PSS IR) Tool and Commissioner Assignment Method (CAM) have been applied within the National Commissioning Data Repository (NCDR) to identify which commissioner is responsible for purchasing each unit of activity.

A number of changes to the PSS IR Tool were introduced in April 2020. NHS Digital have released the latest version of the tool on their website¹⁵.

3.2 Activity breakdown by Commissioner/Provider

Although the more detailed commissioner/provider categories are not required as part of this return, there are a few subsets of activity measures which are still requested to ensure a full picture of activity is captured.

CCG based activity will include the following “of which” category:

- Independent Sector (IS) activity – the subset of total activity commissioned by the CCG which will be commissioned directly from the independent sector. This activity is in addition to, and should therefore exclude any:
 - activity planned to be delivered by providers covered under the existing nationally agreed contract; or
 - activity that would be delivered by those same providers under a re-procured national framework (see the ‘Phase 3 of COVID-19 response and NHS recovery’ letter).

¹⁵ <https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-ssp-planning-tool-2020-21>

Provider based activity will include the following “of which” category:

- Specialised Commissioning – the subset of total activity which is expected to be commissioned by Specialised Commissioning rather than CCG or other sources.

Independent Sector Activity as part of the national contract / framework

The STP/ICS should set out:

- activity planned to be delivered by providers covered under the existing nationally agreed contract; or
- activity that would be delivered by those same providers under a re-procured national framework (see the ‘Phase 3 of COVID-19 response and NHS recovery’ letter).

This will cover elective and diagnostic activity and is requested as a weekly rather than monthly breakdown. It should not include any activity already recorded under the CCG and Provider input tabs.

This is the only part of the template where IS activity delivered under the national contract / re-procured national framework should be captured. Activity delivered by independent sector providers that are covered by the current national contract should be excluded from the CCG and Provider input tabs.

4. STP/ICS plan template

The template will be configured by each STP/ICS through selecting your organisation from the drop-down menu. You will then be asked to provide data for all measures for your relevant CCGs and providers, which will be used to calculate a total STP/ICS view. Each provider will appear only once, using mapping derived from system control totals.

Data should be recorded by month from September 2020 onwards. April 2020 data will be prepopulated for activity wherever these figures are published and available, however there will be no prepopulated data for performance or workforce measures. Please consult the [activity, performance and workforce technical definitions](#) for details of the source data should you wish to consult previously published figures.

4.1 Data sharing

This tab contains important information about how the data submitted in the return will be shared within the system post submission. STPs/ICSs and organisations are asked to take a shared, open-book approach to planning.

To support the development and assurance of plans and to monitor progress, NHS England and NHS Improvement intend to share plans with other NHS organisations and STP/ICS partners, including the production of assurance tools and the pre-population of plans in the final submission template. If you do not consent to the sharing of plans in this way, you can opt out via the relevant tick box in the template.

4.2 Validations

The validation summary provides an overview of all hard validations included in the template. Any validation which has triggered on this page will prevent your file from being submitted. It is important that this page is reviewed prior to submission and any outstanding issues resolved. All validations contain hyperlinks to each cell to reconcile and assist with the error clearance process. Please adhere to these guidelines to help minimise error:

- Avoid dragging and dropping as this can corrupt formulas; please use 'copy' and 'paste special values' for data extracted from other sources.
- The correct signage and currency must be used – e.g. WTE figures should be rounded to two decimal places. Activity number should be provided as whole numbers etc.
- Ensure when submitting that data is not linked to other workbooks.
- No required cell should be left blank – if no activity or WTE value of the type indicated has been planned for then a 0 should be entered. All data should be entered as numbers, with the exception of comments fields – do not use "N/A", "NIL" etc.
- Check the validation section summary to ensure all errors are cleared before submission.

4.3 STP/ICS selection

This page allows you to select your STP/ICS and will populate the rest of the return accordingly. All providers and commissioners are assigned to a single STP/ICS, and this configuration cannot be changed within the template. Please record all

data relating to a particular organisation, and not just the portion that relates to the parent STP/ICS.

4.4 STP/ICS overview

This tab provides an aggregate view of all data submitted throughout the template, giving an overall STP/ICS position. It also includes some additional calculations and visualisations to assist in the assessment of your data to ensure it reflects your expected position. Please review this tab before submission, with particular reference to:

- the overall STP/ICS position and whether the activity and workforce positions align with each other and the expected financial position
- whether activity levels account for seasonality and meet the expectations laid out in the planning letter and
- the level of alignment in activity volumes between providers and commissioners - although it is not expected that volumes will match an indication is provided on this tab to highlight where provider and commissioner values show a high level of variation.

4.5 CCG input

This tab requires the input of activity and performance profiles for September 2020 to March 2021. Full definitions are in the technical definitions document – wherever possible total fields will be auto-calculated. One table must be completed for each CCG assigned to the STP/ICS.

Validations are present against each data row, with a summary of the status of these validations at the top of the page. Hyperlinks are also used to allow the user to navigate to each individual CCG table.

All activity figures should be provided in whole numbers and take account of seasonality and other factors. Comments boxes are also provided to allow for additional commentary to explain the planned profiles.

4.6 Provider input – activity

This tab is the provider equivalent of the CCG input tab, covering provider activity and performance measures.

Providers are only allocated to a single STP/ICS and data submitted here should represent the entirety of the provider's expected activity, not just the activity occurring on behalf of CCGs within the STP/ICS.

All activity figures should be provided in whole numbers and take account of seasonality and other factors. Comments boxes are also provided to allow for additional commentary to explain the planned profiles.

4.7 Independent Sector

This tab requires a weekly breakdown of the expected independent sector activity from providers covered by the current national contract, or those same providers under a re-procured framework (once in place) across the STP/ICS footprint. This should not include any activity captured elsewhere in the template (e.g. other locally commissioned arrangements) and relates to elective and diagnostic activity only.

Data should be provided per week, but otherwise follows the definitions for the relevant measures as set out in the technical definitions. All figures must be entered as whole numbers.

4.8 Provider input - workforce

This section collects whole-time equivalent (WTE) forecast information by staff and professional groups for substantive, bank and agency staff numbers.

Substantive staff WTE should be based on WTEs from the electronic staff record (ESR), or similar workforce system, adjusted for:

- secondments in and secondments out;
- recharges in and recharges out; and
- staff provided or received through provider-to-provider contracts.

The all-staff total represents the total planned workforce. The substantive staff section should represent planned substantive staffing levels, while any staffing gaps between the substantive position and total planned workforce should be captured in bank and agency figures to indicate how the shortfall is planned to be filled.

For each heading, the provider is required to provide the planned monthly profile of WTEs for the 2020/21 financial year.

Occupational codes are mapped against each of the roles and have been included as a guide for trusts.

4.9 STP/ICS input

This tab collects information provided for an entire STP/ICS footprint, covering various performance measures not required/appropriate for collection at provider or commissioner level. This tab also includes measures relating to ambulance trusts. As with the provider tab, each ambulance trust has been assigned to a single STP/ICS, but it is expected that the submission will encompass all activity for that ambulance trust, and not just that activity which relates to the STP/ICS.

5. STP/ICS plan commentary

5.1 Commentary on patient activity and workforce numbers in plans

STPs/ICSs need to provide an explanation of the key elements of their delivery plans that drive the patient activity and performance elements of their plans.

In your commentary, please also set out how key services will be restored inclusively to help address health inequalities.

Area	Areas and assumptions to be covered by commentary
Elective	<ul style="list-style-type: none"> • Key strategic actions and assumptions that underpin: <ul style="list-style-type: none"> ○ Planned referral levels; ○ Outpatient ○ Day case; ○ Ordinary elective activity; and ○ RTT waiting list position • Where not included in the above, the assumed impact of any significant capacity constraints related to minimising the risk of COVID-19 transmission and how these are addressed as part of your plan including: <ul style="list-style-type: none"> ○ The level of activity expected to be delivered through additional sessions e.g. through extended hours / at weekends ○ Actions to maximise independent sector activity under the national contract ○ Availability of workforce and actions to use the skills of people and teams most effectively and efficiently across the system (linked to overall workforce narrative) ○ Availability of protected diagnostic and treatment facilities (surgical and non-surgical) ○ Actions to maximise the use of digital technology to provide care more efficiently • Additional actions planned to sustain the continued recovery of services during the winter period • Any key issues and risks associated with the above
Non-elective	<ul style="list-style-type: none"> • Key strategic actions and assumptions that underpin: <ul style="list-style-type: none"> ○ A&E attendances ○ Non-elective admissions (including 0 vs +1 length of stay) ○ Available G&A beds and occupancy • Where not included in the above, the assumed impact of actions to: <ul style="list-style-type: none"> ○ Minimise demand on A&E services ○ Increase acute admission capacity and improve flow ○ Sustain reductions in length of stay • COVID patient demand • Additional actions planned to sustain the continued recovery of services during the winter period • Any key issues and risks associated with the above

Area	Areas and assumptions to be covered by commentary
Cancer	<ul style="list-style-type: none"> • Key actions and assumptions that underpin planned treatment volumes and waiting time performance • Where not included in the above, the assumed impact of any significant capacity constraints related to minimising the risk of COVID-19 transmission and how these are addressed as part of your plan including: <ul style="list-style-type: none"> ○ Availability of capacity and workforce (both diagnostic – especially endoscopy and CT/MRI – and treatment) to meet current and returning demand, including from independent sector. ○ Availability of protected diagnostic and treatment facilities (surgical and non-surgical)]. ○ Any significant expected variation in access to services for particular patient groups and how this is being mitigated. • Any key issues and risks associated with the above
Diagnostics	<ul style="list-style-type: none"> • Key strategic actions and assumptions that underpin planned activity volumes, where not covered under the elective and cancer elements above. • Any key issues and risks associated with the above

Area	Areas and assumptions to be covered by commentary
<p>Workforce</p>	<ul style="list-style-type: none"> • Key actions and assumptions that underpin the workforce numbers in the completed STP/ICS plan template. This should include a workforce availability assessment that covers the following critical areas: <ul style="list-style-type: none"> ○ Retaining and deploying NHS returners ○ Further recruitment plans ○ Use of bank and agency ○ Use of additional hours (balanced with health and wellbeing considerations) ○ Redesign of teams and roles ○ Managing redeployment following risk assessments ○ Deployment across systems, sectors and organisations ○ Addressing sickness absence ○ Supporting health & wellbeing, including rest and recuperation • An assessment of the match between workforce availability and the workforce requirement linked to the activity and service redesign plans • Plans to complete staff risk assessments on an ongoing basis • Any key issues and risks associated with the above

5.2 Local People Plans

STPs/ICSs are asked to provide their system level response on the priorities set out within 'We are the NHS: People Plan 2020/21 - action for us all'. This narrative should include:

1. a summary of the system response to the actions across the sections of the Plan:
 - a. Looking after our people
 - b. Belonging in the NHS
 - c. New ways of working and delivering care
 - d. Growing for the future
2. any key risks to delivery and further support required to meet each of the actions.

The actions set out within the Local People Plan should be fully aligned with the Phase 3 workforce template and narrative submissions as set out above.

6. Submission process

Each STP/ICS will submit a single completed template to SDCS. This system will then collate the returns and produce extracts post submission.

STPs/ICSs are requested to submit the accompanying plan commentary in a word document at the same time alongside the SDCS template. The commentary should be submitted by email to the regional planning mailbox as set out in Section 7. Local People Plans should also be submitted by email to the regional planning mailbox.

All submitters for the STP/ICS should receive an email from SDCS service shortly before the window opens, to confirm they are the correct submitter. If you do not receive this invitation at least 1 day before the window opens please contact the NHS Digital Data Collections team to request a log in¹⁶.

Data can be submitted at any point once the submission window is open via the [SDCS website](#)¹⁷

Guidance on the SDCS system can be accessed on the [NHS Digital website](#)¹⁸

Wherever possible, on submission validation will be used to ensure plans are complete and that files which breach hard validations cannot be submitted (e.g. missing or invalid data). Please ensure that you review the validation section of your return before submission – this will indicate any remaining errors which would cause your file to be rejected.

6.1 Sign off

The template does not include details of the internal sign off process within each STP/ICS. It is assumed that by submitting the return the STP/ICS confirms that the plan is a reflection of the collective intentions of the system for the rest of the year, that activity and workforce plans align and that the plan is agreed by all STP/ICS partners.

¹⁶ The data collections team can be contacted at data.collections@nhs.net

¹⁷ <https://datacollection.sdcs.digital.nhs.uk/>

¹⁸ <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/strategic-data-collection-service-sdcs>

7. Key planning contacts and resources

7.1 Regional contacts

STPs/ICSs should initially contact their region for advice on planning, using the contact details below:

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net
East of England	england.eoe2021operplan@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net
London	england.london-co-planning@nhs.net

7.2 National and wider technical issues

Subject area	Contact information
SDCS collection portal	data.collections@nhs.net
NHS National Planning Team – activity and performance, workforce and general planning queries	england.nhs-planning@nhs.net
Integrated Planning Tool	england.covid-ipt@nhs.net

7.3 FutureNHS collaboration platform

General updates and resources will be provided on the [NHS Planning FutureNHS collaboration platform](#) throughout the Phase 3 planning round.

You will need a FutureNHS account to access pages, and can get this at: <https://future.nhs.uk/connect.ti/system/home> following the registration process outlined.

7.4 Integrated Planning Tool

An Integrated Planning Tool (IPT) has been developed to support STPs/ICSs in completing Phase 3 returns.

The IPT brings existing data and models together into a single system for planning. It is designed to assist STPs/ICSs in developing local plans and understanding the resource constraints and implications of planned activity.

How to access and further information

For further information regarding the tool, details on how to access and support sessions being made available please refer to the [NHS COVID-19 Data Store FutureNHS collaboration platform](#).

8. Information governance

Information governance requirements on the collection of data from acute, specialist, mental health, community, and ambulance trusts relating to annual operational and strategic planning, intended data uses and further sharing are included in the relevant templates.

Data will be shared within NHS England and NHS Improvement. Any further data sharing will be subject to an opt-out clause as detailed in the appropriate submission template.

Further support and information on information governance can be provided by: england.ig-corporate@nhs.net

Appendix 1: Activity and performance metrics

Measure Reference	Sub Category	Measure Name
E.A.3		IAPT Roll Out
E.B.18		Number of 52+ Week RTT waits
E.B.3a		RTT Waiting List
E.B.26	E.M.26a; E.M.26b; E.M.26c; E.M.26d; E.M.26e; E.M.26f	Diagnostic Test Activity
E.B.30		Urgent cancer referrals
E.B.31		Cancer treatment volumes
E.B.32		Number of patients waiting 63 or more days after referral from cancer PTL
E.H.9		Improve access to Children and Young People's Mental Health Services (CYPMH)
E.H.12	E.H.12a; E.H.12b	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days
E.H.13		People with severe mental illness receiving a full annual physical health check and follow up interventions
E.H.15		Number of women accessing specialist perinatal mental health services
E.H.17		Number of people accessing Individual Placement and Support
E.H.27		Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illnesses
E.K.1	E.K.1a; E.K.1b; E.K.1c	Reliance on inpatient care for people with a learning disability and/or autism
E.K.3		Annual Health Checks delivered by GPs for those on the LD register

E.M.7	E.M.7a; E.M.7b	Referrals made for a First Outpatient Appointment (General & Acute)
E.M.8-9	E.M.8c; E.M.8d; E.M.9c; E.M.9d	Consultant Led Outpatient Attendances (Specific Acute)
E.M.10	E.M.10a; E.M.10b	Total Elective Spells (Specific Acute
E.M.11	E.M.11a; E.M.11c; E.M.11d	Total Non-Elective Spells (Specific Acute)
E.M.12	E.M.12a; E.M.12b	Type 1-4 A&E Attendances
E.M.23		Ambulance conveyance to ED
E.M.26		General and Acute Bed Occupancy

6. COVID-19 data collections: changes to weekend collections

As part of our COVID-19 response, we have been running a number of COVID-19 related data collections over the weekend. The reduction in the national incident level for the COVID-19 response from level 4 to level 3 stated that weekend collections would be stopping from Saturday 8 August onwards - here are more detail on these changes.

In the event of the incident increasing in severity once more, we may need to stand up working on a 7-day per week basis and would be in touch at that point.

For most of the weekend collection we will open the collections for submission on a Saturday/Sunday as normal, but instead of the collection closing that same day, it will remain open until the deadline for the Monday collection. This allows organisations to make no submissions over the weekend (and submit Saturday, Sunday and Monday submissions on a Monday morning), or to continue to upload data over the weekend. This excludes the reporting of deaths, which will continue daily.

The table below list the collections that are covered by this change and, for each one, describes the way in which weekend data will be collected going forwards:

Collection name	Changes to weekend collections
COVID-19 daily sitreps (including NHS Acute, NHS MHLDA, IS Acute and IS MHLDA)	Saturday and Sunday collections will open at 08:00 as usual on Saturday/Sunday morning but will remain open until 11:00 on Monday morning.
Daily discharge collections (including acute and community)	Collections in respect of Saturday and Sunday would open at the normal times but would remain open for submission until Monday.
UEC sitrep	Collections in respect of Saturday and Sunday would open at the normal times but would remain open for submission until Monday.
NHS111 MDS daily	We would not open collections on a Saturday or Sunday. The weekly MDS data already collected on a Monday will be used instead.
NHS111 staffing daily	We would not open collections on a Saturday or Sunday.
Daily deaths data	Continue daily

Coventry and Warwickshire COVID-19 Health Impact Assessment

Coventry and Warwickshire
Joint Strategic Needs Assessment

July 2020



Many thanks are given to colleagues that contributed their time to creating this report. It was created within a short timeframe, across two local authorities and demonstrated the commitment of staff to work positively across the Coventry and Warwickshire patch to support recovery following COVID-19. Thanks is also given to local partner and commissioned organisations that provided data for input into this report which enabled us to demonstrate the wide impacts that COVID-19 has had upon our local population.

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Big White Wall, Carer's Emergency Response Support Service, Change Grow Live, Citizen's Advice Bureau, Coventry and Warwickshire Mind, Coventry and Warwickshire Partnership NHS Trust, Edible Links, Healthwatch Warwickshire CIC, Mental Health Matters, Sport England, Trussell Trust, Warwickshire Police.

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Foreword

Councillor Caborn

Portfolio Holder for Adult Social Care & Health (Warwickshire)

I am pleased to introduce this COVID-19 Health Impact Assessment which demonstrates the impacts of the pandemic across Coventry and Warwickshire.

Our thoughts and sympathies are with those people in our region and around the world have lost loved ones to COVID-19 and many others who have experienced indirect impacts of the outbreak.

This impact assessment outlines a number of different indicators across different sectors that have been negatively affected by the COVID-19 outbreak. Some of these impacts are just as big an issue for health and wellbeing as the impact of the virus itself. It is also clear that COVID-19 has highlighted, and in some cases exacerbated, health inequalities and that the wider impacts of the pandemic and lockdown will fall more heavily on communities most directly affected by the disease itself.

Working together is particularly important as we start to think about the resetting of health and wellbeing and recovery and the role that we can all play in helping to create healthy communities and tackle health inequalities. Please join us across Coventry and Warwickshire in utilising this impact assessment and its recommendations as we move forward to a reset and recovery phase, and reduce the future impact that the pandemic has on residents' health and wellbeing.

Councillor Kamran Caan

Cabinet Member for Public Health and Sport (Coventry)

Welcome to the COVID-19 Health Impact Assessment for Coventry and Warwickshire. This report focuses on the impact the outbreak has had on us locally and the steps we will be looking to take to improve our resilience to COVID-19.

Coronavirus has been tough on most of us, we have all been impacted in some way; whether that has been losing friends, family members and colleagues, being out of work, businesses struggling, or our key workers working tirelessly around the clock. Our thoughts and sympathies are with everyone that has been affected by the virus.

This assessment highlights the areas across our respective communities that have been negatively impacted by the pandemic and lockdown, but also demonstrates the shared understanding of factors needed to support and sustain the recovery across the patch. We know that existing health inequalities have only been intensified, especially in areas struck more directly by the virus and this is likely to continue while coronavirus is still circulating. The population health indicators in this report will enable an understanding of the potential harm for more deprived areas of Coventry and Warwickshire, and the developing impact on ethnic minority groups and on the most vulnerable individuals facing multiple deprivation.

We will continue to work closely together and with our partners in our reset and recovery journey. It is vital that we work to develop a level of trust within our communities and build healthy, active and resilient city-wide partnerships as a priority, especially in the absence of a COVID-19 vaccine.

By coming together and using this impact assessment and its recommendations as an integral part of the Coventry and Warwickshire reset and recovery approach, we can help support our communities to restore

Executive Summary

It is no understatement to say that the COVID-19 pandemic and response to prevent and mitigate the harm that it can cause radically changed how society functions. On the 23rd March a series of lockdown measures were announced in the UK which restricted most travel and shut down non-essential businesses and schools.

These actions successfully interrupted the spread of the disease. In Coventry and Warwickshire, a peak in the number of hospital beds occupied by patients with COVID-19 was reached in early April and the overall trend since then has been an ongoing reduction.

Whilst much harm from COVID-19 has been prevented, it is important to develop a shared understanding of the impact of the events over the last few months to support and sustain a recovery.

This report has been written to do just that. It is part of the Joint Strategic Needs Assessment (JSNA) programme in Coventry and Warwickshire and has been overseen by a project group including members from both Warwickshire and Coventry Business Intelligence and Public Health teams, as well as members from the NHS Clinical Commissioning Groups (CCG).

Key findings

This report has been structured using the Kings Fund 'population health' model. This highlights four interacting areas that influence the health and wellbeing of people in Coventry and Warwickshire.

- Wider determinants of health
- Our health behaviours and lifestyles
- An integrated health and care system
- The places and communities we live in, and with

The connection between these four pillars of population health is important, and underpins two key high-level findings from this report:

1) An integrated recovery: This analysis shows that health and wellbeing has been deeply impacted on by changes across all four quadrants of the model. The implication is that recovery cannot just be contained to one sector and has to be connected across all four to have the biggest chance of success. An integrated recovery is one where we look across traditional boundaries to understand the wider impact of services.

2) The double impact: This report references that the harm from COVID-19 has been unequally distributed across the population and is likely to continue to be so whilst still circulating. This analysis shows that the wider impacts from the pandemic and lockdown will fall more heavily on communities most directly affected by the disease itself. This analysis shows the potential harm for more deprived areas of Coventry and Warwickshire and, as more evidence develops, it will be important to understand the impact on Black, Asian and Minority Ethnic (BAME) groups and on most vulnerable individuals facing multiple deprivation.

The Wider Determinants of Health

This analysis has looked most closely at the economic impact of COVID-19. Mass unemployment events can have a wide and negative impact on health and wellbeing, as alongside the reduction in security it leads to increases in smoking and alcohol use, and puts wider strain on the mental wellbeing of the whole household and relationships.

Across Coventry and Warwickshire there are 17,000 new claimants of either Jobseeker's Allowance, or Universal Credit with a requirement to look for work. This may be an underestimate as there are additionally around 85,000 people locally currently furloughed, and national surveys have shown large amounts of financial concern in that group.

Areas such as Nuneaton and Bedworth, and Coventry which have had a relatively higher claimant count before COVID-19 are the same ones with higher rates afterwards. The area locally with the largest relative increase was North Warwickshire.

Some national studies have assessed the potential impact of COVID on employment sectors, and used that to rank all 383 English local authority areas to see where might have the largest decrease in economic output. Three authorities locally were in the top 15 most impacted: Stratford-on-Avon, North Warwickshire, and Rugby. Decreased outputs from the manufacturing sector were behind that estimated impact, although in North Warwickshire the logistics sector and the construction sector in Rugby also played a large part.

Health Behaviours

Much of the evidence we use to understand health behaviours locally is drawn from national surveys or other data sources that have not been available. There is an evidence gap identified in this report, which prevents us from truly understanding the impact on healthy behaviours in Coventry and Warwickshire. Local surveys would be needed to fill that gap.

Nationally there has been evidence of changes in health behaviours. March saw a 10% increase in supermarket alcohol sales – although national surveys have shown that some people are drinking less than before the lockdown. Others are drinking more, and this is potentially depending on how acutely they perceived the threat of COVID-19. To truly understand the impact on different groups, it is important to identify the groups that have increased alcohol consumption. There is evidence that health care workers are more likely to increase alcohol consumption after a pandemic. Services for people with substance misuse issues, including those who use alcohol, have been maintained over the last few months with some reductions in referrals.

Around one in every 500 adults are estimated to have tried gambling for the first-time during lockdown. Although there has been a reduction in gambling overall, some of the national evidence tells us that 1 in 3 people who gamble have tried new products during lockdown.

Physical activity was one of the exemptions of the lockdown and people could leave the house once-a-day to be active. Walking became one of the most common ways to be active in April. Overall there appears to be an equal split between people doing more, less and the same amount of physical activity although some evidence tells us that people in managerial professions were more likely to be more active than workers who do skilled or unskilled manual work, which may further exacerbate health inequalities.

Google's community mobility reports, that is, reports that chart movement trends over time and place, show that parks were used less during April than prior to lockdown, however there were large increases in access in May – especially during both half-term and the two Bank Holiday weekends.

There was a reduction in the number of referrals to the Stop Smoking in Pregnancy service in Warwickshire, and again, women in more deprived areas are more likely to smoke during pregnancy.

All in all, these trends may serve to exacerbate health inequalities, with people in more deprived communities, in lower-paid employment, or with pre-existing health conditions, may be more likely to experience further deprivation as a result of lockdown.

Integrated Health and Care System

Large reductions in health service contact have been seen across both primary and secondary care. This has the risk of manifesting as a late presentation or increased numbers of preventable deaths. A key challenge for the health service will be to identify, manage, and prioritise, individuals at risk within the capacity available.

There were large reductions in hospital use, even with the increases in the number of COVID-19 patients. For A&E departments across the region, the number of attendances were 40% of what would have been expected based on previous years – not accounting for any expected year-on-year increases from population change.

The reduction in unplanned hospital admissions was not as large and was roughly 75% of previous years. This gives us some early evidence on the changes in casemix, that is, the groupings of patients and treatments; and that attendances may have been for more severe illness on average.

Many planned hospital appointments were cancelled during the pandemic with over an 80% reduction in non-elective admissions. This has led to an increase in 5,000 patients waiting over 18 weeks for an appointment in April alone.

There is some evidence that patients stayed away from general practice. Surveys such as the national flu survey have shown the shift away from face to face contact and towards telephone consultations. There were reductions in referrals from General Practice into acute care, with the largest reduction from routine appointments, however we also saw the number of urgent cancer referrals halve in April compared to previous years.

There has also been a drop in preventative activity in the health service. Pausing screening programmes has led to a weekly total of 679 missed bowel screenings, 811 cervical screenings and 538 breast cancer screenings, across Coventry and Warwickshire. There have also been drops in the dementia diagnosis rate, with a 4% drop in April 2020 compared to the same month in the previous year. This drop was greater than seen nationally. There is some evidence locally and nationally that there has also been a decrease in the coverage of childhood vaccinations.

Referrals to mental health services have dropped. In some instances, this may have been due to changes in circumstances, with fewer patients seen due to educational stressors as a result of school closures, and increases in eating disorder referrals which may reflect more parents identifying this as the referral reason.

Safeguarding has also been impacted and there have been drops in around 100 to 150 referrals each month in Coventry in April and May, compared to the months prior, and in Warwickshire there have been drops of 150 to 200 each month. Analysis by referral source confirms that this is due to a lower proportion of referrals from schools.

The places and communities we live in, and with

Communities and human contact are important for wellbeing. A national Office for National Statistics (ONS) survey found that at the point of lockdown half of adults reported high levels of anxiety, with larger numbers reporting that COVID-19 had impacted on their health. This correlates closely with findings in previous sections showing financial worries amongst furloughed staff, and the Community Mental Health Team seeing isolation as the reason for people accessing support during lockdown.

Nationally, a programme of shielding was introduced to protect people who are clinically extremely vulnerable to COVID-19. Local authorities were responsible for supporting these people with food, medicine, safety checks and essential contact during the lockdown. The number of residents on the Ministry of Housing, Communities and Local Government (MHCLG) and NHS shielding list across Warwickshire and

Coventry has varied from around 3% of the population in Rugby to close to 4% of the population in North Warwickshire.

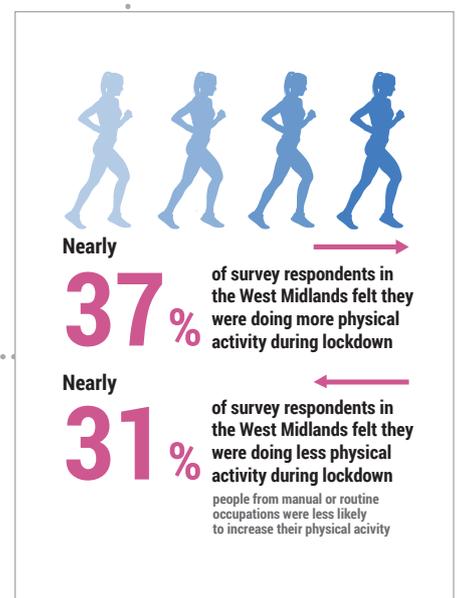
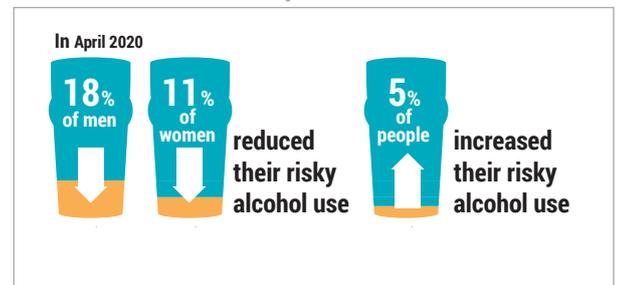
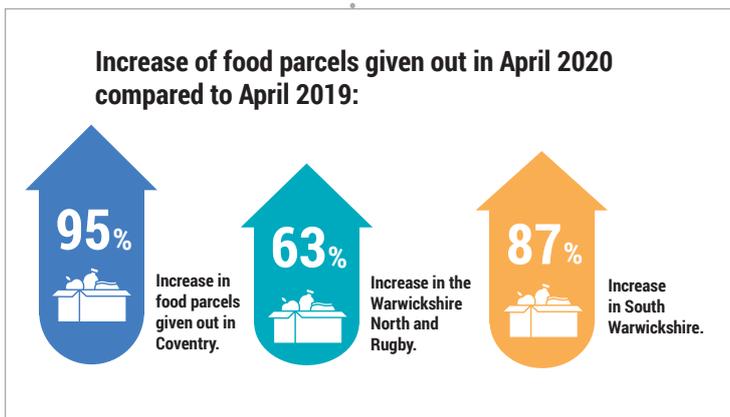
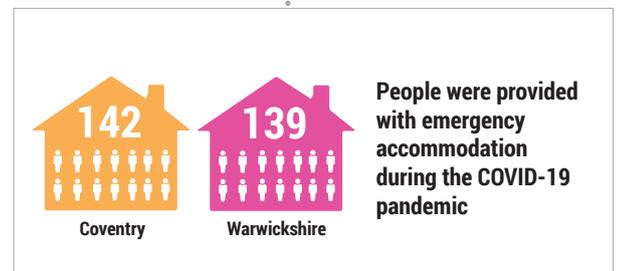
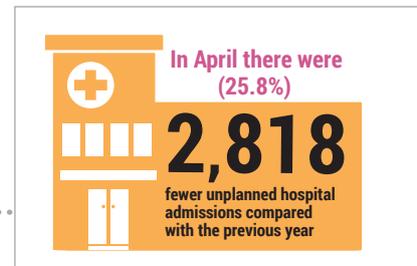
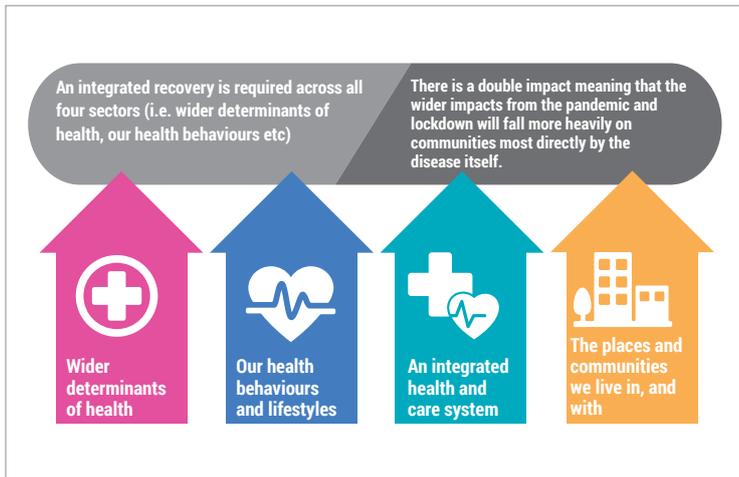
In Coventry, some 14,282 individuals had been identified as needing shielding, and in Warwickshire, the figure was 20,960. The vast majority of people did not require additional support – however, around 10-15% of those contacted required support to acquire food, medication, or regular social contact calls. In addition to the national shielding programme, Coventry also adopted a population health approach to identify and contact some 2,000 additional households locally identified as potentially vulnerable through its own and partner datasets such as council tax and priority services registers, due to multiple risk factors including age, disability, mobility, income or living alone.

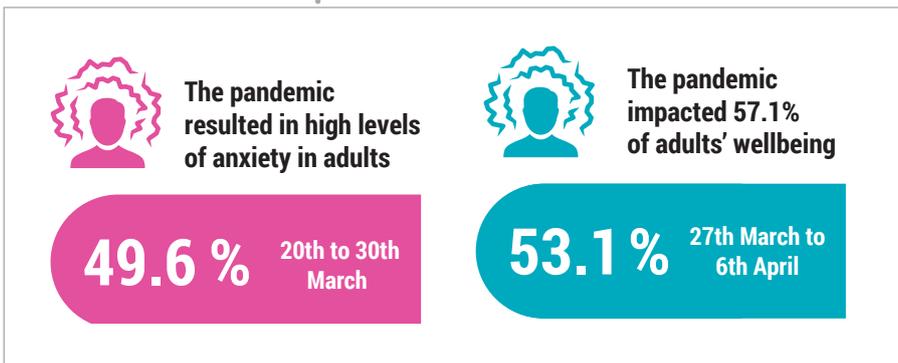
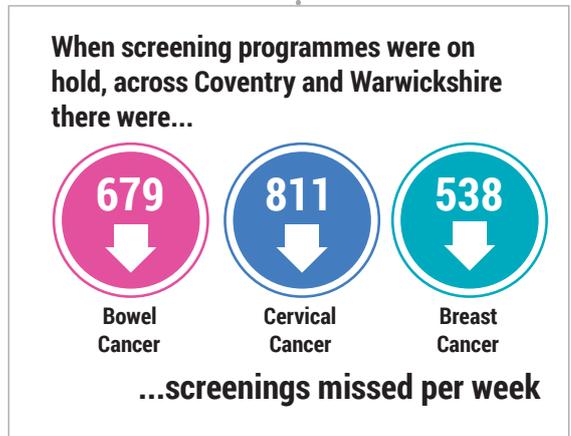
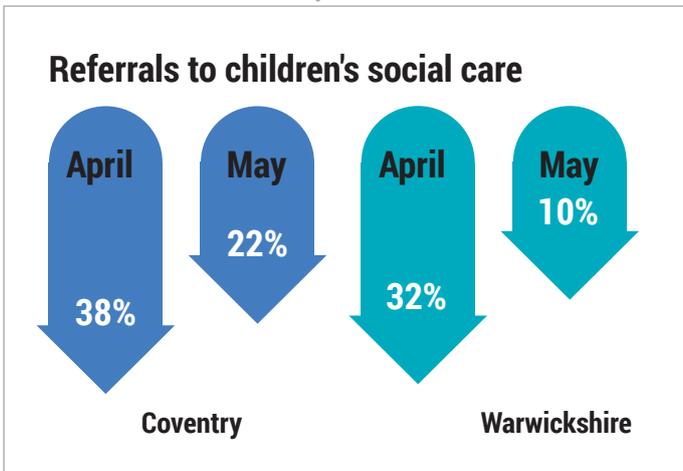
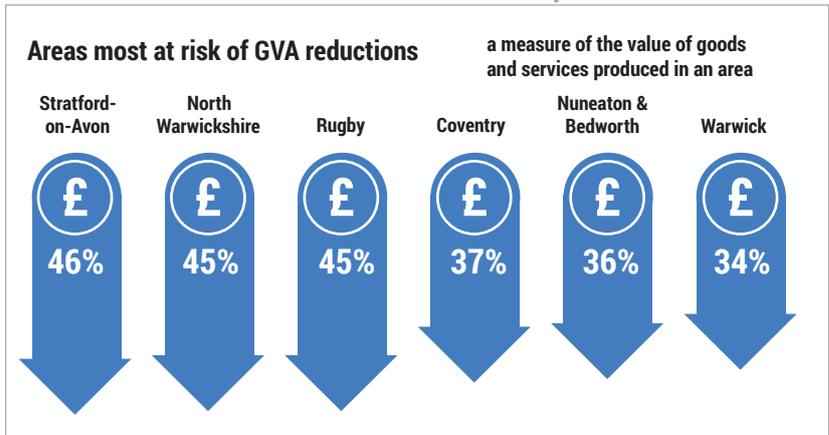
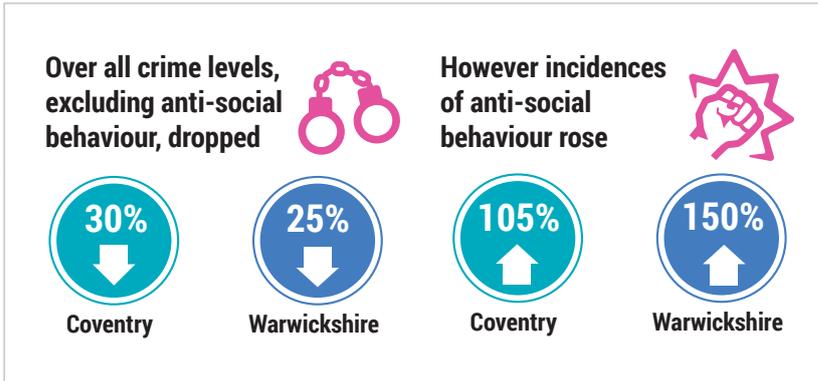
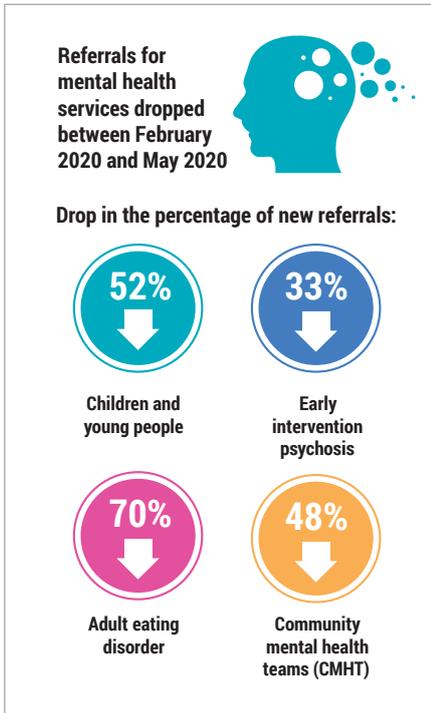
Foodbank use increased during lockdown. Data from the Trussell Trust showed an increase of 95% and 125% in food parcels given out overall in Coventry and Warwickshire respectively compared to the equivalent month a year ago. There was also an increase in food parcels given to families with children.

