

 	Health and Wellbeing Board 6 April 2021
	Report of the Director of Public Health
Epidemiology of Covid-19 in Brent	

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: <small>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)</small>	Open
No. of Appendices:	Appendix 1 – covid-19 epidemiology
Background Papers:	Nil
Contact Officer(s): <small>(Name, Title, Contact Details)</small>	Dr John Licorish Public Health Consultant Community Wellbeing

1.0 Purpose of the Report

1.1 The paper seeks to describe the Epidemiology of Covid-19 in Brent.

2.0 Recommendation(s)

2.1 The board is asked to consider the information provided in the paper.

3.0 Detail

3.1 Coronaviruses are a large family of viruses with some causing less severe disease, such as the common cold, and others causing more severe disease, such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses.

SARS-CoV-2 is primarily transmitted between people through respiratory (droplet and aerosol) and contact routes. Transmission risk is highest where people are in close proximity (within 2 metres). At the moment, human-to-human transmission is occurring extensively. Hence, precautions to prevent human-to-human transmission are appropriate for both suspected and confirmed cases. The disease can present with no symptoms, mild symptoms or as a severe illness leading to hospitalisation and in some cases death.

3.2 *National Situation*

In England by 20 March 2021, the Department of Health and Social Care stated there were 3,754,821 cumulative laboratory confirmed cases of Covid-19. In England, the Office of National Statistics, up to 5 March 2021 reported 127,270 Covid-19 deaths.

3.3 *Burden of illness in Brent*

As of 20 March 2021, Brent has the eighth highest number of cumulative confirmed cases in London with a total of 28,011 confirmed covid-19 cases recorded since March 2020. It is to be noted that at the start of the pandemic there were limitations in obtaining tests hence many cases would have been missed. There are also limits on asymptomatic individuals obtaining testing.

However, if we look at the cumulative rate per 100,000 individuals, taking into account the different age profiles of the London Boroughs. As of 20 March 2021, Brent has the eleventh highest rate per 100,000 in London, with a cumulative rate of 8,494.1 per 100,000.

As of 27 February 2021, Brent has the fifth highest number of cumulative deaths in London, with a total of 835 covid-19 deaths recorded since the beginning of the pandemic.

3.4 *Current Brent Situation*

In the last 7 days up to 20 March 2021, Brent has the third highest number of confirmed cases in London, with a total of 166 confirmed covid-19 cases recorded.

In the last 7 days up to 20 March 2021 Brent has the fifth highest rate per 100,000 of confirmed cases in London, with a total rate of 50.3 per 100,000 recorded.

As of 27 February 2021, Brent has the fifth highest number of cumulative deaths in London, with a total of 835 Covid-19 deaths recorded since the beginning of the pandemic.

3.5 *Health Inequalities*

Age and Sex

The number of Covid-19 cases is highest within the younger working age population in both males and females. Looking at the data below it shows that there were more cases identified within the female population, however it needs to be taken into consideration that males were less likely to go in for Covid-19 PCR testing at the start of the pandemic.

3.6 *Deprivation*

People who live in deprived areas have higher diagnosis rates than those living in less deprived areas. High diagnosis rates may be due to exposure factors such geographic proximity to infections, multi-generational or overcrowded housing or a high proportion of workers in occupations that are more likely to be frontline. Poor outcomes from Covid-19 infection in deprived

areas remain after adjusting for age, sex, region and ethnicity, but the role of comorbidities requires further investigation.

In Brent, however, we saw a peak in cases in those 'somewhat deprived' as opposed to our 'most deprived' quantiles. This could be due to a number of factors including that at the start of the pandemic laboratory confirmed cases were done under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease or required hospitalisation for additional issues, rather than all of those acquired infection.

The trend in the number of diagnosed cases by deprivation quantile shows that cases in the 'least deprived' group peaked earlier and lower than other groups. This was supported by the mortality factors, which showed the epidemic occurring earlier in our deprived areas and among care home residents and staff.

In the latter epidemic in early January, the rates of Covid-19 were higher in the more deprived areas but as the rates have fallen there, is a more even spread of infection across the deprivation deciles? Throughout the pandemic case rates have been higher in the working age population.

Encouragingly, cases in the over 80 and over 60 fell markedly in the latter part of February and March, reflecting the effect of the vaccination programme

3.7 *Ethnicity*

As reported previously to the Board, there was significance noted with regard to ethnicity in the deaths reported from Covid-19. Looking at the data for cases, however, there are issues with regard to its accuracy and misclassification.

The highest diagnosis rates of Covid-19 cases per 100,000 population in Brent were in people of 'Any other' ethnic groups (1897 in females and 1892 in males) and the lowest were in people of White and Asian ethnic groups (54 in females and 42 in males). The analysis was also not able to include the effect of occupation. This is an important shortcoming, because occupation is associated with risk of being exposed to Covid-19 and we know some key occupations have a high proportion of workers from BAME groups.

3.8 *Mortality*

There were two peaks of death, one in April 2020 and one in late January 2021. The highest crude death rates were in Wembley Central, Harlesden and Barnhill. As reported previously to the Board there is evidence of disproportionality with regard to in the deaths reported from Covid-19.

3.9 *PCR Testing*

In the first wave, PCR testing was only available to those who were hospitalised. PCR testing sites were opened first at Harlesden then at Wembley Central. These sites were chosen to provide residents most affected

by the first wave with access to testing. An additional site was opened in Northwick Park.

3.10 *Lateral Flow Testing*

Lateral Flow Tests allow for rapid Covid-19 testing that delivers a result within 30-45 minutes. Lateral Flow Test sites were opened across the borough in December 2020 following the National Lockdown in November 2020.

10 sites, spread across the geography of the borough, were opened in December 2020 to allow for greater, rapid testing capacity. This enables people, notably those who are unable to work from home, to go back to work more safely.

There was therefore an emphasis on ensuring that key workers were able to get access to rapid Lateral Flow Tests. 39% of visitors identified themselves as key workers.

3.11 *Covid-19 Vaccination*

Unfortunately, the vaccination rates reflect the underlying inequality in the borough with vaccination rates for over 80, 75-79, 70–74 all showing higher rates in the north of the borough and lower rates in the south of the borough. There was a general pattern of uptake rates being highest in the White, Indian and Bangladeshi ethnicities. Uptake rates were generally lowest in the Black African, Mixed and Black Caribbean ethnicities. The rates of refusal were also higher in recipients from the most deprived areas of the borough.

4.0 Financial Implications

4.1 None directly

5.0 Legal Implications

5.1 None directly

6.0 Equality Implications

6.1 None directly

Report sign off:

Dr Melanie Smith
Director of Public Health