Briefing Note

CITY OF WOLVERHAMPTON COUNCIL

Title: COVID-19 and BAME Groups **Date: 8 July 2020**

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Intended Audience: Internal ☒ Partner organisation ☒ Public ☒ Confidential ☐

1.0 Purpose

1.1 The purpose of this briefing is to provide an overview of the current issues and considerations in relation to the apparent differential impact of COVID-19 on BAME groups, at a national level, and specific to Wolverhampton.

1.2 Data and evidence are emerging, and although some key findings to date have been highlighted, it is important to recognise that conclusions may change as new knowledge is generated and findings are collated and interpreted, and that more work is needed to understand why differences have been observed, and what we need to do in response.

2.0 Summary of findings to date

National findings

2.1 A variety of reports have provided support to the observation that people from BAME groups are disproportionately affected by COVID-19. After taking account of age, socio-demographic characteristics and some measures of self-reported health, The Office for National Statistics (ONS) found the risk of a COVID-19-related death for people of Black ethnicity was 1.9 times that of White people. For Bangladeshi and Pakistani men and women, the risk was 1.8 and 1.6 times higher than for White people respectively.

2.2 A review published by Public Health England highlighted that age is the predominant factor associated with risk of death from COVID-19. Male sex, deprivation, and being from BAME groups were also associated with increased risk to a lesser extent.

2.3 Although relative risk of admission or death may be increased, absolute risk still remains low for individuals. This is especially true for younger people, since age is the strongest determinant of risk from COVID-19. The majority of people who are infected only have mild to moderate disease, and in fact some have no symptoms at all.

Local findings

2.4 In Wolverhampton, 35.5% of the population is from a BAME group (2011 Census), 18% are Asian, 5% are Mixed, 2% are Other, and 7% are Black. The age and sex profiles differ considerably by ethnic group.

2.5 Information provided by The Royal Wolverhampton NHS Trust shows that the majority of people treated for COVID-19 in Wolverhampton are of White ethnicity.

2.6 After taking age into account through age-standardisation (looking at the numbers we would expect in each group if the population age profiles were the same) and after looking at the proportions of people from BAME groups admitted compared with the proportions in the underlying population, these figures indicate that Black people are more likely to have been admitted to hospital with COVID-19 in Wolverhampton. This methodology accounts for age, but not for underlying health conditions or other factors which can affect risk (such as occupation), and so should be interpreted with a degree of caution.

3.0 Discussion

3.1 Combining all BAME groups together could create misleading findings, because BAME people are not a homogenous group; disaggregation (looking at subgroups, such as Pakistani, separately) should be done where possible. Data limitations at a local level mean that conclusions for subgroups are less reliable; relatively small numbers of cases and deaths, lead to a larger degree of uncertainty around estimates of risk.

3.2 Confounding factors (factors that vary by group and are related to the outcome, like age) make direct comparisons between groups difficult, and careful analysis and interpretation is required to determine whether this is a true association with ethnicity per se, or an unexplained third factor.

3.3 It is important to try and distinguish whether the association is due to an increased risk of exposure, of developing severe disease and being hospitalised, and/or of dying if you develop severe disease.

3.4 All studies have their limitations, especially since the true extent of infection in the community is not known, but there are clear signals that there is a differential impact between ethnic groups which can't be explained entirely by age, geography and deprivation.

3.5 Potential reasons for these differences include;

- Social and cultural reasons for differences in exposure
- Differences in exposure and protection by employment sectors
- Differing levels of underlying health conditions or physiological differences such as obesity, or vitamin D levels
- Genetic susceptibility

3.6 Furthermore, on top of the direct risks from COVID, due to social and economic disadvantage, the impact of control measures like lockdown is also likely to have a bigger impact on people from BAME groups. Wolverhampton as a City is more deprived on average than the UK, with over half of the population living in some of the poorest 20% of neighbourhoods nationally. There is disparity between ethnic groups; with the exception of White Irish and Indian, all other BAME groups in Wolverhampton are more likely to live in the poorest 20% of neighbourhoods than White British people.

4.0 Implications and Next steps

4.1 It is tempting either to dismiss any causative relationship until it is definitively proven, or to jump to misleading conclusions based on early findings. A balance must be struck. We must acknowledge the complex interplay of social, community, occupational and individual characteristics which are difficult to disentangle, and take appropriate and proportionate steps to protect people who may be at increased risk.

4.2 Members of the Health and Wellbeing Together executive group have discussed the information available to date and made a commitment to acting on several areas of work in response to issues raised. These are:

- Staff – we have a duty of care to protect staff at higher risk, including risk assessment and amended duties or redeployment, and appropriate provision of Personal Protective

- Equipment (PPE), but the risk associated with ethnicity should be balanced against the risk associated with age, sex and underlying health conditions. A local risk assessment tool for managers has been produced and shared with partner organisations, which will support these discussions with employees.

- Engagement – hearing the lived experiences of people from different communities, understanding stigma and fear, and the influence of faith, culture, and behaviour. Under the arrangements described in the Wolverhampton Outbreak Control Plan, all partners of the Board will be represented on the Local Outbreak Engagement Board, which will be chaired by the Leader of the Council. One of its key responsibilities will be to ensure adequate engagement with communities to understand how we can ensure that people feel supported and safe during these extraordinary times, and to establish two-way dialogue.

- Mitigating the impact of control measures – recovery plans for services and wider economy should be tailored according to need; all partners will take action to ensure that equity is taken into account during the reset of services, including better equalities monitoring and recording of ethnicity so that data is more reliable.

4.3 In addition to these local commitments, the Public Health England review made a number of recommendations which are expected to be implemented nationally. These include:

- Mandatory collection of ethnicity at death certification
- Culturally competent COVID-19 education and prevention campaigns
- Culturally competent disease prevention and health promotion programmes, focusing on healthy lifestyles and long-term conditions like diabetes

5.0 Recommendations

1. That the evidence is kept under review and any significant developments in understanding are provided at future Health and Wellbeing Together meetings.
2. That the partner agencies provide updates on specific action taken in response and the findings of any equity audits or participatory research are provided at future Health and Wellbeing Together meetings.