There were changes in the types of crime reported. Comparing April 2020 with the previous year, antisocial behaviour more than doubled in Coventry and Warwickshire. Conversely, other than antisocial behaviour there was a 30% reduction in crimes in Coventry and 13% reduction in Warwickshire. Some of the largest falls were related to burglary, theft or robbery. However, there were an additional 250 domestic abuse incidents in Warwickshire in April and May compared to previous years.

Places and communities affect health and health inequalities, and lockdown and social distancing measures as a result of COVID-19 have had substantial impact on the wellbeing of individuals and communities, from mental health, to financial concerns; to access to important sources of support from family and friends. This is particularly true for more vulnerable individuals who are shielding, people facing domestic abuse, and people facing financial difficulties. The longer-term effect of this on health and wellbeing is yet to be fully known.

Health and wellbeing has been significantly impacted by changes across a number of different areas





Introduction

The COVID-19 pandemic and response has radically changed how society functions. Social distancing and isolation measures have resulted in significant changes to daily living for the majority of the population. As both society and the health and social care system work towards recovering from the pandemic, we need to have a shared understanding of what this impact has been. This rapid impact assessment highlights many of the areas that have been immediately impacted by the pandemic, and therefore some of the impacts on health that may need to be addressed in the recovery to meet the needs of the population.

The Coventry and Warwickshire Health and Care Partnershipⁱ started moving towards a population health model prior to the COVID-19 pandemic. Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire populationⁱⁱ. The local approach, promoted by the King's Fund, uses a framework of the four pillars of population health and this report is structured to reflect these pillars:

- Wider determinants of health
- Our health behaviours and lifestyles
- The places and communities we live in, and with
- An integrated health and care system

The report also highlights health inequalities which have been brought to the fore in discussion of the COVID-19 outbreak and response.

It should be noted that this health impact assessment does not contain all indicators that were originally proposed to be included by the project group. This is due to the timeliness and availability of data. However, the assessment will be updated 6 months following publication to include longer term data to provide further insights into the impact of COVID-19.

This report has been written by a project group including members from both Warwickshire and Coventry Business Intelligence and Public Health teams, as well as members from the CCG. It has been written to cover the whole of the Coventry and Warwickshire health and care partnership (HCP) geography.

Health Inequalities

In February 2020, the Institute for Health Equity published the Marmot Review: 10 Years Onⁱⁱⁱ which highlighted that health inequalities are large and have been growing over the past 10 years. Key findings include: life expectancy improvements have stalled and declined for the poorest 10% of women; people can expect to spend more of their lives in poor health; and the health gap between wealthy and deprived areas has grown.

As the COVID-19 outbreak has progressed it has highlighted existing inequalities and in some cases has increased them. PHE has published the report Disparities in the risk and outcomes of COVID-19^{iv} which highlights the following findings:

- **Age and sex** – COVID-19 diagnosis rates increased with age for both males and females. Working age males diagnosed with COVID-19 were twice as likely to die as females. Among people with a positive test, those who were aged 80 or over were 70 times more likely to die when compared to those under the age of 40.
- **Geography** – Diagnoses rates and death rates in confirmed cases among males were highest in London followed by the North West, the North East and the West Midlands. The South West had the lowest rates. For females the North East and the North West had higher diagnosis rates than London, while London had the highest death rate. Local authorities with the highest diagnoses and death rates are mostly urban. Death rates in London from COVID-19 were more than three times higher than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequalities in all-cause mortality rates in previous years.
- **Deprivation** – mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females.
- **Ethnicity** – People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. This is the opposite of mortality rates in previous years when the mortality rates were lower in Asian and Black ethnic groups than White ethnic groups. People of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced. A further PHE report has been published to understand the impact of COVID-19 specifically on BAME groups^v.
- **Occupation** - ONS reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. This analysis expands on this and shows that nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 to 2018.
- **Inclusion health groups** - When compared to previous years, there has been a larger increase in deaths among people born outside the UK and Ireland. The biggest relative increase was for people born in Central and Western Africa, the Caribbean, South East Asia, the Middle East and South and Eastern Africa. This may be one of the drivers behind the differences in mortality rates seen between ethnic groups. Data on rough sleepers suggested a higher diagnosis rate when compared to the general population.

- **People in care homes** - Data from the Office for National Statistics (ONS) shows that deaths in care homes accounted for 27% of deaths from COVID-19 up to 8 May 2020. The number of deaths in care homes peaked later than those in hospital, in week ending 24 April. Analysis shows that there have been 2.3 times the number of deaths in care homes than expected between 20 March and 7 May when compared to previous years, which equates to around 20,457 excess deaths. The number of COVID-19 deaths over this period is equivalent to 46.4% of the excess suggesting that there are many excess deaths from other causes or an under-reporting of deaths from COVID-19.
- **Comorbidities** – Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates. Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This finding is consistent with other studies that have reported a higher risk of death from COVID-19 among patients with diabetes. This proportion was higher in all BAME groups when compared to White ethnic groups and was 43% in the Asian group and 45% in the Black group. The same disparities were seen for hypertensive disease. Several studies, although measuring the different outcomes from COVID-19, report an increased risk of adverse outcomes in obese or morbidly obese people.

Due to the rapid nature of this assessment and the limited availability of more detailed data, some of the analysis in this report has not looked at many of these factors in detail. The inequalities of the impact of the COVID-19 pandemic need to be borne in mind and the local demographics detail presented can support this.

Local Demographics

Locally, the Joint Strategic Needs Assessment (JSNA) analyses the current and future health and wellbeing needs of the population. Demographic information of the local population is collected as part of this. The data below highlights key demographics where the inequalities highlighted above may impact on local communities. Consideration should be given to this information when recovery planning.

Further demographic information can be found on the Coventry and Warwickshire JSNA webpages:

- <https://www.coventry.gov.uk/jsna>
- <https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1>

Age and Gender

COVENTRY

Figure 1 highlights that the population in Coventry is relatively young, with largest numbers between the ages of 20 – 24. Compared to Warwickshire there is a lower number of people aged over 65, who are at increased risk of dying from COVID-19.

WARWICKSHIRE

In comparison the spread of age across the Warwickshire population is relatively uniform with small peaks between the ages 45 – 59 (Figure 2). A significant proportion of the population is aged over 65 and at increased risk of death from COVID-19.

Ethnicity

Ethnicity figures are taken from the 2011 Census. These numbers are expected to have changed in the recent years and should be interpreted with some caution.

Table 1 demonstrates that Coventry has a larger percentage of people who are BAME compared to Warwickshire (26.2% and 7.3% respectively). This indicates that a higher proportion of the Coventry population are at risk of dying from COVID-19 due to the additional risk factors associated with ethnicity.

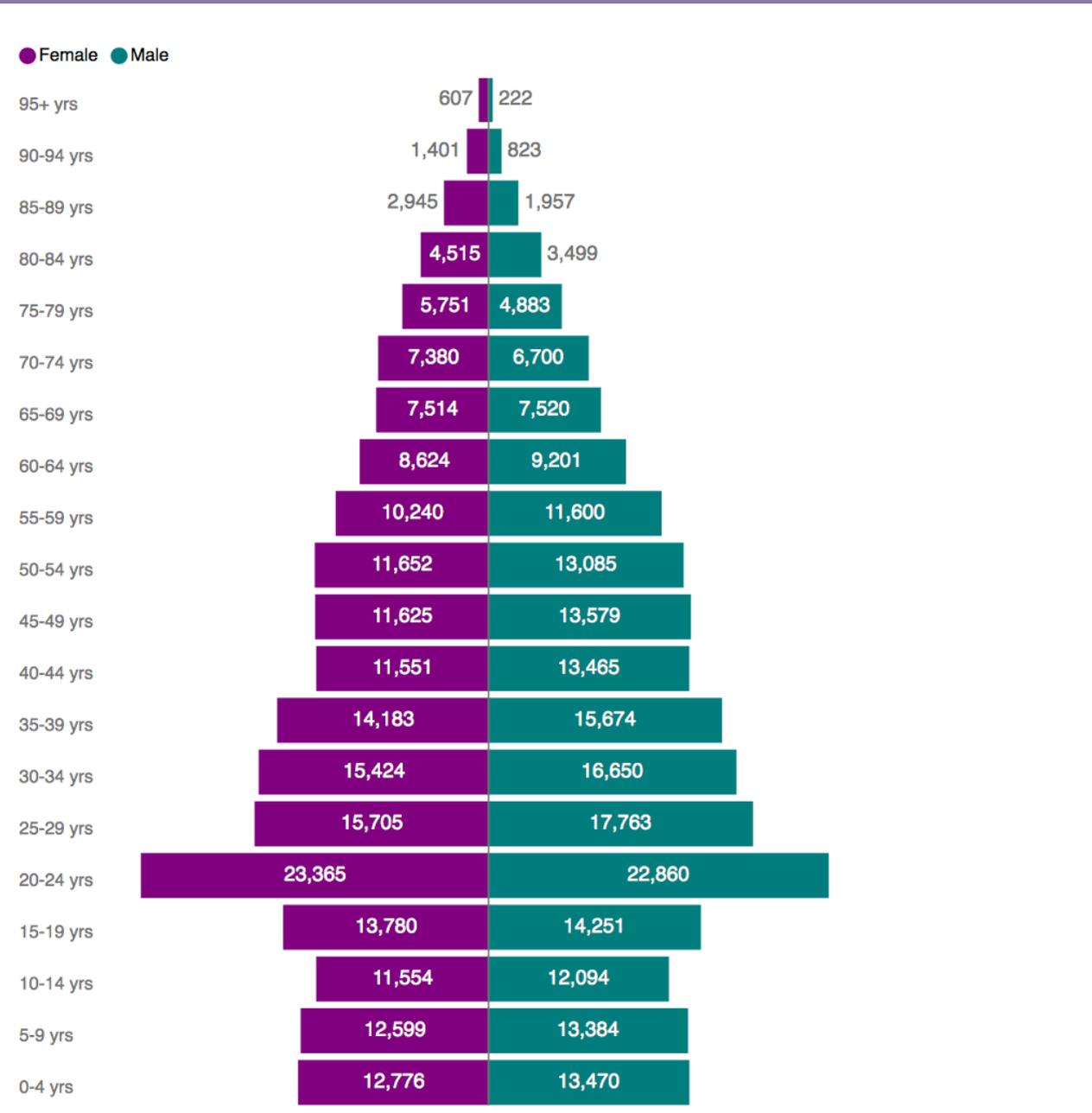
Deprivation

The following figures highlight areas of deprivation in Coventry and Warwickshire. Higher levels of deprivation have been associated with an increased risk of mortality due to COVID-19.

COVENTRY

In 2019 14.4% of Coventry's Lower Super Output Areas (LSOA) were amongst the 10% most deprived in England and 26.7% of LSOAs were amongst the 30% most deprived in England. Figure 3 highlights areas of higher deprivation where residents are at higher risk of contracting or dying of COVID-19. The majority of areas with high deprivation are in the central north east and north east of the city with pockets in the south west and south east.

FIGURE 1 The number of male and female persons in Coventry broken down by age and gender

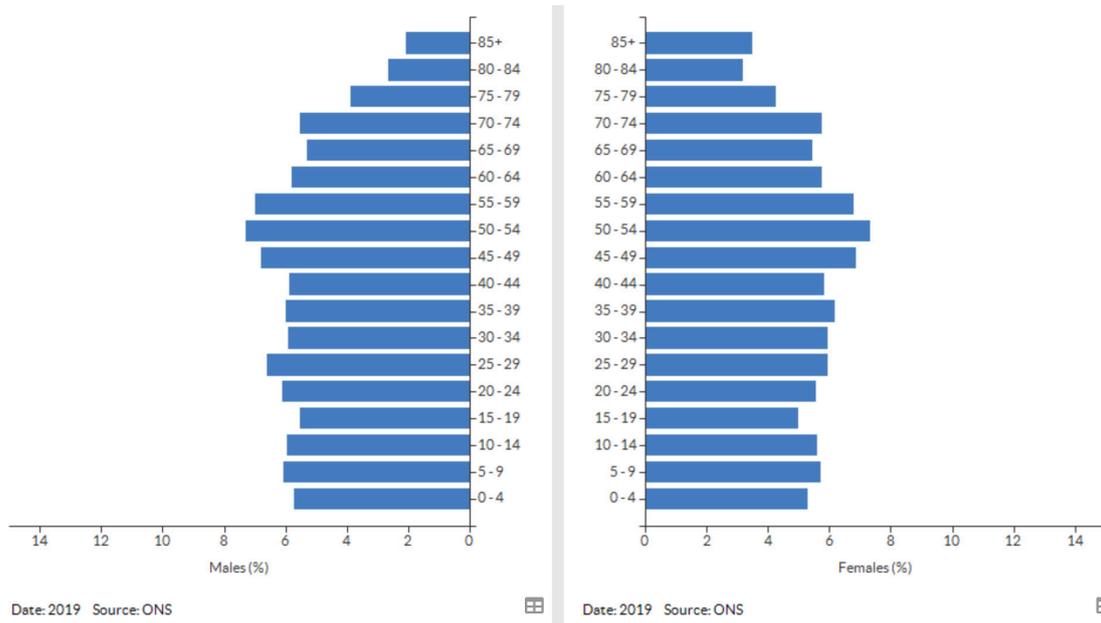


The number of male and female persons in Coventry broken down by age and gender
 Source: Office for National Statistics mid-year population estimates / Insight Team, Coventry City Council

WARWICKSHIRE

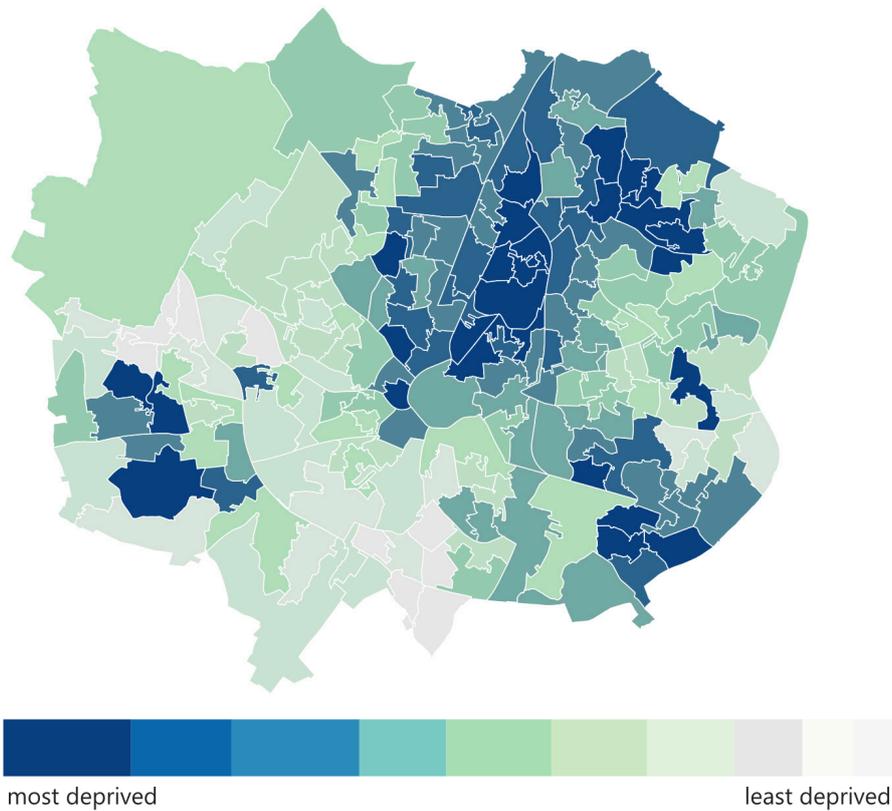
In 2019 Warwickshire ranked 121 out of 151 local authorities for deprivation, with 151 being least deprived. However, there are areas of deprivation across the county and each district or borough contains at least one LSOA amongst the 30% most deprived in England. As illustrated in Figure 4, five LSOAS in Nuneaton & Bedworth Borough and one in North Warwickshire Borough are in the 10% most deprived nationally. Given the national picture, these are areas where residents are at increased risk of contracting and dying from COVID-19.

FIGURE 2 The percentage of male and female persons in Warwickshire broken down by age and gender



Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

FIGURE 3 Heat map illustrating deprivation in Coventry



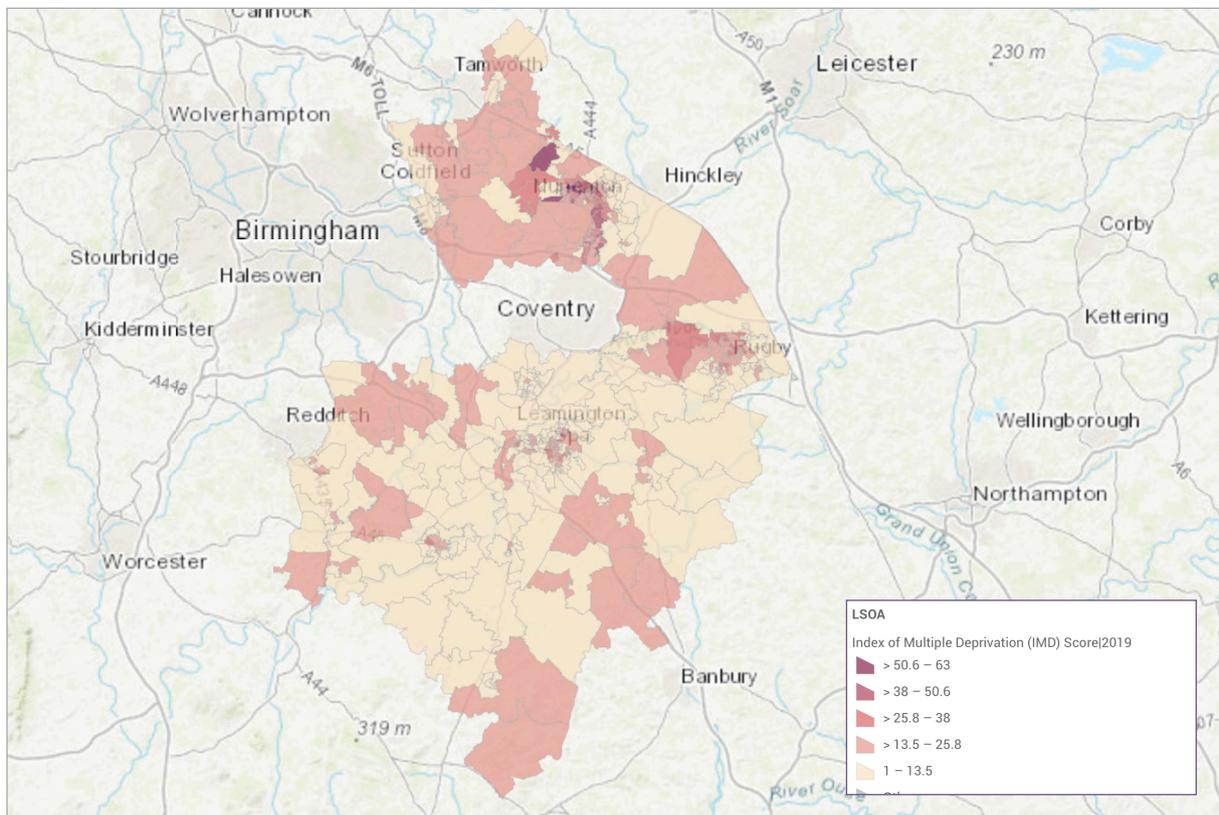
Source: Ministry of Housing, Communities and Local Government / Insight Team, Coventry City Council

TABLE 1 Population ethnicity estimates for Coventry and Warwickshire

	Stratford-on-Avon	North Warwickshire	Rugby
Population Size	55,977,200	366,785	577,933
White English / Welsh / Scottish / Northern Irish / British	79.8%	67%	88.5%
White Irish	1.0%	2.3%	1.0%
White Gypsy or Irish Traveller	0.1%	0.0%	0.1%
White Other	4.6%	4.9%	3.2%
Mixed	2.3%	2.6%	1.5%
Asian	7.8%	16.3%	4.6%
Black	3.5%	5.6%	0.8%
Other	1.0%	1.7%	0.4%

Sources: Office for National Statistics mid-year population estimates / Insight Team, Coventry City Council; Business Intelligence Team, Warwickshire County Council

FIGURE 4 Heat map illustrating deprivation in Warwickshire



Source: Ministry of Housing, Communities and Local Government / Business Intelligence Team, Warwickshire County Council

The Wider Determinants of Health

Claimant Count

What was the previous picture:

The Claimant Count is a measure of those receiving Job Seeker's Allowance, plus those receiving Universal Credit who are required to look for work. Across both Coventry and Warwickshire, the percentage of working age people counted in this group has been gradually rising since April 2019: in Coventry it increased from 2.5% in April 2019 to 3.3% in March 2020, and in Warwickshire from 1.9% in April 2019 to 2.2% in March 2020. Across Warwickshire, the highest rates were in Nuneaton and Bedworth Borough, which were consistently higher than the England rate, and the lowest in Warwick and Stratford Districts.

What does the literature say:

It is well documented that the health of populations is shaped by the socioeconomic context, welfare systems, labour markets, public policies and demographic characteristics of countries. Changes in these key determinants may be reflected in the wellbeing of populations. The original Marmot Review in 2010 shone a light on the importance of good employment for health and wellbeing, and the strong connection between unemployment and mortality^{vi}.

The impact of mass unemployment events has also been studied. Job loss can lead to increases in alcohol use, smoking, overweight and drug misuse, as well as mental health. There are wider impacts on the families of people who become unemployed including poor mental health and relationship stress^{vii}.

A systematic review focusing on mental health outcomes concluded that during periods of economic recession, an increase in unemployment can subsequently lead to a higher prevalence of mental health problems, including common mental disorders, substance disorders, and ultimately suicidal behaviour^{viii}.

What is the current data saying:

In Coventry the Claimant Count numbers increased from 8,030 in March to 15,700 in May (increase of 95.5%); which is lower than the England increase. When compared to May 2019, the percentage of the population who were claimants has more than doubled, from 2.6% in May 2019 to 6.4% in May 2020.

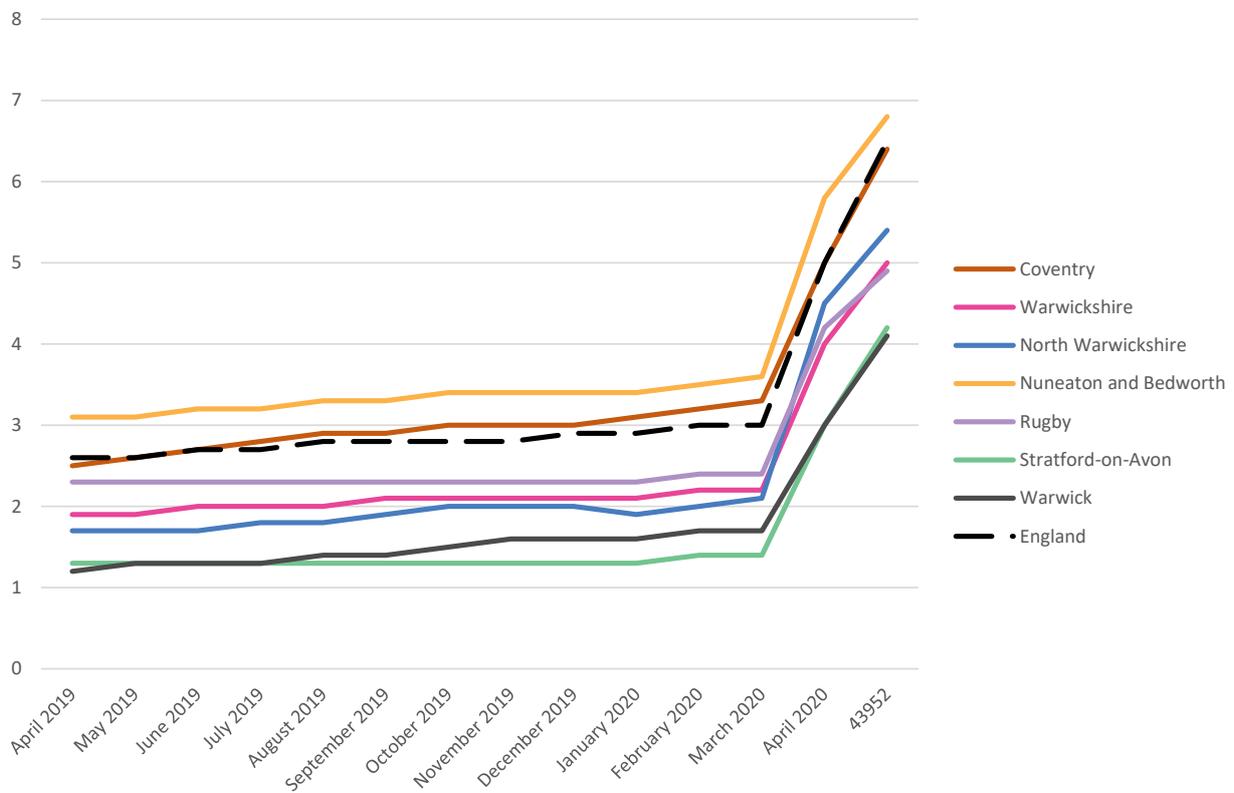
Across Warwickshire the numbers have more than doubled from 7,830 in March to 17,625 in May (increase of 125.1%). This is higher than the England increase of 114.1%. There have been large increases seen across each district and borough, with Stratford-on-Avon District seeing almost three times the number of claimants in May than in March, with more than twice the number in every other district and borough except Nuneaton and Bedworth, which saw an increase of 89.9%.

When compared to May 2019, the percentage of the population who were claimants across Warwickshire has more than doubled, from 1.9% in May 2019 to 5.0% in May 2020. The highest percentage in Warwickshire remains in Nuneaton and Bedworth (6.8%, Warwickshire average 5.0%).

It is important to note that the Government furlough scheme is to some extent masking the extent of the impact of COVID-19 on employment as people currently on furlough are not included in these figures. As such, the impact of COVID-19 on employment may be greater than these figures suggest.

It can be seen from Figure 5 and Table 2 that North Warwickshire has seen the biggest percentage increase in claimants. When comparing May 2019 to May 2020, there are over three times as many claimants. However, Coventry and every district and borough within Warwickshire have at least twice as many claimants in May 2020 as in May 2019.

FIGURE 5 Claimants in Coventry and Warwickshire aged 16+ as a proportion of residents aged 16-64



Source: NOMIS <https://www.nomisweb.co.uk/>

TABLE 2 Percentage increases in Claimant Count across Coventry and Warwickshire

Area	Percentage increase April 2019 to April 2020	Percentage increase May 2019 to May 2020
North Warwickshire	171.0%	222.6%
Nuneaton and Bedworth	88.0%	118.5%
Rugby	85.7%	119.4%
Stratford-on-Avon	138.5%	198.6%
Warwick	138.2%	138.5%
Warwickshire	111.4%	125.1%
Coventry	95.4%	142.8%
Coventry and Warwickshire	103.7%	153.4%
England	93.2%	114.1%

Source: NOMIS <https://www.nomisweb.co.uk/>

Value of goods and services, Gross Value Added

What was the previous picture:

The economies of Coventry and Warwickshire are seen as robust and in the past few years have bucked national trends, helped by a strengthening service sector, which has shown growth in domestic orders^{ix}. The biggest concern was the manufacturing sector where confidence had fallen following a fall in domestic and overseas orders, and the uncertainty around the future trading relationship between the UK and EU.

What does the literature say:

A study published in April 2020 predicted severe adverse effects on employees, customers, supply chains and financial markets will most likely lead to a global economic recession.^x Evidence has shown that employment protects against social exclusion through the provision of income, social interaction, a core role, identity and purpose. Evidence related to economic recovery based on the 2008 financial crisis may not be a suitable proxy measure due to the uncertainty around the end of this pandemic; both the length and scale are not predictable.

What is the current data saying:

Analysis undertaken by the Centre for Progressive Policy (CPP) provided a rank listing of all local district and unitary authorities in the UK in terms of most to least negatively affected by the pandemic. Gross Value Added (GVA) is a measure of the value of goods and services produced in an area. Out of 383 local authority areas, our local areas ranks are shown in Table 3. The main sector causing this decline across Coventry and Warwickshire is manufacturing (see Table 4); this is overwhelmingly the case in Stratford District, where manufacturing is expected to drop by 41%.

A national study by the Institute of Social & Economic Research (ISER), estimated the likely reductions in the workforce from lockdown by sector. While it is hoped that most of these reductions will be furloughed staff (as a result of the Job Retention Scheme), a concern is that this may lead to unemployment in the longer term and also the impact on reduced household income. Using the estimated sectoral percentage reductions in employment from the ISER analysis, we can explore what the potential impact may be locally, and how this may differ from area to area depending on the make-up of the local economy.

In Coventry, of 162,000 jobs, 34,000 (21%) are considered to be at risk, with most affected areas being wholesale and retail trade, and accommodation and food services. This is shown in Figure 6.

Warwickshire could see approximately 70,400 furloughed jobs taken from the local economy as a result of the lockdown measures (approximately 23% of total employment). (14,900 or 30% in North Warwickshire, 9,600 or 20% in Nuneaton and Bedworth, 12,500 or 26% in Rugby, 15,500 or 23% in Stratford and 17,900 or 21% in Warwick) The most affected sectors across Warwickshire would be the Wholesale and retail trade (-23,000) and Accommodation and Food Services (-15,000). This is in line with the sectors most impacted at a national level. This is shown in the Figure 7.

At a national level, according to the Joseph Rowntree Foundation, more than a third of furloughed private renters (37%) are worried about being able to pay their rent when the Coronavirus lockdown ends and there is the potential that they may be made redundant. Additionally, 40% of mortgage holders have suffered reduced income due to Coronavirus, and one in five worried about meeting their housing costs once lockdown lifts.

Nationally, according to the ONS on 12th June 2020, 22% of usual household spending has been prevented by the lockdown (£182 per week).

TABLE 3 Rankings of GVA for Coventry and Warwickshire

Local Authority	Rank	Total GVA (2018) (£m)	Reduction (%)	Main sectors for decline
Stratford-on-Avon	4th	440	46%	Manufacturing
North Warwickshire	12th	531	45%	Manufacturing, Transport and Storage
Rugby	13th	249	45%	Professional, scientific and technical activities, Construction
Coventry	205th	992	37%	Manufacturing
Nuneaton & Bedworth	244th	299	36%	Manufacturing
Warwick	281st	774	34%	Agriculture, mining, electricity, gas, water and waste

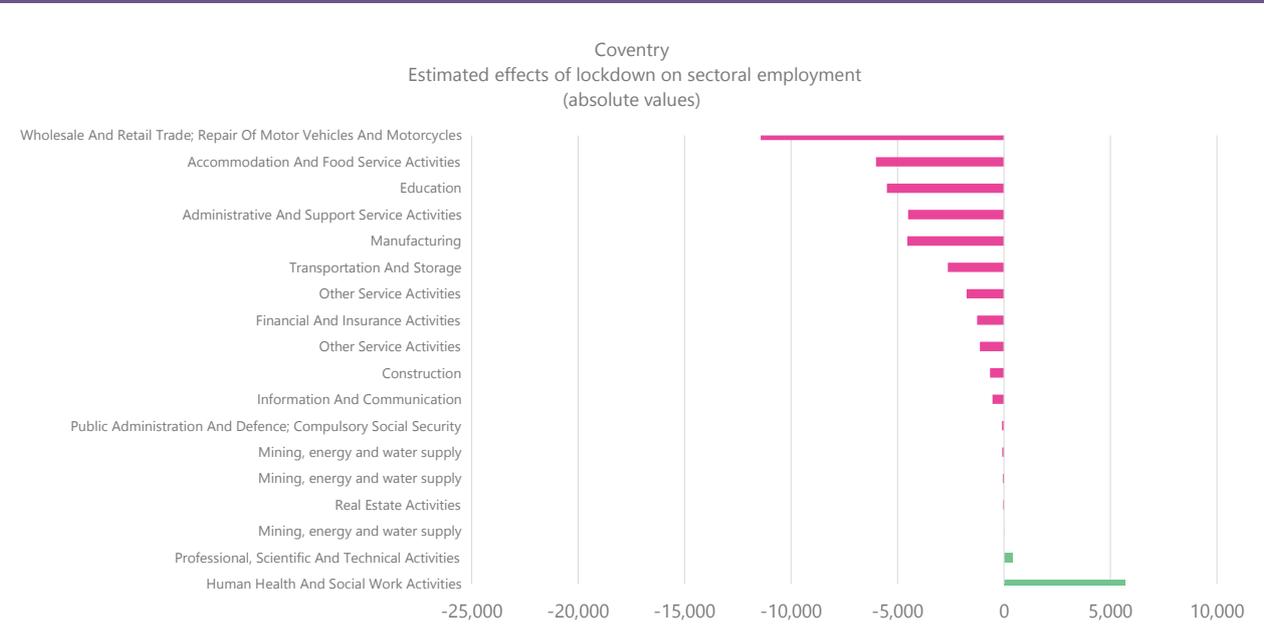
Source: Centre for Progressive Policy (CPP) <https://www.progressive-policy.net/publications/which-local-authorities-face-biggest-immediate-economic-hit>

TABLE 4 Expected reduction in GVA by sector across Coventry and Warwickshire

	Stratford-on-Avon	North Warwickshire	Rugby	Coventry	Nuneaton and Bedworth	Warwick
Accommodation and food service activities	3.3%	2.7%	1.8%	1.9%	1.7%	1.9%
Administrative and support service activities	3.0%	4.0%	3.7%	3.5%	3.5%	7.3%
Agriculture, mining, electricity, gas, water and waste	2.4%	3.8%	1.1%	8.6%	2.4%	22.4%
Construction	5.6%	8.6%	14.4%	2.7%	3.7%	4.2%
Education	3.7%	3.0%	5.2%	9.5%	7.8%	3.0%
Financial and insurance activities	0.7%	4.3%	0.3%	6.9%	0.6%	1.7%
Human health and social work activities	2.9%	1.0%	2.8%	7.4%	11.8%	4.9%
Information and communication	2.9%	2.5%	7.2%	5.1%	1.7%	7.3%
Manufacturing	40.7%	19.3%	11.8%	18.4%	21.7%	7.5%
Other service activities	3.6%	1.6%	2.9%	2.2%	2.4%	4.4%
Professional, scientific and technical activities	4.4%	7.6%	16.3%	4.4%	2.8%	6.3%
Public administration and defence	1.1%	0.8%	2.1%	4.6%	5.5%	3.5%
Real estate activities	15.1%	6.4%	12.4%	10.3%	13.0%	10.7%
Transportation and storage	1.2%	15.7%	9.8%	3.7%	7.4%	2.3%
Wholesale and retail trade; repair of motor vehicles	9.3%	18.6%	8.2%	10.8%	14.1%	12.6%

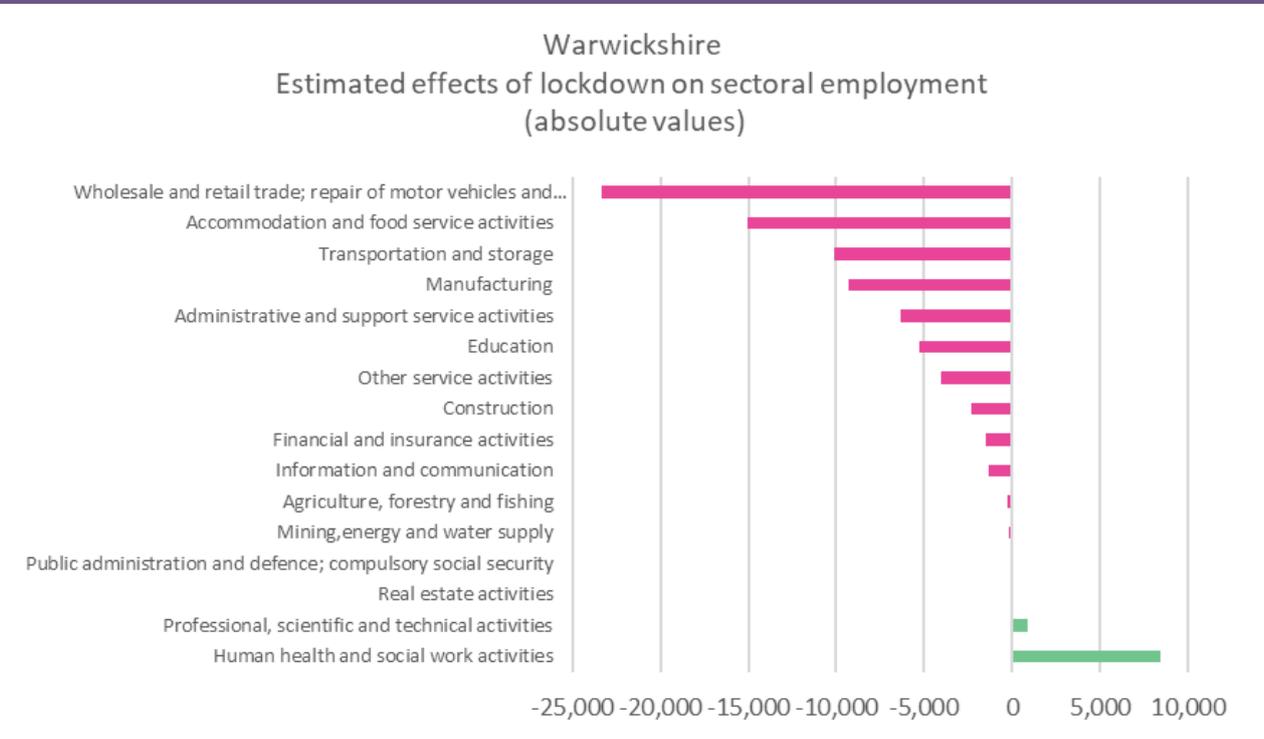
Source: NOMIS <https://www.nomisweb.co.uk/>

FIGURE 6 Estimated effects of lockdown on sectoral employment – Coventry



Source: Institute of Social & Economic Research (ISER)

FIGURE 7 Estimated effects of lockdown on sectoral employment – Warwickshire



Source: Economy team, Warwickshire County Council (Institute of Social & Economic Research (ISER))

Businesses applying for Government initiatives

4TH MAY TO 17TH MAY

The ONS Business impacts of a COVID-19 survey suggests that when considering all industries, 79.4% of businesses applied for the Coronavirus Job Retention Scheme, 15.8% applied for Government-backed accredited loans or finance agreements, and 16.5% applied for business grants funded by the UK and devolved governments. However, this did vary by industry. The sector where the highest percentage of businesses applied to government schemes was Accommodation and Food Service Activities, where 97.1% applied for the Coronavirus job retention scheme, 28.8% applied for Government-backed accredited loans or finance agreements, and 34.0% applied for business grants funded by the UK and devolved governments. When asked what proportion of the workforce was furloughed in the previous 2 weeks, on average 29.7% of the workforce was furloughed. However, this rises to 63.8% for Accommodation and Food Service Activities and 56.4% for Arts, Entertainment and Recreation.

