Health and Wellbeing Board

Date: Tuesday, 15 September 2020
Time: 1.30 pm
Venue: Microsoft Teams

Membership

Councillors:
Councillor Les Caborn (Chair)
Councillor Jeff Morgan
Councillor Dave Parsons
Councillor Izzi Seccombe
Councillor Jo Barker
Councillor Sally Bragg
Councillor Judy Falp
Councillor Marian Humphreys
Councillor Neil Phillips

WCC Officers: Nigel Minns and Shade Agboola

Clinical Commissioning Groups: Sarah Raistrick (Coventry and Rugby), David Spraggett (South Warwickshire), Sharon Beamish (Warwickshire North)

Provider Representatives: Dame Stella Manzie (University Hospital Coventry & Warwickshire), Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Dianne Whitfield (Coventry & Warwickshire Partnership Trust)

Healthwatch Warwickshire: Elizabeth Hancock (Chair)

NHS England: Julie Grant

Police and Crime Commissioner: Richard Long (Office of the PCC)

Items on the agenda: -

1. General

(1) Apologies

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

Board Management

14. Forward Plan

– Gemma McKinnon

291 - 292

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

To download papers for this meeting scan here with your camera

Disclaimers

Webcasting and permission to be filmed

Please note that this meeting will be filmed for live broadcast on the internet and can be viewed on line at warwickshire.public-i.tv. Generally, the public gallery is not filmed, but by entering the meeting room and using the public seating area you are consenting to being filmed. All recording will be undertaken in accordance with the Council's Standing Orders.

Disclosures of Pecuniary and Non-Pecuniary Interests

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it
- Not participate in any discussion or vote
- Must leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the Code of Conduct. These should be declared at the commencement of the meeting
The public reports referred to are available on the Warwickshire Web
https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

Health and Wellbeing Board Informal Briefing Session

Virtual Meeting, Wednesday, 6 May 2020

Minutes

Attendance

Warwickshire County Council
Councillor Les Caborn (Chair)
Councillor Jeff Morgan
Councillor Dave Parsons
Councillor Izzi Seccombe OBE

Shade Agboola, Director of Public Health
Nigel Minns, Strategic Director for People Directorate

Clinical Commissioning Groups (CCGs)
Sharon Beamish, Warwickshire North CCG
David Spraggett, South Warwickshire CCG

Provider Trusts
Dame Stella Manzie DBE, University Hospitals Coventry and Warwickshire (UHCW)
Dianne Whitfield, Coventry and Warwickshire Partnership Trust (CWPT)

Police and Crime Commissioner (PCC)
Richard Long (Office of the PCC)

Healthwatch Warwickshire (HWW)
Elizabeth Hancock

Borough/District Councillors
Councillor Jo Barker, Stratford District Council
Councillor Sally Bragg, Rugby Borough Council
Councillor Judy Falp, Warwick District Council
Councillor Marian Humphreys, North Warwickshire Borough Council

Others Attendees
Chris Bain (HWW), Sebastien Baugh (SWFT), Councillor Margaret Bell (WCC), Gillian Entwistle (South Warwickshire CCG), Simon Gilby (CWPT), Sir Chris Ham (Coventry and Warwickshire Health and Care Partnership), Adrian Stokes (WNCCG).
Rachel Barnes, Helen Barnsley, John Coleman, Charlie Fletcher, Becky Hale, Catherine Shuttleworth, Pete Sidgwick and Paul Spencer (WCC Officers).

1. General

(1) Introduction

The Chair welcomed everyone to the briefing session and he outlined how this virtual meeting would be conducted. Several briefing documents had been circulated for review and discussion. There would also be a verbal update from Sir Chris Ham of the Coventry and Warwickshire Health and Care Partnership. After the briefings, there would be the opportunity for updates from partners and any further questions. The session would be recorded so that any key actions were captured.

The Chair welcomed Richard Long, the new representative for the Police and Crime Commissioner and Charlie Fletcher from Public Health, who would be supporting the Board going forward. He thanked Rachel Barnes, Health and Wellbeing Delivery Manager who was moving to another position within the County Council.

(2) Apologies

Russell Hardy, George Eliot Hospital NHS Trust & South Warwickshire NHS Foundation Trust (SWFT)

(3) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

None.

2. Briefings

Health and Wellbeing Partnerships

An update had been circulated by the three partnerships for the Warwickshire North, Rugby and South Warwickshire areas. The Chair was pleased to see the progress being made, having attended a recent South Warwickshire partnership meeting. There were no questions or comments from the Board.

Homelessness Prevention Strategy

An update on the development of a countywide strategy for tackling homelessness. This included plans for a pathway model, funding for district and borough councils to prevent and tackle homelessness, a hospital liaison pilot and physical and mental health outreach for rough sleepers. The report also outlined the excellent partnership work underway for the COVID-19 response, including offering accommodation to all rough sleepers. The Chair recognised the significant contribution from districts and boroughs. Collectively, significant progress had been made.

Councillor Falp spoke about building on the progress made to date, to provide more permanent accommodation for homeless people. The Chair acknowledged this point and officers at districts/boroughs and the county should work together on the next stages. Councillor Barker gave an update for the Stratford area. Some homeless people were being accommodated in bed and

breakfast establishments and it was questioned whether micro accommodation might be more appropriate. The Chair agreed this was something to follow up. Councillor Bell asked whether bed sit accommodation was seen as a potential solution and if it was being used in other parts of the county. The provision of accommodation and food appeared to be working well in the Stratford area. It could even be an ensuite bedroom rather than a bed sit. It wasn't believed that other areas were providing food as well as accommodation, but this could be researched.

Councillor Seccombe asked about training opportunities for homeless people to assist them in gaining a work placement. The Chair sought views from district and borough members about this suggestion. The view was that some homeless people were less likely to be receptive to a training offer. Helping with life skills was also mentioned.

Simon Gilby of CWPT reminded of the work with districts and boroughs to give an enhanced mental health offer in supporting people into accommodation, specifically recognising the key role of nurses and police colleagues.

Coventry and Warwickshire Health and Care Partnership

A verbal update was provided by Professor Sir Chris Ham, which covered the following areas:

- The redirecting of staff and resources to help NHS colleagues leading the response to the Covid pandemic.
- The country had now gone through the peak surge in demand. He spoke of the way local acute service providers had managed this, working collaboratively with mutual aid arrangements. This had been supported by effective discharge arrangements to free up hospital bed spaces.
- Out of hospital arrangements had been reorganised, providing more telephone and online appointments for both primary care and outpatient appointments, whilst also separating covid patients from other patients.
- The next phase was to restore urgent services such as cancer care. Some people had not been referred for urgent health conditions during the pandemic. Ensuring safe treatment of non-covid patients was referenced, together with the additional services put in place at two private hospitals.
- A current priority was the focus on care homes, notably PPE provision and testing of key workers.
- Widespread community testing and contact tracing were further priorities. It was important that these were effective, to reduce the likelihood of increases in cases and a second peak, as the lockdown measures were relaxed. Using the expertise of local authorities through public health and environmental health was advocated. It was important to make the case for the use of this local knowledge as part of the national contact tracing programme. However, it seemed that a centralised approach would be taken.

