Brent	**Community and Wellbeing Scrutiny Committee** 15 September 2020
	Report from the Director of Public Health

Covid-19 and Brent's Black and Minority Ethnic (BAME) Communities

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers:	None
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1.0 Purpose of the Report

1.1 To provide an overview of the underlying causes of the patterns of infection and mortality from Covid-19 among Brent's Black and Minority Ethnic (BAME) communities, and set out the actions by the NHS and Public Health to identify and address the disproportionate effects of Covid-19.

2.0 Introduction

2.1 Covid-19 is the disease caused by the novel coronavirus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Coronaviruses are a set of viruses that are among the causes of common colds. They have also caused outbreaks of more serious illnesses including Severe Acute Respiratory Syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS). COVID 19 can present with no symptoms, mild symptoms or as a severe illness leading to hospitalisation and in some cases death.

2.2 The burden of Covid-19 has not been shared equally in the society. Older people, men, those living in deprived areas, of BAME heritage, who are obese

or who are living with underlying health conditions have all been at increased risk of dying with COVID 19.

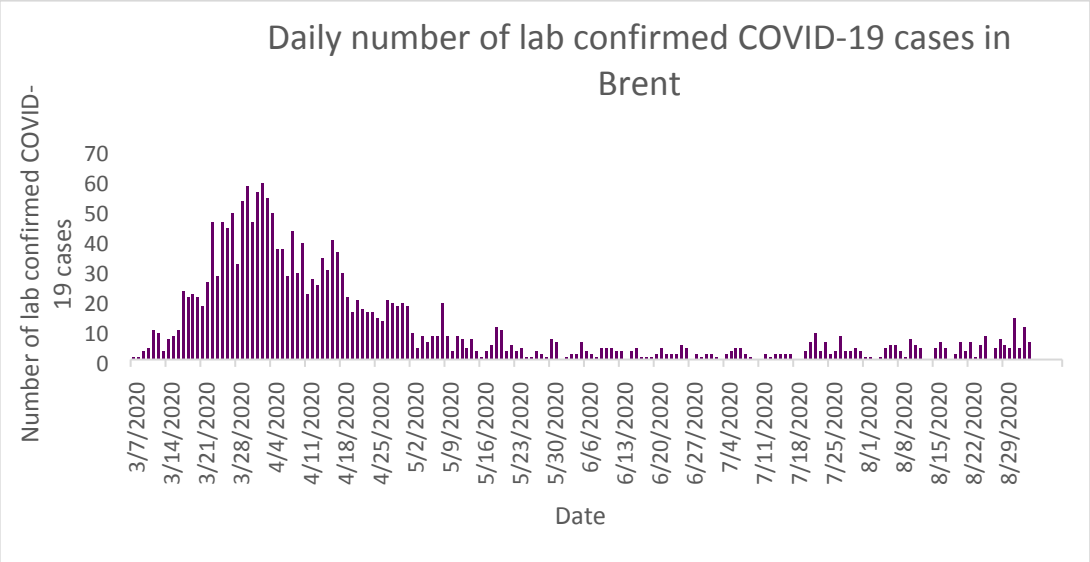
2.3 Health inequalities are not new but in many cases COVID-19 has increased these.

3.0 COVID 19 in Brent

3.1 Morbidity

3.1.1 During the pandemic (up to the beginning of September), almost 300,000 laboratory confirmed cases of Covid-19 had been diagnosed in England with 40,849 cases in London and 1,949 in Brent. Brent has had the second highest number of positive cases amongst London Boroughs. The true number of infections will be higher than this due to asymptomatic infection and limited testing particularly in the early stages of the pandemic when London and Brent were particularly affected.

3.1.2 Cases in Brent peaked the first week in April then declined to a low the week commencing 11th June. Following the announcement of the impending lifting of lockdown the week of the 18th June and the actual lifting on the 23rd of June cases have been on a gradual trajectory upwards with fluctuations.