The number of businesses applying for government initiatives in Coventry and Warwickshire is shown in Table 5 and is increasing.

	Stratford-on-Avon	Warwick	Rugby	North Warwickshire	Nuneaton & Bedworth	Coventry
Total Business Rate Relief	1,141	1,276	582	312	624	1,471
Value	£24,114,867.56	£27,996,711.72	£13,156,826.83	£8,371,335	£16,718,321	£49,193,309
Retail Business Rate Relief	1,115	1,239	562	303	610	1423
Value	£23,896,616.77	£27,572,565.75	£12,991,828.38	£8,302,504	£16,609,566	£48,700,000
Nursery Business Rate Relief	26	37	20	9	14	48
Value	£218,250.79	£424,145.97	£164,998.45	£68,831	£108,755	£493,309
Business Cash Grant Total	2,360	2,246	1,291	1,087	1,471	3,772
Value	£29,255,000.00	£29,125,000.00	£15,022,000.00	£12,460,000.00	£18,070,000	£44,920,000
Small Business Grant Fund	1,783	1,563	987	869	1125	2253
Value	£17,935,000.00	£15,630,000	£9,870,000	£8,690,000	£11,250,000	£22,530,000
15,000 rv >	207	238	102	112	122	1039
Value	£2,070,000.00	£2,380,000.00	£102,000.00	£1,120,000	£1,220,000	£10,390,000
15,000 - 51,000 rv	370	445	202	106	224	480
Value	£9,250,000.00	£11,115,000.00	£5,050,000.00	£2,650,000	£5,600,000	£12,000,000

Source: Coventry City Council, North Warwickshire Borough Council, Nuneaton and Bedworth Borough Council, Rugby Borough Council, Stratford-on-Avon District Council, Warwick District Council

TABLE 6 The take up of the Self-Employment Income Support Scheme (SEISS) across Coventry and Warwickshire

	Total potentially eligible population ¹	Total no. of claims made to 31/5/20 ²	Total value of claims made to 31/5/20 ² (£)	Average value of claims made to 31/5/20 ² (£)	Take-Up Rate ⁵
United Kingdom	3,397,000	2,380,000	6,974,000,000	2,900	70%
West Midlands	262,000	185,000	521,000,000	2,800	70%
Warwickshire County	25,500	17,800	53,500,000	3,000	69%
North Warwickshire	3,200	2,300	6,900,000	3,000	72%
Nuneaton and Bedworth	4,900	3,500	10,100,000	2,900	71%
Rugby	4,400	2,900	8,800,000	3,000	67%
Stratford-on-Avon	7,500	5,200	16,200,000	3,100	69%
Warwick	5,600	3,800	11,500,000	3,000	69%
West Midlands Metropolitan County	117,500	82,600	221,200,000	2,700	70%
Coventry	13,100	9,100	24,500,000	2,700	69%

Source: <https://www.gov.uk/government/statistics/self-employment-income-support-scheme-statistics-june-2020>

Self-Employment Income Support Scheme (SEISS) claims made up to 31 May 2020 show that Warwickshire has about twice the number of potentially eligible people as Coventry. Within Warwickshire, Stratford District has the highest number of eligible people. However, take up is relatively similar across areas, varying slightly within Warwickshire between 67% in Rugby Borough and 72% in North Warwickshire Borough, and 69% in Coventry. This is in line with the West Midlands regional take up (70%) as well as national figures (70%). This is demonstrated in Table 6.

Free School Meals (FSM)

Free School Meals are provided to those who are in receipt of qualifying benefits, which include Income Support and Universal Credit, and apply through their local authority. If a child is eligible for free school meals, they will remain eligible until they finish the phase of schooling (primary or secondary) that they are in on 31st March 2022. In addition, all children in Reception, Year 1 and Year 2 currently receive a free school meal regardless of whether they are eligible. This section considers only those who are eligible due to being in receipt of qualifying benefits.

What was the previous picture:

The numbers of pupils eligible for and claiming free school meals in Warwickshire and Coventry at the school census undertaken in January 2020 are shown in the tables and figures below.

What is the current data saying:

In Coventry, as at 15 June 2020, numbers receiving free school meals through their school is around 5% higher than reported eligible in the Spring 2020 school census (11,600 or 10.7% of child population compared with 11,000 or 10.1% of child population), although in total, when you include further education students, around 12,500 free school meals are being received routinely each day (11.5% of child population).

Area	Total number of school age children eligible and claiming FSM (Nursery to Y13+)	Proportion of children %
Pathways	1974	8.2
Park Edge	1515	11.5
Mosaic	1470	6.7
The Moat	1429	10.1
Harmony	1263	13.6
Families for All	1156	14.0
Aspire	1107	9.2
Wood Side	934	16.2
Coventry (including blank)	11012	10.1
Coventry	13,100	9,100

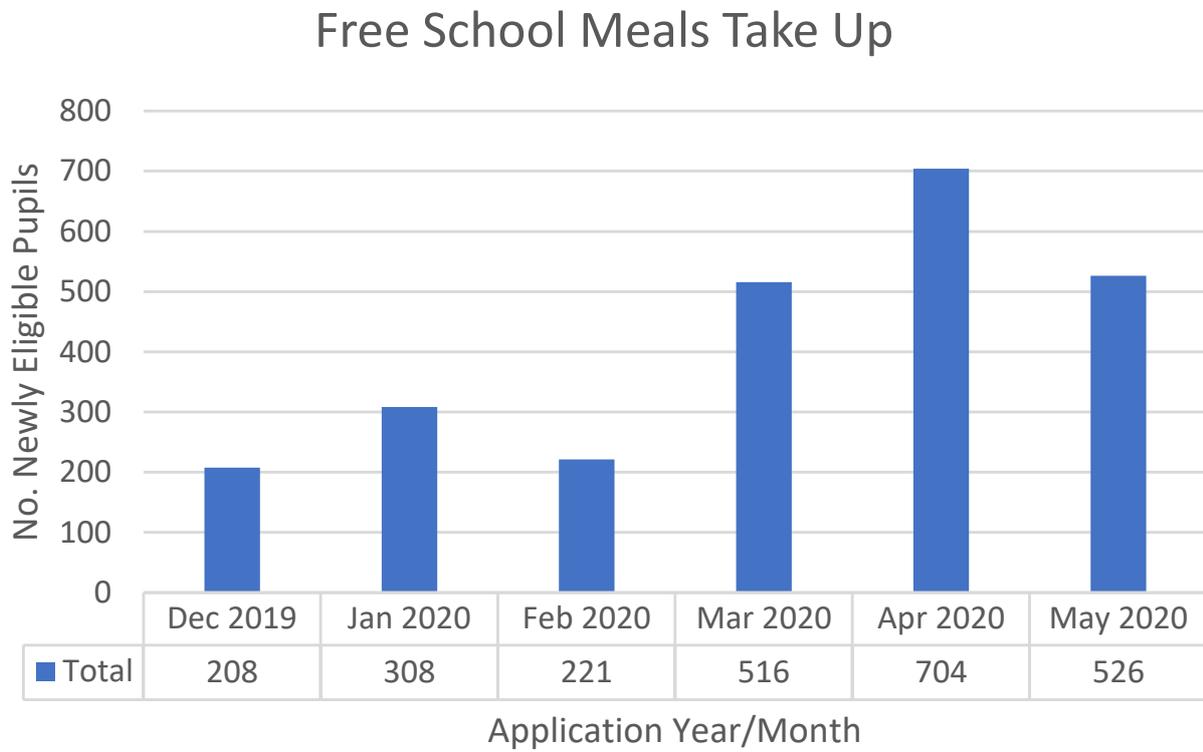
Source: Insight Team, Coventry City Council

Area	Total number of school age children eligible and claiming FSM (Nursery to Y13+)	Proportion of children %
North Warwickshire Borough	1628	14.7
Nuneaton and Bedworth Borough	3478	18.6
Rugby Borough	2546	15.0
Stratford-on-Avon District	1864	9.3
Warwick District	1811	9.9
Warwickshire	11327	13.3

The number of children newly eligible for a free school meal in Warwickshire was 704 in April 2020, over twice as many as those who became eligible in January (308). This dropped to 526 in May, however still way above pre-lockdown numbers. These families receive a weekly shopping voucher worth £15.

In June the government extended the voucher scheme over the school summer holidays. Both Coventry and Warwickshire County Councils also plan to provide support to children who would normally receive free school meals during the holidays (in Warwickshire through the Warwickshire local welfare scheme).

FIGURE 8 FSM eligibility in Warwickshire, December 2019 – May 2020



Source: Education Team, Warwickshire County Council

Our Health Behaviours and Lifestyles

Drug and Alcohol Services

What does the literature say:

Evidence related to previous severe coronavirus outbreaks suggests there is likely to be an increase of alcohol dependence in the population, a study of hospital employees found alcohol dependence to be positively associated with an epidemic even up to 3 years after an outbreak.^{xi}

In addition a study in the US on the current situation found that perceived threat from COVID-19 was linked with increased alcohol use as a coping mechanism. In the study group this was particularly pronounced in women. Alcohol contributes to a wide range of conditions including cardiovascular disease, cancer and liver disease, as well as harm from accidents, violence and self-harm.^{xiii}

What is the current data saying:

According to a survey by Alcohol Change UK in April 2020, 22% of people stated they were drinking on more days than before lockdown, 22% stated they were drinking on fewer days, 43% stated they were drinking on about the same number of days and 12% had given up drinking altogether.

The Understanding Society study by the Institute for Social and Economic Research showed that, using the Alcohol Use Disorders Identification Test, 5% of people had increased their risky alcohol use in April (since 2018/19), whereas 18% of men and 11% of women reduced their risky alcohol use. The reduction in risky alcohol use occurred to the greatest extent in the youngest age group (16 – 34).^{xiv}

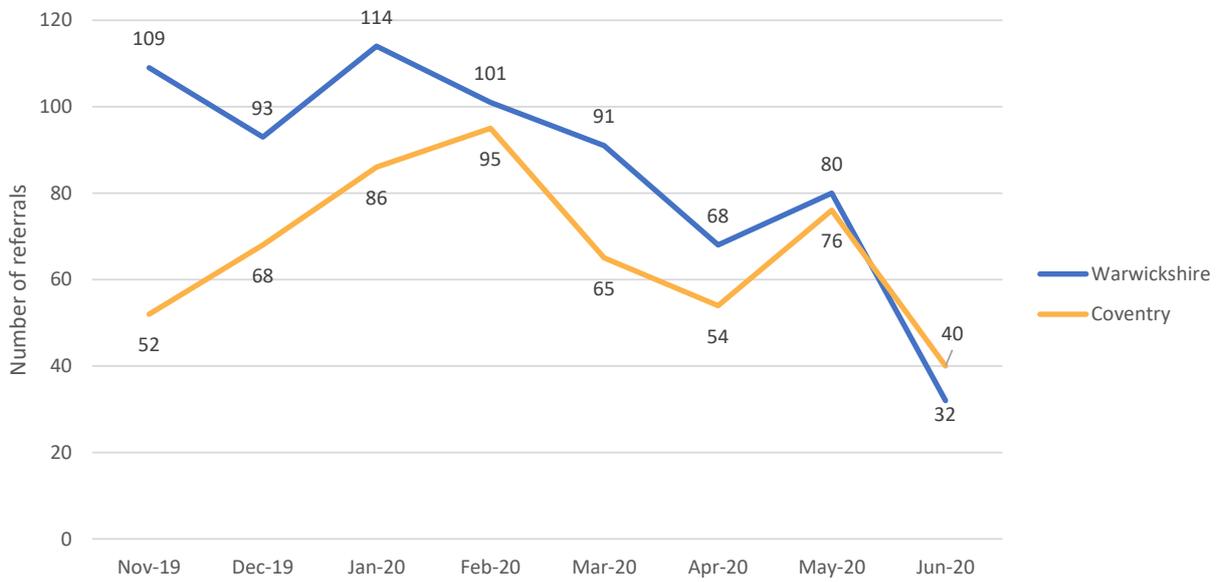
Supermarkets reported a strong increase in volume sales at 10.3% in March 2020 compared with February 2020, while off-licence alcohol sales increased by 31.4% in volume. Off-licenses, however make up less than 1% of total alcohol sales. Online shopping made up 22% of all alcohol purchases, a record high for e-commerce in the UK. Volume of alcohol sales can be more volatile month-on-month; it is likely that there was some stockpiling of alcohol during March, and therefore consumers may not need to replenish their wine, beer or spirits supplies for another couple of months (ONS^{xv}).

Change Grow Live (CGL), the service commissioned to provide drugs and alcohol treatment services across Coventry and Warwickshire, has seen a decline in the number of referrals received in since February 2020, though it started rising again in May 2020. The CGL team, in discussion with other professionals, believes that this is mainly due to new potential service users knowing that they are no longer offering any face-to-face appointments at present (though they are offering telephone/web chats and groups via Zoom). They also believe that potential service users' health concerns around COVID-19 have also affected the numbers (data correct up to 18 June 2020).

Naloxone use: Naloxone is a lifesaving drug given to opiate using service users in case of overdose. Since COVID-19, there has been a dramatic increase in these kits given out by CGL to opiate service users in order to try to minimise risk as they are not being seen on a face to face basis unless absolutely vital. All opiate using service users are offered Naloxone on presentation to the service and the lower numbers previously would be due to new service users or re-issue (the majority of service users carry this), extra was offered to all service users.

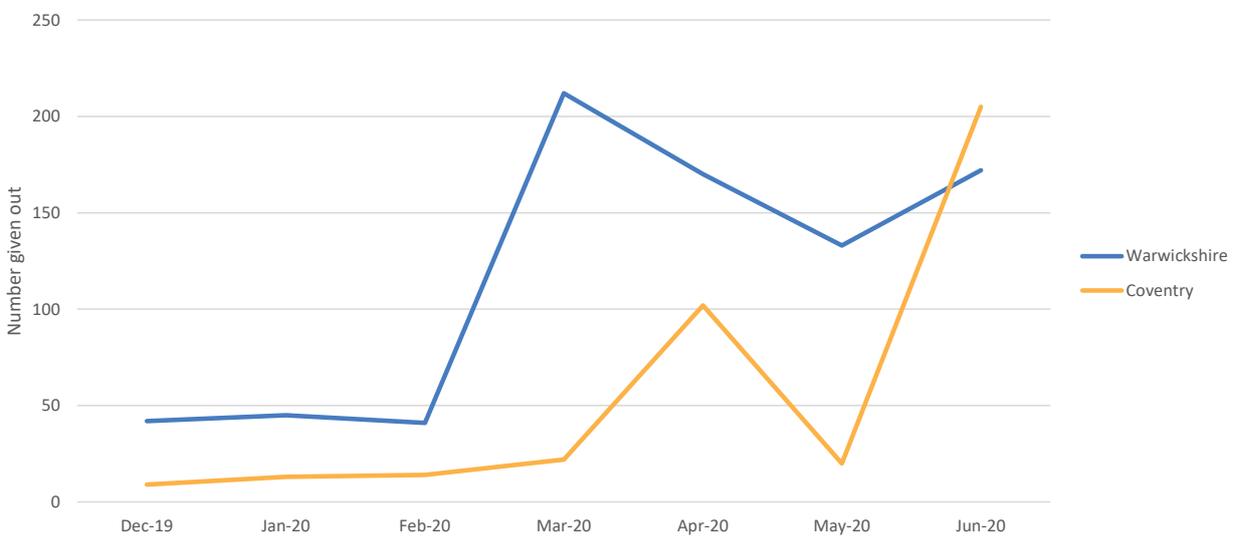
Triage by drug category: Triages take place following a referral, and they mark the beginning of a client's treatment journey.

FIGURE 9 Referrals made to Change Grow Live for alcohol consumption in Coventry and Warwickshire



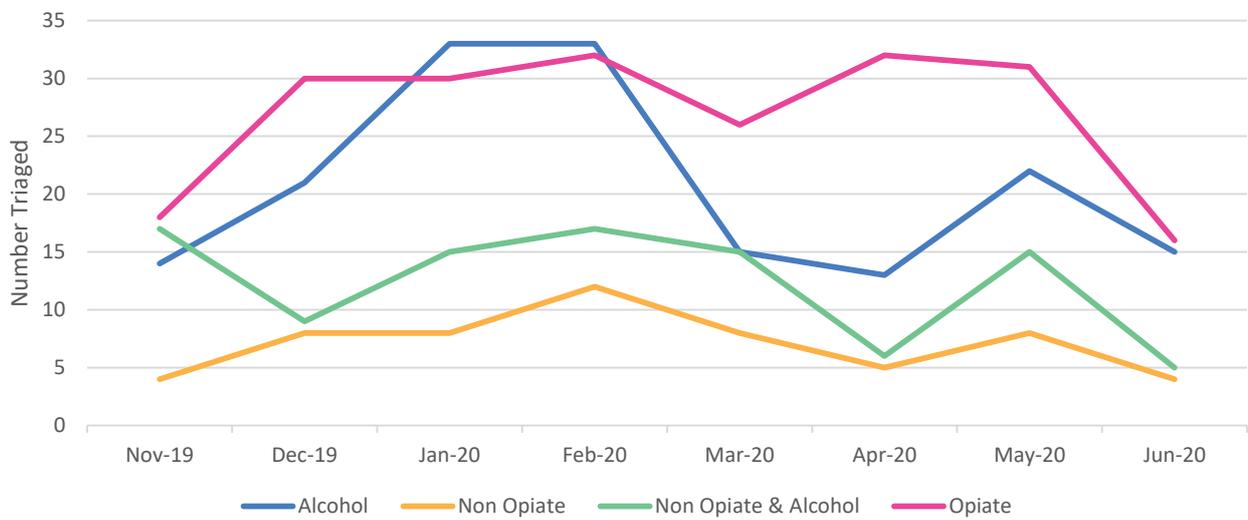
Source: CGL

FIGURE 10 The number of Naloxone kits provided to opiate service users in Coventry and Warwickshire



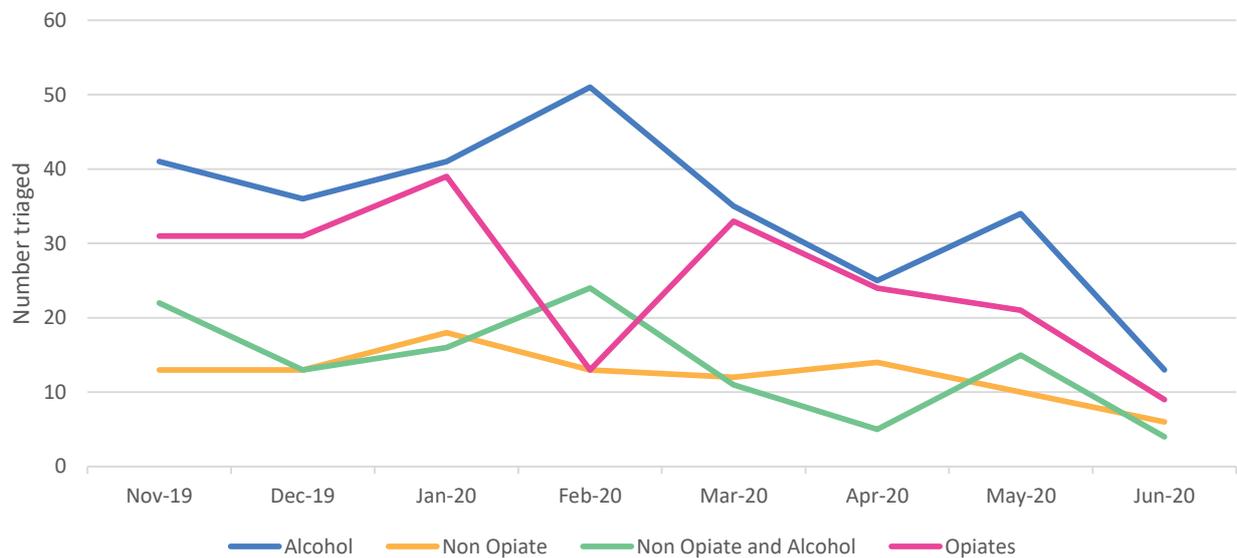
Source: CGL

FIGURE 11 The number of service users triaged by CGL by drug type in Coventry



Source: CGL

FIGURE 12 The number of service users triaged by CGL by drug type in Warwickshire



Source: CGL

COVENTRY

CGL saw a drop in opiate triages in March 2020, going back up to steady figures in April and May and dropping off again in June 2020 (although data for June is only partial, to 16 June 2020). Alcohol triages peaked in January and February 2020 and substantially decreased at the beginning of lockdown in March 2020. As discussed above, this may be due to potential service users being unaware that the service was still available or health concerns around COVID-19. Non opiate and non-opiate & alcohol triage numbers remained steady.

WARWICKSHIRE

There are no specific trends in drug types in new triages that have increased or decreased on a notable scale except alcohol (which increased dramatically in February 2020 and has slowly decreased over the following months) and heroin triages (dropping to 8 in February at the start of the outbreak and back up to an average figure in March).

Trend by Contact Type: There has been a substantial increase in the number of Recovery Worker contacts (i.e. where service users have been contacted within the last 4 weeks by text, call and video call) in both Coventry and Warwickshire. Recovery Worker contacts is a new measure that CGL introduced in March.

Anecdotally within Warwickshire, there appears to be crystal meth use in Nuneaton, which is not normally reported in Nuneaton. In South Warwickshire, drugs are still easily available, though purity has dropped and there is a slight increase in cost. In Rugby, ease of obtaining drugs varies, however there are also reports of reduced purity.

Gambling

Prior to the COVID-19 pandemic, there is evidence that gambling is easier to access in more deprived areas^{xvi}. Since the pandemic, fewer consumers are gambling but some people, who are gambling already, are trying new products.

The crisis does not appear to have attracted many new consumers to gambling. According to YouGov research from 16-17 April, only 0.2% of all adults surveyed stated that they had started gambling for the first time during the last four weeks. For comparison, research by the Gambling Commission in 2019 found that 47% of respondents participated in gambling in the past four weeks^{xvii}.

Operator data on overall active player accounts indicates a 3% decrease, driven in part by real event betting (active players down 11%), where clearly the chance to bet on top quality sport has disappeared.

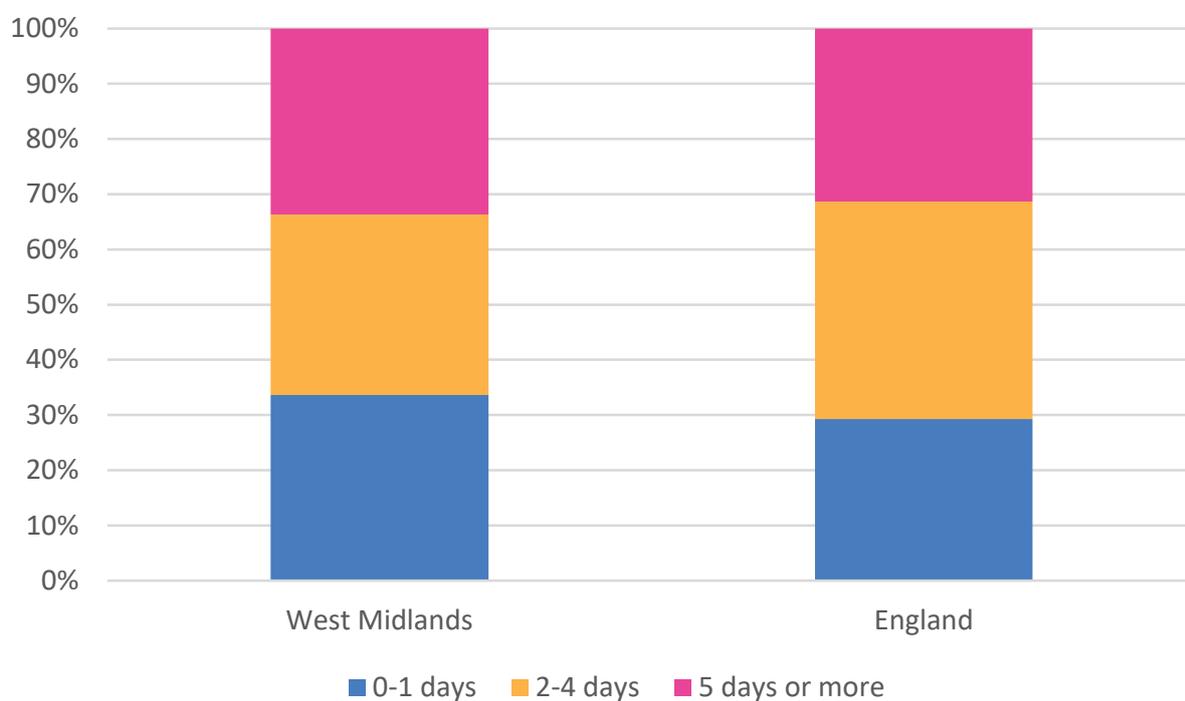
The YouGov research shows that a third of past four-week gamblers say they have tried one or more gambling activities for the first-time during lockdown. Operator data shows that certain products are seeing active player increases compared to this time last year (some from low comparative bases of players), which are generally those with a faster play cycle, such as slots (The Gambling Commission^{xviii}).

TABLE 9 Physical activity undertaken during the COVID-19 lockdown restrictions compared to before restrictions were introduced in the West Midlands and England

Area	More	Neither more nor less	Less
West Midlands	34.5%	35.0%	30.6%
England	35.9%	29.5%	34.6%

Source: Sport England

FIGURE 13 Days of physical activity undertaken during the COVID-19 lockdown restrictions in the West Midlands and England



Source: Sport England

TABLE 10 Physical activity undertaken during the COVID-19 lockdown restrictions compared to before restrictions were introduced in ABC1 and C2DE grouping

Activity undertaken	ABC1	C2DE	All
More	39.5%	30.0%	35.0%
Neither more nor less	27.8%	35.3%	31.3%
Less	31.9%	32.1%	32.0%

Source: Comres Global and Sport England

TABLE 11 Physical activity undertaken during the COVID-19 lockdown restrictions by age group

Activity undertaken	16-17	18-24	25-34	35-44	45-54	55-64	65+
More	36.9%	47.5%	42.6%	39.7%	31.5%	28.8%	17.1%
Neither more nor less	17.9%	19.3%	20.3%	27.9%	40.7%	35.6%	50.5%
Less	40.5%	31.8%	34.8%	30.7%	27.0%	34.8%	30.6%

Source: Comres Global and Sport England

Physical Activity

In a survey for Sport England^{xix}, from 24th to 27th April 2020, 2,006 adults aged 16+ were asked about their physical activity. These results are split by region. In the West Midlands, 34.5% of respondents were doing more physical activity than before the lockdown restrictions, and 35.0% were doing the same amount. This is compared with 35.9% of respondents in England doing more physical activity, and 29.5% doing the same amount.

When asked, “On how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?”, 34% stated on none or only one day, compared to 29% for England, whereas 34% stated 5 or more days, compared to 31% in England (Figure 13).

When asked about the type of activity, in the West Midlands the most common activity is walking, which 62% of people had done in the last week (England 61%). Home activities such as online workouts or DVDs (16%), running or jogging (15%) and cycling (12%) were also common activities, although all of these were slightly less popular in the West Midlands than in England as a whole^{xx}.

Looking at data collected between 3 April and 25 May, there were 1722 people surveyed in the West Midlands and there are some differences when looking at National Statistics Socio-economic classification social grade (NS-SEC) and age of respondents. ABC1 is roughly “middle class” and C2DE is roughly “working class” based on the occupation of the head of the household. Table 10 shows that a higher percentage of people in the ABC1 classification (broadly people in managerial and professional occupations) responded as having undertaken more physical activity during lockdown than those in the C2DE classification (broadly skilled or unskilled manual workers or people who are unemployed).

Table 11 illustrates whether respondents felt they had undertaken more, less or similar activity during the COVID-19 lockdown restrictions compared to before the restrictions were introduced. 18 – 24 year olds were the group reporting the highest percentage of respondents doing more activity during lockdown (47.5%) with those aged 65+ reporting the lowest percentage (17.1%). 16 – 17 year olds were the group reporting the highest percentage of respondents doing less activity during lockdown (40.5%) with those aged 45 – 54 reporting the lowest percentage (27%).

A survey of gym members conducted by Leisure-net solutions showed that 52% of respondents stated that they have been less active since the lockdown, and only 22% said they have been more active^{xxi}.

WARWICKSHIRE

In Warwickshire, support packs have been produced containing links and ideas for physical activity during lockdown. These have been sent to partners and providers across all districts and boroughs. Referrals for weight management, having been at between 1052 and 1360 for the previous four quarters, are at 43 referrals for Q1 of 2020/21 (data up to 11th June 2020).

Many of the local leisure centres have moved classes online since March 2020, offering reduced rates for access to online workouts and training plans.

Those on the Fitter Futures program have been contacted to offer advice and support on accessing exercise online. Of the 252 people contacted, 130 (51.6%) were completing no exercise at all. While it is not possible to link this data, it is likely that these people are doing less physical activity than before the lockdown.

Google Community Mobility Reports

The Google Community Mobility Reports chart movement trends over time by geography, across different categories of places such as retail and recreation, groceries and pharmacies, parks, transit stations, workplaces, and residential. This report is based on the location of users' phones.

MAY REPORT

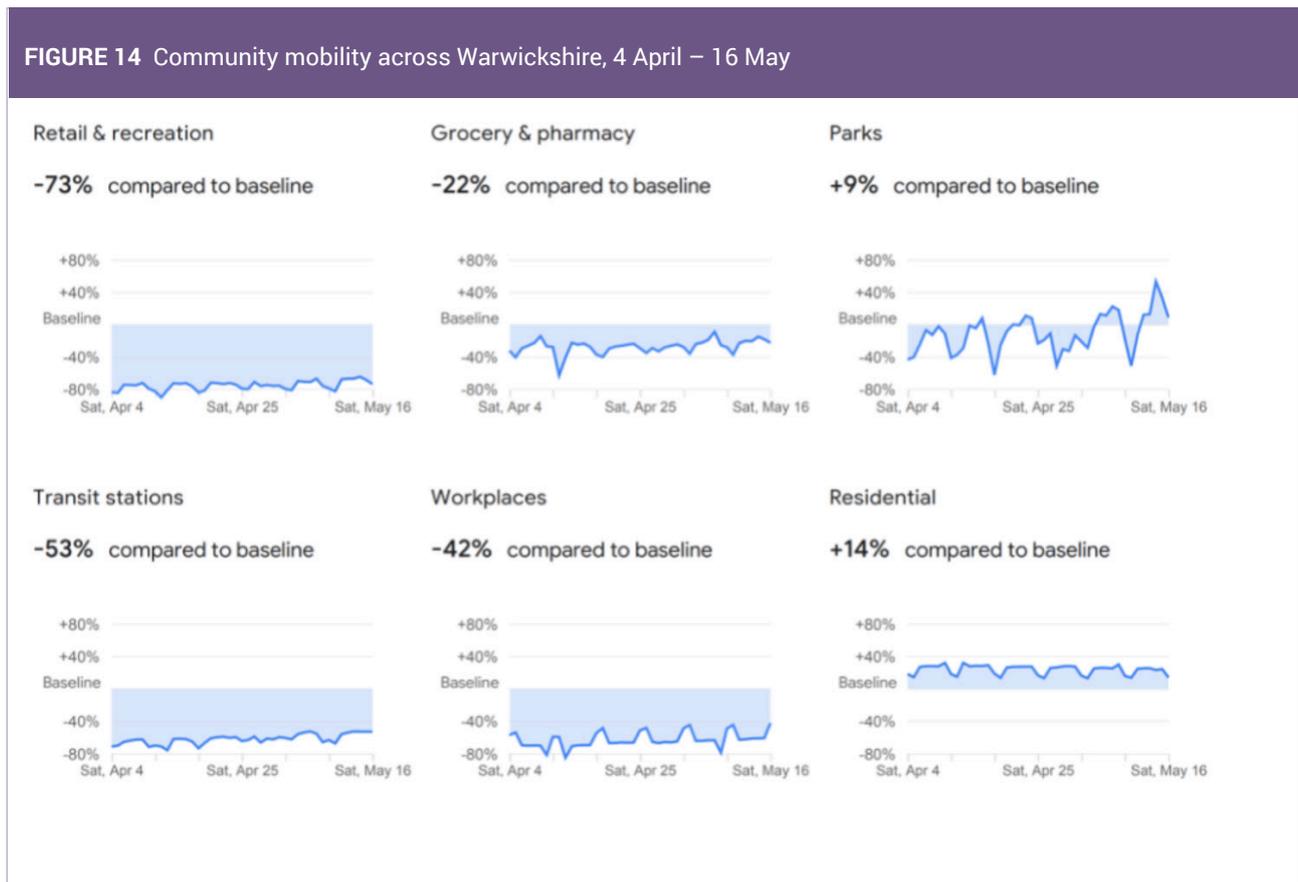
As expected, the reports for May show large reductions (-73%) in population mobility. There has been a 9% increase in visits to parks in Warwickshire compared to the baseline, which is notably less than the 33% increase across the West Midlands Metropolitan Area (including Coventry).

JUNE REPORT

There is a large increase in visits to parks for both Coventry and Warwickshire in this data, perhaps most noticeably over the half term and bank holiday at the end of May. Residential is still higher than baseline, but not as high as in the previous report. These changes perhaps reflect people's return to work, being allowed out for exercise more than once a day and being able to relax in parks.