Discussion took place on the following areas:

- The logistical work required in acute hospitals to create 'clean' areas for the treatment of non-covid patients, as urgent services returned to their normal levels.
- The importance of involving public health in the next stages, especially contact tracing, due to the local knowledge of staff.

- The challenges currently faced of managing Covid and reinstatement of services at the same time as capitalising on the innovation put in place in responding to the pandemic. There was a lot of work for staff during this transition period.
- People transferring from hospitals into care homes and the risk of bringing Covid into the home. Testing now took place as part of the transfer. Earlier in the pandemic, people were moved from hospitals to care homes, to ease the expected pressure on hospitals. Approximately two weeks ago the local system agreed a policy of keeping care homes 'clean' and not admitting people with covid to them. Isolation options were being put into place.
- Where Covid cases were identified in care homes, there was support from the infection team and staff training on isolation was provided. Where the care home wouldn't re-admit a resident, alternate arrangements were made for example through Myton Hospice. CCGs had been asked to provide staff to deliver Covid training.
- People in care homes who tested positive for Covid were initially put in isolation, rather than being relocated to a hospital. The decision to transfer was dependent on the level of health support required. Dementia patients would be confused if transferred to a hospital. Moving people from care homes could be risky to their health and the staff in the care home had more knowledge of each resident.
- On testing and tracing, Councillor Seccombe shared the views of Sir Chris Ham that it should be delivered locally. Staff were well placed, understood their local community and were more able to deliver this than through a centralised approach. This view had been raised directly with the Secretary of State for Health.
- The roll out of antibody testing to people suspected of having recovered from the virus. This would help to reduce fear and enable those people to assist more. The anticipated relaxation of social distancing was a concern. On contact tracing, a view that people won't sign up to use the proposed mobile telephone application.
- The government had determined to have a national approach on contact tracing, despite the representations made. The involvement of public health and environmental health directors at the regional and local level was still being pursued through professional bodies and the LGA. The benefit of their local knowledge was a key aspect. Discussions were ongoing with lead officers locally, to determine the best way forward for the Coventry and Warwickshire area.
- Shade Agboola, Director of Public Health (DPH) provided a link to the covid testing page on the government website: https://www.gov.uk/apply-coronavirus-test. She confirmed that lobbying was ongoing amongst the DPH in the region for contact tracing to be delivered locally, but it appeared this was unlikely to succeed. Public Health England (PHE) had suggested there would be some local responsibility and it was hoped that more clarity would be provided at a meeting later in the day. She commented on the degree of involvement of public health to date, for example on PPE. She also spoke about the mobilisation of staff and the role of Liz Gaulton, the Coventry DPH as the regional lead. PHE was seeking to second staff to work for them. This would require local public health departments to make capacity to release the staff. The Chair and County Council Leader voiced their strong concerns at this proposal. Sir Chris Ham shared his concerns regarding the centralised approach, at the expense of using local knowledge and referred to some of the decisions taken to date.

Warwickshire Better Together Programme

A progress report on the Better Together Programme. No comments were submitted.

Children 0-14 Unintentional Injuries

A progress report. No comments were submitted.

Mental Health and Wellbeing

An update on work to support mental wellbeing and reduce rates of suicide. The Chair noted that interventions appeared to be having a positive impact as suicide rates were more in line with the national average for the period 2016-18. NHSE/I had awarded additional funding of £186,000 for 2020/21. The potential impact from Covid were recognised.

Discussion took place on the following areas:

- Simon Gilby advised that CWPT provided a telephone helpline, which was available for both children and adults 24 hours per day, seven days a week. He offered to supply further details for circulation.
- Councillor Seccombe asked about access to services. School closures for most pupils meant that mental health issues were not as visible. Whilst the suicide numbers did not seem to have changed significantly, there was concern about the potential for service pressures when the lockdown ended. There was a need to re-build support systems around children. Mr Gilby offered to provide more detail after the meeting. He confirmed there had been a reduction in demand during the pandemic, but all services were continuing to be delivered, with some being by telephone or virtual contact. It was acknowledged that this was not always as good as face-to-face contact. There had been a significant reduction in IAPT referrals. Data was being reviewed to see who was accessing the telephone helpline. CWPT was working with others in the region and nationally to share experience, knowledge and expertise. This would help to asses likely demand areas. Some upscaling of services had already commenced to respond to referral rates. This would also require work with primary care over the coming months. There was an opportunity for greater use of digital solutions going forward.
- Warwick District Council was providing information to signpost people to available mental health support services. A related point was support available for councillors. Simon Gilby added that psychological support for both NHS and social care staff was being provided.
- Healthwatch Warwickshire was receiving increased numbers of calls from people in lockdown with anxiety issues. This may be due to people fearing they had the virus, or those living with a mental health issue, addiction or behavioural challenge. The CWPT telephone helpline would assist, but there would be a need for ongoing support for some time.
- Examples were given of people experiencing mental health difficulties. At a Stratford food bank, residents had openly shared their anxieties. For staff in front line roles at the District Council who were handling many difficult calls, some may also need support themselves.

Feedback from the Place Forum

A report on the Place Forum held in March. The Chair referred to the legacy of the Year of Wellbeing, recognising the volunteer support throughout it. No further comments were submitted.

Forward Plan

This listed items for Board meetings in 2020-21. It was noted that the forward plan and priorities may need to be reviewed after the Covid pandemic.

3. Updates from Partners and Questions

The Chair invited updates. All organisations were working differently in response to the Covid pandemic, making better use of technology. There was a need to ensure that this innovation wasn't lost. Sharron Beamish agreed that a lot had been accomplished, stating the need to continue to work in partnership. The Chair noted that each organisation would be putting in place recovery plans and he asked that these were shared. Chris Bain paid tribute to both County Council and NHS colleagues for their support and cooperation with Healthwatch during this period.

The meeting closed at 2.35pm

……..……..
Chair

Agenda Item 2

Health and Wellbeing Board

Draft Health and Wellbeing Strategy 2020-25

15 September 2020

Recommendation(s)

1. That Board members note the update on the refresh of the Health and Wellbeing Strategy and endorse the proposed approach to consultation *(noting the likely delay to the process due to Covid-19).*

1. Executive Summary

1.1 The Health and Wellbeing Board has a statutory duty to develop a Health and Wellbeing Strategy (HWBS) under the Health and Social Care Act 2012. The HWBS should translate findings from the Joint Strategic Needs Assessment (JSNA) into priorities to help determine actions by local authorities, NHS and other partners to address the wider determinants that impact on health and wellbeing.