3.2 Mortality

3.2.1 According to the most recent publication by the Office for National Statistics (ONS) between 1st March 2020 and 31st July 2020, there were 51,831 deaths involving COVID 19 in England and Wales[1]. Taking account of the age structure of the population, this equates 90.2 deaths per 100,000 population (the age standardised mortality rate). Over this period there were 491 deaths

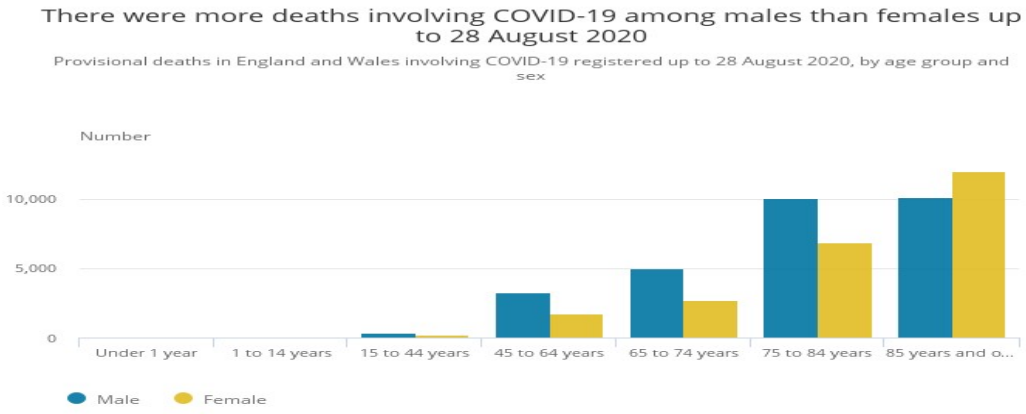
[1] "involving COVID-19" refers to deaths that had COVID-19 mentioned anywhere on the death certificate, whether it was the underlying cause of death or not

involving COVID 19 in Brent, an age standardised mortality rate of 218 per 100,000.

4.0 Disproportionality

4.1 ONS and Public Health England have analysed COVID deaths and have shown a disproportionate impact by age, gender, ethnicity, deprivation of area of residence, occupation and underlying health conditions.

4.2 Nationally and in Brent, higher death rates have been seen in men than in women.



Source: Office for National Statistics – Deaths registered weekly in England and Wales

4.3 As the female population is older than the male it is important to adjust for age when comparing rates in men and women

4.4 Table 1: Numbers and age adjusted rates for deaths involving COVID 19 1st March 2020 to 31st July 2020

	Persons		Men		Women	
	Deaths	Rates	Deaths	Rates	Deaths	Rates
England	49,232	91	27,130	119	22,102	70
London	8,536	143	5,042	195	3,494	103
Brent	491	218	300	299	191	156

4.5 ONS analysed 12,000 COVID deaths comparing death certificates to census data with the following findings:

4.5.1 BAME populations in England and Wales are younger than white populations and as age is a strong influence on death rates, it is important to take account of age. When this is done:

- Black males are 4.2 times more likely to die from a COVID-19-related death than White males;

- Black females are 4.3 times more likely to die from a COVID-19 related death than White females.

4.5.2 In the analysis, socioeconomic circumstances or deprivation was also analysed. Deprivation measures consider income levels, housing, education and other features of the area where individuals live. These measures are known to have a significant impact on health and disease. The more deprived areas had mortality rates twice that of less deprived areas. This analysis was undertaken at a national level. Locally there was an observed correlation between deprivation and numbers of deaths. However the smaller numbers and the location of care homes mean statistical correlations cannot be demonstrated.

4.5.3 As BAME populations tend to be more deprived, it is important to adjust for the influence of deprivation in looking at the impact of ethnicity. Doing so allows us to compare the risk for a black male living in an area of deprivation compared to one living in an affluent area:

- Black males are 1.9 times more likely to die from a COVID-19-related death than White males;

- Black females are 1.9 times more likely to die from a COVID-19 related death than White females.

4.5.4 Some, but by no means all, of the disproportionate impact of COVID on Black communities can be attributed to deprivation.

4.5.5 People of Bangladeshi and Pakistani, Indian and Mixed ethnicities also had statistically significant raised risk of death involving COVID-19 compared with those of White ethnicity.

