

Briefing Note

Title: COVID-19 in Wolverhampton

Date: 14 July 2020

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Job Title: Director of Public Health

Intended Audience: Internal Partner organisation Public Confidential

1. Purpose

- 1.1 The purpose of this briefing is to provide a summary of the current available data relating to Coronavirus (COVID-19) in Wolverhampton.

2. Data Sources and surveillance

- 2.1 Routinely available data can be found on Public Health England (PHE) pages from GOV.UK¹, the Office of National Statistics (ONS)², NHS England³, and the Government Office for Science⁴.
- 2.2 A group of Public Health specialists from The Royal Wolverhampton NHS Trust and City of Wolverhampton Council regularly review data from all available sources, including patient level data which is not in the public domain, which informs the work of the Outbreak Control Planning Group. A full list of indicators and lines of analysis is available on request. Data for local authorities are also reviewed by Public Health England and the Joint Biosecurity Centre nationally.
- 2.3 Data availability relies on people accessing testing when symptomatic; some of the barriers to testing through Pillar 2 (no internet access, non-English speaking, low literacy levels) are likely to coincide geographically with parts of the City where social distancing is more difficult due to population density. Targeted communications work and localised testing approaches are being introduced to mitigate this.

3. Confirmed Cases of COVID-19

- 3.1 Since the first local case on 7 March 2020, there have been 1,385 confirmed cases in the city (as at 13 July 2020), giving a cumulative rate of 526 cases per 100,000 population (England average 444).

¹ Source: <https://coronavirus.data.gov.uk/#category=utlas&map=rate&area=e08000031>

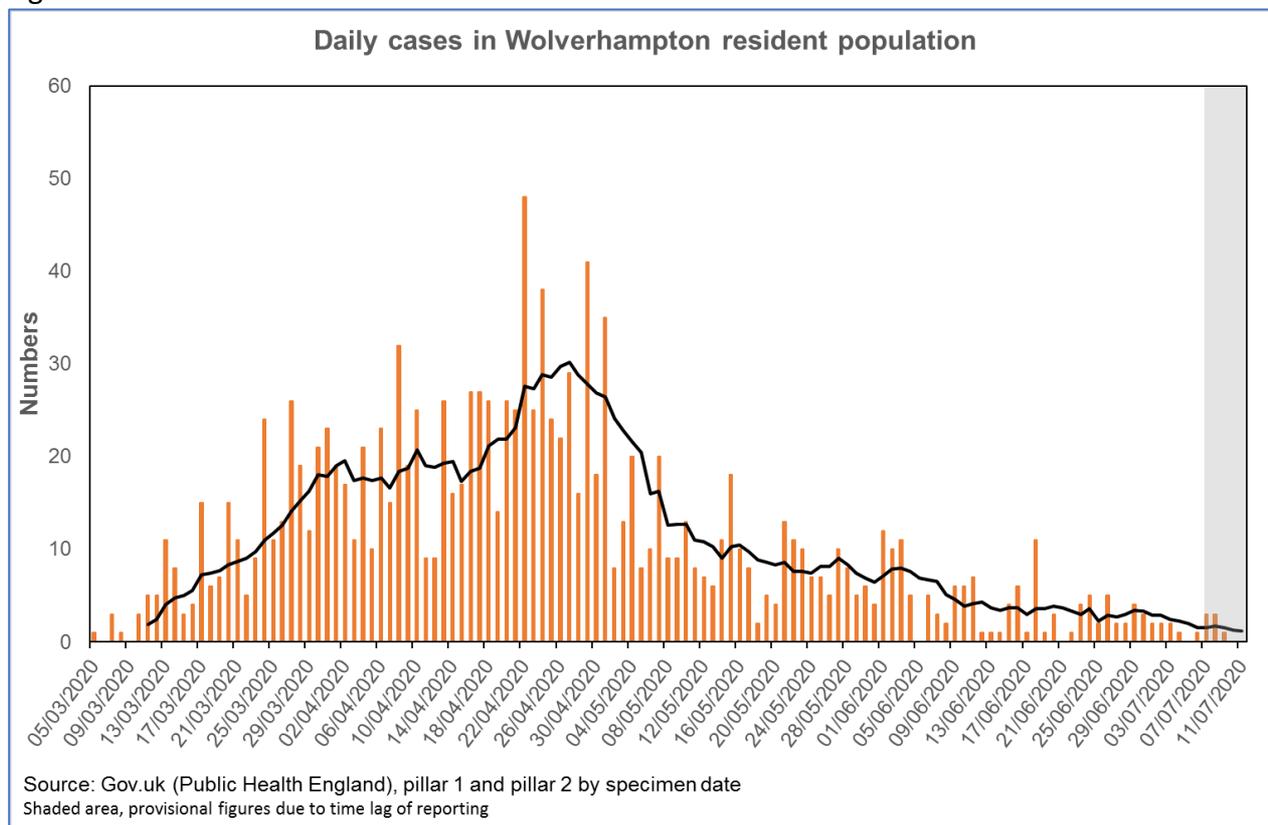
² Source: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases>

³ <https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/>

⁴ <https://www.gov.uk/guidance/the-r-number-in-the-uk>

3.2 The latest week's data shows that there have been only 8 cases in the City. The positivity rate (proportion testing positive out of all those tested in the community) is 3% (England 2%). There have been no new COVID-19 related hospital admissions in the last 7 days.