1.2 The Board has agreed to refresh the HWBS to align with developments in the wider system including the Coventry and Warwickshire Health and Care Partnership, Five-Year Health and Care Plan, and the Coventry HWBS in Coventry for 2019-23.

1.3 This report provides an update on work to refresh the HWBS since the last meeting and outlines the proposed approach to consultation for endorsement by the Board. *NB Timescales for the consultation have been delayed due to recent events regarding Covid-19 and indicative timeframes in section 5.1 will be confirmed in due course.*

2. Refreshing the HWBS

2.1 Work to refresh the Warwickshire HWBS is progressing and is informed by evidence from the JSNA (both from the data and community feedback); learning from the current strategy; and feedback from senior leaders.

2.2 Progress to date includes a stock take of the current strategy; completion of the place-based JSNA in 22 areas with comprehensive feedback from communities and data from a wide range of sources; and the views of senior leaders to help shape proposed priorities.

2.3 Whilst it is recognised that health is generally good overall in Warwickshire compared with the rest of the country, there are significant inequalities and

challenges. There is a growing and ageing population with increasing demand for services. People from communities with good education and good jobs tend to live over 7 years longer for men and 5 years longer for women.

2.4 A greater focus on prevention and early intervention is needed to help people live well in Warwickshire, particularly around the wider determinants of health, our behaviours and lifestyles and in our places and communities as shown in the Population Health model (Figure 1).

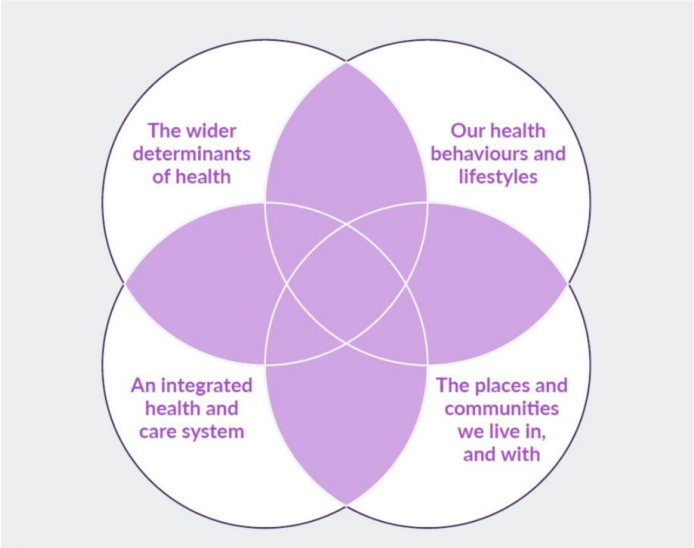


Figure 1: Population Health Model ***(Ref. A vision for population health: Towards a healthier future, The King's Fund, November 2018)***

2.5 The impact of the COVID-19 outbreak on health and wellbeing outcomes has been assessed through Health Impact Assessment (HIA) and is informing the refresh of the HWBS.

2.6 The proposed vision for the refreshed HWBS is: *Living Well in Warwickshire,* with three strategic outcomes of:

- People will lead a healthy life;
- People will be part of a strong community; and
- People will experience effective and sustainable services.

2.7 The main themes from the evidence to date are summarised in Figure 2.

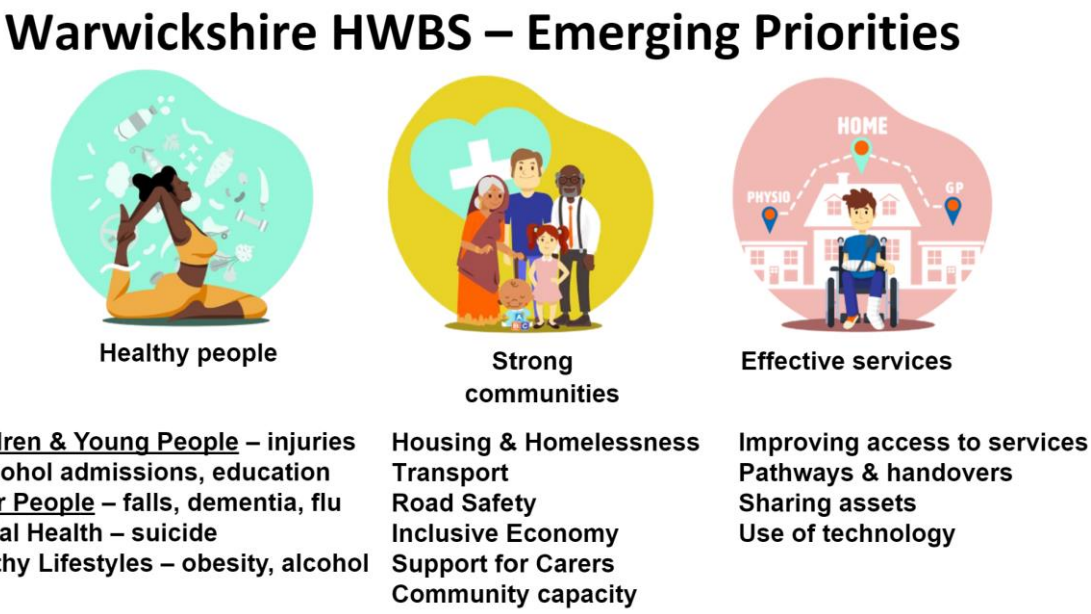


Figure 2: Proposed Priority Areas for the Health & Wellbeing Strategy 2020-25

2.8 It is proposed to focus on two specific areas over the next 12 to 18 months where partners can make a real difference by working together. These areas can be used to test the new ways of working and bring the population health model to life in developing plans to address inequalities across our communities. The following initial priorities are proposed based on feedback from both senior leaders and the JSNA:

- Help our children and young people have the best start in life;
- Help people improve their mental health and wellbeing, particularly around prevention and early intervention in our communities.

2.9 Public consultation is now required to confirm the draft priorities and help shape the HWBS. It is proposed that the consultation will engage with the public and key stakeholders in various ways:

- Information and an online questionnaire will be publicly available on WCC's consultation and engagement hub (the survey can be accessed via this preview) – to be shared and promoted by all HWB Board members and via social media;
- Paper copies will also be made available on request;
- Roadshows will be delivered in each of the five districts in high footfall locations. *NB This is being reviewed in the light of COVID-19 as Roadshow events may need to be adapted for virtual delivery*;
- Targeted engagement will be carried out with key groups including those with protected characteristics (as outlined in the Equality Impact Assessment in the Appendix); and
- Formal and informal presentations will be delivered with partners including community and voluntary sector groups.

2.10 A draft Equality Impact Assessment (EqIA) has been developed and can be found in the Appendix of this report. The draft EqIA is due to be reviewed in September 2020 and will reflect:

- Further equalities impact's which have been highlighted during the pandemic;
- Changes to the consultation approach in the light of social distancing guidelines and measures.