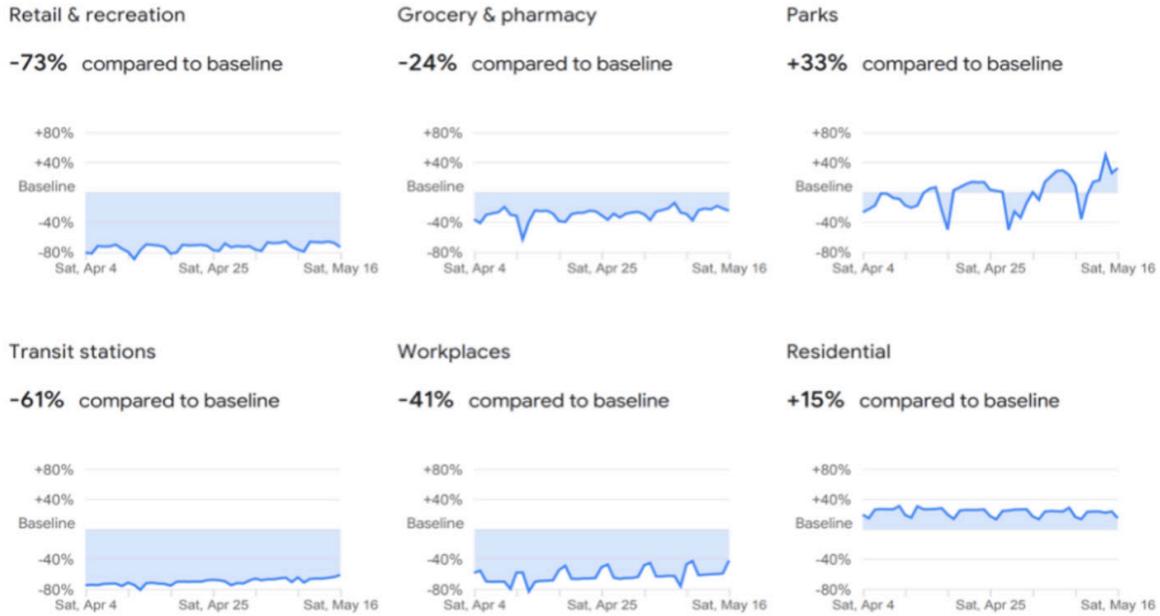
WARWICKSHIRE

FIGURE 14 Community mobility across Warwickshire, 4 April – 16 May



WEST MIDLAND METROPOLITAN AREA (INCLUDING COVENTRY)

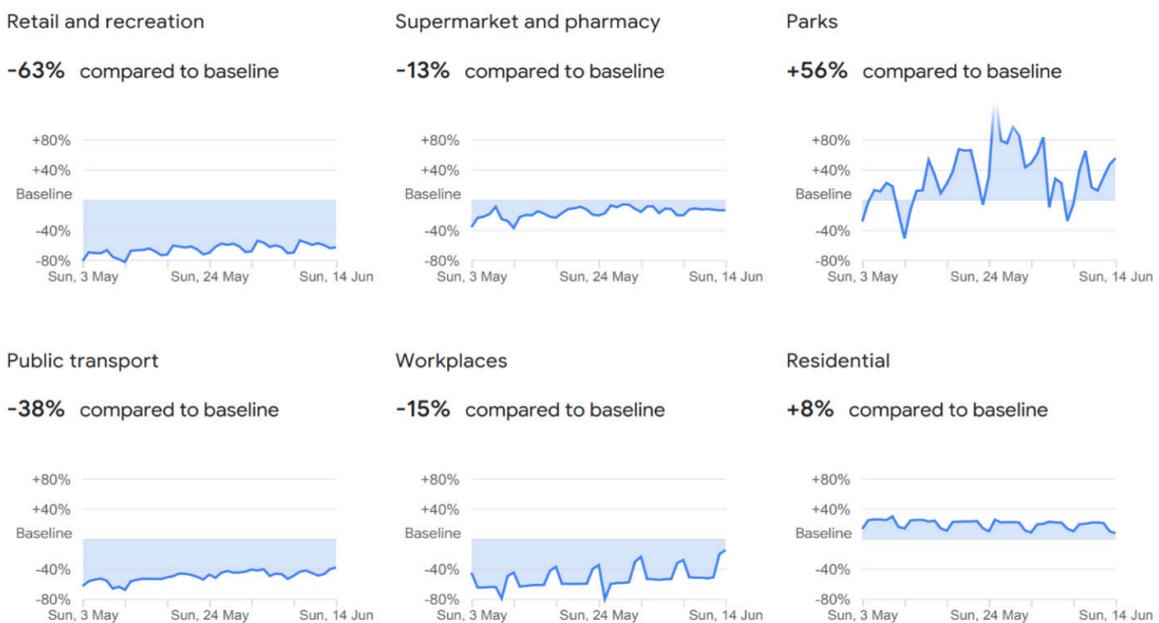
FIGURE 15 Community mobility across the West Midlands (including Coventry), 3 May – 14 June



Source: Google

WARWICKSHIRE

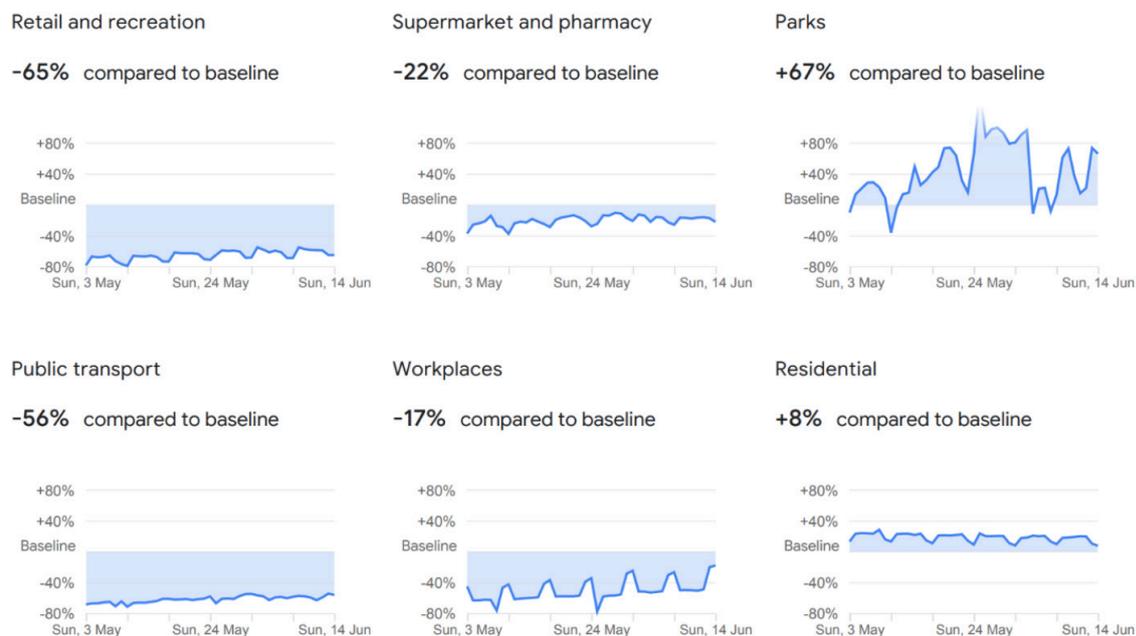
FIGURE 16 Community mobility across Warwickshire, 3 May – 14 June



Source: Google

WEST MIDLAND METROPOLITAN AREA (INCLUDING COVENTRY)

FIGURE 17 Community mobility across the West Midlands (including Coventry), 3 May – 14 June



Source: Google

Stop Smoking in Pregnancy Service

Smoking during pregnancy was associated with exposure to the UK 2008-2010 economic recession during pregnancy and this relationship is partly mediated by financial stress.^{xxii} Health inequalities in smoking during pregnancy are affected by economic recession, as those who are most likely to smoke are also most likely to experience the financial stress resulting from economic recession.

WARWICKSHIRE

There were 191 referrals between 1st April 2019 and 16th June 2019, of which 66% set a quit date and 53% had quit at 4 weeks. The number of referrals to the Stop Smoking in Pregnancy Service in Warwickshire has dropped to 139 for the same period in 2020, with the biggest drop in Rugby Borough. The number setting quit dates is 83% and may rise for those who have been referred towards the end of this period, showing a big improvement on the 2019 figures. Engagement levels are said to be higher overall. It is not yet possible to compare quit rates as not enough time has elapsed, however the picture is a positive one. At present equivalent data is not available for Coventry.

An Integrated Health and Care System

The health and care sector in Coventry and Warwickshire saw large changes during the pandemic as services were directed towards preparing for and responding to increasing numbers of patients with COVID-19. Locally a peak in the number of hospitalised patients diagnosed with COVID-19 occurred in early April.

This analysis looks at how health service use for other reasons has changed.

A&E Attendances

Overall, A&E attendances in April 2020 reduced by 62.0% compared with April 2019 across the Coventry & Warwickshire HCP footprint. All 3 CCGs have seen a reduction in A&E attendances, with South Warwickshire and Warwickshire North similarly so at 56.2% and 57.1% respectively. Coventry and Rugby saw a slightly higher reduction of 66.1%. This is illustrated in Figure 18.

Non-Elective (Unplanned) Admissions

Non-elective activity reduced in April and there were 2,818 fewer unplanned admissions compared with the previous year. This is a reduction of 25.8%. The reduction was made up of a 30.7% reduction in emergency admissions, and 8.8% reduction in non-emergencies. All 3 CCGs have seen a reduction in emergencies, with Coventry and Rugby and Warwickshire North similarly so at 27.4% and 30.0% respectively. South Warwickshire saw a larger reduction of 37.5%. This is illustrated in Figure 19.

This percentage reduction in unplanned admissions is less than A&E attendances, where a large proportion of these patients would have been admitted from. This could therefore be early evidence of the change in case-mix of patients attending A&E, and that that patients attending A&E during lockdown were more likely to have severe illness requiring admission.

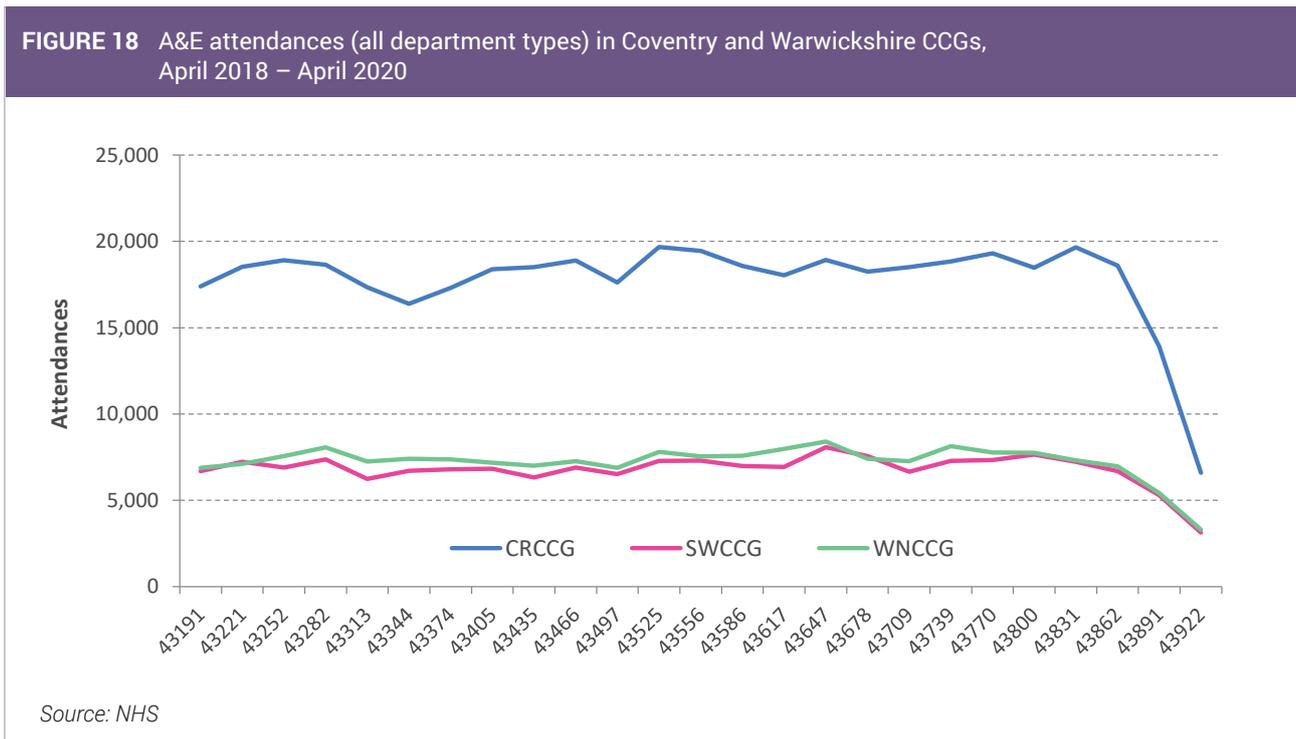
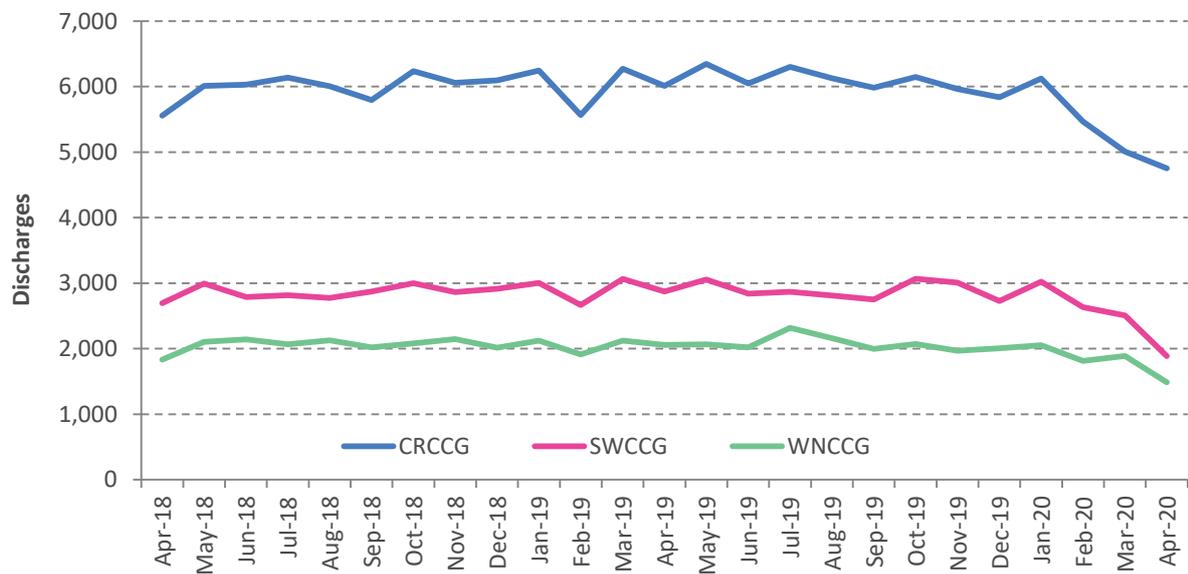


FIGURE 19 Non-elective admissions in Coventry and Warwickshire CCGs, April 2018 – April 2020

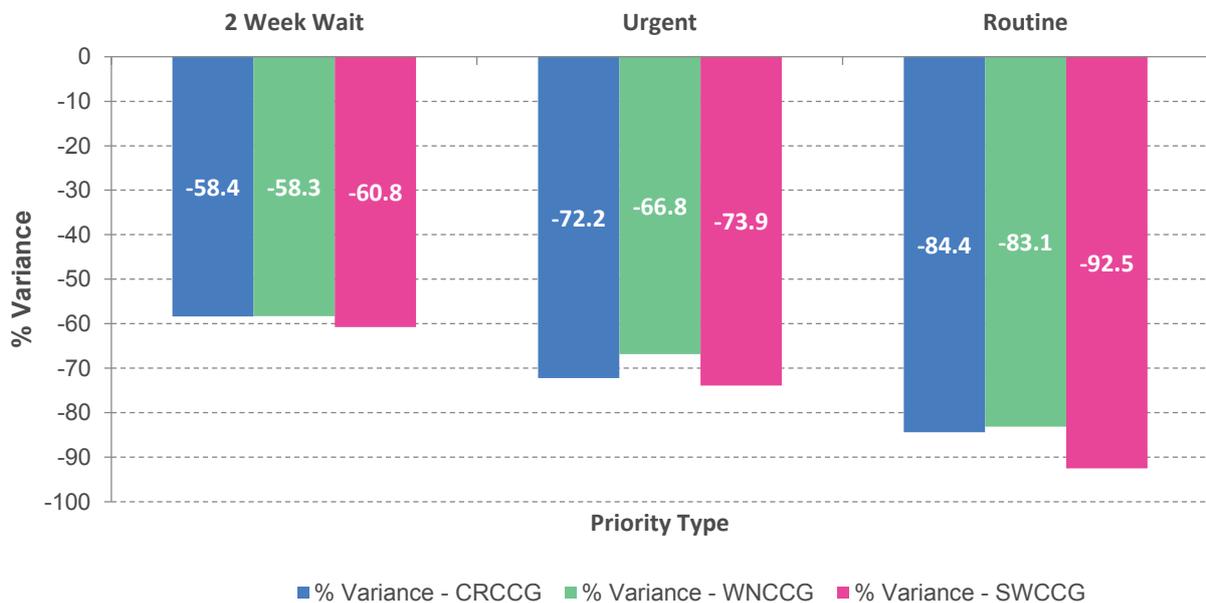


Source: NHS

GP Referrals (E-Referrals data)

Total referrals decreased by 80% across Coventry & Warwickshire CCGs in April 2020 compared with April 2019, with the biggest decrease seen in SWCCG (83.3%). Routine referrals have decreased by 85.9%, Urgent referrals by 71.8% and two week waits by 59.1% across Coventry & Warwickshire. This is illustrated in Figure 20.

FIGURE 20 GP referrals across Coventry and Warwickshire CCGs, April 2019 compared to April 2020



Source: NHS

Outpatient Attendances

Outpatient activity has decreased by 74% across the 3 CCGs when comparing April 2019 to 2020. Outpatient First attendances have decreased by 70% across Coventry & Warwickshire CCGs, with the biggest % decrease seen in CRCCG, with a reduction of 73.1% (11,000 attendances). Outpatient Follow up attendances have decreased by 64% across Coventry & Warwickshire CCGs, with the largest activity reduction seen at CRCCG, with a reduction of 73.3% (19,000 attendances). This is illustrated in Figure 21.

Elective (Planned) Admissions

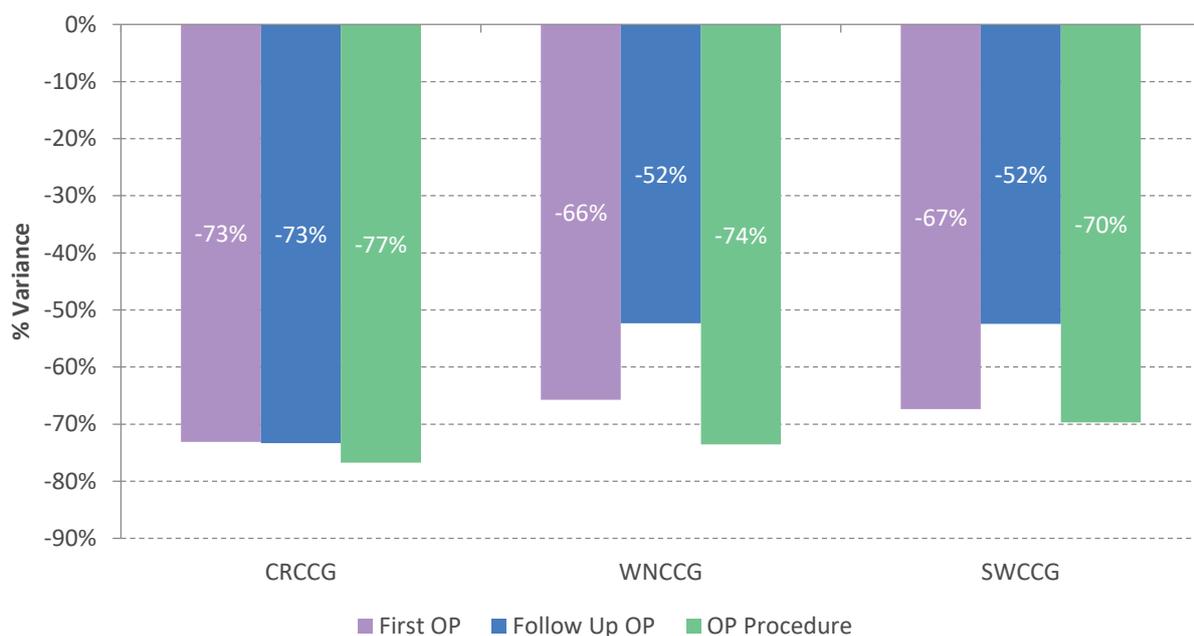
Day cases have decreased by 68% across Coventry & Warwickshire CCGs comparing April 20 to April 19, with the biggest decrease seen in WNCCG (81.2%). Electives have decreased by 81% across Coventry & Warwickshire CCGs, with the biggest decrease again seen in Warwickshire North CCG (89.7%). This is illustrated in Figure 22.

Waiting Lists

The total Referral to Treatment Waiting List (Incomplete Pathways) is at its lowest level during the last 12 months. However, this is due to the new clock starts (referrals) being extremely low due to the COVID-19 pandemic as outlined in the Referrals section. However, as referrals start to flow back into the system, this will extend waiting times and the total numbers on the waiting list. This can already be seen in the increase to the backlog (those patients waiting more than 18 weeks) in April 2020. This is illustrated in Figure 23.

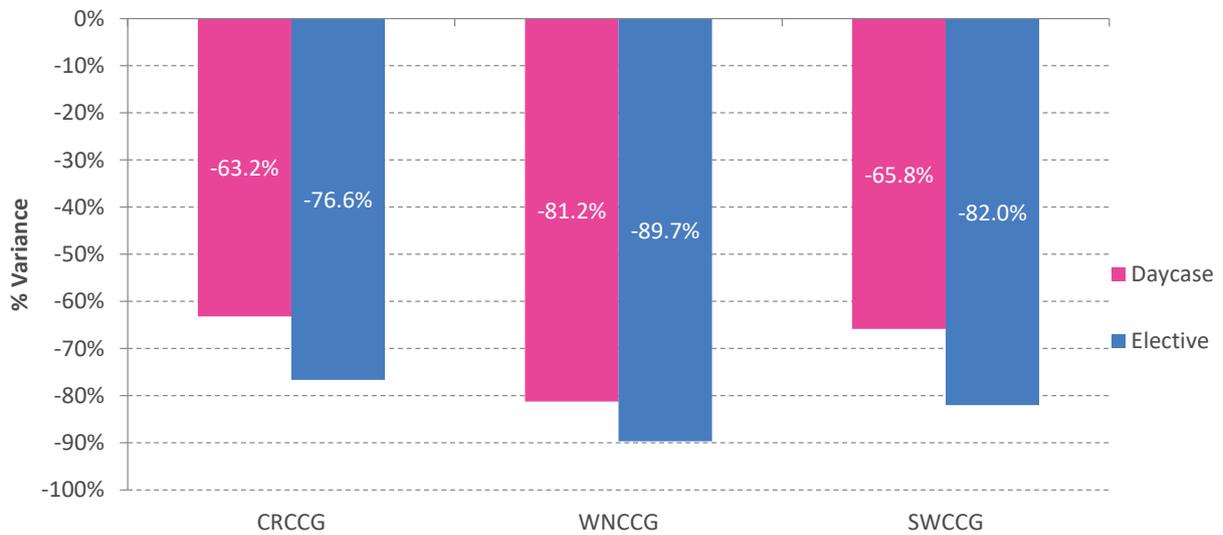
Performance of the 18-week target (which should be 92%) has decreased to 68.7% across the system with those patients waiting more than 18 weeks increasing from 7,610 in April 19 to 18,123 in April 20.

FIGURE 21 Outpatient attendances across Coventry and Warwickshire CCGs, April 2019 compared to April 2020



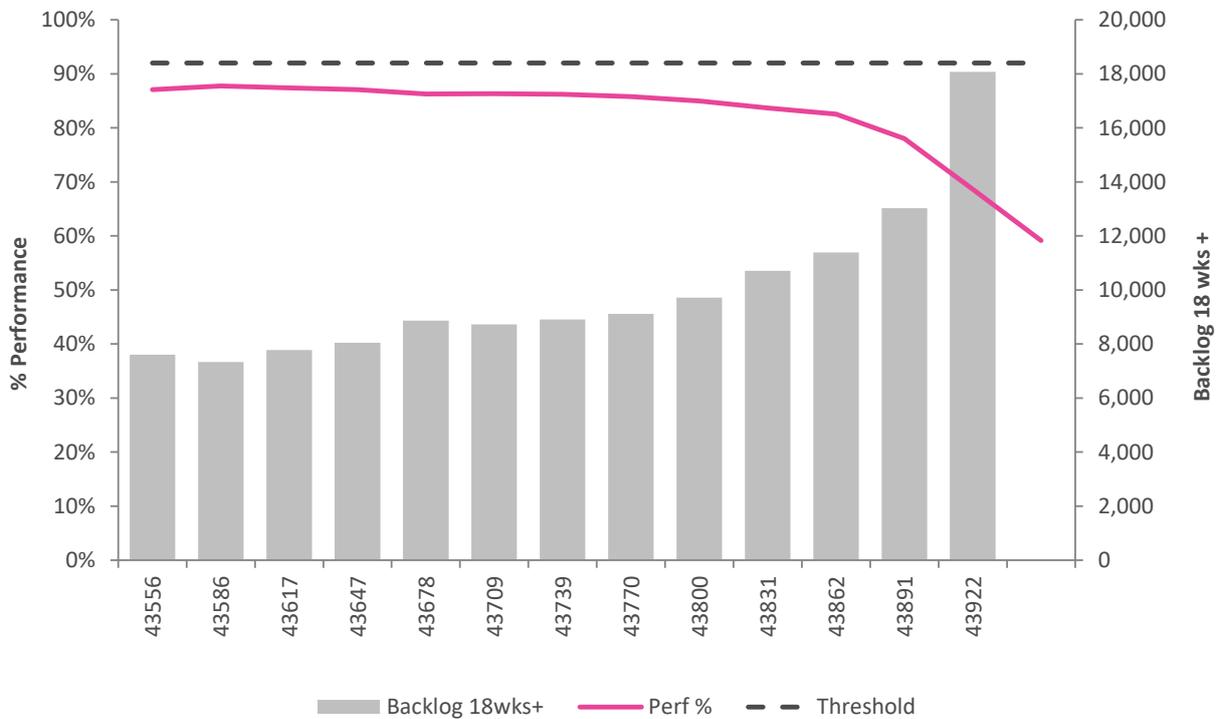
Source: NHS

FIGURE 22 Elective admissions across Coventry and Warwickshire CCGs, April 2019 compared to April 2020



Source: NHS

FIGURE 23 Waiting lists across Coventry and Warwickshire CCGs, April 2017 – April 2020
April 2019 compared to April 2020



Source: NHS

Referrals to the Multi-Agency Safeguarding Hub (MASH) and Children in Care

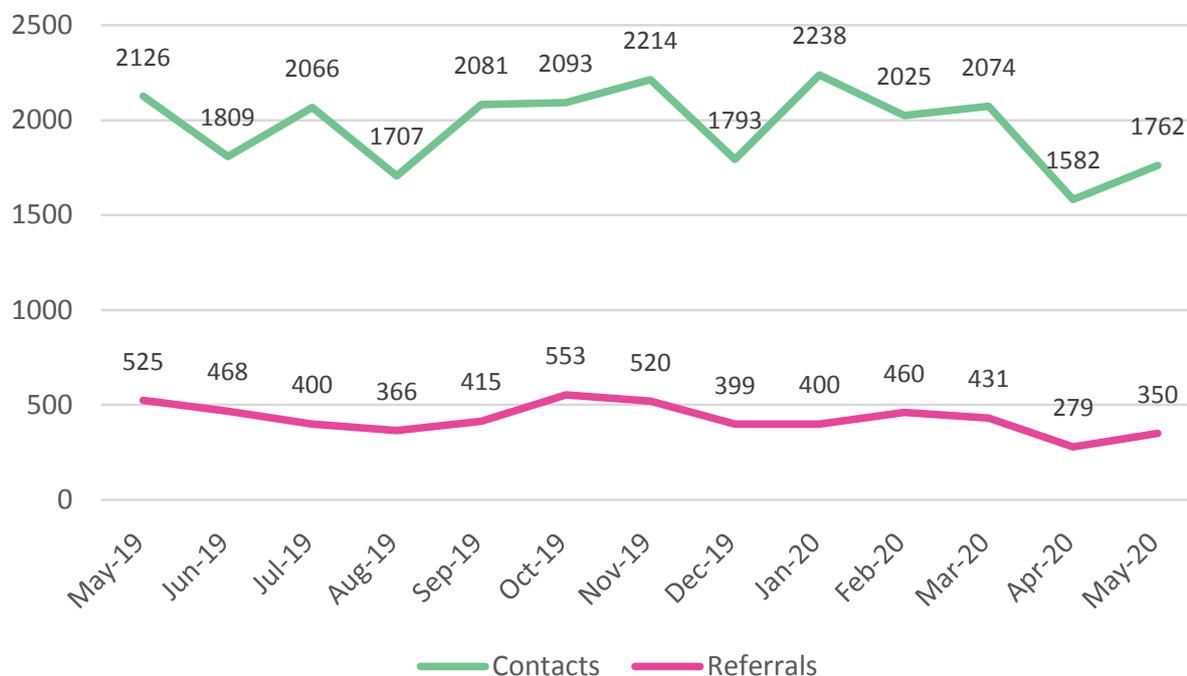
COVENTRY

In Coventry, the number of referrals to children’s social care has decreased from an average of 448 per month over the period from May 2019 - March 2020 to 279 (a 38% decrease) in April 2020 and 350 (a 22% decrease) in May 2020 (around 100 –150 less than expected in a month for Coventry). The number of reported contacts has also trended down for these two months, around 1700 per month compared with over 2000 for the equivalent period in 2019.

The number and percentage profile by source of referral in April and May 2020 has also changed, reflecting school and other public sector closures at the end of March, and with referrals made by the police accounting for a relatively larger proportion of all referrals in May 2020.

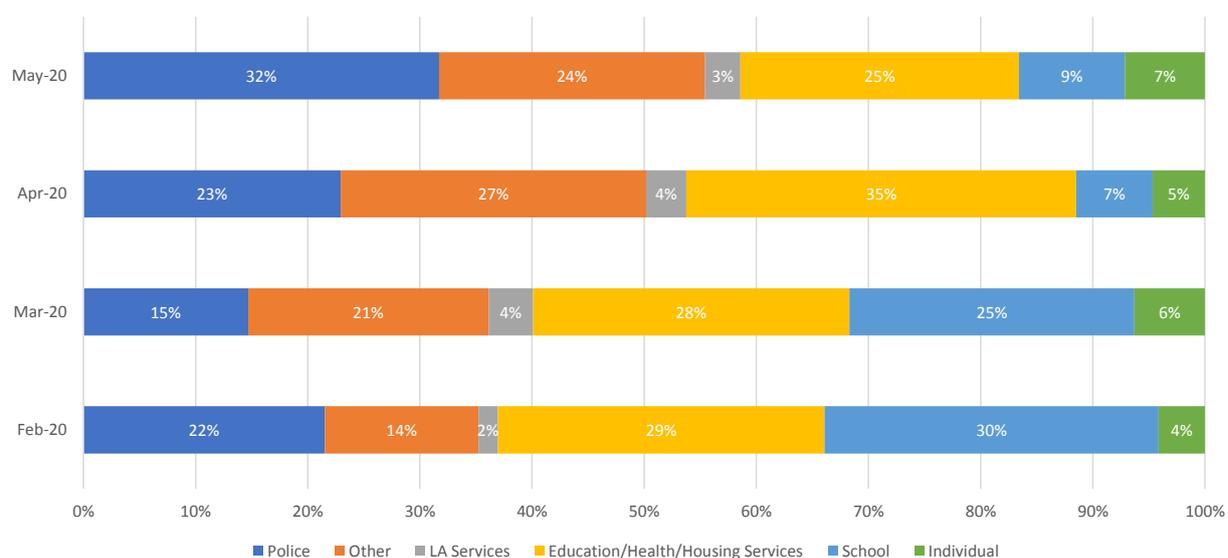
Reported data suggests actions taken following a referral have also shifted. In April and May 2020, only 70% of all referrals made were followed through with a Children and Families Assessment, compared with 85% routinely from May 2019 – Mar 2020; and Other Actions taken have grown from around 13% of all referral’s pre-lockdown to 28% of all referrals in April/May 2020.

FIGURE 24 MASH referrals in Coventry between May 2019 and May 2020 Source: NHS



Source: Insight Team, Coventry City Council

FIGURE 25 MASH contacts and referrals by source in Coventry between February and May 2020



Source: Insight Team, Coventry City Council

WARWICKSHIRE

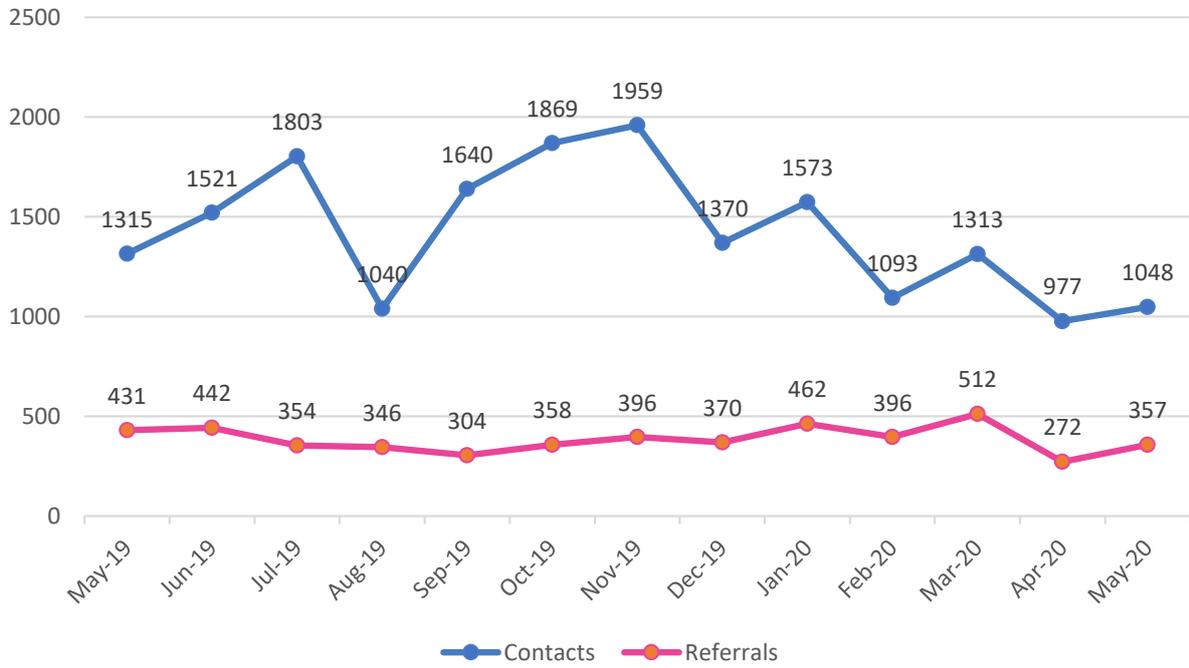
Total contacts to the Warwickshire MASH fell by 25.6% from March 2020 to April 2020, and total referrals fell by 46.9%. However, between April and May there was an increase of 7.3% in contacts and 31.3% in referrals (all contacts that have the next step of a single assessment are identified as a referral; all others are identified as a contact). Between the period May 2019 – March 2020 the Warwickshire MASH experienced a decrease in referrals from an average of 397 per month to 272 (a 31.5% decrease) and 357 (a 10.2% decrease) in April and May respectively.

In terms of the source of MASH contacts and referrals, the Police has become the top source, and the percentage of contacts and referrals from schools has fallen from 25% to 10%, although levels in May are slightly higher than in April.

At 31 May 2020, Warwickshire's looked after population was 772, whilst the number of looked after children excluding asylum seekers was 702, both numbers similar to the previous month. The number of children in care has risen significantly since March, this has been via court applications and the breakdown of family relationships with teenagers during the lockdown.

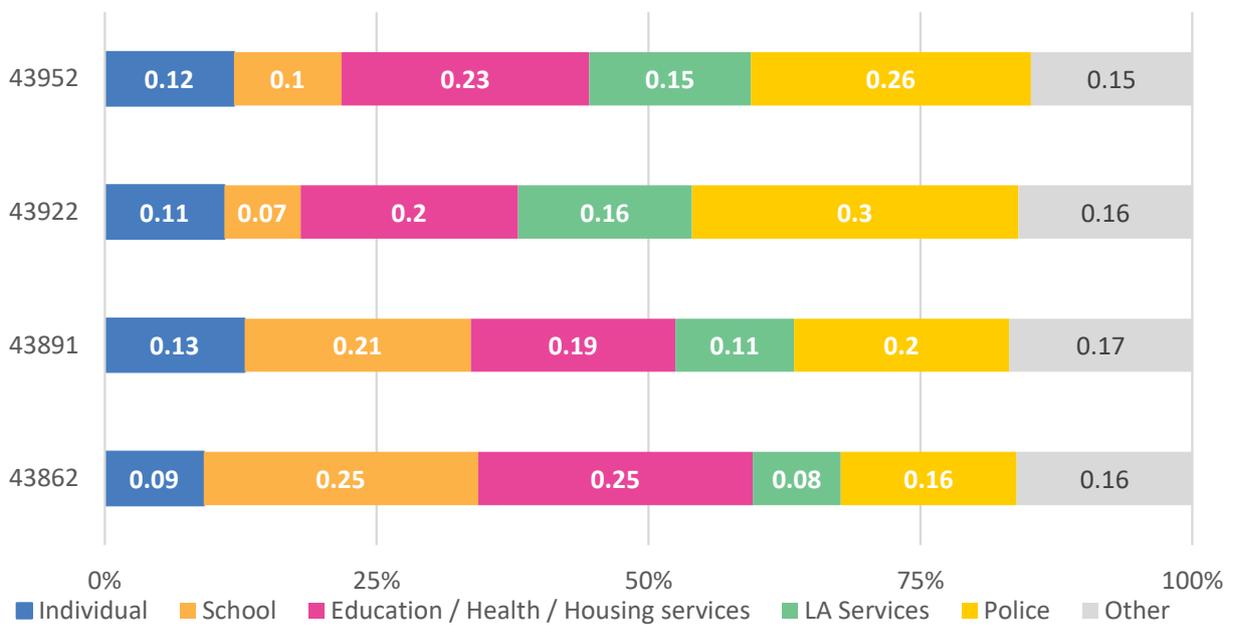
The largest cohort of children looked after continues to originate from North Warwickshire, Bedworth and Nuneaton. Across the district and borough teams the most notable increases in May were seen by Bedworth and North Warwickshire Children's Team (increase of 6 children) whilst the most notable reduction was seen by Warwick Children's Team who saw a reduction of 9 cases.

