
To: Coventry Health and Wellbeing Board

Date: 27 July 2020

From: Liz Gaulton, Director of Public Health and Wellbeing

Title: Disparities and COVID-19

1 Purpose

- 1.1 This report proposes steps for the Health and Wellbeing Board to take in response to national evidence showing the unequal impact of COVID-19 on different groups.¹

2 Recommendations

- 2.1 To agree that the Marmot Partnership Group take the strategic lead on supporting the system to address health inequalities relating to COVID-19.
- 2.2 To agree that 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 COVID-19 has had on people from Black, Asian and minority ethnic (BAME) groups.
- 2.3 To request that the Marmot Partnership Group provides a progress update in 6 months.
- 2.4 To consider how Board members may together add value through reviewing COVID-19 related inequalities through the lenses of our employees and wider communities.

3 Information/Background

- 3.1 The COVID-19 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 PHE undertook a rapid review into disparities around the risk and outcomes of COVID-19 that explored risk factors including age, sex, ethnicity, co-morbidities, deprivation and occupation.² Building a picture of different risk factors and their relative size is important because no one person or group is defined by a single characteristic. A short summary on selected risk factors associated with increased risk of death from COVID-19 from selected PHE and Office for National Statistics (ONS) reports can be found in Appendix A.

¹ Public Health England. [Disparities in the risk and outcomes of COVID-19](#). London: PHE; 2020.

² Public Health England. [Disparities in the risk and outcomes of COVID-19](#). London: PHE; 2020.

- 3.3 National analysis has shown that people from most BAME groups have a higher risk of dying from COVID-19 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 groups.⁴
- 3.4 As part of their disparities report, PHE engaged with over 4,000 people to understand their views on the reasons for the inequality for those in BAME groups.⁵ This led them to propose seven recommendations:

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/coronaviruscovid19relateddeathsbymethnigroupenglandandwales/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 Public Health England. [Beyond the data: Understanding the impact of COVID-19 on BAME groups](#). London: PHE; 2020.

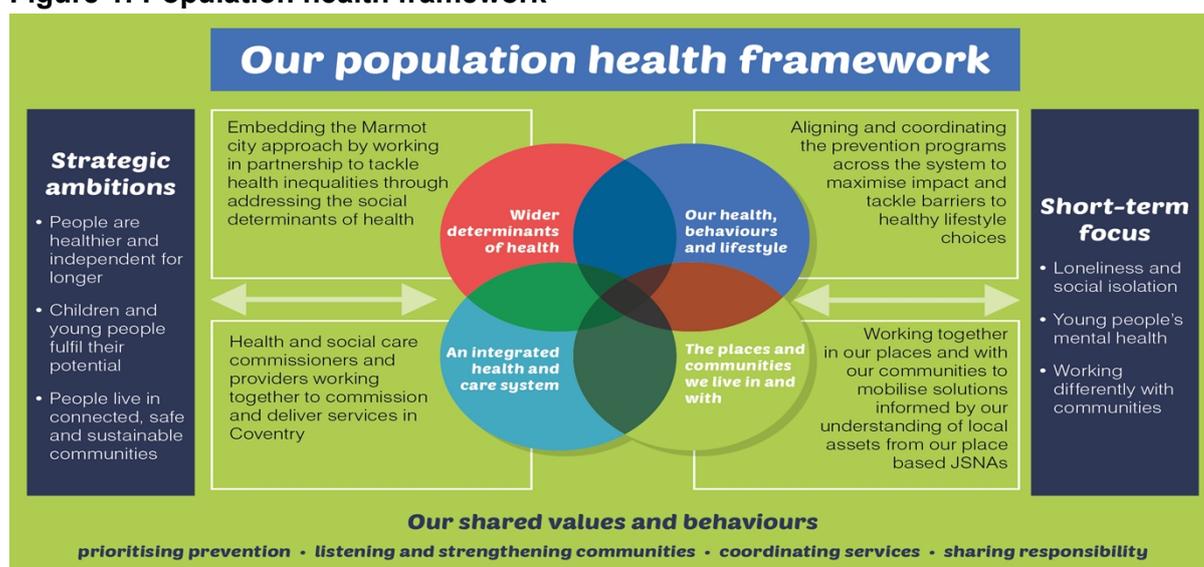
1. *Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.*
2. *Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.*
3. *Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.*
4. *Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.*
5. *Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.*

6. *Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.*
7. *Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.*

4 Factors underpinning recommendations

- 4.1 In Coventry, there already exists a multi-agency group that works to reduce health inequalities: the Marmot Partnership Group.
- 4.2 The Joint Health and Wellbeing Strategy that was adopted by the Health and Wellbeing Board last year is based around four pillars (Figure 1).⁶ One of these is to address the wider determinants of health, such as income deprivation and housing. This work is being led by the Marmot Partnership Group and, as such, the group is well placed to take the strategic lead on work to reduce health inequalities associated with COVID-19, including the local implementation of the PHE recommendations.
- 4.3 Nonetheless, this work, and the recommendations, touch on all four pillars in Figure 1 and so there would be a need for collaboration with other groups, such as the One Coventry Board, which oversees work on the bottom right pillar ('The places and communities we live in and with').

Figure 1: Population health framework



Source: Coventry Health and Wellbeing Strategy 2019–2023

⁶ Coventry Health and Wellbeing Board. [Coventry Joint Health and Wellbeing Strategy 2019-2023](#). Coventry: Coventry City Council; 2019.