2.11 The WCC Marketing and Communications team will support communications and it is anticipated that the costs of the consultation will be covered within existing budgets. The support of HWB Board members and wider partners is requested in promoting the questionnaire and gathering feedback.

2.12 The feedback from the consultation and engagement will be analysed by WCC Business Intelligence and used to inform the Strategy refresh.

3. Financial Implications

3.1 There are no financial implications from this update at the current time as it is anticipated that the communications and engagement activity will be covered within existing resources.

4. Environmental Implications

4.1 There are no direct environmental implications from this update at this stage. However, as and when more detailed plans are being developed, the relevant Officers will be involved to provide scrutiny and assurance where necessary

5. Timescales associated with the decision and next steps

5.1 It is proposed that the consultation and engagement activity is carried out over a five-week period. The original plan was to carry out engagement during May and June, with the aim to capture feedback to inform the draft Strategy for the September Board meeting as outlined in Table 1. However due to delays related to COVID-19 it is now proposed that the five week consultation and engagement period takes place between September and December 2020, with the aim to capture feedback to inform the draft Strategy for the January Board.

	Original timescales	New Indicative timescales
Health and Wellbeing Board approval	6th May 2020	15th September 2020
Consultation period	11th May to 20th June 2020	28th September to 2nd November
Mid-point review	29th May 2020	12th October
Analysis of results and consultation report	26th June to 27th July 2020	2nd November to 30th November
Draft report for HWB Board	14th August 2020	9th December 2020
HWB Board	15th September 2020	6th January 2021
Feedback to stakeholders	26th October 2020	15th February 2021
Implementation Date	1st November 2020	1st March 2021

Table 1: Original Proposed Timescales and New Indicative Timescales for Consultation and Engagement on the HWBS

Appendices

1. Draft Equality Impact Assessment

	Name	Contact Information
Report Author	Gemma Mckinnon,	gemmamckinnon@warwickshire.gov.uk
Director of Public Health	Dr Shade Agboola	shadeagboola@warwickshire.gov.uk
Lead Director	Strategic Director for People, Nigel Minns	nigelminns@warwickshire.gov.uk
Lead Member	Portfolio Holder for Adult Social Care & Health, Cllr Caborn	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication:
WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse.

Appendix 1 – Draft Equality Impact Assessment

EQUALITY IMPACT ASSESSMENT (EIA)

Health and Wellbeing Strategy refresh 2020 – 2025

Before completing this document please refer to our 'Guide to Equality Impact Assessments' here.

Service/policy/strategy/practice/plan being assessed	**Health and Wellbeing Strategy refresh 2020 – 2025**
Business Unit/Service Area	Public Health (on behalf of the Warwickshire Health and Wellbeing Board)
Is this a new or existing service/policy/strategy/practice/plan?	Existing Strategy (refresh)
EIA Review team – list of members	Rachel Barnes, Rob Sabin, Lucy Rumble, Sue Robinson
Do any other Business Units/Service Areas need to be included?	Business Intelligence, Communications, wider Health and Wellbeing Board partners
Date of assessment	March 2020
Are any of the outcomes from this assessment likely to result in complaints from existing services users, members of the public and/or employees? *If **yes** let your Assistant Director and the Customer Relations Team know as soon as possible*	**No**

Details of service/policy/strategy/practice/plan

Scoping and Defining	
• What are the aims, objectives and outcomes of the service/policy/ strategy/practice/plan?	The Health and Wellbeing Board has a statutory duty to produce and deliver a Health and Wellbeing Strategy for Warwickshire to help improve health and wellbeing in the local population and reduce health inequalities. The strategy outlines the vision, objectives and priorities based on the findings of the Joint Strategic Needs Assessment (JSNA) including performance data and feedback from communities and senior leaders across the health and care system. The objectives of the refreshed strategy need to be reflected in the commissioning plans of Warwickshire County Council (WCC) and its partners. Generally, health in Warwickshire is good overall but it varies widely across the county and we are facing significant challenges over the next five years with an aging population and rising demand for services. We are proposing a vision of 'Living Well in Warwickshire' and three high level strategic outcomes: • People will lead a healthy and independent life. • People will be part of a strong community. • People will experience effective and sustainable services. We are also proposing two short term areas of focus in the next 12-18 months: • Help our children have the best start in life • Help people improve their mental health and wellbeing, particularly around prevention and early intervention in our communities. We plan to carry out public consultation and engagement to help shape the priorities and our approach to delivering the vision of 'Living Well in Warwickshire'. We would like to hear residents' views on this.
• Who are the customers?	Residents and local communities in Warwickshire
• How has equality been considered in the development or review so far?	Equality is a key consideration in the development of this consultation and achieving the vision that people and communities are 'Living well in Warwickshire'. Since 2018 we have been building our understanding of needs and assets across the county by looking at a wide range of evidence and listening to as many people as possible including those with protected characteristics. We have talked to around 2000 people and 300

	community organisations about key issues as part of our Joint Strategic Needs Assessment (JSNA). We have heard the voice of patients through organisations such as Healthwatch and the Clinical Commissioning Groups, and talked to groups such as the Youth Parliament, Children in Care Council, and the Equality and Inclusion Partnership (EQuiP) to help identify priorities. However, there have been a number of key gaps identified where engagement needs to be increased, including: • Residents in North Warwickshire • Those unemployed • Under 30s (including under 18s) • Some ethnic minority groups We need the feedback and views of all communities across Warwickshire to ensure that we are focusing on the appropriate priorities and outcomes in our refreshed strategy.
• What is the reason for the change/development?	The Health and Wellbeing Strategy is a high-level plan for improving health and wellbeing and reducing health inequalities for Warwickshire residents. It is used by Warwickshire County Council (WCC) and other local health and care partners to inform plans for commissioning and delivering services. It also shapes work with partners to help meet health and social care needs and address the wider social determinants of health. The Strategy is owned by the Warwickshire Health and Wellbeing Board, which brings together senior leaders from WCC, district and borough councils, acute and community NHS trusts, the Clinical Commissioning Groups (CCGs), NHS England, the Police and Crime Commissioner, and voluntary sector organisations. The current Strategy runs to the end of 2020 and needs to be refreshed for 2020-25. We need to ensure that we have the views of communities and residents across Warwickshire in order to focus on the appropriate priorities and outcomes.
• How does it fit with Warwickshire County Council's wider objectives?	The Health and Wellbeing Strategy refresh 2020 – 2025 supports the Council Plan and its Vision: "to make Warwickshire the best it can be, sustainable now and for future generations" and its two overarching priorities: 1. For Warwickshire's communities and individuals to be supported to be safe, healthy and independent to help the most vulnerable children and adults. 2. For Warwickshire's economy to be vibrant and supported by the right jobs, training, skills and infrastructure. This will support communities and businesses to develop skills, attract investment, maintain the county's transport network and enable young people to access a place in a high-quality educational setting.

