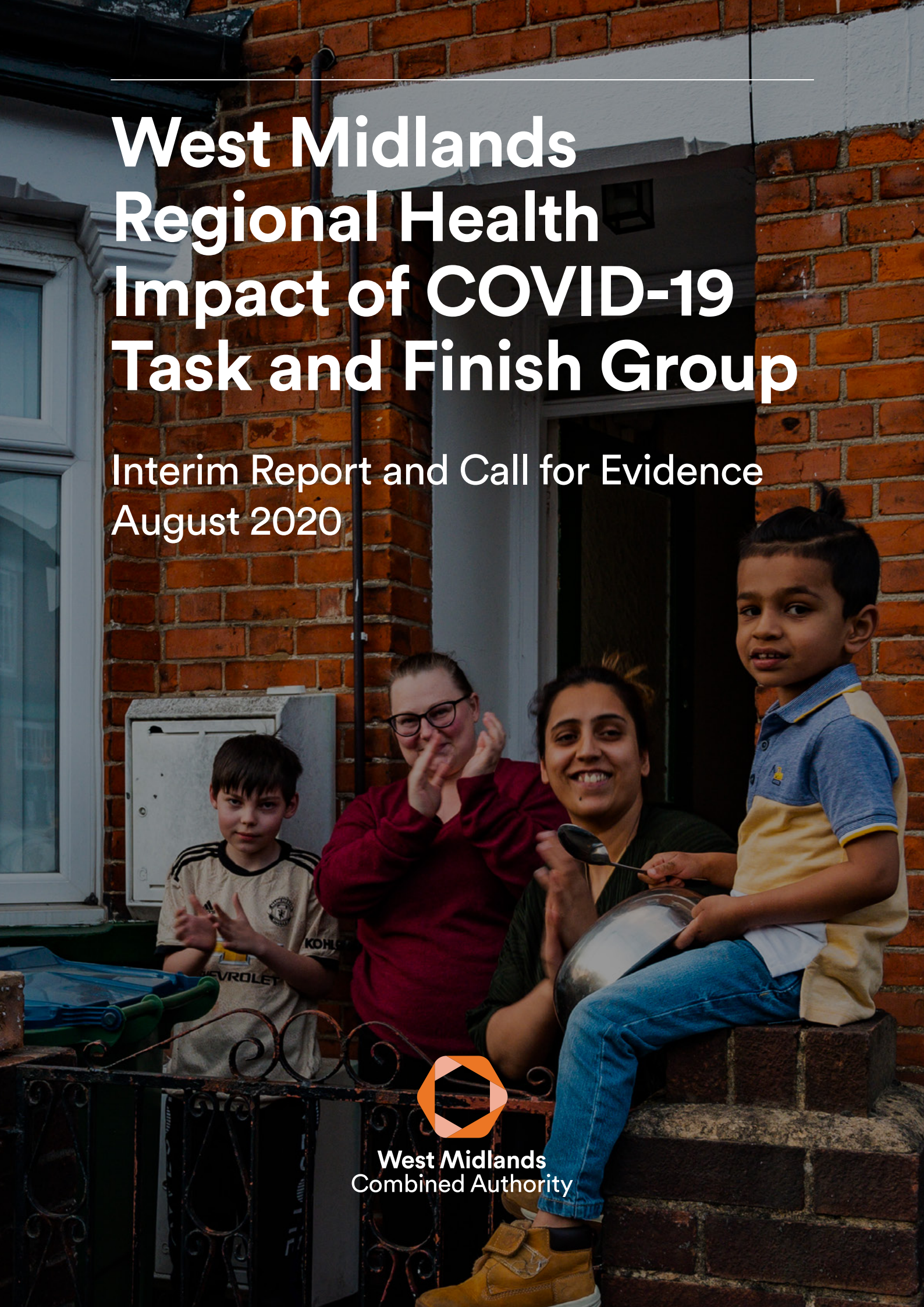
West Midlands Regional Health Impact of COVID-19 Task and Finish Group

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, communty 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 multivariant 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 area[3] 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%).