FIGURE 26 MASH referrals in Warwickshire between May 2019 and May 2020



Source: Business Intelligence Team, Warwickshire County Council

FIGURE 27 MASH contacts and referrals by source in Warwickshire between February and May 2020



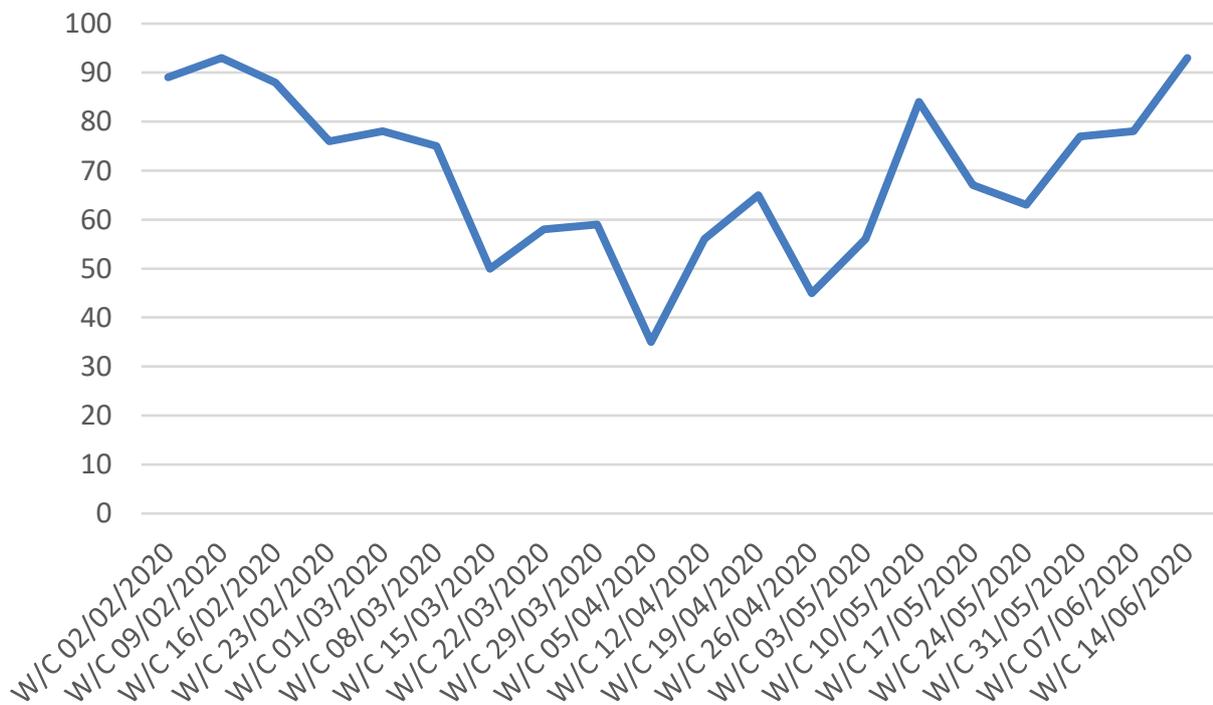
Source: Business Intelligence Team, Warwickshire County Council

The Department for Education are currently collecting data from local authorities on a fortnightly basis which includes figures on referrals and children entering care. Nationally, there are less referrals being received from schools (5.5% nationally) and a much larger proportion from the Police (38.5% nationally) although this is only based on referrals received over a week and has only been collected in one of the surveys so far. Interestingly, Warwickshire appear to be receiving a larger proportion of referrals from health services in a week than was seen nationally. However, this data is only based on a snapshot of a week so should be treated with caution.

From a looked after children perspective, the Department for Education are collecting data on the number of children who started to be looked after in the last week. This has been collected in each of the three surveys unlike the referrals by source which was only collected as part of Wave 3. On average Warwickshire are accommodating 3-4 children a week which is line with regional/national averages whilst our statistical neighbours have a slightly higher average of 4-5 children.

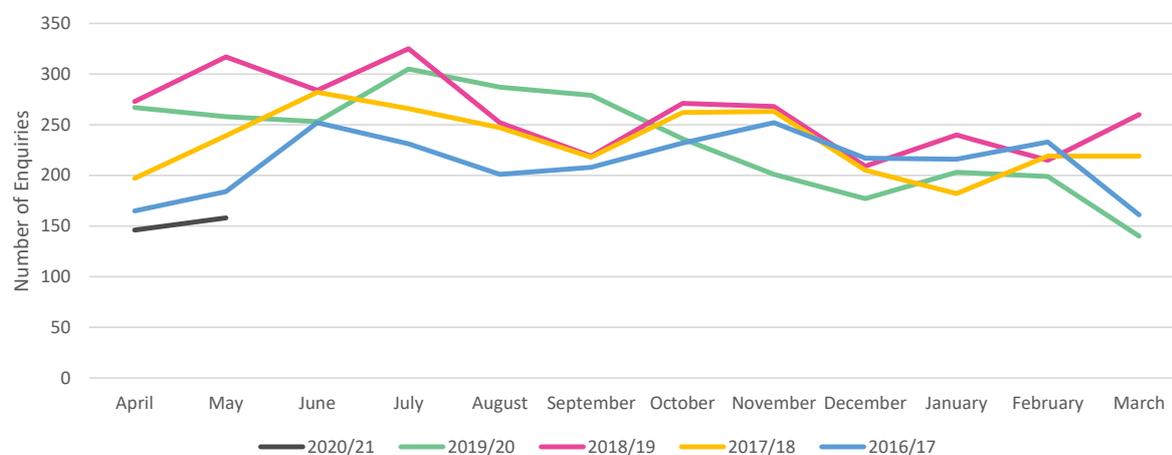
According to the charity Barnardos, the number of children needing foster care in England, Wales and Northern Ireland has increased 44%, to 2,349 in the period of 1 March to 23 April 2020, from 1,629 for the same period in the previous year^{xxiii}. Meanwhile the number of enquiries from people looking to become foster parents for the charity fell from 302 to 161 - a 47% drop. The charity states that the coronavirus pandemic has increased pressure on vulnerable families, leading to family breakdown, which will impact more families as the crisis continues. At the same time, the change in circumstances that many people have experienced and uncertainty about the future has meant that fewer enquiries about fostering are being made.

FIGURE 28 New worker involvements received in Coventry between February 2020 and June 2020



Source: Insight Team, Coventry City Council

FIGURE 29 Adult safeguarding concerns received in Warwickshire between April 2016 and May 2020



Source: Business Intelligence Team, Warwickshire County Council

Adult Social Care

COVENTRY

The number of people in Residential and Nursing placements in Coventry saw a significant decrease in April and May 2020, from 1056 people in placement at the end of March 2020 to 963 at the end of May 2020. This is due both to a decrease in those starting placements (55 in March 2020, 37 in April 2020); and a high number of ended placements particularly in April 2020, including a high number of deaths in placement in April 2020. This has reduced to levels similar to 2019/20 in May 2020.

Numbers of people in placement for home support are higher than in 2019/20, at 1158 at the end of May 2020, compared to 1119 at the end of May 2019. Housing with care services have reduced from last year (394 May 2020, 413 May 2019), however this can be linked to a decline since January 2020. Numbers in placement for Supported Living have remained stable at around 190 clients.

Overall, initial contacts for new clients decreased significantly during March and April and have been steadily rising again since May as illustrated in Figure 28. Safeguarding assessments however, increased, from around 60 per week before COVID-19 to around 75 per week since 23 March (as of 22 June).

WARWICKSHIRE

The number of people in Residential and Nursing placements in Warwickshire saw a decrease from 1,862 in March 2020 to 1,788 in May 2020 (however, this figure is higher than the number for May 2019, which was 1,757). Between April and May 2020, admissions to permanent residential / nursing care dropped from 81 to 42. There have also been a high number of deaths in April 2020.

The total number of My Assessment Forms completed in the month had increased in April to 528 (from 451 in March 2020), however May saw a drop to 409. This is higher than the monthly average for 2019/20 (347). The number of planned reviews has dropped from 521 in March 2020 to 228 in April and 208 in May.

Safeguarding concerns received are at a low level, although rising slightly since March, they are much lower than in 2019 (May 2020 – 158, May 2019 – 258).

Cancer Screening

Screening services have all been paused across the UK. The implications of this will be that opportunities to identify cancers early may be missed. Looking at the total number of people eligible for screening the number who would attend each week can be calculated. Whilst screening programmes have been paused are a total of 679 missed bowel screenings, 811 cervical screenings and 538 breast cancer screenings, across Coventry and Warwickshire.

Overall, the number of urgent referrals has dropped to around 25% of usual levels in England. This is largely because fewer people are going to their GP, but in some instances GPs may have been reluctant to risk sending a patient to the local hospital. Every week that this goes on, over 2,300 cancer cases are likely to be going undiagnosed across the UK – and these will be stacking up over time (source: Cancer Research UK).

There have also been disruptions to cancer treatment. A large survey called Understanding Society COVID-19 had 17,450 Study participants. Of them, 3,414 respondents aged 16 and over from across the UK report one or more long-term health conditions, such as cancer or cardiovascular disease. The data shows that during April 2020, 63% of people with long-term health conditions, such as cancer or cardiovascular disease, who needed NHS treatment did not receive it. Around 10% of patients cancelled appointments themselves. The highest level of continued treatment was for those with cancer, but only 40% received treatment in this period. 56% of cancer patients had their treatment cancelled or postponed by the NHS and 4% postponed treatment themselves^{xxiv}.

However, certain hospitals in England have now been designated as ‘cancer hubs’ – such as in London, Manchester, Leeds and several other locations – and are creating ‘COVID-free zones’ for cancer treatment. However, this may mean a longer journey for residents of Coventry and Warwickshire to access treatment^{xxv}.

TABLE 12 Screenings missed per week in Coventry and Warwickshire

Area	Bowel Cancer	Cervical Cancer	Breast Cancer
Coventry and Rugby CCG	278	407	232
South Warwickshire CCG	247	249	184
Warwickshire North CCG	154	155	122
Total for Coventry and Warwickshire	679	811	538

Source: Business Intelligence Team, Warwickshire County Council

Child Immunisations

Early data indicates that in March 2020, there has been more of an impact on the early vaccinations than on the first dose of MMR which is usually administered after 12 months. In Warwickshire North CCG, it is likely that more than twice the percentage of eligible children have not been vaccinated for hexavalent in March 2020 than in March 2019. Anecdotal evidence suggests this increasing across all area in April and May, with an increase in the number not having the MMR vaccination. A four week campaign is being launched in Warwickshire on Monday 29th June (#CarryOnVaccinating) to help promote the importance of attending or re-booking scheduled vaccination appointments during the COVID-19 outbreak. This will focus on vaccinations during pregnancy, the MMR and preschool boosters.

Nationally, a study in Eurosurveillance journal, a medical journal covering epidemiology, showed that MMR vaccination counts fell across England from February 2020 but began to improve in mid-April^{xxvi}. There has also been a gradual decline in hexavalent vaccination counts throughout 2020 which were not believed to be related to social distancing measures, however these have also improved from mid-April.

Dementia Diagnosis

What does the literature say:

Social restrictions have had a substantial impact on the management of outpatient clinics with cancellations or postponement of outpatient visits. Vulnerable patients, including elderly people with cognitive impairment (CI) or dementia, have an increased risk of serious morbidity, admission to intensive care units, and death when infected with COVID-19 because of their advanced age and frequent medical comorbidities. Consequently, they have been highly recommended to adhere to social distancing, increasing caregiver burden. Furthermore, these measures might lead patients with CI to a faster cognitive deterioration and to worsening of behavioural and psychological symptoms of dementia, inducing in turn higher caregiver distress.^{xxvii}

What is the current data saying:

The estimated diagnosis rate for dementia in those aged 65+ was already showing a downward trend in Coventry and Warwickshire and has continued to fall between March and April 2020; across the HCP this has reduced from 59.4% to 57.8%; a reduction of 1.6 percentage points. This was slightly less than the national reduction, which was 2 percentage points. There was a further decrease in May 2020.

TABLE 13 Screenings missed per week in Coventry and Warwickshire

Area	Diagnosis rate March 2020	Diagnosis rate April 2020	Difference
England	67.4	65.4	-2.0
Coventry and Warwickshire	59.4	57.8	-1.6
NHS Coventry and Rugby CCG	60.6	59.5	-1.1
NHS Warwickshire North CCG	57.8	57.1	-0.7
NHS South Warwickshire CCG	58.9	56.1	-2.8

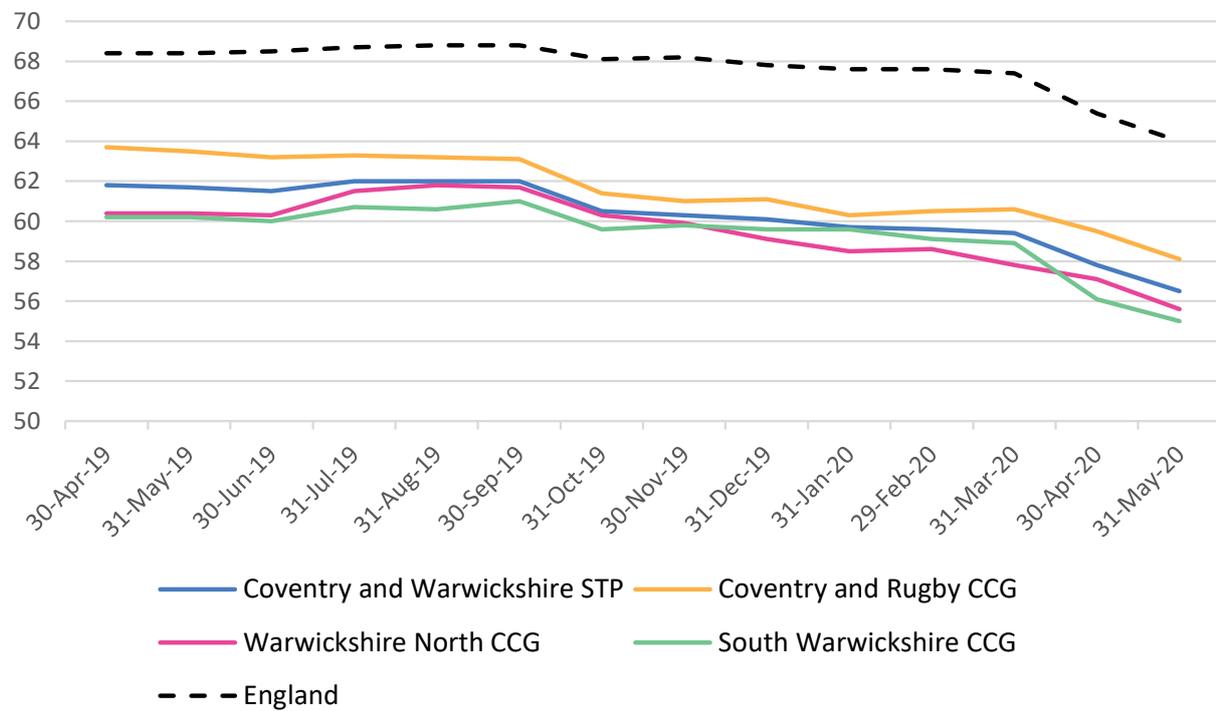
Source: NHS Digital^{xxviii}

TABLE 14 The difference between dementia diagnosis rates in April 2019 and April 2020 across Coventry and Warwickshire

Area	Diagnosis rate April 2019	Diagnosis rate April 2020	Difference
England	68.4	65.4	-3.0
Coventry and Warwickshire	61.8	57.8	-4.0
NHS Coventry and Rugby CCG	63.7	59.5	-4.2
NHS Warwickshire North CCG	60.4	57.1	-3.3
NHS South Warwickshire CCG	60.2	56.1	-4.1

Source: NHS Digital

FIGURE 30 Dementia diagnosis rate from April 2019 to May 2020 across Coventry and Warwickshire



Source: NHS Digital

In South Warwickshire this figure showed a more significant change, from 58.9% to 56.1% - 2.8 percentage points; whereas in Coventry and Rugby and Warwickshire North, the difference was much smaller than the national figure.

Since April 2019, across Coventry and Warwickshire the diagnosis rate decreased by 4 points, compared to a national average of 3 points; with all three CCG seeing a bigger decline than the national figure, as demonstrated in the tables and figure below.

Mental Health Services

Referrals to Coventry and Warwickshire Partnership NHS Foundation Trust (CWPT) for mental health services dropped between the period February 2020 – May 2020, as illustrated in Table 15. The majority of attended care contacts were down for the majority of mental health services apart from the children and young people (CYP) service and adult eating disorder service.

It is felt that reductions in referrals to the CYP service reflect that the primary need of patients changed. The service often sees patients presenting with educational stressors, which were reduced during the COVID-19 outbreak period due to the school changes that were put in place. These changes have also provided people with more time to manage distress at home. It should be noted that eating disorder referrals have increased due to parents identifying disordered eating earlier.

In the adult eating disorder service the re-referral rate has increased from previously discharged patients and new presenting cases have been of a higher acuity.

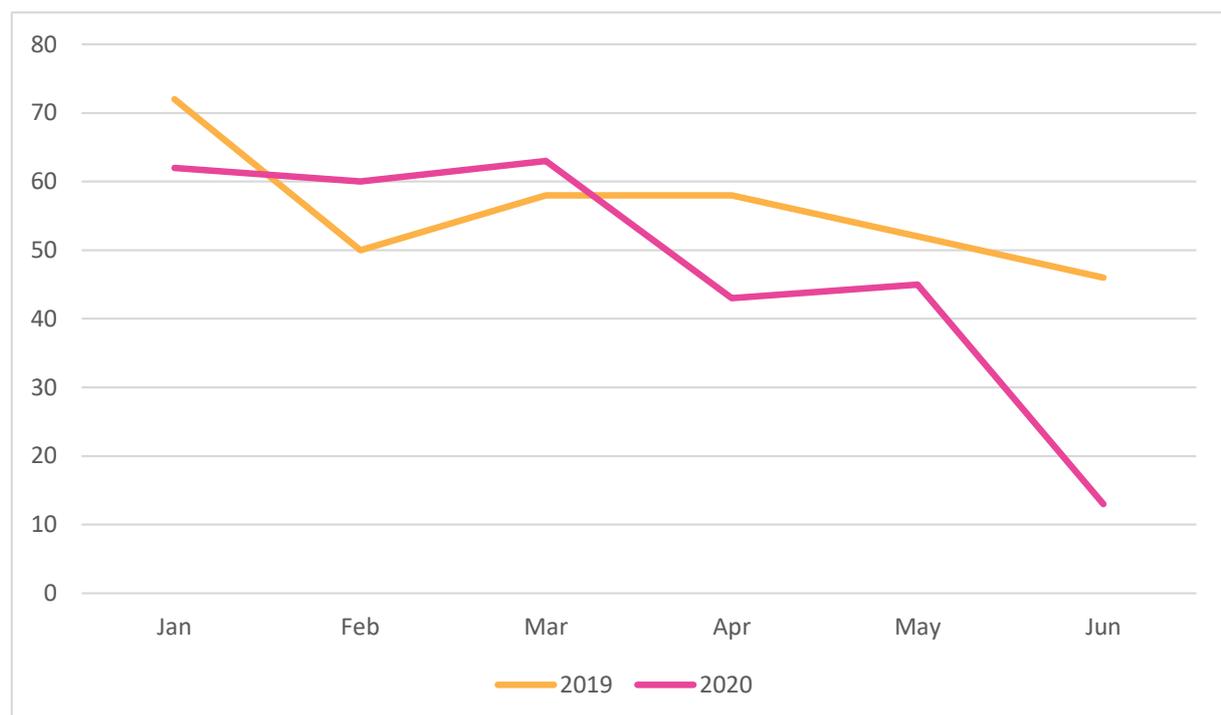
The Community mental health team service found that isolation has been described as a trigger for people accessing support.

TABLE 15 Percentage change in new referrals and attended care contacts in secondary mental health care services in Coventry and Warwickshire

Service Type		Estimated % change from February to April	Estimated % change from February to May
Children and young people	New referrals	-64%	-52%
	Attended care contacts	2%	-16%
Early intervention psychosis	New referrals	-31%	-33%
	Attended care contacts	-17%	-39%
Adult eating disorder	New referrals	-68%	-70%
	Attended care contacts	127%	59%
Community mental health teams (CMHT)	New referral	-60%	-48%
	Attended care contact	-14%	-29%

Source: Coventry and Warwickshire Partnership NHS Foundation Trust

FIGURE 31 New user registrations to the Big White Wall online e-mental health service in Warwickshire (correct as at 19 June 2020)



Source: People Strategy and Commissioning, Warwickshire County Council

COVENTRY

By contrast, Coventry Safe Haven, which provides out of hours crisis support and some medium-term support for adults suffering from mental health problems, has reported a substantial increase in service users since March.

Coventry Safe Haven offers initial support and some medium-term support to adults (18+) suffering from mental health problems in Coventry. They report that they had expected an influx of service users suffering

TABLE 16 Service user contacts made by the Warwickshire Safe Haven service (correct as at 19 June 2020)

Month (2020)	Number of service user contacts
January	-
February	51
March	35
April	19
May	17
June	7

from mental health problems when lockdown began, but in fact demand dropped considerably initially. The Service Manager suggested that this was because service users may have been unaware that the service was still available during the initial lockdown. Since then, demand has been rising substantially. It has continued to rise after lockdown restrictions have started to be lifted. There has been a change in the type of mental health problems reported by service users from what is typical, with a greater proportion now reporting high level anxiety, self-harm and suicidal ideation. There are also substantially more people calling where mental health support is their primary need.

Factors contributing to the increased demand for mental health support

Coventry Safe Haven have found that social isolation in particular has contributed to an increase in depression, self-harm and suicidal thoughts. Service users have often tried to stay in touch with family and/or friends virtually but are struggling with the lack of physical presence and contact, and have found that it has changed the dynamics of their relationships. Some service users are struggling with adjusting to lockdown then quickly having to adjust again now that lockdown is being eased. Coventry Safe Haven has found that many service users are experiencing anxiety around the lack of adherence to social distancing guidance. Some service users who have already recovered from COVID-19 have been suffering from ongoing panic attacks and anxiety as a result. The Service Manager noted that the lack of simple, easy to understand messaging around COVID-19 has also contributed to anxieties. In addition, service users have reported having to wait multiple days for a call back from their GP about their mental health concerns.

WARWICKSHIRE

Warwickshire County Council commissions a range of mental health services which have been available to support people via telephone and online during the coronavirus outbreak. Some services were already accessible in this way (e.g. e-mental health service, telephone helpline) but others have had to alter their methods of delivery from a face-to-face service (e.g. Wellbeing for Warwickshire, Safe Haven).

Some of these services have not been able to provide real-time data which demonstrates whether they have been impacted by COVID-19 but the e-mental health and safe haven services have been able to provide this data.

New user registrations to the Big White Wall online e-mental health service have not differed significantly from the same period in 2019, as illustrated in Figure 31. Table 16 highlights that the Safe Haven service, which provides face-to-face, phone, text and email support, has seen a reduced number of contacts since the COVID-19 outbreak started. It should be noted that this service changed providers on 1 April 2020 and this may have impacted residents' knowledge of the service.

Unpaid Caring

While studies about caregiving and COVID-19 are not yet available, it is highly likely that due to a combination of social distancing and lock down restrictions the disproportionate impact of the virus on older adults, caregivers of adults living both in community and long-term care are very likely to have been impacted.

According to the ONS Opinions and Lifestyle survey, the percentage stating that “I am spending more time caring for others” has fluctuated between 36% and 46% nationally for the period post COVID-19^{xxix}.

A UK-wide online platform, mobiliseonline.co.uk, was launched in March to provide online support for carers through the pandemic. The common challenges listed are financial (due to extra caring responsibilities and costs), the need for an emergency plan should a carer become ill and the need to keep a routine in order to cope well.

CRESS (Carer’s Response Emergency Support Service) has been supporting carers in Coventry and Warwickshire; and have offered additional services during COVID-19 for carers who are vulnerable or caring for someone with a high level of caring needs, for example they cannot leave the person they are caring for alone. They have been offering a short break for the carer, for example to take exercise, go shopping or collect prescriptions; and have also supported carers with going shopping for essential supplies.

COVENTRY

Between March and May 2020 CRESS delivered 50.75 planned hours, and 335.25 emergency hours, in Coventry. They also saw an increase in the number of carers signposted to the service, suggesting more unpaid carers needed supported during COVID-19.

Coventry City Council data suggests that during April and May 2020 fewer clients received respite care and replacement care home support compared to 2019/20; however, the number of carers receiving direct payments remained relatively stable.

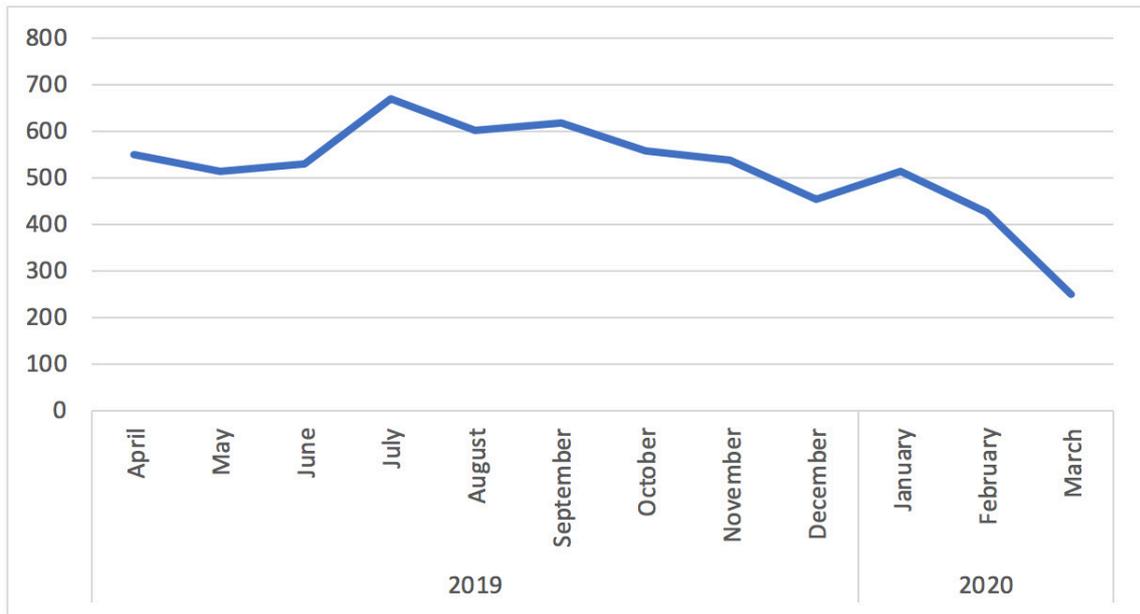
Health Checks

COVENTRY

In Coventry, the NHS health check programme has not been delivered during the COVID-19 outbreak. GPs deliver the majority of health checks and they stopped doing these in March. The Healthy Lifestyles Coventry service also deliver some on an outreach basis but, again, these were suspended in March as they cannot be delivered in a socially distanced way. Healthchecks also rely heavily on blood tests delivered by phlebotomy services / pharmacies which are more limited. This pause in services can be seen across the country.

From January to December 2019, there were 7,499 health checks completed in Coventry, which is an average of 625 per month. This includes those completed by GPs and the HLS service (90% are completed by GPs). We can therefore estimate that this is the number of health checks per month that have been missed during the COVID-19 pandemic. In the three months of April to June, taking the averages for health check findings for the UK from the NHS, there could have been between 47 and 63 people diagnosed with high blood pressure, between 9 and 23 people diagnosed with type 2 diabetes, and between 188 and 313 identified as being at high risk of cardiovascular disease^{xxx}.

FIGURE 32 The number of NHS Healthchecks completed by GPs in Warwickshire from April 2019 to March 2020



Source: Strategic Commissioning, Warwickshire County Council

WARWICKSHIRE

There has been a decline in the number of health checks completed in Warwickshire in the past year, with 551 health checks in April 2019 and 250 in March 2020. There have been none completed since the beginning of lockdown and increased social distancing in March may go some way to explaining the low numbers for that month.

Looking at the average number in the 11 months leading to March gives a monthly average of 544 health checks a month across Warwickshire (completed by GPs). This does not include a smaller number which are completed elsewhere. This is therefore the potential number of missing health checks. In the three months of April to June, taking the averages for the UK from the NHS, there could have been between 41 and 54 people diagnosed with high blood pressure, between 8 and 20 people diagnosed with type 2 diabetes and between 163 and 272 people identified as being at high risk of cardiovascular disease^{xxxi}.

The Places and Communities We Live In, and With

Communities and social contact are important components of maintaining good mental wellbeing, however measures to control the spread of COVID-19 depended on reducing social contact. This was achieved through lockdown measures and 'shielding lists' that identified those who were clinically vulnerable to severe infection and who would need additional support to successfully social distance.

The approach to supporting or working with communities is often 'asset based' and considers how communities can build on the assets and resources already available. Because of this the response to COVID-19 has looked different in each local authority.

Supporting vulnerable residents during and following lockdown

There has been a tremendous response by existing and newly formed third-party organisations and community groups to support vulnerable residents who are shielding or struggling to cope during lockdown.

Ring-fenced funding and additional support have been available especially to both sustain the third-party sector or help them to adapt to supporting changing needs.

To enable a rapid response, schemes have been funded and mobilised quickly (e.g. Heart of England Coronavirus Fund, National Lottery) and processes for delivering schemes and accessing them have been simplified (e.g. some foodbank schemes have not required a formal referral to them during COVID-19).

Funding gaps are being identified and attention is now moving from directly supporting people during lockdown to supporting them through the longer-term impacts that lockdown may have on the wider determinants of health.

Funding is also beginning to be made available to undertake research and evaluation of the impact of lockdown upon communities and to assess the effectiveness of initiatives which aim to support them. Emerging themes include: access to food and medicines, adapting access to routine support, befriending and advice services and tackling issues of anxiety, loneliness, relationship breakdowns, financial difficulties, crime, homelessness and health inequalities.

Shielding Hub Formal Lists and Activity

Many vulnerable residents have been identified by formal lists generated by for example the NHS, Local Authorities and private service providers, or more informally through charitable and community networks.

The number of residents on the MHCLG/NHS shielding list across Coventry and Warwickshire (as outlined in Tables 20 and 21) has varied from around 3% of the population in Rugby to close to 4% of the population in North Warwickshire, compared with close to 4% of the population nationally, and around 3.5 - 3.6% for both West Midlands and Warwickshire populations.

While there is some variation across the patch, reflecting the underlying demographic and general health of the population, the profile of residents on NHS shielding lists within Warwickshire and Coventry follow a similar trend to what has been reported nationally (< 1% of 0-18 years population, 3% of 19-69 years population, 11-13% 70+ years population).

Reported activity from local shielding hubs suggest that some but not all residents on NHS shielding lists required any immediate further additional support from the Local Authority when contacted. Additional residents (i.e. not on NHS shielding list) have been identified and added to local shielding lists.

TABLE 17 Numbers and percentages of people on the NHS shielding list across England, the West Midlands, Coventry and Warwickshire				
	England	West Midlands	Warwickshire	Coventry
All	2,229,797	207,940	20,370	13,445
% population	3.98%	3.52%	3.57%	3.67%
Male	1,051,407	98,300	9,725	6,165
% population	3.98%	3.36%	3.45%	3.31%
Female	1,178,338	109,635	10,650	7,270
% population	4.16%	2.92%	3.69%	4.02%
0- 18	93,969	8,755	675	640
% population	0.75%	0.64%	0.55%	0.77%
19-69	1,173,894	109,410	10,185	7,835
% population	3.26%	2.92%	2.81%	3.18%
70+	961,934	89,770	9,530	4,950
% population	13.08%	11.36%	10.99%	13.56%
<i>Source: NHS Digital, accessed 4 June 2020^{xvii}</i>				

TABLE 18 Numbers and percentages of people on the NHS shielding list across England, the West Midlands, Coventry and Warwickshire					
	North Warwickshire	Nuneaton & Bedworth	Rugby	Stratford-on-Avon	Warwick
All	2570	4760	3,330	4,795	4,915
% population	3.96%	3.69%	3.11%	3.76%	3.45%
Male	1255	2200	1585	2370	2315
% population	3.92%	3.48%	2.97%	3.81%	3.25%
Female	1315	2560	1750	2425	2600
% population	4%	3.90%	3.25%	3.71%	3.65%
0- 18	85	210	115	115	150
% population	0.64%	0.72%	0.45%	0.45%	0.52%
19-69	1200	2625	1835	2135	2390
% population	2.90%	3.20%	2.75%	2.73%	2.54%
70+	1280	1930	1380	2550	2390
% population	12.36%	10.97%	9.15%	10.58%	12.19%
<i>Source: NHS Digital, accessed 4 June 2020^{xvii}</i>					

COVENTRY

Operation Shield

Locally, as of 29 May, there were 14,282 individuals identified through the MHCLG/NHS vulnerable/shielded lists, of which 12,579 have been contacted.

Since end-March, 22,617 calls have been made, of which 12,649 were answered and 9,961 were not answered. The vast majority of people did not require additional support – however, a small proportion did.

The Council has been working with partners to compare the names on the NHS / MHCLG vulnerable / shielded lists with other datasets, including:

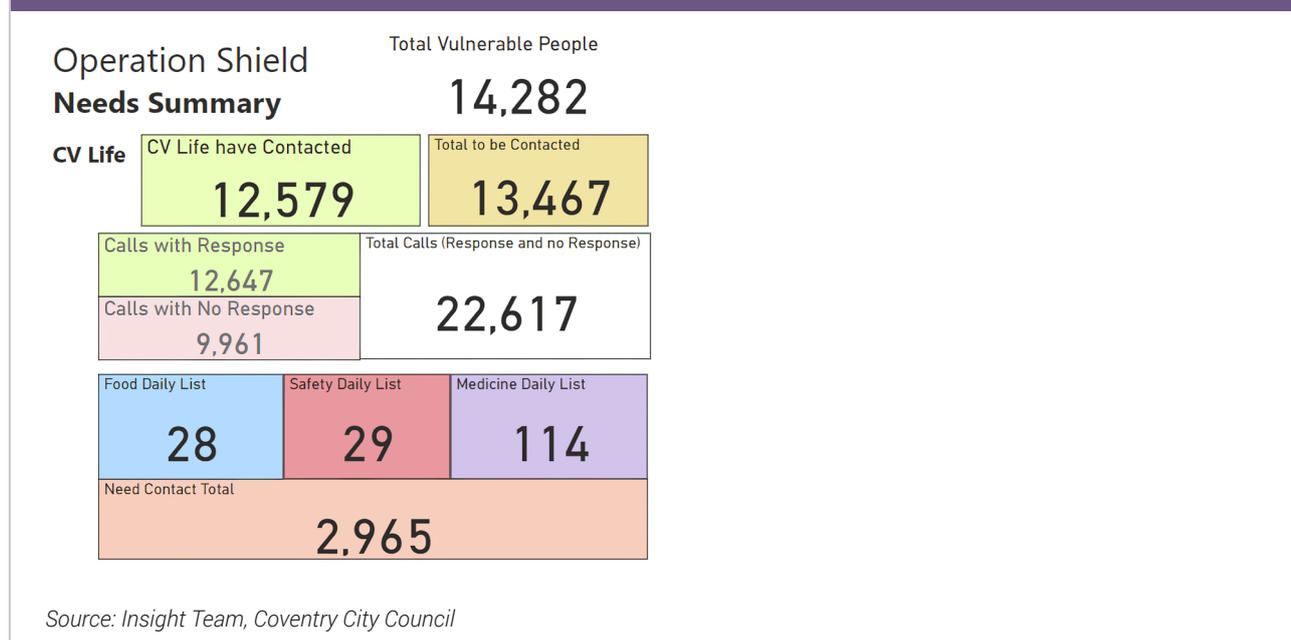
- Coventry City Council (adult social care);
- NHS Coventry and Warwickshire Partnership Trust;
- NHS Coventry & Rugby Clinical Commissioning Group (Primary Care Networks); and
- NHS University Hospitals Coventry and Warwickshire.

Shield+

In addition to Operation Shield, Coventry has embarked work to identify, contact, and support our most vulnerable residents including those not on the shielded lists; combining addresses of other residents who may be vulnerable or may become vulnerable because of the prolonged lockdown due to risk factors including age, mobility, income or living alone. This includes:

- waste services assisted collections – addresses where households are identified as having nobody with the level of mobility to move their wheelie bins to the designated pickup point;
- Council Tax single person discount – identifying older people aged 70+ who are living alone;

FIGURE 33 Summary of data for Coventry Operation Shield (as of 29 May 2020)



- free school meals and early years pupil premium – children living in low-income families who may be struggling especially in light of difficulties with the roll out of the government voucher scheme;
- safe and well checks – list of residents who have had a safe and well visit and their frailty scores, held by the West Midlands Fire Service. Visits are focused on the most vulnerable people in our communities;
- self-presenting individuals – people presenting to the local authority, e.g. via telephone calls to the contact centre or emails to community resilience, asking for help or support; and
- priority services register – list of residents and addresses of various categories of vulnerable residents (disability, mobility, language difficulties, etc.) held by Western Power Distribution and compiled with other utilities including Cadent and Severn Trent.