• Why might it be important to consider equality and the protected characteristics?	To ensure that the views of residents and communities are fed into the consultation and that their life experiences and expectations help shape the Health and Wellbeing Strategy. To ensure those who maybe seldom heard, socially isolated or experience barriers to social inclusion are proactively engaged with and supported to be part of the consultation wherever possible.
Information Gathering	
• What sources of data have you used? *You must keep a record of any data you have currently used as supporting evidence*	Extensive data has been collected as part of the place-based JSNA across 22 areas in Warwickshire from 2018-20, and it is proposed the consultation on the HWB Strategy is an extension of this engagement activity. The aim of the JSNA is to carry out research into local health needs and assets and put in place coordinated interventions to address these issues. Over 2000 residents' and professionals' surveys have been completed to collect information to identify health and wellbeing needs of people in Warwickshire. In addition, 16 stakeholder events have been delivered across all 22 JSNA areas to identify local needs and which communities may be adversely affected by inequalities in health. The Business Intelligence team have produced detailed needs assessments through analysis of national and local data. The reports highlight themes and recommendations associated with the health and wellbeing needs of the community: https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1/jsna-place-based-approach At the close of the survey at the end of February 2020, 1769 residents' surveys had been completed. Male (including trans man) - 518 (29.3%), Female (including trans woman) - 1168 (66.0%), Under 18 - 26 (1.5%), 18 – 29 - 80 (4.5%), 30 – 44 - 424 (24.0%), 45 – 59 -423 (23.9%), 60 – 74 - 564 (31.9%), 75 + - 204 (11.5 %), White – British - 1556 (88.0%) Focus groups have been carried out with Youth Parliament and Children in Care Council to capture the views of children and young people in a variety of circumstances. Also stakeholders and partners such as EQuIP, WCAVA, Young People First, schools, schools consortiums, local community groups and youth organisations, Warwickshire Young Carers, Healthwatch, Compass, WCC colleagues have all been given presentations and information and asked to support the JSNA process by inviting partners and colleagues to stakeholder events and by circulating the on-line survey. GPs surgeries, Town and Parish Councils, Clinical Commissioning Groups and South Warwickshire Foundation Trust (SWFT) have all received information and requests were made for these partners to support the consultation process. Public Health colleagues have attended events to promote the surveys and stakeholder events. The WCC Localities Team have also conducted

	surveys and events with residents and community groups/organisations throughout Warwickshire. Social media campaigns have taken place targeting young people: a radio campaign was delivered between December 2019 to February 2020 and the press were approached with articles promoting the surveys and stakeholder events. Case studies have been shared and the JSNA has been promoted through internal and external communications and newsletters.
• What does the data you have tell you about your customers and about protected equality groups?	People from poorer socioeconomic backgrounds and those with long-term health conditions and disabilities may experience more barriers to social inclusion and are at greater risk of experiencing inequalities in health. The public consultation on the draft Health and Wellbeing Strategy will provide the opportunity to engage further with protected equality groups wherever possible, utilising the expertise and networks of organisations such as TAPPSPG (Third, Public and Private Sector Partnership Group) and EQuiP (Equality and Inclusion Partnership).
• What do you need to know more about?	More detailed information and equality monitoring regarding protected equality groups as part of consultation.
• How could you find this out and who could help you?	Using the Health and Wellbeing Strategy refresh 2020-25 consultation and through the use of community engagement roadshows and surveys, with the support of organisations such as Beehive Consulting, WCAVA, EQuIP, Healthwatch and internal colleagues.
Engagement and Consultation	
• Who will you consult with from protected equality groups?	Females, older people, BAME groups and people with a long-standing illness or disability, and young people via engagement as part of the JSNA and the HWB Strategy consultation (as outlined above).
• Who else could you consult with?	Wider consultation on protected characteristics including BAME and sexual orientation, disability, and young people.
• Who can help you to do this?	Partners on the HWB Board and Voluntary and third sector organisations will be asked to support further consultation to capture feedback.
Monitor and Evaluate	
(14) How will you monitor and evaluate the service/strategy/practice/plan?	In the longer-term success will be measured by improved health outcomes and reduced demand on services from developing and mobilising the refreshed HWB Strategy e.g. healthy life expectancy, demand on adult social care services, and attendances at primary and secondary care. In the short term, success will be measured via the number of people engaged in the Health and Wellbeing Strategy 2020-25 refresh consultation and support for the draft priorities.

Please note: Further information and advice about the corporate consultation process can be found here.

(15) Analysis of impact and potential actions:				
Protected characteristics from the Equality Act 2010	**What do you know? Summary of data about/feedback from your service-users and/or staff**	**What does this mean?**		**What can you do?** **All potential actions to:** ● **Eliminate discrimination/mitigate negative impact** ● **Advance equality of opportunity** ● **Foster good relations**
		Positive impacts identified (actual and potential)	**Negative impacts identified (actual and potential)**	
Age	The number of people aged over 65 is increasing significantly across Warwickshire. People are living longer but live with poor health for longer. Public services are struggling to meet the increase in demand. Services for older people is an overarching theme identified in the JSNA.	Increased preventative and early intervention solutions to develop resources and assets to meet the needs of an ageing population.	Some older people may not have the opportunity to engage in this process due to transport and accessibility issues.	Identify solutions to engage this group of people, working with other community groups and organisations that have the expertise and understanding regarding the needs of those over 65.
Disability	Living with a disability may increase the chances of experiencing poor health and social isolation	This consultation will seek to engage a wide range of residents and members of the	Ensuring that those with disabilities can access the consultation process may be	Engage partner organisations that have the knowledge, relationships and expertise associated with a range of disabilities. Engage those with disabilities in the consultation process through roadshows and/or questionnaires.

		community, including people with a range of disabilities	challenging.	
Sex	Women are generally living longer than men. This in itself creates challenges. As a result women may experience more poor health conditions associated with old age. There is an increased prevalence of men experiencing poor mental health.	Women have shown a greater interest in the JSNA consultation. This has helped to gain a greater understanding of the needs of women.	Ensuring the needs of both men and women are met equally. Exploring mechanisms to overcome the gender bias in the JSNA consultation and engage equal numbers of both genders.	Use different methods and mechanisms to engage both men and women.
Race	BAME communities may have a greater chance of experiencing poverty and or social isolation. The consultation will seek to engage these communities to help to identify mechanisms to overcome these barriers.	BAME communities engaged and given greater opportunities to address health and wellbeing issues specific to their needs.	Inadvertently excluding minority communities and therefore not meeting their needs.	Proactively engage BAME communities within their neighbourhoods and work with partners with existing relationships and networks.
Religion or belief	No information available			More engagement in this area will be carried out. All residents and members of the community will be

				proactively engaged in the consultation. Relationships and networks will be developed with members of these communities and community groups or organisations working with these communities.
Gender Reassignment	No information available			As above.
Pregnancy and Maternity	No information available			As above.
Sexual orientation	No information available			As above.
Marriage and Civil Partnership (NB: only in relation to due regard to eliminating unlawful discrimination)	No information available			As above.