4.5.6 After taking into account age and socioeconomic circumstances or deprivation:

- Bangladeshi and Pakistani ethnic group males are 1.8 times more likely to die from a COVID-19-related death than White males;

- Bangladeshi and Pakistani ethnic group females are 1.6 times more likely to die from a COVID-19-related death than White females.

4.5.7 Public Health England review also found increased risk of dying from those not born in the UK as opposed to those born in the UK. It is unclear whether this accounts for some of the ethnic differences.

4.5.8 Health inequalities between ethnic groups were entrenched before COVID 19 but it is possible that COVID is widening these.

4.5.9 Occupations which have close contact with large numbers of other people, for example health and social care staff, have an increased risk of dying from Covid-19.

4.5.10 Individuals with pre-existing conditions and particularly those with multiple conditions are at increased risk of dying from Covid-19. Of particular importance appear to be obesity, diabetes and hypertension. One study showed the risk of dying in hospital in England with Covid-19 for an individual with diabetes is 1.81 times time more than that of an individual without diabetes. Public Health England found that diabetes mellitus was present on 21% of the death certificates with Covid-19. There is also some evidence that poor outcomes with diabetes were noted with less well controlled disease

5.0 Possible reasons for the disproportionate impact

5.1 There are three possible reasons for the disproportionate impact of COVID on BAME communities:

1. Increased exposure to the virus
2. Increased susceptibility to severe disease
3. Access to and use of health care

5.2 Exposure to the virus

5.2.1 Brent BAME population are high users of public transport. Buses in particular remained crowded during the pandemic as did bus stops in the Wembley and Harlesden area.

5.2.2 Brent BAME communities have high levels of inter-generational living with those at risk including the elderly and those with long-term conditions being exposed more than those in smaller households.

5.2.3 BAME communities have high attendance to temples, churches, mosques and other places of worship with large communal activities such as services, weddings and funerals. These were implicated in spread elsewhere and it is likely were these were factors in the early part of the epidemic

5.2.4 BAME community members are less likely to be working from home and often in zero hour contracts or cash in hand situations therefore less likely to be able to social distance or self- isolate.

5.2.5 BAME community members are more likely to be frontline workers and less likely to be managers and able to influence their working conditions

5.3 Susceptibility to severe infection

5.3.1 While levels of adult obesity are relatively low in Brent (compared to England), 50% of residents are overweight or obese. It is estimated that over 11% of the adult population has diabetes, compared to an England rate of 8.5%. Diabetes is more prevalent in Black and South Asian patients, and our high levels of diabetes may be one reason for the higher death rate seen locally.

5.3.2 Fewer patients are recorded on their GP records as having high blood pressure than is the case for England (12.4% compared to 14%). While this may indicate a lower prevalence, the size of our Black and South Asian communities who would be expected to have higher rates of hypertension might suggest under diagnosis. Of those who are diagnosed, significantly fewer patients have their blood pressure controlled in Brent than nationally.

5.4 Access to and use of health services

5.4.1 It has been hypothesised that more deprived communities may have poorer access to health care and that this could have played a part in the pattern of mortality (the inverse care law). Early in the pandemic, NHS England instructed primary care to move away from face to face appointments in favour of telephone and on line access. There was a concern that this model of care may have disadvantaged the digitally excluded.

5.4.2 There is some evidence from elsewhere that Black men were particularly unwell on presentation to hospital and more likely to be admitted direct to ITU. This could indicate a reluctance to seek help earlier or a more rapid progression of disease in this group of patients. There is no evidence of poorer outcomes for BAME patients admitted to secondary care locally. However the completeness of recording ethnicity limits our ability to analyse this.

6.0 Action taken to date to address health inequalities

6.1 The disproportionate impact of COVID reflects entrenched structural inequalities within society which will not be remedied in the short term and over which the council and the NHS have limited influence. However there are actions which the council and the NHS can and should take, both in the immediate and longer term and for the borough as a whole and targeted on particularly affected areas or communities.