After accounting for available resources this resulted in a list of just over 2,000 households across the city which have been contacted - 1,485 by phone (of which 10% required support) and 520 via door-knocking (of which 3% required support). Table 19 outlines the contacts made through Shield+:

TABLE 19 Contacts made through Shield+	
Completed telephone contact	Totals
Total households contacted	1485
Total telephone contacts made	1989
Average telephone contact attempts per household	1.34
Total people requiring support	142
% of households requiring support	10%
Pre Door knocking	Totals
No of households awaiting door knocking	125
% requiring door knocking	6%
Telephone contact attempts made before door knocking	188
Average contact attempts per household	1.5
Completed door knocking	Totals
Total households 'knocked'	520
Total 'knocks' made	448
Average contact attempts per household	0.86
Total attempts to contact through neighbours	141
Total people requiring support following door knocking	14
% of households requiring support	3%
Telephone contact attempts made before door knocking	1022
Average contact attempts per household	1.97
Totals	
Customers contacted and completed	2005
Telephone contacts made	3199
<i>Source: NHS Digital, accessed 4 June 2020^{xvii}</i>	

FIGURE 34 Coventry City Council vulnerable people data set

Unique NHS Numbers	Operation Shield	CCC Adult Social Care (Snapshot)	CWPT Forum Health Centre	Total CWPT	CWPT Walsgrave	GP Forum Health Centre	Total GP VPL	GP Walsgrave	UHCW	PCN Sowe Valley
14544	14259	880	30	34	4	354	431	77	2953	1108
CCC ASC	880	892	3	4	1	14	19	5	133	97
CWPT Forum HC_VPL	30	3	30	30	(Blank)	28	28	(Blank)	10	(Blank)
CWPT_VPL	34	4	30	34	4	28	31	3	11	(Blank)
CWPT Walsgrave VPL	4	1	(Blank)	4	4	(Blank)	3	3	1	(Blank)
GP Forum HC VPL	354	14	28	28	(Blank)	355	355	(Blank)	80	(Blank)
GP VPL	431	19	28	31	3	355	432	77	91	(Blank)
GP Walsgrave VPL	77	5	(Blank)	3	3	(Blank)	77	77	11	(Blank)
UHCW	2953	133	10	11	1	80	91	77	3212	197
PCN Sowe Valley	1108	97	(Blank)	(Blank)	(Blank)	(Blank)	(Blank)	(Blank)	197	1134

Number of People on Operation Shield without an NHS Number

64

Source: Insight Team, Coventry City Council

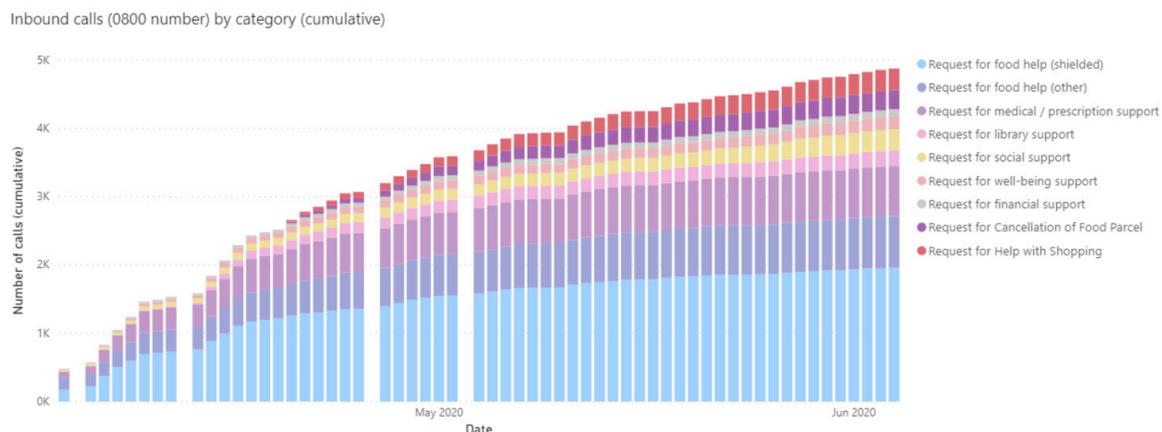
WARWICKSHIRE

As of 4th June 2020, there were a total of 20,960 on the shielded list in Warwickshire. Of these, 2,799 were requiring help to get essential supplies delivered.

As at 4th June, there have been 1959 requests for food help from those who are on the shielded list, 756 from those not on the shielded list, 733 requests for medical / prescription support, 230 requests for library support (Warwickshire Library staff have made contactless deliveries of books), 312 requests for social support, 191 for well-being support, 102 for financial support, 278 for cancellation of food parcel and 318 requests for help with shopping.

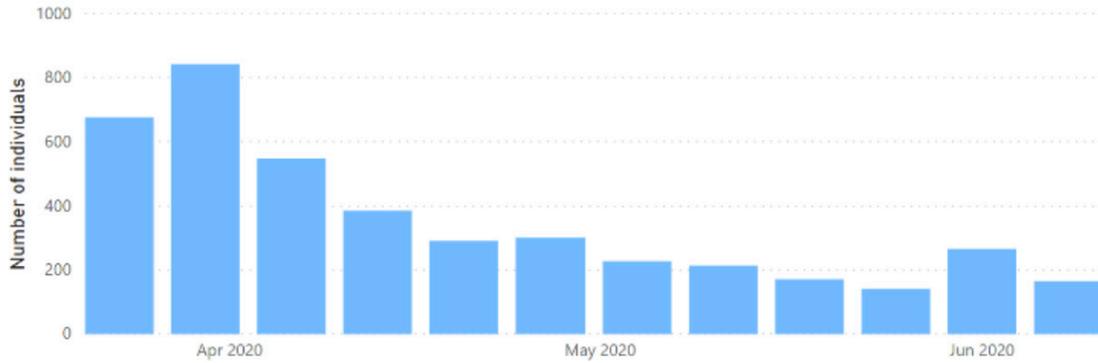
The main areas where people are requiring support are in the towns of Nuneaton, Bedworth, Rugby and Leamington.

FIGURE 35 Cumulative calls received by Warwickshire County Council for support broken down by request type



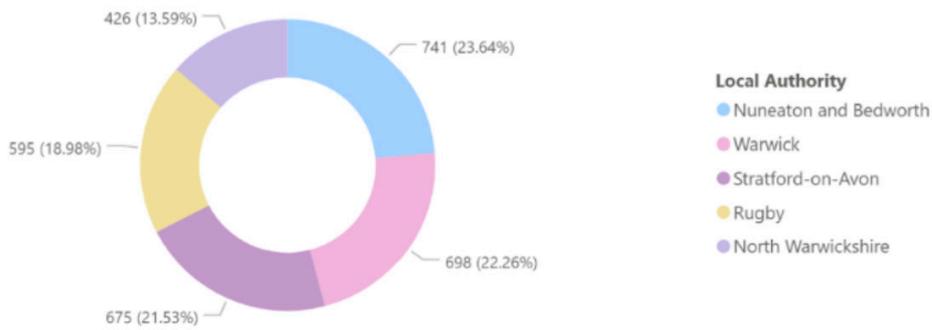
Source: Business Intelligence Team, Warwickshire County Council

FIGURE 36 New individuals indicating they potentially require support (essential supplies)



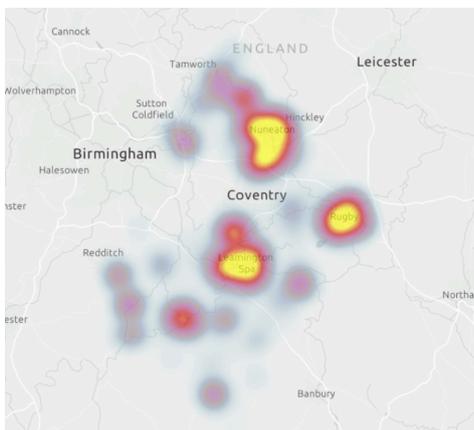
Source: Business Intelligence Team, Warwickshire County Council

FIGURE 37 People potentially requiring support by district / borough in Warwickshire



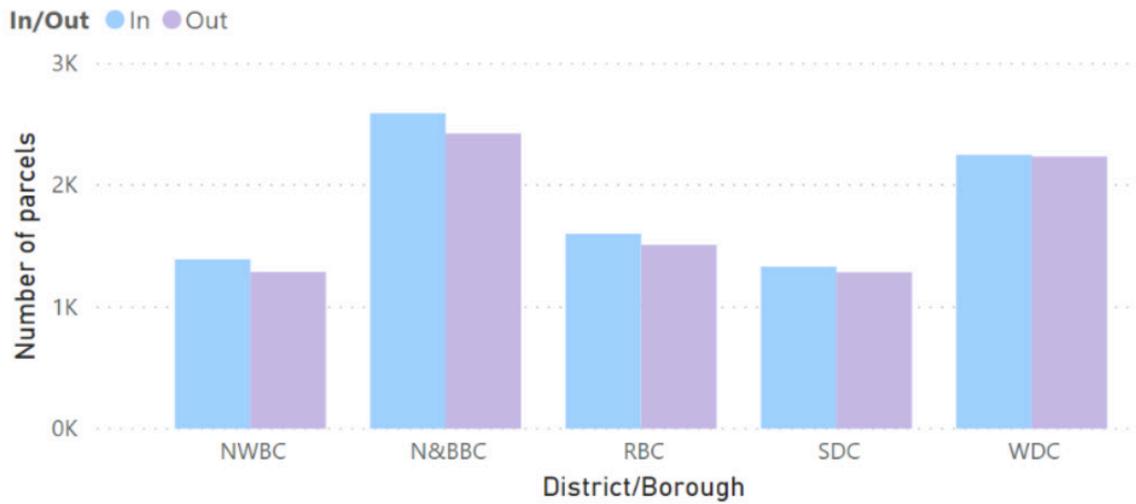
Source: Business Intelligence Team, Warwickshire County Council

FIGURE 38 Heatmap of people potentially requiring support in Warwickshire



Source: Business Intelligence Team, Warwickshire County Council

FIGURE 39 Food parcels received by and distributed by districts / boroughs in Warwickshire



Source: Business Intelligence Team, Warwickshire County Council

Food Bank Activity

Across the UK, food bank activity has significantly increased due to the COVID-19 pandemic. The Independent Food Aid Network (IFAN), which connects more than 300 food aid providers across the UK, reported a 175% increase in the number of emergency food parcels distributed by food banks in April 2020 compared with April 2019.

The outbreak of COVID-19 and subsequent lockdown have also changed how some food banks are operating; with 24% of organisations in a recent report by IFAN either seeing an increase in self-referrals or starting to accept self-referrals as a result of the COVID-19 outbreak. Before the outbreak, only 4% of organisations sampled ran a delivery service, this has increased to 57% in order to allow for social distancing^{xxxii}.

COVENTRY

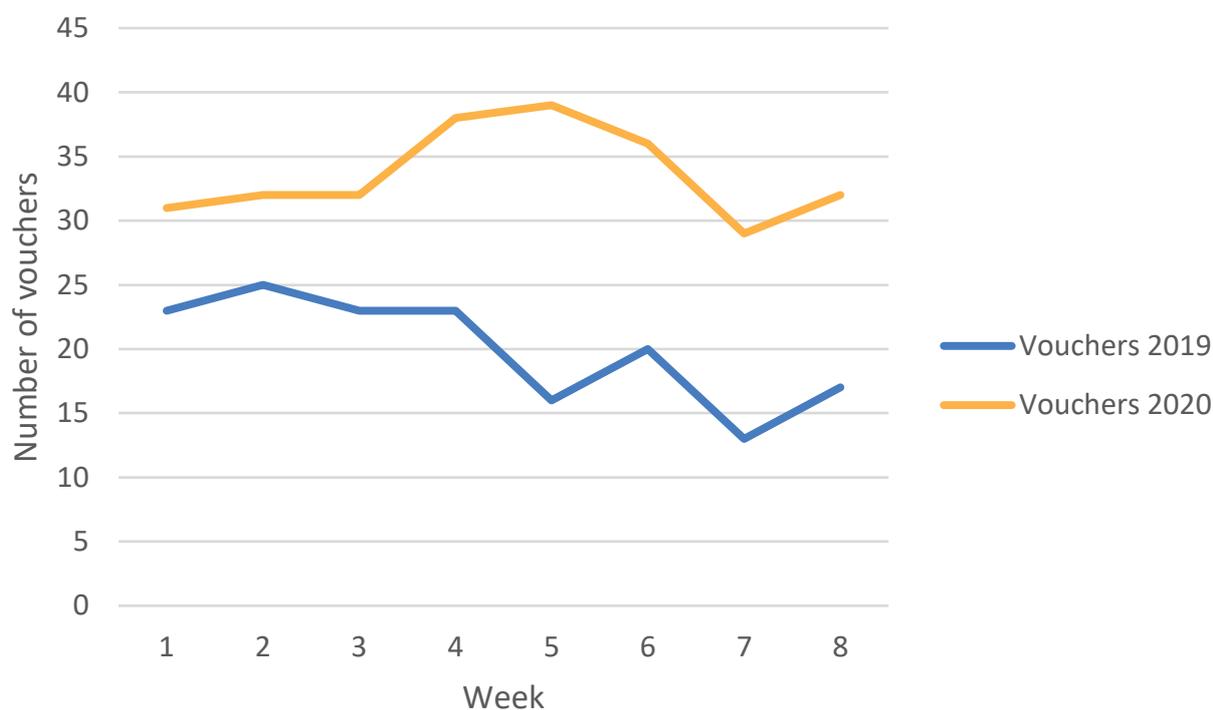
The Trussell Trust in Coventry saw a 95% increase in food parcels given out overall and an 106% increase in food parcels given out to children in April 2020 compared with April 2019.

This is supplemented by other food provision across the city: 10 emergency food hubs have been set up; 5 of which operate as social supermarkets. These have been providing food to many families in the city, for example the social supermarket in Foleshill ward is distributing around 250 parcels a week. Coventry City Council also supported 671 residents with food between 3 April and 4 June 2020 via calls into its contact centre.

WARWICKSHIRE

At the beginning of lockdown, the Trussell Trust in Warwickshire saw a 125% increase in food parcels given out overall and a 217% increase in food parcels given out to children in the last two weeks of March 2020 compared with the last two weeks of March in 2019.

FIGURE 40 Food vouchers received by Ediblelinks in Warwickshire between March and April 2019 and 2020



Source: Nuneaton and Bedworth Healthy Living Network

This increase continued in April 2020, where there was a 63% increase in food parcels given out to foodbanks in North Warwickshire (Includes foodbanks located in North Warwickshire, Nuneaton and Bedworth and Rugby Boroughs) an 87% increase in South Warwickshire (includes foodbanks located in Stratford-on-Avon and Warwick Districts).

Data from Ediblelinks, an independent foodbank in North Warwickshire Borough, shows a 68% increase in the 8 weeks commencing 16th March 2020, compared with the corresponding weeks in 2019, with 269 vouchers received from families or individuals needing to use the foodbank in this period in 2020 compared with 160 in 2019. There has been a 45% increase in the number of people helped (55% increase in adults and 34% in children). Figure 40 shows the number of vouchers received by Ediblelinks from families or individuals in the 8-week period commencing 16th March 2020 compared with the same weeks in 2019.

The increase in need is believed to be bigger but is not shown in these figures due to several “pop up” initiatives which have started since the beginning of lockdown. One of these is located at St John’s church in South Leamington, which was providing an average of 100 meals a week from April to both families and single people. They reported that some people have found it difficult to obtain vouchers for a food parcel as many of the usual suppliers are currently shut.

Citizens Advice Bureau (CAB) Activity

COVENTRY

The impact of COVID-19 on Coventry Citizens Advice has included a drop in the number of enquiries supported, and changes in the types of issues people have contacted CCA about. March 2020 saw a 25% fall in enquiry numbers compared with February, and the number of enquiries dealt with by CCA in April and May 2020 was lower than 2019; this corresponds to a decrease in advice capacity available, which was

around 75% of pre-COVID levels, due to the temporary suspension of two projects and the 'furloughing' of volunteer advisers.

Whilst this decline can be seen in most issue areas; there were some issues for which enquiries rose. In April 2020, CCA saw a 92% increase in enquiries about employment issues compared with April 2019, predominantly of concerns around 'pay and entitlements', terms and conditions' of employment', 'parental and carers rights' and questions around the government's Job Retention and SEIS Schemes. These declined in May 2020. Housing and Homelessness also saw an increase of 48% compared to April 2019, including actual or threatened homelessness and disputes with private sector landlords; and continued to be a common issue for enquiries in May 2020. CCA also saw a rise in new issues arising in April 2020, including credit card and personal loan debts, Council tax benefit eligibility and Job Seekers Allowance. In May 2020 enquiries around Universal Credit and Benefits shifted from a focus on making applications to coping with the wait for the first payment and dealing with award decisions.

In April 2020 CCA saw an increase in the number of younger adults (under 35s) accessing the service; although this declined in May it was still higher than usual. A higher proportion of clients were female (51%, April 2019, 54% April 2020), disabled (54% April 2019, 60% April 2020) and white (68% April 2019, 78% April 2020). Whilst the proportion of clients who were female and white decreased slightly in May 2020, BAME clients were still relatively under-represented in CCA's COVID-19 client base and the proportion of disabled clients increased again to 62%.

CCA note that some groups have fallen through the 'safety net' constructed around COVID-19. These groups include: the self-employed not covered by the SEISS, those with no recourse to public funds not covered by the Job Retention Scheme and the 'new homeless'.

As the lockdown is lifted in incremental steps, and temporary protections are withdrawn, CCA expect to see marked increases in demand for all their services, across all fronts; but particularly on debts, benefits, housing and employment.

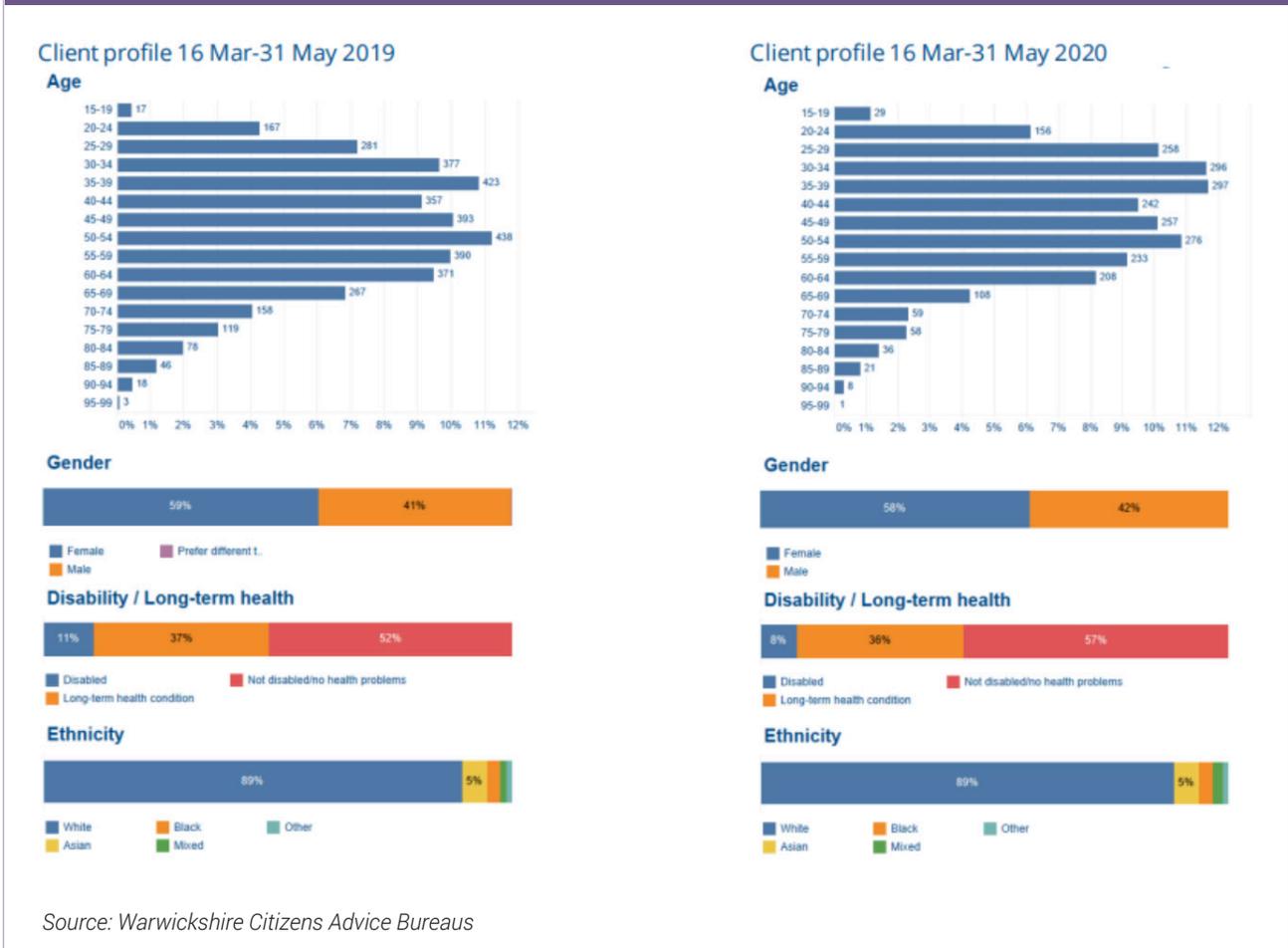
WARWICKSHIRE

Means of communication for Coventry Citizens Advice and the three CABs in Warwickshire (North Warwickshire, South Warwickshire and BRANCAB) had been about two thirds in person up to 20th March 2020, with most of the remainder being phone calls, and with very little online contact. In Warwickshire, there had been a small increase in the number of enquiries from 2018/19 to 2019/20, particularly those relating to Universal Credit.

Data across all Warwickshire Citizens advice from 16th March to 31st May 2020 shows a slight decrease in the number of clients and an increase in the complexity and number of issues per client (in line with national trends). Demand is expected to increase as lockdown lifts. Of those who have been in contact, a greater proportion are aged in their 20s and 30s and a smaller proportion are aged 55+. The increase of clients in their 20s and 30s may be down to a preference of using online contact methods, as well as an increased need in this age group. A greater proportion of contact has related to Universal Credit and Employment issues. There is expected to be an increase in clients with issues such as debt, financial capability, benefits, employment, and requests for welfare assistance. Face to face visits are likely to restart in June for the most vulnerable clients, those with English as a second language, and those where issues cannot be dealt with remotely.

In South Warwickshire, comparing the period 18th March 2020 to 30th April 2020 with the data for the year from 1st April 2019 to 31st March 2020, there were increases in the average number of clients per week, from 115.62 in the annual data, to 533.33 in the six week period in March and April 2020. In terms of the issues raised, there was an increase in employment and universal credit related queries, with debt related queries concerning debt relief orders and unsecured personal loans. There has been a proportional rise in queries from those in the 30-34 and 75-79 age groups. With the client being at home, they are able to

FIGURE 41 Client profiles across all Warwickshire Citizens advice – 2019 compared to 2020



focus on details which are readily at hand, and by homeworking staff are able to concentrate more on the allocated client (than they would in a busy office environment), and therefore the quality of advice given has risen markedly.

At BRANCAB (Bedworth, Rugby and Nuneaton CAB), there has been a particular increase in the number of queries relating to employment. At North Warwickshire Citizens Advice Bureau, there has been a particular increase in the number of queries relating to disability benefit.

Community Safety

CRIME AND DISORDER

With the notable exception of crimes associated with domestic abuse and anti-social behaviour, recorded crime numbers nationally during the initial 6 weeks following lockdown were notably lower than the same time last year (in total around 25% fewer crimes were recorded).

However, with the easing of lockdown, it is thought that recorded crime rates will at least bounce back to pre-lockdown levels and concern that gang related crimes, along with those relating to domestic violence and abuse, will spike, especially over the coming summer months.

Concern has also been raised about the longer-term impact of the lockdown on crime rates if long term economic difficulties and mental health issues are not addressed.

COVENTRY

Coventry saw a significant year on year rise in recorded crimes for anti-social behaviour (ASB) in April 2020 but an overall drop in recorded crime when those relating to ASB are excluded (drop of 30%). The drop in recorded crime can be explained by lockdown measures with more people staying at home and fewer people on the street. Trends in recorded crime relating to domestic abuse cannot be discerned from this dataset.

WARWICKSHIRE

Table 21 shows crime data in Warwickshire using categories available for Coventry, for the period available for Coventry (April 2020), so it can be compared. This dataset masks the increase in domestic abuse related crimes reported directly from the Warwickshire Police Crime Information System. Warwickshire saw a larger increase in ASB compared to Coventry (150% increase and 104% increase respectively). Warwickshire also saw an increase in incidents relating to drugs and possession of weapons for which Coventry saw a decrease.

Recorded crime data sourced from Warwickshire Police Crime Information System suggests Warwickshire is following the national trend. In April 2020, total recorded crimes were 25% fewer than the same month the previous year, but only 13% lower in May 2020. However, overall figures mask the true trends of specific types of crime, such as those relating to hate offences and domestic abuse, which, in line with the national picture, are all notably higher than the same time last year.

	April 2019	April 2020	% change
Anti-social behaviour	440	897	104%
All excluding anti-social behaviour	2441	1698	-30%
Other crime *	38	49	29%
Public order	125	151	21%
Violence and sexual offences	873	768	-12%
Possession of weapons *	27	22	-19%
Drugs *	41	30	-27%
Vehicle crime	284	178	-37%
Other theft	172	102	-41%
Criminal damage and arson	263	152	-42%
Burglary	253	126	-50%
Shoplifting	196	70	-64%
Robbery *	80	25	-69%
Theft from the person*	21	6	-71%
Bicycle theft *	68	19	-72%

Source: <https://data.police.uk/>
 * indicates small numbers

TABLE 21 Comparison of crime incidents in Coventry in April 2019 and April 2020

	April 2019	April 2020	% change
Anti-social behaviour	1019	2543	150%
All excluding anti-social behaviour	3517	2654	-25%
Drugs*	75	117	54%
Other Crime*	57	70	23%
Possession of Weapons*	36	42	17%
Public Order	182	183	1%
Violence and sexual offences	1257	1105	-12%
Criminal damage and arson	346	237	-32%
Vehicle crime	360	246	-46%
Shoplifting	296	186	-37%
Bicycle theft*	45	28	-38%
Other theft	405	216	-47%
Burglary	372	190	-49%

Source: <https://data.police.uk/>
 * indicates small numbers

From 16 March to 18 May 2020, there were 16 Road Traffic Collisions (RTCs) in Warwickshire where there were either fatalities or serious injuries. This compares with an average of 53 for the same period in 2019. The number involving a cyclist was 3 in 2020 and 4 in 2019. However, when looking at collisions where there were slight injuries, there were 12 in 2020 and 19 in 2019. (Source: Traffic & Road Safety Team, Warwickshire County Council) Attendances by the Fire Service at RTCs in the period 1st March to 3rd May 2020 were half the number in the same period in 2019 (28 compared with 56). (Source: Warwickshire Fire and Rescue)

Domestic Abuse

Nationally, information published by Refuge suggests the rise in domestic abuse incidents during lockdown is much higher than suggested by reported crimes recorded or referrals to services.

During the initial stages of the COVID-19 crisis, Refuge reported around a 50% increase in demand to its helpline call service, and a 300% increase in visits to its website. Refuge is now reporting an increase of 66% in calls to its helpline and a 950% rise in visits to its website compared with the period before lockdown, although this is partially offset by reported instances of domestic abuse tending to peak during the summer months.

COVENTRY

The level and pattern of domestic abuse reports have fluctuated significantly during the COVID-19 outbreak and the lockdown period. The number of crimes with a domestic abuse marker reported to police in

TABLE 22 Crime incidents in Warwickshire in April and May 2019 compared to April and May 2020

	April 2019	April 2020	% YOY	May 2019	May 2020	% YOY
Anti-social behaviour	1015	2543	151%	1195	2238	91%
All excluding anti-social behaviour	3485	2611	-25%	3509	3043	-13%
Hate Offences & Crimed Incidents	66	53	-20%	59	73	24%
Domestic Abuse (DA) Offences & Crimed Incidents	844	958	14%	894	1049	17%
Violence Against Person Without Injury – DA related	292	327	12%	311	355	14%
Violence Against Person With Injury – DA related	152	154	1%	135	142	5%
Rape	34	22	-35%	46	37	-20%
Other Sexual Offences	73	56	-23%	79	77	-3%
Violence With Injury	383	279	-27%	379	343	-10%
Violence Without Injury	744	707	-5%	757	867	-15%
Residential-Dwelling Burglary	158	74	-53%	131	78	-41%
Residential Non-Dwelling Burglary	265	134	-50%	203	133	-35%
Personal Robbery	45	19	-58%	27	25	-7%
Shoplifting	296	186	-37%	334	165	-51%
Total Vehicle Crime	359	245	-32%	364	261	-28%
Criminal Damage & Arson	348	236	-32%	366	278	-24%

Source: Warwickshire Police Crime Information System

Coventry up to and including March 2020 are shown below. Data for April is not yet available but police report that following an initial dip, the final two weeks of the month has seen a return to previous levels. Third party reporting (i.e. from neighbours) has increased.

As at 28 April 2020 there are approximately 70 individuals / families in temporary accommodation with domestic abuse as the primary reason for homelessness; this reflects a 10% increase in the first weekend following a national Home Office campaign launched 11 April 2020.

The Council continues to work with the Regional Domestic Abuse Leads Group, which includes updates from the West Midlands Police and Crime Commissioner. Additional local partnership forums have been established to ensure communication between agencies and support mitigation of the risks; these include:

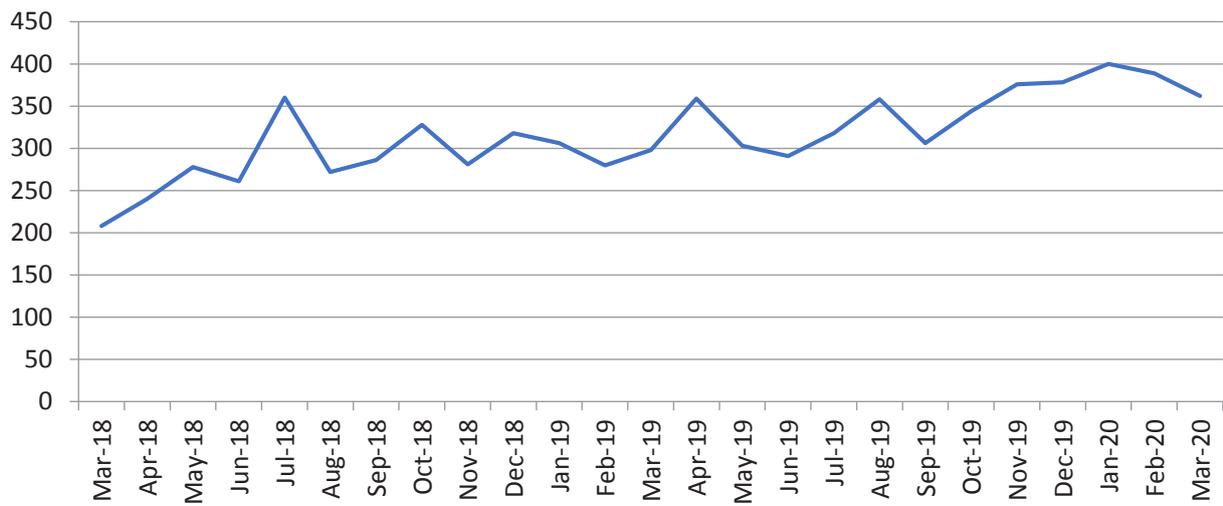
- fortnightly meetings of key stakeholders including WMP, C&R CCG, Children’s Services, specialist providers and Housing, etc.
- weekly accommodation-focused meeting including housing, providers, Children’s services and police.

Discussions are underway to explore whether Coventry Haven can conduct ‘safe and well’ contacts with

households with a history of known domestic abuse supported by the Council's COVID-19 vulnerable residents' support scheme.

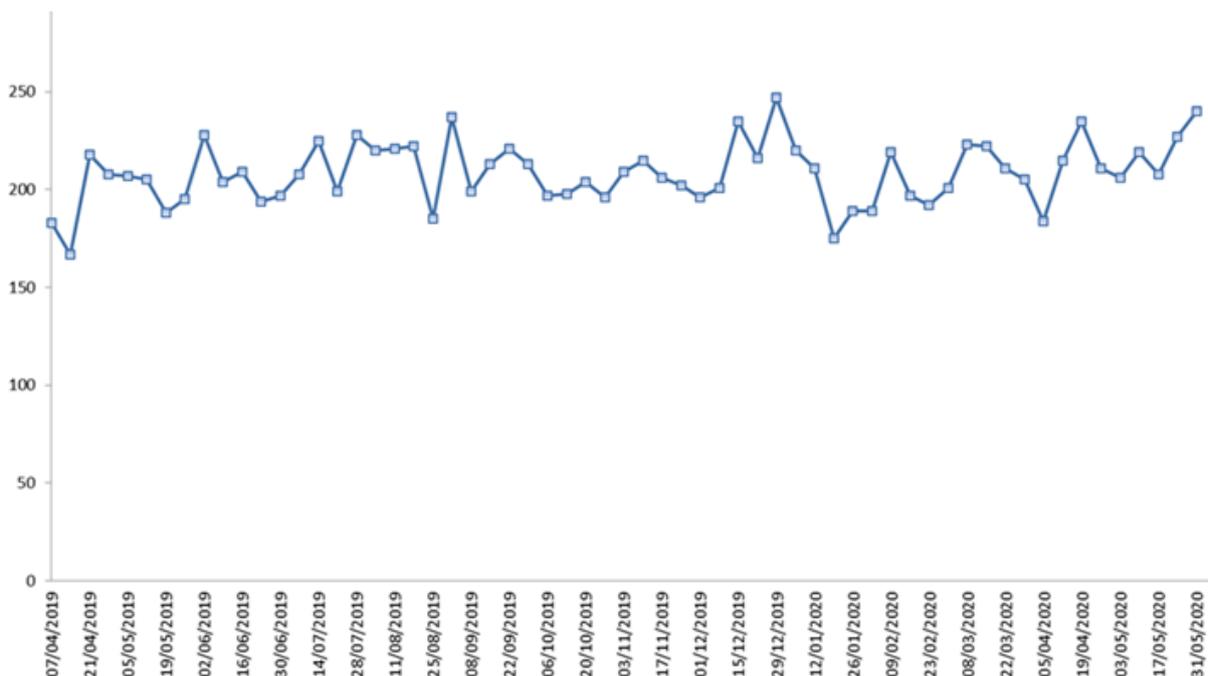
Local domestic abuse support providers report a significant fluctuation in the number of contacts to the Safe to Talk helpline. The average number of weekly calls to the helpline was 35-40 pre-COVID-19 and has fluctuated between 6 contacts (in the week immediately following lockdown) and 77 contacts (week commencing 4 May 2020).

FIGURE 42 Domestic abuse incidents recorded by Coventry Police



Source: Insight Team, Coventry City Council

FIGURE 43 Domestic abuse incidents recorded by Warwickshire Police



Source: Warwickshire Police Crime Information System

WARWICKSHIRE

Reported domestic abuse has increased during the 3 months of March, April and May 2020 (illustrated in Figure 43) to the highest levels seen since July 2018. It can be suggested that the increase in reports represents a willingness and ability of residents to report this type of behaviour despite the lockdown situation. In contrast though, it may also be the case that many more offences and incidents may currently be 'hidden' and only be noted and reported as residents are able to leave their homes and access support services in the coming months. It is likely that these raised levels will continue into July.

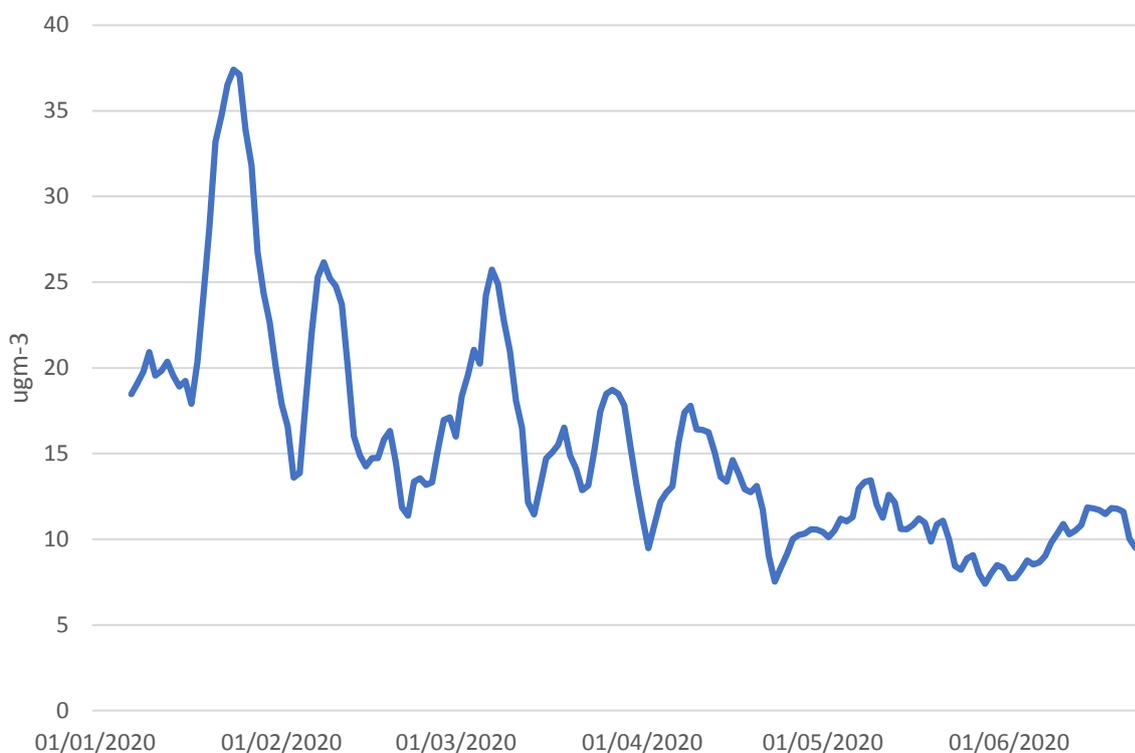
Referrals to Refuge in Warwickshire remained fairly constant throughout the lockdown.