(16) Outcomes of Equality Impact Assessment		
Action	**Timescale**	**Responsibility**

Engagement is required with all groups within the Protected Characteristics in order to identify health and wellbeing needs.	**Oct 20 – Nov 20**	**Public Health**

Date of Next Review	**September 2020**

Name and signature of Officer completing the EIA	**Rachel Barnes**
Name and signature of Assistant Director	**Shade Agboola**
Name and signature of Directorate Equalities Champion	

If you would like any equalities support or advice on this completed document, please contact the Equalities Team on 01926 412370 or equalities@warwickshire.gov.uk

This page is intentionally left blank

Agenda Item 3

Health and Wellbeing Board

Health and Wellbeing Partnerships

15 September 2020

Recommendation

The Health and Wellbeing Board is asked to:

1. Note and support the progress made by the three Health and Wellbeing partnerships in Warwickshire

1. Background

1.1 The Health and Wellbeing Partnerships (HWP) in the three places of Warwickshire North, Rugby and South Warwickshire are critical to the successful delivery of the Health and Wellbeing Strategy, the new Coventry and Warwickshire Health and Care Partnership and the place-based Joint Strategic Needs Assessment (JSNA). Their role in the wider Health and Wellbeing system is outlined in the diagram in Appendix A. This report provides an update on progress made by the partnerships and future plans.

2. South Warwickshire Health and Wellbeing Partnership

2.1 The South Warwickshire Healthy Citizens Forum (HCF), which oversees the SW Healthy and Wellbeing Delivery Group and South Place Co-ordination Group, agreed in January 2020 to prioritise Mental health, outcomes for Children and Young People and action on Climate Change. These priorities were reviewed in April following the COVID-19 pandemic and were agreed as still relevant; an additional priority to collaborate to support recovery from COVID-19 was added.

2.2 In July the HCF considered their partnership contributions in light of the NHS Confederation 5 Point Plan for Integrated Care Systems, mapping activity against each of the 5 areas: Anchor Networks; Workforce; Embedding Health; Developing Local Supply Chains and Civic Restoration. It was agreed further focus is required on developing a joint approach to procurement, developing the local supply chain and commissioning for Social Value.

2.3 The South Warwickshire Health and Wellbeing Delivery Group is updating a local action plan to reflect COVID-19 response and recovery priorities. This includes partners supporting vaccination campaigns; working with communities and volunteers to build awareness of and trust in the Test and Trace programme; promoting digital inclusion through laptop recycling schemes; upskilling communities on mental health and suicide prevention;

and strengthening data sharing on the impacts of the pandemic on local communities.

2.4 In response to the HCF's request for further work on commissioning and procurement the partnership will be bringing together a task and finish group to bring procurement officers and officers from Economy and Skills to explore opportunities to develop the local supply chain. The partnership will also link in with the work of Warwickshire County Council to develop a shared approach to commissioning for social value.

2.5 The partnership is also supporting the development of mental health hubs to ensure holistic support is available to those accessing mental health services and continues to support the Stratford Housing Plus project.

3. Rugby Health and Wellbeing Partnership

3.1 The Rugby HWP agreed new terms of reference earlier in the year and since then has been chaired by the Executive Director of Rugby Borough Council. WCC Public Health are providing the secretariat and working closely with RBC to develop the partnership. Under the new terms of reference, the role of the partnership is to lead responsibility for delivering actions to improve the health and wellbeing of communities in Rugby. This includes the actions emerging from and informed by the JSNA.

3.2 Alongside the new terms of reference for the HWP, Rugby also saw the formation of the Delivery Board, as part of the Health and Care Partnership governance. This board has established itself through a series of meetings during the pandemic that supported joint working at the time. There is a strong working relationship between the two groups with the Delivery Board meeting between the HWP meetings. This way of working has allowed conversations and shared work between the two groups to be sustained.

3.3 The identification of priorities for health and wellbeing in Rugby has been the core work of the partnership over the previous months. This has been supported by the completion of the JSNA programme, and a thematic analysis was carried out on the JSNA place-based profiles to draw out issues that were consistent across each of the five areas.

3.4 The themes and high level priorities were presented at the July HWP, and included: poverty and inequality, future demand for services, healthy lifestyles, injury prevention, mental health, preventative healthcare and managing long term conditions, asset based approaches and social connections, healthy aging, access to services and, crime and community safety.

3.5 Further work is being done in partnership with the delivery board to triangulate the themes against the previous engagement work and plans of different organisations. Similarly the same presentation on JSNA themes was given to the Rugby BC Cabinet. An agenda item on September's partnership will work to refine these themes and prioritise a smaller number of actions that the HWP can lead or oversee.

3.6 Other agenda items for the HWP have included provision of health care and promotion of health for new and future residents of the Houlton development, recovery and restoration plans of the organisations on the HWP, and implications of the recent smoking in pregnancy review for Rugby.

3.7 The HWP has also supported a grant funding bid to the Kings Fund Healthy Communities Together programme.

4. Warwickshire North Health and Wellbeing Partnership

4.1 Warwickshire North HWP has been taking a strategic view on a range of health and wellbeing priorities across the two boroughs. The membership includes representatives from North Warwickshire Borough Council, Nuneaton and Bedworth Borough Council, Warwickshire North CCG, George Eliot Hospital, Primary Care Network, SWFT, WCC, and Warwickshire CAVA.

4.2 The partnership has been delivering on a set of priorities and feels it has made a significant impact, as outlined at previous HWB Board meetings. However, it recognises that the needs of the population have changed significantly, and partners priorities' have also changed. There have been changes in both Member and officer representation and the partnership currently has an independent Chair.

4.3 At last meeting in June the partnership discussed key concerns in the patch regarding immunisations with the Health Protection Lead Nadia Inglis. There was a discussion regarding plans to tackle low up take of immunisations in North Warwickshire such as the Childhood vaccinations rates (including further concerns since COVID-19). The Partnership also reviewed the recommendations of the smoking in pregnancy review.

4.4 COVID-19 in the patch is of high concern and members wish to be further updated on the situations which arise in the area even after the incident has closed. Although the HWP members were being informed from Public Health and other sources, they were also concerned about incidents and were appreciative of updates on management and processes. At the next meeting there is a plan to ensure that further updates on preparedness and incidents.

4.5 The partnership is working with the Place Executive to develop priorities that are aligned with the findings of the JSNA and compliments the Place Executive's priorities. We aim to have this at the next meeting.

5. Financial Implications

5.1 There are no direct finance implications from this update at this time. However, as more detailed plans are developed, the relevant Officers will be involved to provide scrutiny and assurance around spend and benefits where necessary.

6. Environmental Implications

6.1 There are no direct environmental implications from this update. However, as more detailed plans are being developed, the relevant Officers will be involved to provide scrutiny and assurance on this area where necessary.