6.2 In the short term, action has focused on mitigating the impact of COVID and preparing for a possible second wave.

6.3 Testing

6.3.1 Early identification and self-isolation of cases of COVID is an important tool in reducing community transmission. The initial model of community testing was for regional testing centres (originally located at Ikea Wembley, then moved to

Heathrow) with mobile testing units (originally located in the car park at Willesden Sports Centre two days a week, now at Neasden Temple car park). Tests were booked through the internet or by phone and residents were asked to drive to the test centre. Recognising that this model risked excluding residents without easy access to the internet or a car, the Council negotiated with DHSC and Deloittes to site a hyperlocal walk through test centre in Harlesden – one of the areas of Brent which had been particularly badly hit.

6.3.2 The Harlesden test site can be booked through the Council (as well as through the national portal). This arrangement allows us to offer wrap around support from the Community Hubs team where needed and to provide work arounds for residents without email, phones or ID.

6.3.3 Between 10th June and 6th September 2020, 8826 tests have been completed at the Harlesden site, of which 3492 were booked through the Council. The ethnicity of those booking through the council was:

6.3.4 Table 2: Ethnicity of those booking a COVID test through the Council

Ethnicity	
White	1048
Black African, Black British, Black Caribbean	794
Prefer not to say	701
Asian, Asian British	446
Other	274
Mixed, multiple ethnic groups	145

6.4 **Communications**

6.4.1 One of the recommendations from the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities' was for the development and implementation of culturally competent COVID 19 education and prevention campaigns. In response to the disproportionate impact of the pandemic, the council has developed targeted communications including working with local community leaders to reinforce individual and household risk reduction strategies and to reinforce messages on early identification, testing and diagnosis.

6.4.2 Working collaboratively, London boroughs and the GLA have developed culturally competent communications tools which resonate with Londoners, including information in community languages. The tool kit has been shared with local community and mutual aid groups who have been encourage to make use of its material freely.

6.4.3 Nonetheless, community engagement continues to show that local people feel a need for more consistent and repeated messaging. We will continue a proactive campaign including writing to every household in the Borough.

6.5 **Occupational risk**

6.5.1 In response to the recognition both of the clinical risk factors for severe COVID and the increased risk for BAME, older and male staff the Council's Occupational Health and Public Health teams devised a bespoke risk assessment. This is being completed by all staff before their return to the workplace.

6.6 **Health and Wellbeing Board Consideration and Response to Disproportionality**

6.6.1 In May 2020, a report detailing the disproportional impact of Covid-19 on certain communities was presented to the Health and Wellbeing board. Following this, an Inequalities Working Subgroup of the Board and a Strategic Oversight Group has been formed to drive work to reduce health inequalities in the short, medium and long-term.

6.6.2 The work will involve both a borough wide and hyperlocal approach. The borough wide approach will entail core interventions identified by the Subgroup. The 'hyperlocal' approach will target areas disproportionately affected by Covid-19. A fluid approach will be taken to identify and target specific areas and communities requiring a hyperlocal intervention with the Alperton and Church End localities being focused on in the first instance.

6.6.3 The Working Subgroup is currently meeting on a weekly basis with representation from Brent Council, Brent CCG, LNWLHT and CNWL to ensure Brent takes a joint approach to tackle health inequalities. *The core purposes of the subgroup is to:*

- *Oversee and drive the operational delivery of the borough wide and hyperlocal action plans.*
- *Identify any blockages to individual organisations or to Strategic Oversight Group as appropriate.*
- *Ensure there are strong links with the core work of representative organisations and the local community.*

6.6.4 The Strategic Oversight Group is meeting on a monthly basis with strategic and executive input from Brent Council, Brent CCG, LNWHT and CNWL. *The core purposes of the Strategic Oversight Group is to:*

- *Provide direction in light of the decisions of the Health and Wellbeing Board.*
- *Unblock any issues that the subgroup are unable to tackle.*
- *Provide oversight and challenge to ensure progress.*

6.6.5 In line with the recommendations of the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities', the Working Group have agreed that the voice of the communities most affected must inform action to improve outcomes in target areas. For this reason, community engagement will form the basis of the hyperlocal approach with two Community

Co-ordinators will be recruited in early October to act as a focal point across partners and communities in Church End and Alperton.