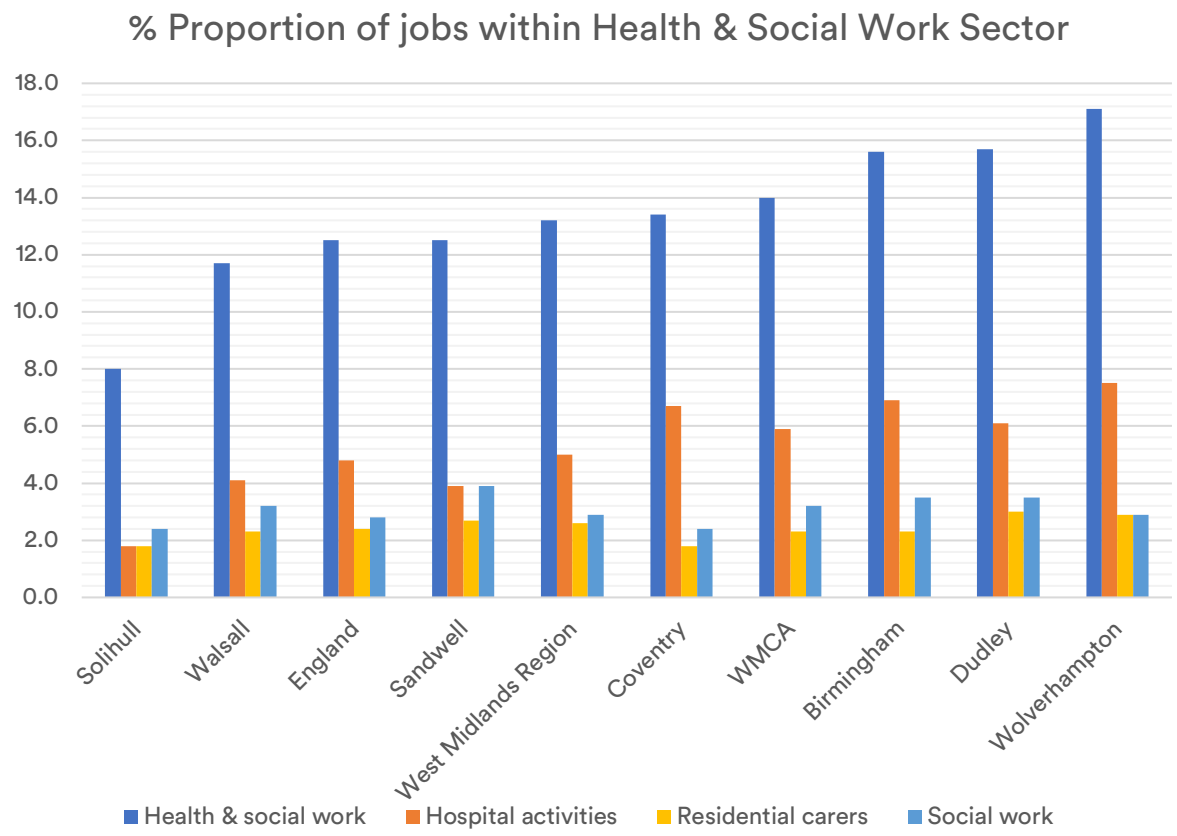

Figure 1

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 Region[4], 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%).