7. Next steps

7.1 The HWB Partnerships will refresh their action plans in line with evidence from the JSNA which is now complete. Three partnership plans will then be produced, outlining health and wellbeing priorities for each area, in line with the refresh of the HWB Strategy for 2020-25 and also the Coventry and Warwickshire Health and Care Plan. Further updates on progress will be provided to future meetings of the Health and Wellbeing Board

Appendices

1. Appendix 1 – Current Structure of the Health and Wellbeing System

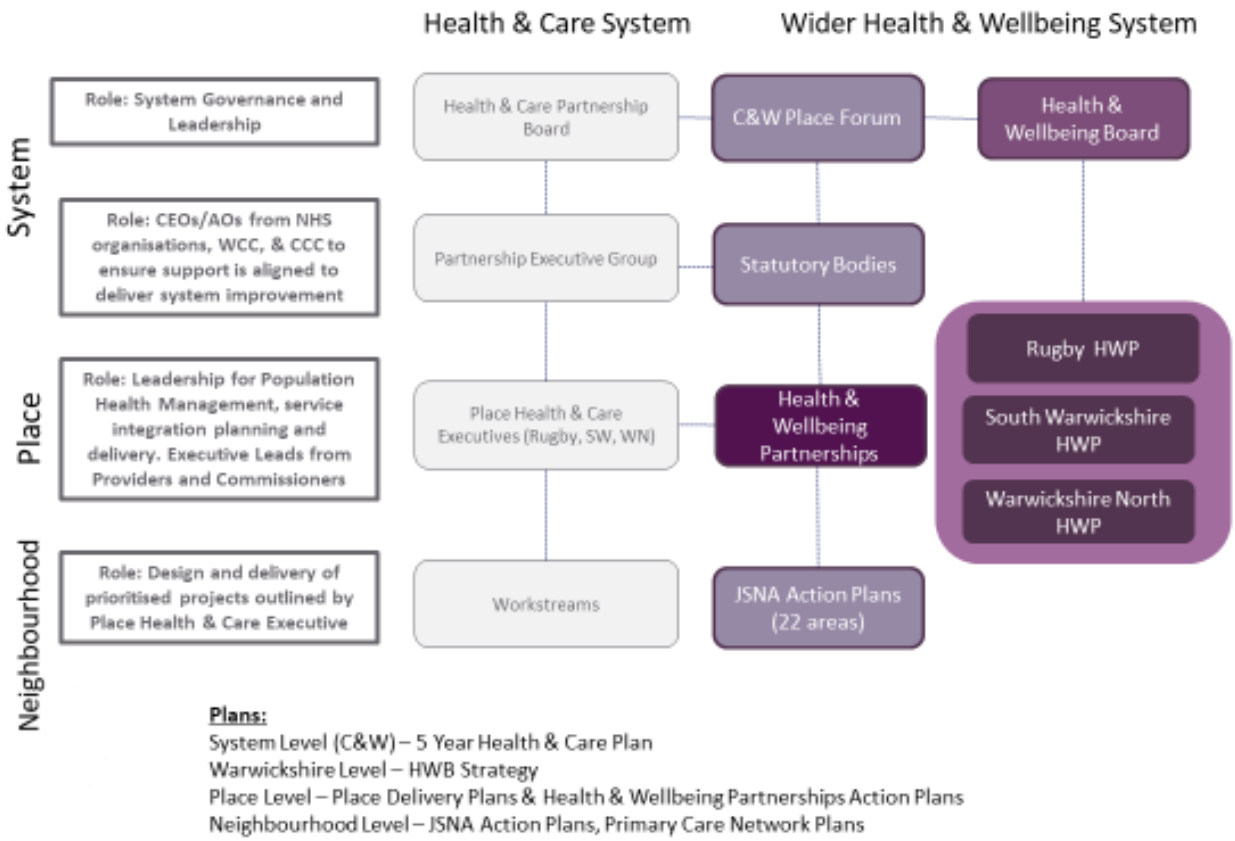
Background Papers

None

	Name	Contact Information
Report Author	Liann Brookes-Smith, Emily Van de Venter, Duncan Vernon	LiannBrookes-Smith@warwickshire.gov.uk, emilyvandeventer@warwickshire.gov.uk, duncanvernon@warwickshire.gov.uk
Director of Public Health	Dr Shade Agboola	shadeagboola@warwickshire.gov.uk
Lead Director	Nigel Minns	nigelminns@warwickshire.gov.uk
Lead Member	Cllr Caborn	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication: WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

Appendix 1: Current Structure of the Health & Wellbeing System - showing the role of the Health & Wellbeing Partnerships at 'Place' level



Plans:
System Level (C&W) – 5 Year Health & Care Plan
Warwickshire Level – HWB Strategy
Place Level – Place Delivery Plans & Health & Wellbeing Partnerships Action Plans
Neighbourhood Level – JSNA Action Plans, Primary Care Network Plans

This page is intentionally left blank

Item X

Health and Wellbeing Board

15th September 2020

Warwickshire Safeguarding 2019-2020 Annual Report

Recommendation

It is recommended that:

1. The Health and Wellbeing Board receive the 2019-2020 Annual Report for Warwickshire Safeguarding and note the progress the partnership has made against its strategic priorities during the course of the year.

1.0 Key Issues

1.1 Warwickshire Safeguarding is required to produce and publish an annual report in accordance with the statutory requirements governing its establishment i.e. The Care Act 2014 (Adults) and Working Together 2018 (Children).

1.2 The partnership is required to share its annual report with the following offices, including its members and wider public:

- Leader of the Local Authority and the Chief Executive, reflecting the fact that they are responsible for establishing the Boards
- Office of the Police and Crime Commissioner
- Clinical Commissioning Groups
- The Chair of the Local Health and Wellbeing Board
- The Local Healthwatch

2.0 Options and Proposal

2.1 The annual report provides a high-level overview of key performance data in relation to safeguarding children, young people and adults, details of work undertaken against each of the strategic priorities; and learning and improvement work conducted throughout the year.

2.2 During the course of 2019-2020 the partnership finalised its new governance structure and constitution to enable it to transition into Warwickshire Safeguarding. The new strategic partnership infrastructure to safeguard children, young people and adults came into effect 29 September 2020 with a

newly agreed strategic plan setting out its priorities for 2019-2021 which centre around the following:

- Effective Safeguarding
- Prevention and Early Intervention
- Exploitation

2.3 Since September 2019 the Executive Board has continued to meet on a monthly basis to discharge its statutory duties by overseeing, reviewing and agreeing the coordination of local work to safeguard and promote the welfare of children and adults across Warwickshire.

The two Safeguarding Partnership Groups (children and adults) have contributed to the partnership's assurance work through thematic reviews and safeguarding reviews for children and adults.

The newly formed subgroups responsible for the management and oversight of safeguarding reviews and the exploitation of children and adults have put in place new terms of reference for each of their subgroups and continued to develop and execute their respective workplans.