Air Quality

The Air Quality Expert group, acting on a request from Defra, is calling for evidence from the research and air quality management user communities to address a set of urgent short-term questions related to recent and ongoing changes in UK air quality. This request for evidence is to provide focused and rapid scientific evidence that can support decision-making on air quality management in the coming weeks and months.

There are four Defra monitoring sites in Coventry and Warwickshire, two in each area as demonstrated in Figure 44. The four sites all monitor particulate matter PM10 (i.e. 10 micrometers or less in diameter) and nitrogen dioxide (NO₂) levels (microgram per cubic meter $\mu\text{g m}^{-3}$).

FIGURE 46 NO₂ recordings taken at the Allesley Defra monitoring site between January and June



Source: Defra

FIGURE 47 NO₂ recordings taken at the Leamington Spa, Rugby Road Defra monitoring site between January and June



Source: Defra

COVENTRY

NO₂ levels at both Coventry Defra monitoring sites reduced significantly since lockdown measures were introduced in March, as demonstrated in Figures 45 and 46. The lowest recordings were towards the end of April and start of May. NO₂ levels have remained relatively low in June.

WARWICKSHIRE

NO₂ levels at both Leamington Defra monitoring sites reduced since lockdown measures were introduced in March, as demonstrated in Figures 47 and 48. Whilst there was some variation in March and April, May and June recordings have been particularly low at the Leamington Spa, Rugby Road site. The Leamington Spa site recorded a continued decline in NO₂ levels from early March with a small increase in June.

Rough Sleeping and Homelessness

In response to the Coronavirus pandemic, the Ministry for Housing, Community and Local Government (MHCLG) launched a scheme called “Everyone In” to provide emergency shelter for rough sleepers who had not been assessed formerly to be owed a statutory duty to accommodate.

Ring-fenced funding of £3.2m was allocated to local authorities to deliver the scheme (now ended), with the expectation by government (Ministry of Housing, Communities and Local Government MHCLG) that local authorities and the third party sector should try to continue to support recipients of the scheme, many having very complex health and care needs and not previously well engaged with statutory homeless services.

FIGURE 48 NO₂ recordings taken taken at the Leamington Spa Defra monitoring site between January and June



Source: Defra

TABLE 23 Numbers of people sleeping rough or at risk of sleeping rough who were provided with emergency accommodation during the COVID-19 outbreak

	Reported total number (1)	Households (1000's)	Per 1000 households	Snapshot as at 31st May 2020 (2)
England	14,610	/2,2595	0.64	
London	4,450	/3,545	1.25	
Rest Of England	10,160	/19,050	0.53	
Warwickshire	139	/242	0.31	139*
North Warwickshire	2	/27	0	2*
Nuneaton & Bedworth	42	/55	0.31	42*
Rugby	18	/45	0.42	18*
Stratford-on-Avon	50	/55	0.24	50*
Warwick	27	/60	0.43	27*
Coventry	142	/147	0.96	99

Source: MHCLG ^{xxxiii}

*Due to the data collection process moving to a monthly cycle these figures should be seen as an approximation and may change. Last updated 8/6/2020 - for May 2020 (London 15/05, ROE 7/05)

TABLE 24 Numbers of people supported in accommodation under a statutory duty as at 31 December 2019					
	Households in temporary arranged by LA	With children	Per 1000 households	In temporary in another local authority	Duty owed but made own arrangements
England	88,330	62,580	3.78	24,430	6,350
London	58,680	43,920	16.55	21,440	1,860
Rest of England	29,650	18,660	1.49	2,990	4,490
West Midlands	4,900	3,720	2.03	3,510	2,720
Warwickshire					
Warwickshire	261	94	1.08	6	2
North Warwickshire					
North Warwickshire	1	1	0.04	0	0
Nuneaton & Bedworth					
Nuneaton & Bedworth	69	29	1.25	6	0
Rugby					
Rugby	103	44	2.29	0	0
Stratford-on-Avon					
Stratford-on-Avon	71	18	1.30	0	0
Warwick					
Warwick	17	2	0.28	0	2
Coventry					
Coventry	672	367	4.57	0	8

Source: MHCLG

On 14 May 2020 MHCLG announced £6m of emergency funding would be available to provide relief for frontline homelessness charitable organisations who are directly affected by the COVID-19 outbreak, whether that be to help alleviate the financial impact of COVID-19 on the organisation or to provide new or adapted services to homeless people affected by COVID-19.

A MHCLG survey estimates that over 14,500 rough sleepers have been supported with emergency accommodation nationally during the pandemic. Table 23 shows the total number of people sleeping rough or at risk of sleeping rough who have been provided with emergency accommodation in response to the COVID-19 pandemic (1), and Snapshot of number being supported as at 31st May 2020 (2)

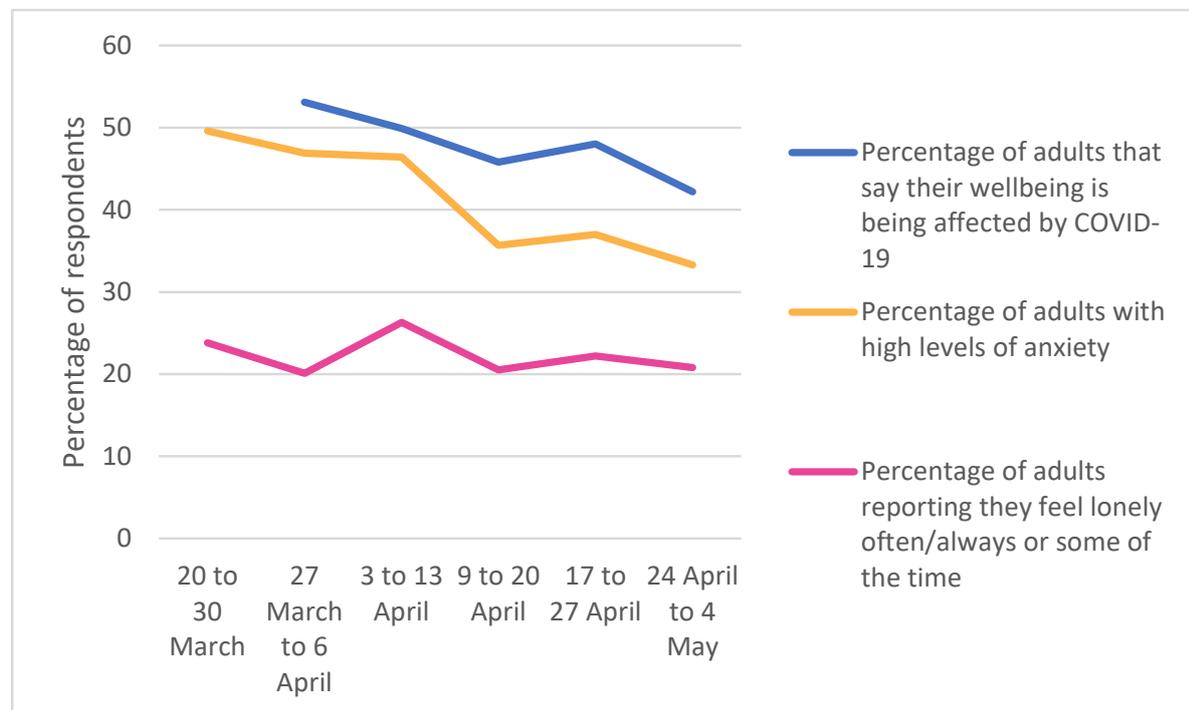
Whilst the long-term impact of the pandemic on levels of homelessness and the concomitant deterioration in health and well-being are acknowledged, they are poorly understood in terms of level of need and there is a very significant time lag of up to 9-12 months if relying on MHCLG quarterly data to measure this.

Further, the full impact of the pandemic on levels of homelessness (or risk of homelessness) will not be fully realised especially until the government suspension on Section 21 notices and evictions is lifted (currently until September 2020).

Whilst MHCLG quarterly published data is a good source for both establishing a baseline and for measuring the impact of the pandemic on levels of homelessness, it is recommended that in-house data be used to provide more timely information. For example, Coventry City Council are monitoring change in reasons why households are approaching housing and homeless services (e.g. threatened with eviction, fleeing domestic violence, relationship breakdown) and numbers being supported in temporary accommodation.

The most recent data available for numbers being supported in accommodation under a statutory duty from MHCLG is for 31 December 2019 (see Table 24).

FIGURE 49 ONS survey respondents' self-reported feelings of wellbeing, anxiety and loneliness between 20 March and 4 May 2020



Source: ONS

Mental Health – Anxiety and Loneliness

There are significant numbers of studies that suggest mental health will be a key issue that will have to be addressed after an epidemic. Survivors of previous coronavirus outbreaks (SARS & MERS) had considerable prevalence of psychological disorders such as post-traumatic stress disorder (PTSD) (38.80%, CI 30.93 to 47.31), depression (33.20%, CI 19.80 to 50.02) and anxiety (30.04%, CI 10.44 to 61.26) beyond 6 months^{xxxiv}. However even those not directly affected by the virus are likely to experience mental health challenges. Studies also reported on general psychological symptoms emotional disturbance, depression, stress, low mood, irritability, insomnia, post-traumatic stress symptoms and anger amongst members of the public post quarantine.^{xxxv}

What is the current data saying:

The Office for National Statistics (ONS) Opinions and Lifestyle Survey has an added COVID-19 module. This is not broken down into regions. However across Great Britain the percentage of adults with high levels of anxiety has reduced from 49.6% in the period 20th to 30th March to 33.3% in the period 24th April to 4th May, as highlighted in Figure 49. The percentage of adults who say that their wellbeing is being affected by COVID-19 has also fallen from 53.1% in the period 27th March to 6th April to 42.2% in the period 24th April to 4th May.

Overall of those married or in a civil partnership, 39% reported feeling anxious, compared to 19% in the last quarter of 2019. In addition to this, those aged 75 and over were almost twice as likely as those aged 16 to 24 to report feeling anxious during lockdown. Before the pandemic, this age group was less likely to feel anxious.

The ONS also reported that older people (aged over 60) were worried about their access to groceries, medication and other essentials. Younger people (aged 16 to 29) were worried about the impact on their schooling and university courses, their work and their relationships. Coping strategies for older people included reading and gardening, and for younger people watching films, streaming services and socialising over the internet.

A further study found increased loneliness and anxiety during lockdown had particularly impacted people with disabilities. Almost three quarters (74%) of disabled people taking part in this study told us that they were feeling very or somewhat worried about the effect coronavirus was having on their lives and almost half (49%) said they had been lonely in the previous seven days.

The Understanding Society Study by Ipsos MORI and Kantar in April 2020 found that younger age groups reported the highest levels of loneliness (from the question “In the last four weeks, how often do you feel lonely?”), with 17% of 16 to 34 year olds saying they “often” feel lonely, compared to 4% of those aged 70 and over.

Health Watch Surveys

HEALTHWATCH WARWICKSHIRE AND HEALTHWATCH COVENTRY

During June there were 879 responses to a survey about people’s experiences of health and social care during the pandemic. 388 (44%) people reported that they had used a healthcare service and experienced changes to services (changes included adjustments, postponements and cancellations).

72% of respondents reported that the COVID-19 pandemic had a negative effect on their wellbeing (either some impact or a great impact).

The majority of the responses related to health rather than social care services. This survey is ongoing and more detailed results will be available at a later date^{xxxvi}.

Recommendations

This report has been a comprehensive assessment of the immediate impacts of responding to the COVID-19 pandemic. There are two high level conclusions which will be critical as we look at recovery planning.

1) An integrated recovery: This analysis shows that health has been deeply impacted on by changes across all four quadrants of the model. The implication is that recovery cannot just be contained to one sector and has to be connected across all four to have the biggest chance of success. An integrated recovery is one where we look across traditional boundaries to understand where services have the potential to impact across all four quadrants of the Kings Fund model.

2) The double impact: This report references that the harm from COVID-19 has been unequally distributed across the population and is likely to continue to be so whilst still circulating. This analysis shows that the wider impacts from the pandemic and lockdown will fall more heavily on those communities directly affected by the disease itself. This analysis shows the potential harm for more deprived areas of Coventry and Warwickshire and as more evidence develops it will be important to understand the impact on BAME groups, and the most vulnerable individuals.

In addition there are a series of recommendations based on the analysis in each of the four quadrants of the Kings Fund model

- Approaches to economic recovery can consider how 'Inclusive Growth' concepts that track the pattern as well as pace of growth can mitigate against a double impact in more deprived communities.
- The evidence presented here on areas and sectors most at risk can be used to better target and design interventions to support economic recovery
- The health sector can play a role in identifying individuals who have become unemployed and explore preventative actions to mitigate any impact on health behaviours and wellbeing.
- Local evidence needs to be collected on health behaviours through both planned and bespoke questionnaires and other engagement to understand the impact on health behaviours.
- There is an opportunity to encourage those who have adopted more healthy behaviours to maintain them. This needs to specifically consider the need to reduce health inequalities and how to address the barriers that prevented people in more deprived areas or lower paid professions from becoming more physically active.
- Health and social care organisations need to consider how to support front line staff to prevent increases in alcohol use seen following other pandemics.
- More detailed analysis with clinical input needs to be carried out to understand the patient groups and conditions that have contributed to the decrease in hospital use, and their relative acuity. This will help to identify actions that mitigate the impact.
- The figures presented in this report on patients awaiting treatment, or who have missed screening and immunisation appointments should be used in recovery planning. An integrated approach to recovery is needed across NHS organisations to prevent attempts to reduce the backlog from overwhelming parts of the system.
- COVID-19 has had a broad impact on mental wellbeing and social isolation that needs to be addressed by all sectors as part of the recovery.
- Although there are plans to reduce the services available from shielding hubs, there are still health needs and anxieties in that group. The recovery phase must think about the ongoing support available to these groups.

- Improvements in air quality have shown the potential to protect the public from this harm and opportunities to maintain some of the behaviours that have led to the reduction need to be considered, alongside additional work to support a shift onto more active forms of travel.
- As well as the work to support rough sleepers housed during COVID-19 into more permanent accommodation, the role of services in supporting those individuals needs to be reviewed to ensure that appropriate services are in place.

This report describes the immediate impact of COVID-19 and a further review of evidence will need to be considered in order to understand the longer-term implications, especially on the groups at risk of a 'double impact'. In preparing for this Warwickshire County Council will carry out horizon scanning activities to identify new research and evidence which informs the later analysis.

Appendices

Appendix 1 – Claimant Count data including CCG data

Area	Percentage increase April 2019 to April 2020	Percentage increase May 2019 to May 2020
North Warwickshire	171.0%	222.6%
Nuneaton and Bedworth	88.0%	118.5%
Rugby	85.7%	119.4%
Stratford-on-Avon	138.5%	198.6%
Warwick	138.2%	138.5%
Warwickshire	111.4%	125.1%
Coventry	95.4%	142.8%
Warwickshire North CCG	105.5%	140.6%
Coventry and Rugby CCG	93.6%	138.5%
South Warwickshire CCG	138.3%	230.0%
Coventry and Warwickshire	103.7%	153.4%
England	93.2%	114.1%

Source: NOMIS <https://www.nomisweb.co.uk/>

Appendix 2 – Locations and details of Defra monitoring sites in Coventry and Warwickshire

Monitoring site	Location (Latitude/Longitude)	Type	Networks
Coventry Binley Road UK-AIR ID: UKA00634	52.407708,-1.490082	Traffic Urban	Automatic Urban and Rural Network UK Urban NO2 Network
Coventry Allesley UK-AIR ID: UKA00592	52.411563,-1.560228	Background Urban	Automatic Urban and Rural Network
Leamington Spa Rugby Road UK-AIR ID: UKA00564	52.294884,-1.542911	Traffic Urban	Automatic Urban and Rural Network UK Urban NO2 Network
Leamington Spa UK-AIR ID: UKA00265	52.288810,-1.533119	Traffic Urban	Automatic Urban and Rural Network Non-Automatic Hydrocarbon Network

Source: Defra, <https://uk-air.defra.gov.uk/networks/find-sites>

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Social determinants of health and the role of local government

Foreword

The desire for good health can be seen all around us, whether in people taking more exercise or in trends on social media. The COVID-19 pandemic has added to concerns about health and wellbeing. It is common to receive emails that begin with the general greeting: “I hope you are well”. In local government it is important to consider what we can do to improve health within our communities, so that residents live longer happier and healthier lives. Health is often thought of as more of a concern for the NHS than for local government, but in reality, local government has an even greater potential to influence health improvement than does the NHS. As was quoted in the recent All Parliamentary Report on longevity: “We have been caught in a false view that our national health means the NHS.”¹

Health improvement has always been a fundamental responsibility of local government and this was emphasised further with the transfer of public health responsibilities in 2013. It is now seven years since that transfer. It is 10 years since the landmark publication of the Marmot report, ‘Fair Society Healthy Lives’² and it is also 10 years since the Local Government Association (LGA) last produced a report on the social determinants of health.³

The role of local government at that time was set out as the following: as an employer; through the services it commissions and delivers; through its regulatory powers; through community leadership; through its well-being power. Local government still has all these roles in improving health and tackling the social determinants of health, but the world has moved on over a decade and the developments during that time are considerable.

Therefore, it is the right time to look again at what local government can do to improve health especially by tackling social determinants. There are opportunities to see what innovation and new activity has been undertaken across the country and how that can be repeated elsewhere. In the context of COVID-19 it is important to remember that it is often the effects of social determinants of health that have made people more vulnerable to the virus. Conversely the social effects of the virus on employment and the economy will have an additional impact on health.

1 All Party Parliamentary Group on Longevity: ‘The Health of the Nation A Strategy for Healthier Longer Lives’

2 www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

3 www.local.gov.uk/social-determinants-health-and-role-local-government

Opportunities for health improvement by tackling the social determinants of health have been taken up across the country. The examples and case studies detailed in this report express the opportunities for health improvement and what has already been achieved.

I am particularly pleased to see the range of activity that shows how councils can lead on health improvement. This includes new relationships between councils and their populations, innovative work between county and district level and seeing how economic development and health improvement are inextricably linked. Through these, and other examples, we can see why it was right to transfer public health responsibility back to local government and how health is central to the role of councils.



Councillor Ian Hudspeth

Chair, LGA Community Wellbeing Board

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What is health?

We all want to be healthy but may pause a little if we are asked what it means to be healthy. Is health something that we can grasp, something that we can measure and can improve, or is it the absence of disease and sickness? We may have one idea of health when raising a toast to someone's good health at a social occasion and another idea of health when considering what services are needed to improve the health of local residents. It is helpful to give some consideration to the definition of health so that we can be on firm foundations when looking to improve health in a community.

The longstanding definition of health from the World Health Organization (WHO) formulated in 1948 is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This was an important definition in that it considered health as something positive rather than an absence of disease. The focus on generating health rather than concentrating on sickness has opened the way for local health improvement in communities and to a focus on listening to people rather than simply sticking with a medical model of disease. It is also potentially helpful to see health in the context of the three areas of physical, mental and social wellbeing, especially if these are given similar weight when decisions on priorities are being made.

The WHO definition is by no means perfect though and has come under criticism in recent years. It was originally drawn up when rapidly progressing illnesses were more prominent and life expectancy much shorter than it is today. As populations become older, long-term conditions become more common and screening and early diagnosis increases, so conceptions of health change. A complete state of health may not be possible for someone living with diabetes, but they can still be healthy. A person

may be diagnosed as HIV positive but with appropriate support and treatment this may have little or no effect on life expectancy.

Health is about what makes us feel good physically, mentally, socially and spiritually. It is about how we react to the strains and stresses of life and are not only resilient to them but have the potential to bounce back even stronger. We can be healthy if we do not have a recognised disease but can also be healthy if we can manage a condition and look to live life to the full.

Focusing on good health and what makes us well, rather than on bad health and what makes us sick, moves us to consider assets rather than deficits. People and communities have assets which determine their health, and these can be built on and strengthened. Looked at from this point of view we can see health as a public good, as something that everyone should work towards and the best attainable health as a human right.

Given the priority of health in our lives as individuals and for communities, it is important to consider how health can be measured and how we can know if a community is becoming healthier. However, measuring health is not as easy as measuring illness. The most straightforward way of seeking to measure health is to consider how long people live. Life expectancy can be calculated for one area and compared with another, but it is only a snapshot in time and not an accurate prediction. Also, it does not consider quality of life or include any aspect of people's experience of life. Healthy life expectancy can also be calculated and may be more useful in comparisons. It uses responses to questions about the level of people's general health to calculate a figure for how long people will stay healthy. Healthy life expectancy will always be lower than life expectancy and the gap can be used to give an indication of overall levels of ill health.

What makes us healthy?

If we ask ourselves at an individual level what makes us healthy, we are likely to think about positive aspects of life such as getting exercise, having a good night's sleep or perhaps spending time out with family or friends. Similar ideas are reflected in advice on how to be healthy, both in terms of physical health and mental health. For example, the five ways to wellbeing have been put forward as methods for improving our health:

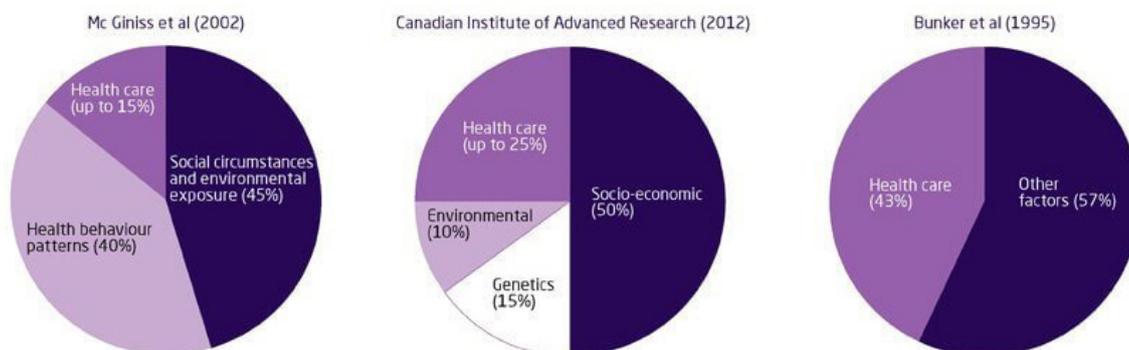
- connect
- be active
- take notice
- keep learning
- give.

If we think about what makes us sick, then we may think of behaviours such as smoking, environmental factors such as pollution or more medical areas such as genetics or specific diseases. We may also think about our relationships with other people and factors such as discrimination or loneliness.

The factors that improve the health of a community are very similar to those that improve the health of an individual. Getting good and effective healthcare is important for both an individual and a community, but it is only a part of the picture. We may want to consider the extent to which healthcare affects our health compared with other factors. How much do genetic factors influence health? How much does our health depend on our behaviour? How much do hospitals contribute?

Three estimates for the contribution of factors in the determination of health are shown in the charts below. While they are different from each other, they all show that the contribution that healthcare makes to our overall health is far less than 50 per cent. It is other factors that make up the majority of the contribution.

These other factors are predominantly the wider determinants of health or the social determinants of health.



Sources:

McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) The case for more active policy attention to health promotion. *Health Affairs* 21 (2) pp.78-93.

Canadian Institute of Advanced Research, Health Canada, Population and Public Health Branch. AB/NWT 2002, quoted in Kuznetsova, D. (2012) *Healthy places: Councils leading on public health*. London: New Local Government Network. Available from New Local Government Network website

Bunker, J.P., Frazier, H.S. and Mosteller, F. (1995) The role of medical care in determining health: Creating an inventory of benefits. In, *Society and Health* ed Amick III et al. New York: Oxford University Press. pp 305-341.

The World Health Organization (WHO) offers this definition of social determinants of health:

“Social determinants of health are the conditions in which people are born, grow up, live, work and age. These conditions influence a person’s opportunity to be healthy, his/her risk of illness and life expectancy. Social inequities in health – the unfair and avoidable differences in health status across groups in society – are those that result from the uneven distribution of social determinants.”

Social determinants of health and health inequities are amenable to change through policy and governance interventions.”⁴

The conditions which make up the social determinants of health are wide-ranging and include the following:

- income level
- educational opportunities
- occupation, employment status, and workplace safety
- gender inequity
- ethnic inequality
- food insecurity and inaccessibility of nutritious food choices
- access to housing and utility services
- early childhood experiences and development
- social support and community inclusivity
- crime rates and exposure to violent behaviour
- availability of transport

- neighbourhood conditions and physical environment
- access to safe drinking water, clean air, and toxin-free environments
- recreational and leisure opportunities.

In addition to each individual factor, these influences interact with each other in a complex way. For example, poor health or lack of education can impact on employment opportunities which in turn constrain income. Health is certainly influenced by behaviours, with smoking, alcohol consumption, unhealthy diet and physical inactivity most prominent among behaviours that are related to ill health in the UK. However, these behaviours are largely themselves influenced by social determinants of health including income, employment and access to healthy environments. Also, where healthcare is important for improving health and combatting illness, the access to and use made of that healthcare is affected by social determinants of health. This has led some people to call social determinants the causes of the causes of poor health.

The impact of the social determinants of health and especially material deprivation is shown clearly through health inequalities as set out 10 years ago in the Marmot report. People in richer areas live longer than those in poorer areas. Not only that, but there is an even bigger difference in healthy life expectancy, the length of time that people live in good health. People in poorer areas live shorter lives and for more of that time they are in poor health. There are many reasons for these differences, but most at their core come down to social determinants of health.

“The single most important intervention is to understand that there is no single most important intervention.”

Harry Rutter, London School of Hygiene and Tropical Medicine

4 www.euro.who.int/en/health-topics/health-determinants/social-determinants/social-determinants

We can see a picture of many factors interacting and affecting the health of individuals and communities.



Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?⁵

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The 10-year review of the Marmot report⁶ found that health has got worse for people living in more deprived areas, inequalities have increased, and life expectancy has fallen for women in deprived parts of England.

“It’s not your genetic code, it’s your [post]code.”

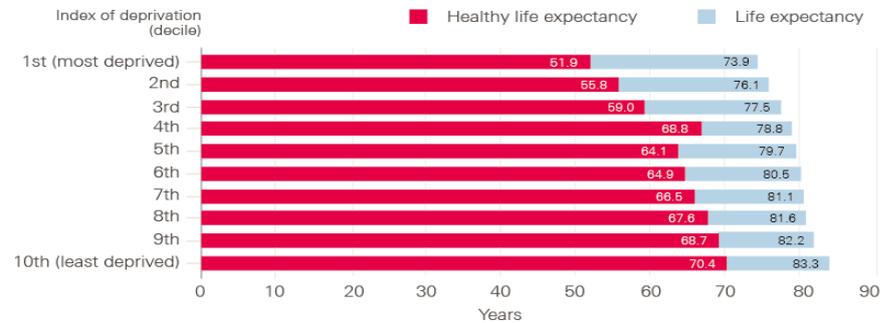
Larry Cohen, Building a thriving nation

5 Working paper prepared for the King’s Fund International Seminar on Tackling Inequalities in Health, September 1993, Ditchley Park, Oxfordshire. London, King’s Fund, accessible in: Dahlgren G, Whitehead M. (2007) European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional office for Europe: www.euro.who.int/_data/assets/pdf_file/0018/103824/E89384.pdf.

6 www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on

The charts below show the relationship between deprivation and both life expectancy and healthy life expectancy using national data. Greater deprivation is associated with lower life expectancy and even lower healthy life expectancy.

Total male life expectancy and healthy life expectancy at birth by decile of Index of Multiple Deprivation, 2014–2016

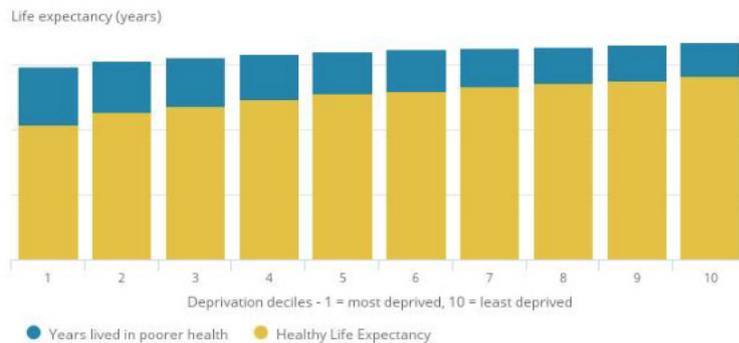


Note: Life-expectancy estimates shown are calculated on a period basis.

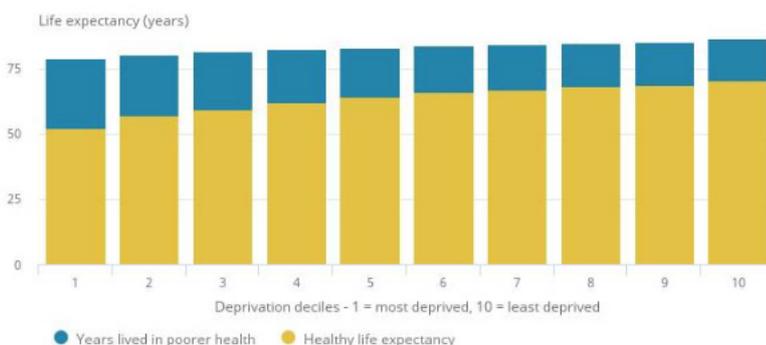
The Health Foundation © 2018 Source: Health Foundation analysis using Office for National Statistics data, *Health State Life Expectancies*, UK: 2014 to 2016.

Source: www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on

Male healthy life expectancy at birth and years lived in poorer state of health: by national deprivation deciles, England, 2015-2017

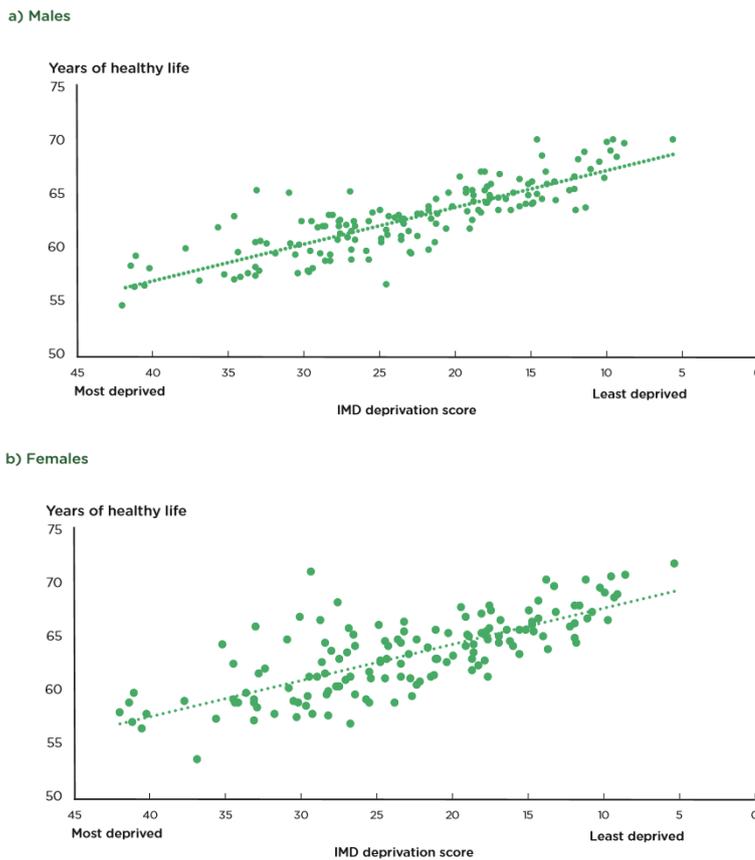


Female healthy life expectancy at birth and years lived in poorer state of health: by national deprivation deciles, England, 2015-2017

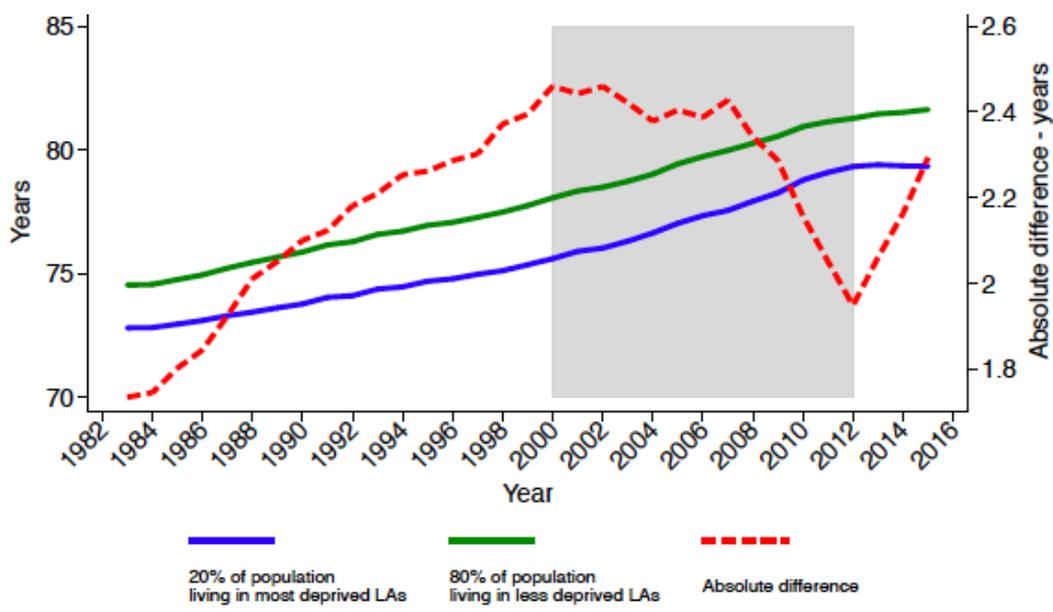


Source: Office for National Statistics – Annual Population Survey, 2011 Census

This is also shown clearly when healthy life expectancy is mapped against material deprivation for each English upper tier local authority for 2018 separately for men and women.



When efforts were targeted at reducing health inequalities, including addressing deprivation and the social determinants of health, there was a narrowing in the gap. However, once those targeted efforts ceased the gap widened again. This is shown in the following chart presenting information relating to the English Health Inequalities Strategy.

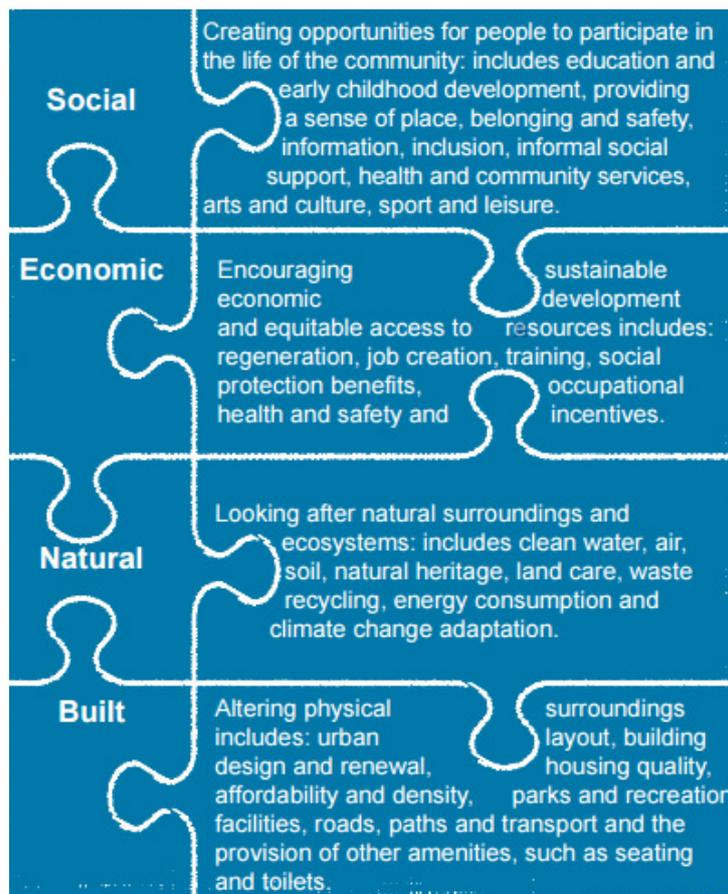


How can we improve health?

Improving health for communities can only be done if the social determinants of health are tackled, in addition to the provision of good quality care and work to ensure behaviour change. There is little use in simply treating people for a health condition if the cause of that condition is not also addressed.

Tackling social determinants includes improvements in housing, education and employment as well as ensuring a health promoting environment. Each of the social determinants of health can be improved to give an overall improvement in the health and wellbeing of communities.