6.6.6 Initial meetings with both communities took place on Tuesday 8 September and Wednesday 9 September 2020. Local community leaders from a range of faith, community and voluntary organisations were invited to speak about:

- How Covid-19 has affected local residents
- What has been done well to protect people from Covid-19
- What could have been improved to better protect people from Covid-19
- What can be done differently to protect people from a potential second wave
- What can be done to reduce health inequalities in the long-term

6.6.7 Representatives from Brent Council, Brent CCG, CNWL and LNW University Healthcare NHS Trust were there to briefly set the context and listen to the views and thoughts of the community.

6.6.8 The communities' views supported a need for Community Champions to:

- help shape health and wellbeing messages around Covid-19
- distribute messages to the community through various channels
- empower people to be active and promote healthy living
- actively engage with the community on health issues

6.6.9 The Community Champion opportunity was well received by the community; several attendees have already volunteered to become a volunteer. In addition paid Community Health Educator roles have been proposed which would be remunerated positions open to community members who are able to contribute more time to this work.

6.6.10 A programme of follow-up community meetings will be developed to take this work forward.

6.6.11 In response to recommendations from the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities', Public Health and the CCG are developing a proposal to engage a community research partner to support community participatory research. Researchers will engage with community stakeholders engage as equal partners 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.

6.7 **New model of primary care**

6.7.1 Brent CCG is developing a new multidisciplinary health team to 'take primary care to the people'. Initially this will operate with 10 GP practices in Church End and Alperton. A dedicated team of health professionals will be recruited

with condition specific expertise to provide capacity, case management and to link residents with existing health services.

6.8 Themes from the Church End and Alperton community engagement events

6.8.1 **Church End**

- Participants praised Northwick Park Hospital's response to the pandemic.
- People are still afraid to visit public buildings.
- Some of are not fully informed of information/advice therefore educating residents is crucial.
- Many people are not wearing masks, particularly on Church Road. Messages around facemasks need to be clear without offending people.
- Question of whether health services play a key role for self-care and those with long-term conditions (such as diabetes and hypertension)
- Need to invest in Church Road and the local community, as the area is unappealing. This is reflected by local drug dealing, crime, poor employment opportunities and run down businesses.
- Many people face multiple issues even before the pandemic including stress and financial issues.
- New people are approaching foodbanks.
- People tested for Covid-19 are not reflective of the local community – question of what we are doing to encourage people to take tests.
- Young people face mental health issues, which is a primary reason for large gatherings and house parties in the area. Young people are aware of the risks but they are battling with their mental health. Need role models/influential people from area through to communicate through songs and messages. Need to think about education, prospects and access to networks.
- Access to GPs online has been difficult, especially for those whose first language is not English. Confidence in services is low.
- Older people are more isolated now.
- Worry that people are being forgotten about if they need medical help but don't engage with health services or local support. A helpline was

suggested so people's needs can be explored to signpost them to support and services. Need to build local people's knowledge.

- Concern over people who are not eligible for support services but housed in HMOs.

- Educating and raising knowledge of landlords will help maintain hygiene standards.

- Need to hear from those who have lost people.

- Attendees are happy to be a part of the solution by working with us as community champions.

6.8.2 **Alperton**

- Messaging needs to be reinforced and shaped for people who do not speak English as their first language.

- Channelling tailored messages through places of worship and Asian radios would be effective. Could work with the Multi-faith forum.

- Measures are not being followed on high road - displays and signboards are insufficient. Signs on shops are usually handwritten. Some shops are doing well which could be replicated by other shops.

- Need to work with community leaders to identify vulnerable people eg create register of HMOs.

- Strategy needs to focus on prevention and long-term outcomes.

- Community is pessimistic as opposed to central government, which changes guidelines frequently.

- Many organic community groups exist which need to be engaged with.

- More enforcement needed where people aren't following measures.

- Easy to get GP appointments, however many people are nervous. They need health services but uptake is low. Lack of internet and no phone line is another issue.

- National Covid-19 test system was down and busy highlighting the barriers to securing a test. Testing may not be reflective of local communities – may need to encourage people to take tests and raise

awareness of sites.

- Issue of people having symptoms but not getting tested due to risk of losing job or income.

- There are opportunities despite the negatives – people are walking and being active whilst maintaining social distancing measures.

- Attendees look forward to working with us to find solution

REPORT SIGN-OFF

Dr Melanie Smith

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