Figure 1 – Confirmed COVID-19 cases



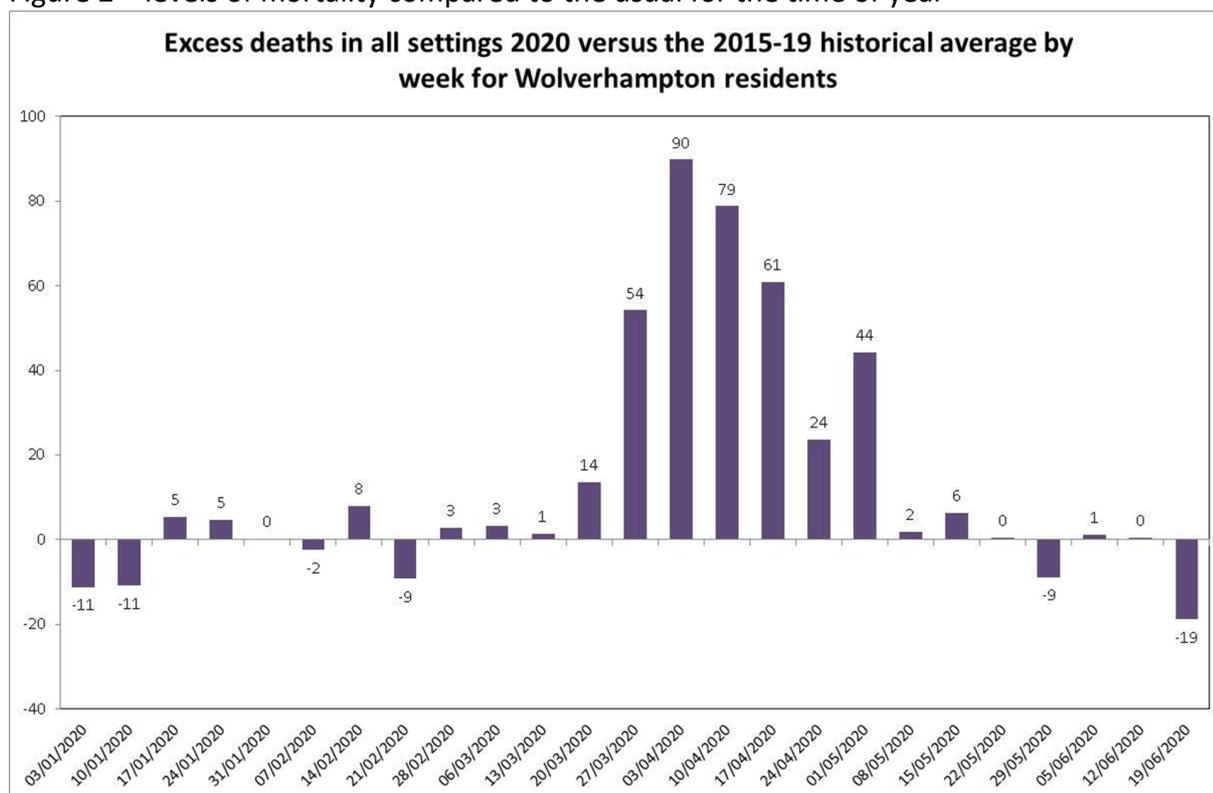
4. Mortality

4.1 Age-standardised all-cause mortality is the most robust way to compare the overall impact of the pandemic between areas, due to limitations of defining COVID-19 deaths, and age differences in populations. Between 1 March and 31 May 2020, the age-standardised rate of all-cause mortality was 423 deaths per 100,000 in Wolverhampton. This rate is not significantly different from our neighbouring authorities that have similar levels of deprivation and population demographics (Sandwell 429, Walsall 415).

4.2 According to recorded cause of death on the medical certificate, the number of COVID-19 deaths up to 26 June 2020 in Wolverhampton was 300. Of these, 71% (213) were deaths in a hospital setting, 21% (62) in a care home, and the remainder at home, hospice or elsewhere.

4.3 In the last week, there have been no COVID-19 deaths at The Royal Wolverhampton NHS Trust. Overall mortality levels in the City are now back below normal levels for the time of year.

Figure 2 – levels of mortality compared to the usual for the time of year



5. Demographics

During the peak of the pandemic we mainly saw cases diagnosed via Pillar 1 (hospitalised people and health and social care staff). Consequently, the age distribution was skewed towards older age, and men and ethnic minorities were overrepresented compared to the population, as this was reflective of those who are more likely to be hospitalised. Cases were widely distributed across the whole City. A different demographic pattern is seen in Pillar 2 data (community testing), with most cases in working age adults, and a slight overrepresentation of women.

6. Escalation framework

Decisions on local action in the event of a rise in cases will be taken on a case by case basis and may differ according to the specific circumstances. Collaboration with PHE (Public Health England), the Joint Biosecurity Centre and NHS Test and Trace would be the first stage of response (Figure 3). PHE has so far declined to give a specific case threshold that would trigger a local lockdown; a triangulation of data sources and a detailed review of the local epidemiology is required to understand the specifics of the situation and respond appropriately, bearing in mind the potential economic and social impact of further lockdowns.

Figure 3 – National Framework for responding to a local rise in cases