‘Why treat people and send them back to the conditions that made them sick?’⁷



Source: www.local.gov.uk/health-all-policies-manual-local-government

7 Marmot M. The Health Gap: The Challenge of an Unequal World. London: Bloomsbury Publishing, 2015

In Wales, the importance of improving social determinants in order to ensure future wellbeing has been recognised nationally through the Well-being of Future Generations (Wales) Act 2015. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

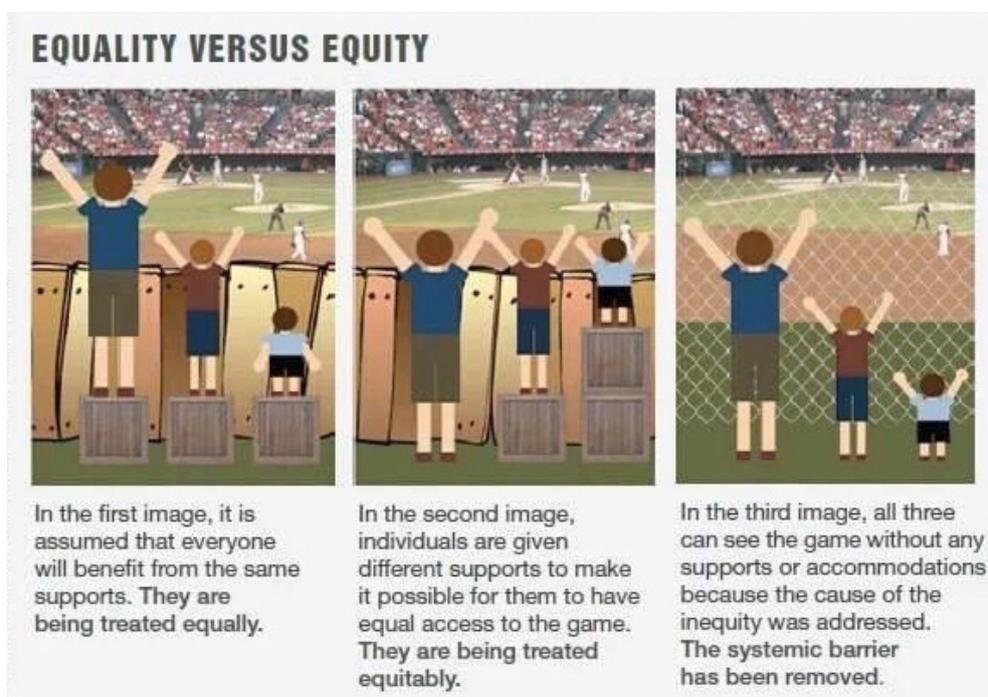
Tackling the social determinants of health is closely bound up with reducing health inequalities, since the factors that influence overall health are the same as those that result in differences, inequalities and inequity in health. Also, more equitable communities tend to be more healthy communities.

The Marmot Review in 2010 set out evidence and actions needed to reduce health inequalities in England and its principal focus was on the social determinants of health. The report created six domains in which improvement was needed and progress could be monitored:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure a healthy living standard for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill-health prevention.

The report emphasised that the work in these domain areas covered everyone in the country and all communities. Work needed to be universal, but also applied proportionately depending on need.

Different amounts and types of support will be needed for different groups of people in order to ensure they have the opportunity to reach their health potential. Causes of inequality and inequity will need to be addressed, including for people who face discrimination on grounds such as age, gender, ethnicity or sexuality.



Source:

The role of local government

The drive to improve health and wellbeing is at the core of the work of all local government. The Health and Social Care Act (2012) made this more visible for upper tier local authorities both with the duty to take such steps as they consider appropriate to improve the health of the people in their area and with the transfer of the public health function back from NHS to local government which took place in 2013. Health and wellbeing boards have become established to act as the principal forum for local health improvement and partnership.

This responsibility for health and wellbeing is not new but rather has a long history. From the Victorian Public Health Acts, it was local government that held the principal responsibility for the health and wellbeing of their populations. This can still be seen reflected in the mottos of several English councils 'Salus populi suprema lex', translated as 'The health and welfare of the people should be the highest law'. Improving health in Victorian times concentrated on developments in sanitation, living and working conditions, and tackling infectious diseases. Local government was clearly best placed to do this and has continued to lead in these areas.

More recently though, the development of effective treatments for illnesses and the creation of the NHS has shifted the focus of health improvement towards hospitals and general practice. Medicines and not communities have been seen as the route to health. However, this view is completely inadequate as has already been shown by the contribution that social determinants make to

people's health. These elements relate closely to the work of councils. Once we see health in its broad context, the central role of local government becomes clear. In particular, the role of councils in tackling the root causes of poor health is shown to be crucial.

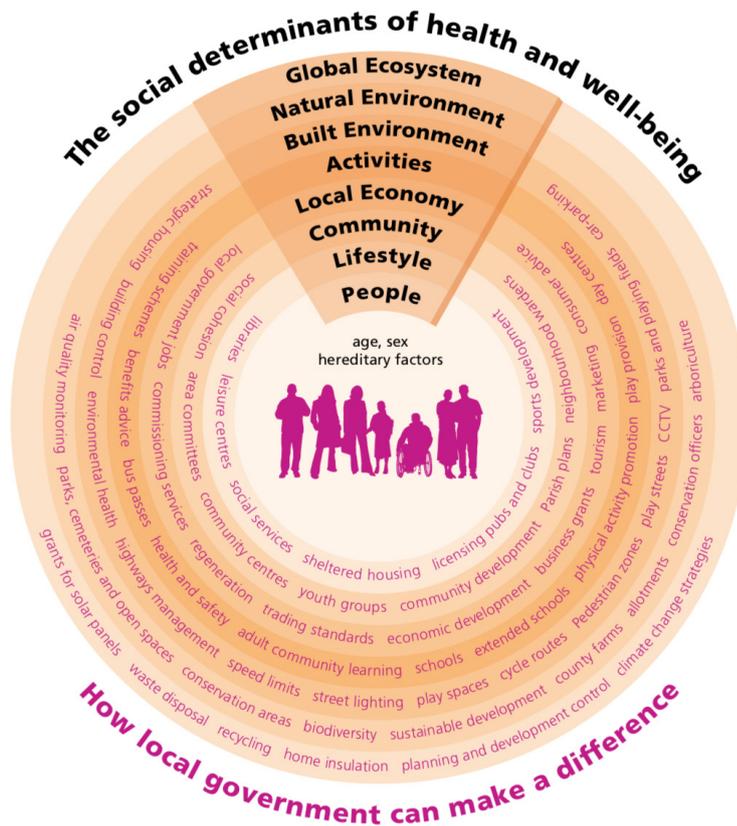
This is made clear in the 10-year review of the Marmot report. 'The social determinants approach continues to be highly relevant to local authorities, particularly given the strong focus on place, wellbeing and cross-sectoral working by local governments, which social determinants approaches require, and which local government is well set up to deliver.'

'The important determinants of health that could effect the change necessary for a substantial improvement in health all lie outside the health sector'⁸

The roles that local government undertakes to improve health through tackling social determinants include: civic leadership; as employer and anchor institution; securing services; planning and licensing; as champion of prevention.

The following diagram shows the widening circles of influence on people's health. These circles are, of course, interpenetrable. For example, your lifestyle 'choices' are influenced, even to a large extent constrained by the social, economic and environmental conditions in which you live.

8 Mytton, O., Aldridge, R., McGowan, J., Petticrew, M., Rutter, H., White, M., & Marteau, T. (2019). Identifying the most promising population preventive interventions to add 5 years to healthy life expectancy by 2035, and reduce the gap between the rich and the poor in England. <https://doi.org/10.17863/CAM.41816>



The actions of local authorities have an influence, sometimes big, sometimes small, in every one of the circles illustrated below and therefore on the health of their residents. The lower half of the diagram shows only some of the local government activities that impact on the social determinants of health in each one of the circles of influence. Some services, of course, such as the planning function, have an influence in more than one circle – in this case potentially impacting on biodiversity, the ‘liveability’ of the environment and opportunities for physical activity and recreation.

Civic leadership

The fundamental importance of the role of councils remains, above all, as the lead organisations for local communities and the leaders for tackling the wider determinants of health. Councils are place shapers and place leaders. Health improvement is generated with civic leadership and local government has responsibilities relating to most of the factors

that affect people’s health. Councils take the lead in local developments and partnerships, building up the assets of communities. This encompasses building up communities through support for local voluntary sector organisations and leadership.

Civic leadership for health improvement includes local sustainable development, supporting the economy and developing jobs, as well as developing the knowledge and skills of local people. It also includes improving community safety, both working directly and in partnership, helping people to feel safe and well.

As part of the leadership for health improvement, many councils have adopted a Health in All Policies approach⁹. Health in All Policies is a method that systematically and explicitly considers the health implications of the decisions we make. It targets the key social determinants of health, looks for synergies between health and other core objectives and the work we do with partners and tries to avoid causing harm with the aim

9 www.local.gov.uk/health-all-policies-manual-local-government

of improving the health of the population and reducing inequity. This is usually combined with a programme of health impact assessment.

As employer and anchor institution

Local government is often one of the largest employers in a community and will also have a significant proportion of routine and manual staff. Working life is a major determinant of health and so councils have the opportunity as employers to improve the health of their own staff with the knock-on effects on their families while also being exemplars for other employers. Good employment practices in general where employees feel valued will improve health, while access to active travel, healthy food and smoke-free environments will be beneficial.

In addition to their role as a local employer, councils are also anchor institutions that provide support across communities. They influence and commission work that employs people more widely in food production and catering, manufacturing and services. Council policy and practice in these areas can support employment and improve health.

Securing services

Local government is responsible for commissioning or providing important services that contribute to improving and safeguarding people's health. These include environmental health and the public health responsibilities transferred in 2013 such as sexual health, substance misuse and children's public health nursing. The role of local authorities goes far beyond these individual service areas, but the knowledge and skills of these local authority staff groups can be crucial in co-ordinating work across departments and in supporting communities to improve their health and wellbeing.

Many more services provided or commissioned by local government contribute to health improvement either directly or through tackling the social determinants of health. The Marmot report centred on the importance of a good start in life and the role of councils is crucial for this, especially for children and families with the most needs. Children who are looked after are an essential consideration for councils in their corporate parent role and their lifelong health can be greatly improved with the right social and educational support.

Vulnerable adults may have some of the poorest health outcomes in the community. For example, women with a learning disability have a life expectancy 18 years lower than women without a learning disability¹⁰. This gap can be reduced through support for housing, educational, employment and social opportunities.

Carers face challenges which affect their wellbeing, these are often linked with social determinants of health. The work of councils in supporting carers has the opportunity to improve their wellbeing and overall health.

An example of work undertaken is in the London Borough of Redbridge, where there are estimated to be 27,000 carers, around 10 per cent of the local population. Carers are supported through the borough's Social Prescribing Service and through voluntary organisations that are commissioned.

Redbridge Council has established a Carers Network for staff which supports their vision of achieving 'One Brilliant Borough' from an end to end organisational perspective all the way into the community. They are working closely with carers themselves, council partners, Clinical Commissioning Group, the voluntary sector and other partners to develop a Carer Friendly Borough.

¹⁰ NHS Digital. Health and care of people with learning disabilities, experimental statistics: 2017 to 2018. 24 Jan 2019. <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2017-to-2018>.

Leisure services provided or commissioned by councils have a direct opportunity to improve health through support for physical activity and they can also be used to tackle health inequalities through programmes aimed at those with the poorest health. Similarly, libraries can act as a hub for improving mental health and providing health improving advice and information. Many council facilities and services can work to combat isolation and loneliness which is a major cause of ill health.

Planning and licensing

Planning and regulating the built environment have a major influence on people's health. The quality of housing and infrastructure and access to jobs and services are vital determinants of health. The promotion of active travel has benefits throughout life, from active school travel plans, through cycling to work, to an active and healthier older age. Homelessness has a huge effect on health, as does the ability to have a warm home. Promoting green space and the natural environment is beneficial for both physical activity and mental health. Access to health services and health promoting activity is important, as is the freedom to avoid unhealthy influences. Several councils have taken the lead in reducing the growth of fast food outlets, especially near schools.

Since alcohol misuse is a major cause of ill health and premature death, it is important to prioritise the reduction in harmful alcohol consumption through a variety of ways in addition to treating addiction. The use of licensing for health improvement is important, even though the powers are relatively limited at present; various opportunities and examples are set out in a recent LGA publication¹¹. The licensing objectives in the 2003 Act are: prevention of crime and disorder; public safety; prevention of public nuisance; protection of children from harm. These all relate to the health of the population.

One example of effective action outlined in the recent publication comes from Cornwall. Cornwall public health raised concerns over the potential impact of a music festival's request to increase its capacity, on public safety and protection of children from harm. The team worked with the applicant and other responsible authorities to negotiate additional conditions to the license. A variety of agencies including public health worked in partnership with the event management team throughout the application process and afterwards to ensure safety measures were in place. This included an increase in the number of volunteers onsite in various welfare roles, alongside the paramedic services. The outcome of this engagement was that safeguarding of young event goers was taken more seriously and thefts decreased.

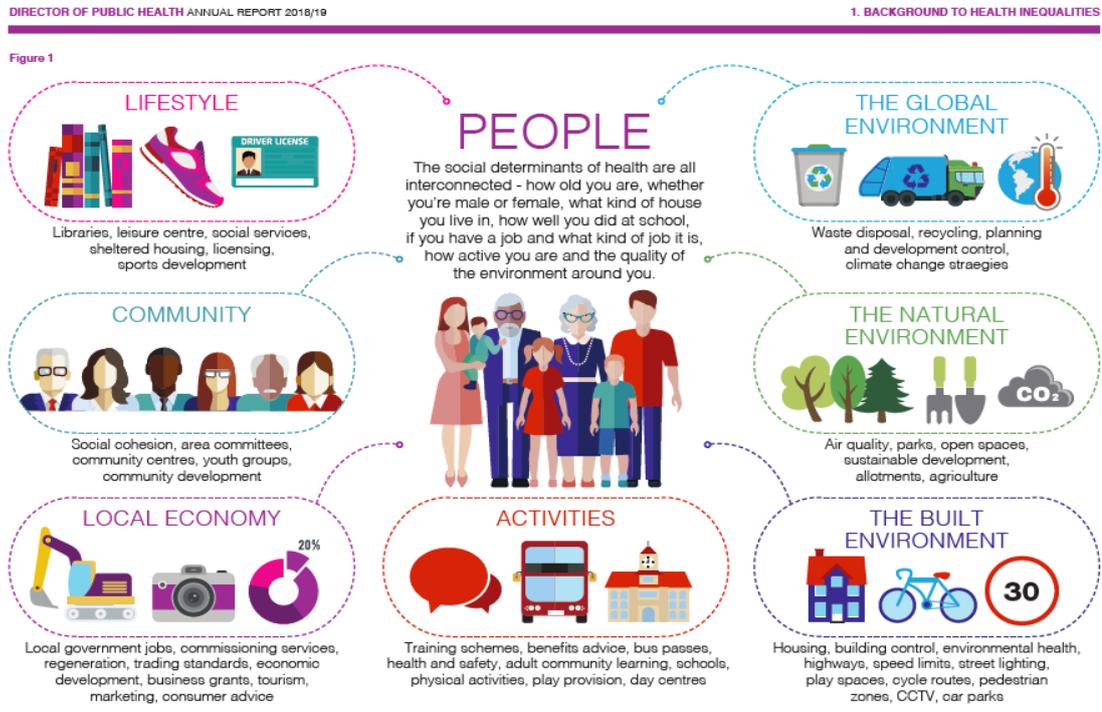
As champions of prevention

Local government actions and services are centred around the improvement of well-being and the prevention of poor outcomes. This is true for children's services, adult social care and economic development among many others. The public health services and responsibilities that transferred to local government in 2013 are principally concerned with prevention. Even when they relate to treatment, such as sexual health and substance misuse, they are designed to prevent further harm in the community. Conversely the NHS remains principally concerned with treatment rather than prevention.

Efficient, effective, cost effective and evidence based preventative interventions and programmes exist and many have the potential for delivering savings in a short space of time. For example, once people stop smoking their risk of heart disease drops almost immediately, while savings from initiatives to reduce harmful alcohol use or manage severe obesity can potentially be realised in the same year that money is spent.

11 Public health and the Licensing Act 2003

Therefore, local government has the opportunity to be the champion for prevention in its place and locality, taking the lead for health improvement through tackling social determinants.



Source: Northamptonshire ADPHR 2018 Designed by Gavin Willis Creative Marketing www.gwcm.co.uk

Case studies

Opportunities for health improvement by tackling the social determinants of health have been taken up across the country. The following detailed examples and case studies express the opportunities for health improvement and what has already been achieved.

Coventry

In 2013, organisations in Coventry committed to becoming a 'Marmot city' with the aim of reducing health inequalities. Differences in health outcomes in the city mean that healthy life expectancy can be as much as 16 years higher in one area compared to another.

The decision to become a Marmot city has provided a platform from which to bring together organisations across the public and voluntary sector. A steering group was set up to drive forward actions across the city to address health inequalities and it reports directly to the health and wellbeing board. The group is co-chaired by the West Midlands Fire Service and Cabinet Lead for Public Health. Coventry's Marmot partners cover interests and sectors across the city and include public health, education and libraries, employment and skills and procurement from Coventry City Council, as well as West Midlands Fire Service, Public Health England, Institute of Health Equity, Voluntary Action Coventry, West Midlands Police, Department of Work and Pensions, Working Together Welfare Reform Group, local voluntary sector partners, Coventry and Warwickshire Chamber of Commerce, Coventry and Warwickshire Local Enterprise Partnership, Coventry Law Centre and Positive Youth Foundation.

Being a Marmot city sets Coventry apart. It makes clear the values that should underpin decisions. The Marmot principles connect to every function of the council and help to communicate the role that everyone has in supporting the health of the community. This has influenced work in many areas such as planning, transport, licensing, housing, procurement, education and early years.

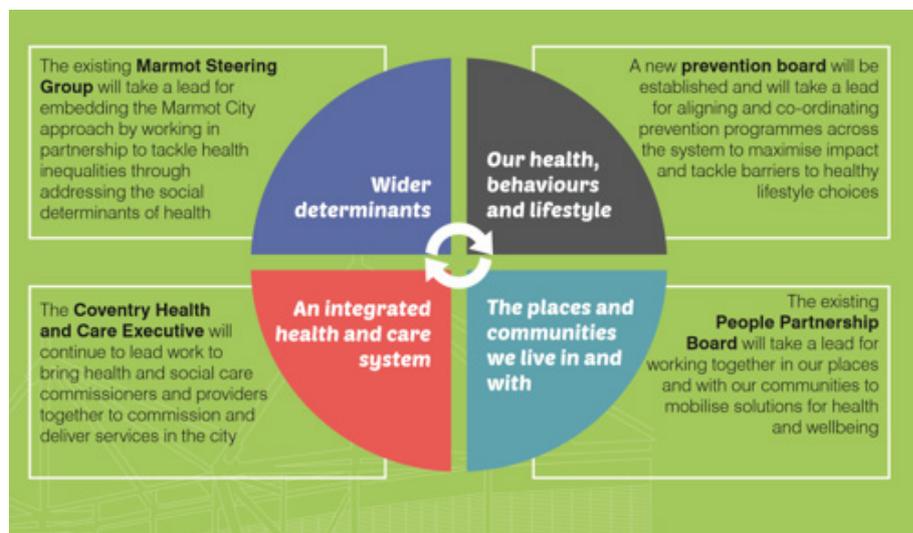
The Marmot work has influenced the council's adoption of the One Coventry approach, whereby the council will be working with partners and the public, sharing resources and looking for opportunities to work together and do things differently. It has been said that 'partnership is now in our DNA as a city' and the commitment to be a Marmot city was renewed in 2016.

Partners recognise the need to break the connection between poverty and poor health and that communities are often best placed to improve health. In their commitment to overcoming the lack of resources and capacity, community assets have been utilised creatively to address local needs.

“Health must not be viewed in isolation. We recognise the importance of education, good work, affordable and appropriate housing, leisure opportunities and a healthy environment to the quality of life of local people.”¹²

The importance of the Marmot principles and tackling the social determinants of health is

¹² Coventry Health and Wellbeing Strategy 2019-2023



Source: Coventry Health and Wellbeing Strategy 2019-2023

shown in the population health management approach that Coventry have adopted, building on work from the King's Fund. The Marmot Steering Group takes the lead for addressing social determinants as one of the four enablers of the population health management framework.

One of the many examples of specific activities in Coventry aimed at tackling the social determinants of health is the Job Shop: The Job Shop provides a service which is open to everyone living in Coventry. In working with customers, staff identify those who have lower and moderate levels of need and those who are more vulnerable, with higher levels of need. Services are then offered according to levels of need, with those who are assessed as being furthest from the job market able to access a wide range of services suited to their needs. So, the service is universal but targeted proportionately to those in greater need. There are 6.6 per cent more Coventry residents in work than seven years ago when the Job Shop opened.

The Marmot city approach in Coventry has been evaluated and outcomes studied. It is likely to be too early to be sure of population level outcomes, but there are encouraging signs. Healthy life expectancy is improving, and the city now ranks high compared

with statistical neighbours on this measure. Fewer Coventry neighbourhoods are now amongst the 10 per cent most deprived in England; 18.5 per cent of the city's Lower Super Output Areas were amongst the 10 per cent most deprived in 2015 (rank: 46th) and this has improved to 14.4 per cent in 2019 (rank: 64th). Across the West Midlands Region, only Coventry and Staffordshire saw an improvement in the relative ranking at the local authority level.

In addition to the population-wide outcomes there are many individual pilots and programmes that have contributed to a reduction in health inequalities. The approach to health in the city has changed and this can only have been a beneficial contribution to securing benefits such as UK City of Culture 2021.

Moving forward Coventry will continue to work with partners taking a Marmot Approach to improving health inequalities, building on existing strengths and alignment of priorities across the public, private and voluntary sector and Coventry will be working with other councils who want to develop this approach.

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Liverpool City Region Wealth and Wellbeing Programme

Summary

Liverpool City Region (LCR) covers a population of approximately 1.5 million and functions as a city region with a Combined Authority. The six council areas that make up the city region are Liverpool, Halton, Sefton, Wirral, Knowsley and St Helens.

The Wealth and Wellbeing Programme in Liverpool City Region had its initial drive in the established link between work and health. Being in work is, generally, better for an individual's health than not being in work and better still if that work is shaped and structured in a way that enhances the health of employees.

From that starting point the programme developed the link between low productivity, a major concern of economic planners, and poor health and quantified the impact of poor health in terms of lower economic output. It was then a short step from knowing that the way the economy functions has a major impact on the health of the population to exploring just what it would mean if we started measuring economic success in terms of wellbeing outcomes.

The programme is now progressing to propose further investment in employee support programmes to help people suffering now from lack of employment owing to poor health and to develop with people in communities what it would mean to plan the economy around wellbeing and to shape the changing world of employment so that the needs of employers and employees are best met through a focus on a health enhancing workplace.

Productivity and health

Building on the National Health Science Alliance Wealth and Health report with further analysis by University of Liverpool it was possible to quantify the impact of poor health on economic productivity in several ways. When looking at the gap in productivity

between the economy of the LCR and the rest of the country this analysis found that 33 per cent of the gap can be attributed to ill health. This equates to £3.2 billion in lost gross value added and that is about 10 per cent of the total economic output of the LCR economy on an annual basis.

Further analysis by Public Health England made it clear that the major impact of health on the economy is through mental ill health and some way after that through musculo-skeletal problems. A work and health profile was produced for the city region and for each of the six boroughs that make up the city region.

Connecting across the system

Early in the programme the council leadership advised that the work should progress through engaging with communities and the bringing together of parts of the system that might not usually have much interaction. The emphasis was on a system leadership approach that invited views from as wide a range of perspectives as possible.

This approach took its most tangible form in six workshops, one in each of the six boroughs, on a different aspect of the wealth and wellbeing programme. The intention was to place less emphasis on the presentation of good practice, although that is important at times, and to provoke discussion by posing questions. Workshop themes included links to the environmental agenda and asked whether it was more important to have a good job for everyone or a good quality environment for everyone. The workshops helped to engage people in discussion on work, health and the economy that would not otherwise have happened.

A compelling narrative

It is important, in any programme that is considering large scale change, to have a good understandable story at the core of the programme. It is crucial that, in this case, the story is built upon the views of people most affected by the current state of work and health. A commission was made to gather the

views of around 40 people across the region who are experiencing the impact of ill health on employment. This has been written up in a report and presented in a video. It is the basis for development of a story about work, health and the economy in the LCR that will become a compelling narrative for change.

What to do?

A review of the evidence base on health and work showed good evidence for employee support programmes, particularly individual placement and support schemes for people with severe mental illness, but also others, as a sound investment to support people with health problems to engage with work again. Building on the good practice in the region in this area will be a feature of the programme as it moves into the next decade.

Much is being done through Fair Employment Charters, Healthy Workplace Charters and other activities to shape the workplace to be better for the health of employees. The Wealth and Wellbeing programme will bring a stronger health focus to this work in LCR and will take onboard the national reviews of the changing world of work to ensure that health for its own sake, and because we know that a healthy workforce is better for business, is prioritised.

Finally, the programme has tapped into the national and international interest in wellbeing economics. In 2020 we will be engaging across the communities, health services, employers and councils of LCR to ask what would it mean to have wellbeing at the core of economic planning for a city region; what would be different from the current focus of economic planning; what different priorities, actions and investment could follow if the main goal of economic planning was population wellbeing?

By asking questions and inviting views from any quarter that is interested we believe that we stand a better chance of making a difference. We are establishing the belief that an economy that functions effectively for everyone is better for health and wellbeing

and a population with better health and wellbeing is better for an effective and fair economy. And that economic planning is a legitimate interest of anyone interested in a healthier population.

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Wigan

The new relationship generated in Wigan between residents and their public services known as the Wigan Deal has received widespread praise and awards. The focus has often been on service transformation and the capacity to maintain and improve the services delivered to residents in the face of austerity. However, improvement in physical and mental health is also a crucial part of the work in Wigan. The Wigan Deal for Health and Wellness has roles and responsibilities for both public sector services and for residents. The aim is to maximise health and wellbeing through the following methods: developing leadership and culture change; commissioning levers; investment in health and wellbeing services; developing staff skills and competence; staff health and wellbeing; asset-based community development for health.

Creating community health and wellbeing using the assets of the community is at the heart of the work. It is about co-production and respecting every citizen and about working together so that people can reach their full potential. The deal is essentially about the health of the public and the culture of health improvement is being embedded within all organisations. Health is being seen by residents as more about a happy and healthy place to live and less about NHS

services. It is inevitable that this approach will tackle the social determinants of health, since they are what the local people recognise as being of prime importance in the health and wellbeing of the local community.

“The deal is a great vehicle for health and wellbeing being core to everything.”

Building up a community narrative is vital both for residents and services. It is about identifying the assets within the community that meet community solutions. It is about finding resilience rather than deprivation and is about using insight from communities together with intelligence gained from studying small geographical areas (Lower Super Output Areas) with up to date information. This means that local people and their elected councillors can link their own local narrative with what is happening at borough level.

Investing resources follows the same principles of focusing on community assets and community narrative. The pooled budget of the ‘Wigan pound’ is invested in communities with intelligent use of expert advice and evidence, building on community assets and aspirations and not telling people what to do. This is helped by peer mentoring and continuing conversations with communities. Health outcomes have been easily woven into community investment plans and the ethos of health improvement has spread to the extent that questions have come from communities about how work will meet public health outcomes.

The community is seen as the solution to health improvement and indeed the concept of the anchor community has been put forward in Wigan mirroring the idea of an anchor institution. An anchor community is a set of assets and relationships that are essential to the way that part of Wigan works.

The success of the approach undertaken in Wigan will take many years to show full effects, but it is beginning to be shown in health outcomes for the borough. For example, the rate of smoking is low and the

gap between smoking rates between the population as a whole and routine and manual workers is the smallest in Greater Manchester. When it comes to healthy life expectancy the progress appears considerable. Since 2009/2010, female healthy life expectancy in Wigan has risen by 20 months and male healthy life expectancy by 26 months. This is closing the gap on the national figure and is better than geographical and statistical neighbours.

For further information:

www.wigan.gov.uk/Council/Strategies-Plans-and-Policies/Public-health.aspx

Bristol One City Approach

The innovative Bristol One City Approach brings together a huge range of public, private, voluntary and third sector partners within Bristol. They share an aim to make Bristol a fair, healthy and sustainable city, a city of hope and aspiration, where everyone can share in its success. It is in this vein that the One City Plan was developed in 2019. The plan sets out the city’s key challenges up to 2050 and brings the city together around a shared vision. The plan is a living, breathing document that is refreshed annually. Drawing from feedback, input and consultations from a wide range of stakeholders and communities throughout the year, the city office has produced the second iteration of the One City Plan for 2020. The interdependent challenges of growing an inclusive, sustainable city that both resolves social fractures and inequalities and reaches carbon neutrality sit at the heart of the future. They are stitched throughout the plan.

The plan adopts the form of six interdependent themes: connectivity, environmental sustainability, learning and skills, economy, homes and communities, and health and wellbeing. Each strand is owned by a multi-agency thematic board of experts, who regularly meet and interact to explore interconnections and work together to address challenges. The one

city approach promotes systems change by facilitating participation and collective leadership between many different sectors and organisations. In doing so it brings clarity on what the city is trying to achieve together, creates extra resilience, creates new space to solve complex city challenges more efficiently, and increases the sustainability and scalability of new innovations.

The health and wellbeing board has played a pioneering role in this approach, working with the other one city thematic boards and organisations across different sectors in order to meet the ever-changing needs of the communities and improve wider determinants of health. Reducing inequalities in health between the most and least economically deprived areas of Bristol is central to the board's vision. The board has had input into several initiatives to address poverty including the Fuel Poverty Action Plan and plans for Bristol to become a Living Wage City. Connectivity to the other thematic boards is crucial in order to address these social determinants of health. For example, in 2019 the board held a housing and health development session with the Bristol Homes Board. The board is also working collaboratively with the environment board to ensure 30 per cent of fleet are non-fossil fuel in public sector organisations by 2026, and with the learning and skills board to support the links between health and literacy.

In 2020, the three key priorities for health and wellbeing are:

1. An updated community and cross-sector approach to tackle hate crime has been adopted across the city to help agencies coordinate prevention activities and reduce hate crime
2. Bristol is on the way to becoming an Adverse Childhood Experience (ACE) aware city with 20 per cent of the public sector workforce trained in trauma informed practice
3. Fifty organisations will have committed to adopting and implementing the mental health at work core standards

They know that it is simply not possible to achieve any of these goals by working in silos, but only if the scale of their ambition is matched with a joined up, place-based approach that integrates the collective resources and efforts of all partners. The approach has resulted in a number of wellbeing successes in 2019, including the launch of a world leading approach to tackling period poverty and period stigma, Period Friendly Bristol (PFB). PFB includes both a donation and distribution network of period products, with a web app telling people where they can get products for free if they need them. It also includes a pioneering education programme, designed collaboratively by Bristol City Council, The Real Period Project, a menstrual education charity, and City to Sea, a Bristol based sustainability organisation tackling single use plastics. The education programme, along with free training and resources, has now been offered to all schools in Bristol. Other achievements for the approach include 16 organisations in Bristol, including Bristol City Council, committing to tackling mental health stigma and discrimination through signing the Time to Change Employer Pledge, and the World Health Organization's acceptance of Bristol's application to become a member of the Global Network of Age-friendly Communities.

For further information:

Visit the Bristol One City website to find more about the approach and to view the One City Plan Dashboard, which provides a filterable, searchable catalogue of the goals in the Bristol One City Plan.

Hertfordshire

County and district councils in Hertfordshire have a strong partnership aimed at health improvement. This work includes healthy hubs, where the context is to provide a one-stop-shop that delivers or hosts a range of health improvement services from central or multiple locations. In addition to service delivery, there is a longstanding recognition in Hertfordshire of the importance of housing and the built environment in the health of the population. It is clearly recognised that health improvement is not the responsibility of public health alone, but that a range of disciplines can work together with their own specific strengths.

Hertfordshire has produced health and wellbeing planning guidance which sets out the fundamental importance of planning in improving the health of the population. It is grounded in health impact assessment, Marmot principles and the work of the Town and Country Planning Association. The guidance includes consideration of air quality, food and healthy choices, housing and development design, neighbourhood and community spaces, movement and access, local economy and employment and quality open space, play and recreation.

Health impact assessment (HIA) is an important feature of the work. A county council position statement was adopted in November 2019 that sets out clear guidance to planners and developers in the absence of national guidelines for HIAs. The intention is to establish a consistent approach and increase the quality of HIAs submitted with planning applications.

Public health within the county council is also working with four local planning authorities using expert facilitation from the Town and Country Planning Association to help the authorities build health and wellbeing policy provisions into their local plan making process.

One example where having a health and wellbeing policy in a local plan can directly influence strategic growth is the development of 10,000 new homes in East Hertfordshire where Hertfordshire has been working with

East Herts District Council, Essex County Council (public health) and Harlow Borough Council as part of a much wider area of growth. So far this has seen the development of the Harlow and Gilston Healthy Towns Framework and engagement with developers on HIA and a health strategy that supports the wider determinants.

Housing quality has also been addressed. In support of the Hertfordshire Health and Wellbeing Strategy, a housing quality working group has been established involving county council public health, borough and district council environmental health, clinical commissioning groups, NHS Community Trust and fire and rescue. Out of this has developed the Herts Warmer Homes Scheme which levers government ECO funding to target excess winter deaths and tackle poor health outcomes resulting from cold homes and fuel poverty. Commissioned and delivered by public health on behalf of Hertfordshire's 10 district and borough councils, the scheme has been running for three years and has so far received 913 referrals. By January 2020 there were 151 completed installations and 35 pending installations, with some qualitative evidence of improved health outcomes. The scheme is expected to continue with district and borough councils taking ownership of its delivery.

Continuing professional development training on housing quality is a more recent initiative. It has been designed for health and social care professionals visiting people in their own homes and is very much intended as a preventative intervention. The training has been enabled and facilitated by public health but delivered by environmental health colleagues. The sessions have been well received and the teams are looking to broaden the audience. A crucial element of the training has been ensuring that health and social care professionals are confident in their ability to direct residents to the most appropriate environmental health or housing services.

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Please see page 2 onwards for background to items

17th June 2020
Covid-19 - Impact, Reset and Recovery
8th July 2020
Sustainability and Climate Change
29th July 2020
Education and Vulnerable Children
19th August 2020
Not required
16th September 2020
Jobs, Regeneration and Economy Draft Scrutiny Annual Report 2019-20
7th October 2020
Health Inequalities
4th November 2020
Covid-19 Behaviour, Compliance and Enforcement
Future items to be identified according to emerging priorities
9th December 2020
13th January 2021
10th February 2021
10th March 2021
21st April 2021
Dates to be identified
Climate Change Digital Skills One Coventry Plan City of Culture 2021 Brexit Policing and Community Safety Centre for Public Scrutiny – Scrutiny Review outcomes

Date	Title	Detail	Cabinet Member/ Lead Officer
17th June 2020	Covid-19 - Impact, Reset and Recovery	To consider the current position, plans for re-set and recovery and identify areas for further scrutiny	Cllr Duggins Gail Quinton
8th July 2020	Sustainability and Climate Change	Scruco will consider the interrelationships between air quality, travel, transport, access to education and employment, health and inequalities, etc Scruco will want to ensure the new normal maximises benefits to all and makes a positive contribution to climate change and a sustainable future for the city and its residents.	Cllrs O'Boyle, Hetheron, Caan, T Khan Andy Williams Brett Willers Andrew Walster Colin Knight
29th July 2020	Education and Vulnerable Children	Scruco will consider the impact of school closures on education and wellbeing of children and young people, especially those from vulnerable families	Cllrs Maton, Seaman Kirston Nelson John Gregg
19th August 2020	Not required		
16th September 2020	Jobs, Regeneration and Economy	To consider the impact of Covid-19 and implications for recovery and re-set on jobs regeneration and the economy. To invite members of SB3 as well	Cllr O'Boyle Andy Williams
	Draft Scrutiny Annual Report 2019-20	To consider the draft annual report before it goes before Council	Cllr Brown Adrian West
7th October 2020	Health Inequalities	To consider the impact of Covid-19 and implications for recovery and re-set on health inequalities. To invite members of SB5 as well	Cllr Kamran Caan Liz Gaulton
4th November 2020	Covid-19 Behaviour, Compliance and Enforcement	A item how the guidance and restrictions as a result of Covid-19 are being managed in the City.	Cllr AS Khan
Future items to be			

SCRUCO Work Programme 2020-21

Date	Title	Detail	Cabinet Member/ Lead Officer
identified according to emerging priorities			
9th December 2020			
13th January 2021			
10th February 2021			
10th March 2021			
21st April 2021			
Dates to be identified	Climate Change	To follow up from the initial meeting on 8 th July	Cllr O'Boyle Bret Willers
	Digital Skills	To look in more detail how steps being taken to improve digital skills, to narrow the digital gap and to ensure there are sufficient skills in the job market to meet future demand	Cllr Hetheron Cllr Maton Cllr Lloyd
	One Coventry Plan		Cllr Duggins
	City of Culture 2021	An update on progress and impact of Covid-19	Cllr Duggins
	Brexit		
	Policing and Community Safety	To include plans for City of Culture 2021	Helen Kirkman (WMP) Joy Adams Cllr AS Khan

Date	Title	Detail	Cabinet Member/ Lead Officer
	Centre for Public Scrutiny – Scrutiny Review outcomes	The CfPS undertook a scrutiny review during 2019-20. This item will consider the recommendations and next steps.	Cllr Brown Adrian West