- 4.4 The Marmot Partnership Group is in the process of setting up a subgroup to look at inequalities for BAME groups, aiming to develop two to three actions in relation to these recommendations and also to identify and share good work that is already happening. Other subgroups around the COVID-19 inequalities response are also being determined.
- 4.5 Organisations represented on the Health and Wellbeing Board will already be taking action in the area of COVID-19-related inequalities and it is proposed that this will be enhanced through a co-ordinated review through the lenses of our employees and wider communities.
- 4.6 Examples of local actions that have been taken in recent months include:
- the COVID-19 health impact assessment, being conducted jointly with Warwickshire County Council, considers health inequalities
 - the Coventry local outbreak implementation plan explicitly considers the need for community engagement to build trust and participation, including culturally appropriate messaging, which links to the fifth BAME report recommendation⁷
 - Migrant Health Champions have been helping to spread COVID-19-related messages within their communities
 - Coventry City Council has undertaken a Talent Inclusion and Diversity Evaluation (TIDE) self-assessment to assess how well it fosters diversity and inclusion in its workforce.
- 4.7 While the PHE recommendations will provide a framework for specific action to reduce inequalities for BAME groups, the remit of the Marmot Partnership Group will continue to be focused on reducing COVID-19-related inequalities across all sectors of our population.

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⁷ Coventry City Council. [COVID-19 Outbreak Control. Coventry Local Outbreak Implementation Plan](#). Coventry: Coventry City Council; 2020.

Appendix A: COVID-19 and inequalities

PHE's review into disparities in risk and outcomes from COVID-19 was published in early June 2020.⁸ A multivariable survival analysis within this assessed the risk of death among those with a positive test result (based on Pillar 1 testing), which meant that factors other than the risk factor of interest could be accounted for.⁹

The largest single risk factor in this analysis was age. Relative to those aged under 20, the risk of dying among those with a positive test result was three times higher for those aged 40–49, nine times higher for those aged 50–59, 26 times higher for those aged 60–69, 50 times higher for those aged 70–79 and 70 times higher for those aged 80 and above.¹⁰ Age was also the largest risk factor in an analysis restricted to those of working age (defined as ages 20–64).

Sex was also a risk factor; the risk of dying given a positive test result was over 50% higher in men than women. In the working age population, this risk was almost twice as high for men than women.¹¹

Deprivation also affects risk: in people of working age with a positive test, relative to those living in the least deprived quintile, people living in all other deprivation quintiles had at least a 32% increased risk of death, with people in the most deprived quintile having approaching double (93% increased risk) the risk of dying relative to those living in the least deprived quintile.¹² In the all-age analysis, this relationship was weaker, and only those living in the most deprived or second most deprived quintiles had a significantly greater risk of dying than those in the least deprived quintile, by 16% and 10% respectively.

By ethnic group, the largest disparity identified in the PHE analysis was in people of Bangladeshi ethnicity, who had twice the risk of death compared with those of White British ethnicity, while people of Pakistani ethnicity had a 44% increased risk of death. Significant increased risks were also found for people of Chinese, Indian, Other Asian, Black Caribbean, and Black Other ethnicity relative to those of White British ethnicity. People of White Irish ethnicity had a lower risk of death relative to those of White British ethnicity. This analysis accounted for age group, sex, region, and deprivation quintile, but not co-morbidities (including obesity) or occupation.

Another analysis by the ONS found a significantly higher risk of COVID-19 mortality in most BAME groups relative to people of White ethnicity.¹³ This analysis was on deaths 'involving COVID-19' (it did not require this to have been confirmed by a test) and used fewer ethnic groupings than the PHE analysis.

When the data was adjusted for age and split by gender, the ONS found significantly higher risks in people of Black, Bangladeshi or Pakistani, Other, Indian, Mixed, and Chinese (men only)

⁸ Public Health England. *Disparities in the risk and outcomes of COVID-19*. London: PHE; 2020. Pillar 1 tests (patients and healthcare staff) up to 13 May 2020.

⁹ Pillar 1 tests (patients and healthcare staff) up to 13 May 2020.

¹⁰ This accounted for sex, ethnicity, region, and deprivation quintile, but not co-morbidities (including obesity) or occupation.

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¹² This analysis accounted for age group, sex, ethnicity, and region, but not co-morbidities (including obesity) or occupation.

¹³ 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>]. Accessed 2020 Jul 02.

ethnicity relative to those of White ethnicity. The highest increased risk was in those of Black ethnicity, with mortality rates 3.3 times higher in Black men than White men and 2.4 times higher in Black women than White women.

The ONS found that some, but not all, of the association could be accounted for by socio-economic, household and geographical characteristics and factors relating to occupation; after accounting for these characteristics, there remained a smaller but still significant increased risk for those of Black, Indian, Bangladeshi or Pakistani (men only), and Other (men only) ethnic groups. In this adjusted model, the rates remained highest in those of Black ethnicity and were 2.0 times higher in Black men than White men and 1.4 times higher in Black women than White women.

A different ONS analysis on occupation has found that certain occupational groups and specific occupations have had higher mortality rates from COVID-19, presented separately by sex and accounting for age but not other factors.¹⁴ In men, specific occupations with higher mortality rates included taxi drivers and chauffeurs, bus and coach drivers, chefs, and sales and retail assistants. For women, this included sales and retail assistants. Both men and women working in social care had increased death rates.

¹⁴ Office for National Statistics. Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020 [<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020>]. Accessed 2020 Jul 09.