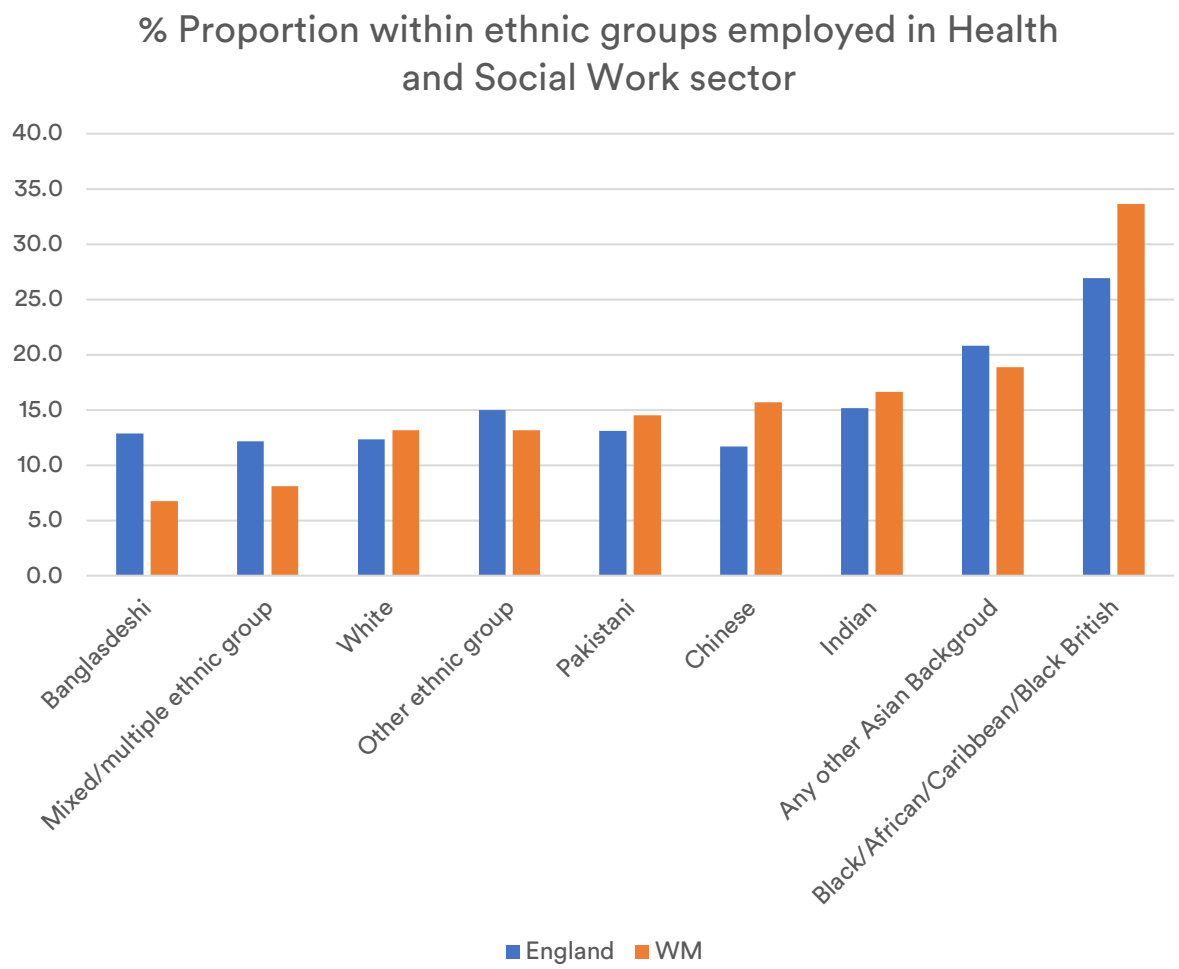

Figure 2

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 area[6] 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 Region[7], 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 estimated[8] 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 area[9], 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 Region[13] 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 Region[14], 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 Midlands[15] 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 area[17], 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 area[18], 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 Region[20] 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 ratings[24] 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

Research[26] 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 area[27] 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 2021[28]

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 area[29] 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 Midlands[31], 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 area[37] 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 Midlands[39], 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 area[42] 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 estimated[43] 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 estimated[44] 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.

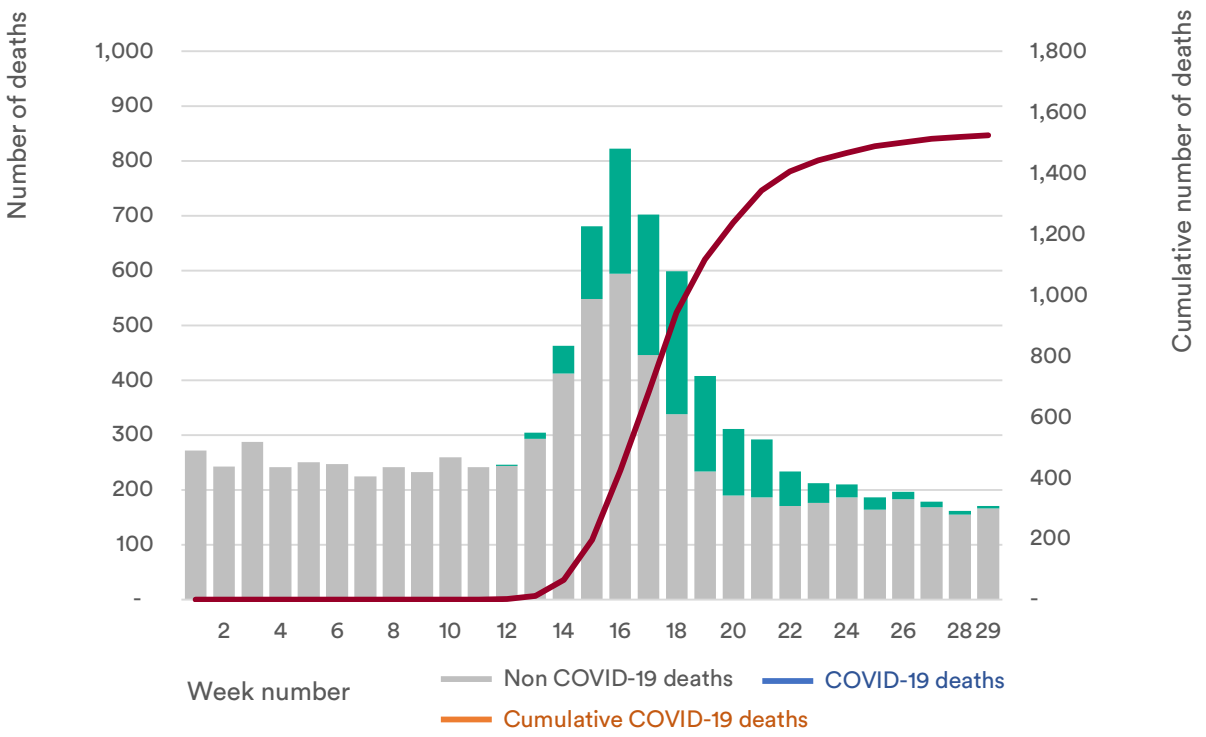

Figure 3 - Trend in numbers of deaths by cause and cumulative COVID-19 deaths, deaths that occurred up to 17 July 2020 but were registered up to the 25 July 2020, by week, where place of death was recorded as 'Care Home', West Midlands ONS region[50]

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 obesity[51]
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 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 incresing 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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