The Education Subgroup meetings have continued to provide opportunities for wider engagement with schools and educational settings to improve understanding and awareness of the new ways of working introduced by Warwickshire Safeguarding; and engage them in the development and delivery of the partnership's strategic priorities.

2.4 A new Quality Assurance Framework has been developed and implemented to support the partnership fulfil its statutory responsibility to seek assurance on the effectiveness of safeguarding practices from across its partner agencies.

The 'Exploitation of Children and Adults' was the focus of Warwickshire Safeguarding's new strategic thematic review which sought assurance from a selection of partner agencies on their compliance with Warwickshire's safeguarding policy and procedures, the delivery of safeguarding training; and effective engagement of service users in decision making (children, young people, adults and families). Evidence of the above was gathered through the completion of single agency self-evaluations, on-line surveys with staff, conversations with professionals and service users.

This information was used to formulate an overarching multi-agency action plan for the partnership which has now formed part of the Exploitation Subgroup's workplan. A comprehensive report detailing the findings of this strategic thematic review has been published to support wider understanding and awareness of exploitation across the county.

2.5 Warwickshire Safeguarding has also introduced new and improved opportunities for sharing learning from Children's Safeguarding Practice

Reviews (formerly known as Serious Case Reviews) and Safeguarding Adults Reviews.

The development of 7 Minute Briefings enables the partnership to place the spotlight on specific areas of safeguarding practice to promote awareness and understanding of policy, procedure and application. Lessons Learned Briefings provide a snapshot overview of case specific details with key points of learning for both professionals working with children and adults, and the community at large.

These new resources have been welcomed by the partnership and are actively being used to support single-agency learning and development and service improvements.

2.6 The partnership has seen a significant increase in the number of safeguarding referrals being submitted for review of cases where the child or adult has experienced/or is suspected to have suffered abuse or neglect.

Warwickshire Safeguarding has now streamlined its processes to provide a consistent approach for the scoping of safeguarding review referrals for both children and adults, in line with Working Together 2018. This enables the partnership to swiftly gather information from partner agencies to undertake a Rapid Review of the case of the child or adult, review the involvement and role of each partner agency; and identify any key learning which can be shared across the wider partnership to help prevent similar occurrences in future cases. Provided below are total numbers of referrals and rapid reviews conducted:

- **No. of referrals received = 21** (11 Adult cases, 10 Children's cases)
- **No. of Rapid Reviews conducted = 14** (8 Adult cases, 6 Children's cases)
- **No. of referrals progressing to full review = 4** (1 Adult case, 2 Children's cases and 1 joint adult and child case)

3.0 Timescales associated with the decision and next steps

3.1 The Annual Report will now be published on Warwickshire Safeguarding's website and distributed amongst partner organisations for wider circulation.

Background papers

1. Warwickshire Safeguarding Annual Report 2019-2020

	Name	**Contact Information**
Report Author	Amrita Sharma	amritasharma@warwickshire.gov.uk Tel: 07766367414

Head of Service	Pete Sidgwick	petesidgwick@warwickshire.gov.uk Tel: 01926 742962
Strategic Director	Nigel Minns	nigelminns@warwickshire.gov.uk Tel: 01926 412665
Portfolio Holder	Cllr Les Caborn Cllr Jeff Morgan	cllrcaborn@warwickshire.gov.uk Cllrmorgan@warwickshire.gov.uk

Warwickshire Safeguarding

Annual Report

2019-2020

Warwickshire Safeguarding

Introduction by Independent Chair & Scrutineer

Warwickshire Safeguarding came into effect in September 2019 and I am very pleased to introduce this year's annual report which focuses on our New Partnership Arrangements for Safeguarding Children and Adults.

The Warwickshire model replaces the previous Warwickshire Safeguarding Children Board (WSCB) and Warwickshire Safeguarding Adults Board (WSAB) structures with:

- A Safeguarding Executive Board for adults and children.
- A Warwickshire Safeguarding Children's Partnership and a Warwickshire Safeguarding Adults Partnership.
- Quality Learning and Improvement Hubs

Much of this year has been spent developing a culture that supports the collaborative working arrangements needed to safeguard Warwickshire's vulnerable adults and children. It is encouraging to see the development of opportunities for dialogue, growing mutual respect between all organisations, and an increased understanding of each other's roles and responsibilities.

At the time of writing this report Warwickshire, in common with the rest of the country, is managing the impact of the Coronavirus pandemic. All services have had to adapt to ensure services are delivered safely and continue to offer support whilst reducing the risk of COVID-19 transmission. Working through a pandemic will inevitably form an important part of next year's annual report, and the legacy of the pandemic particularly in terms of mental illness, isolation, wellbeing, and safeguarding will be fully explored. In the coming months attention needs to be paid to developing commissioning intentions that reflect these new needs, but for now I would like to thank everyone involved in maintaining high standards of professional practice and care.

With new reforms and legislation transforming the safeguarding landscape, there is a distinct focus not only around protection but also the prevention agenda, exploitation and contextual safeguarding. Warwickshire Safeguarding partners have established effective working practices in these areas and progress has been made in key areas including audit, communicating & information sharing, and challenge & scrutiny.

During the period of this report Warwickshire Safeguarding has seen an increase in the number of referrals for safeguarding reviews from across the partnership in respect of both adults and children. This increase is seen as positive and demonstrates a growing confidence in professionals and a willingness to consider circumstances that might point to abuse or neglect. I would like to commend the business team for their work in developing a wide range of tools to support learning from reviews. The seven-minute briefings and lessons learned briefings have been particularly well received.

The coming year is likely to be challenging. The risk of a resurgence of coronavirus is increasingly real. Warwickshire Partnership has developed a good foundation on which to collectively support each other when ways of working become more challenging and complex –and society is infinitely more complex. The partnership knows itself better and acknowledges that more needs to be done in every area, however it has achieved a lot in its first year and should be congratulated.

Elaine Coleridge Smith
Independent Chair & Scrutineer
Warwickshire Safeguarding

Key Facts (Adults)

Warwickshire Safeguarding

3144
CONCERNS RECEIVED
(3483 in 2018/19)

298
SECTION 42 ENQUIRIES
(192 in 2018/19)

Section 42 Enquiries – Top 3 primary support reasons:

- Physical Support
- Mental Health
- Learning Disability

Top 3 Types of Abuse for concluded Section 42 Enquiries

Financial or Material Abuse	Physical Abuse	Psychological Abuse
36.29%	14.97%	14.21%

Concluded Section 42 Enquiries – Top 2 locations of risks:

- Own Home
- In the community (excluding community services)

Asked what outcome they want	Risk Reduced or Removed	Outcome Fully or Partially Met
64.79%	68.9%	94.94%
(71.24% in 2018/19)	(81.62% in 2018/19)	(94.07% in 2018/19)

22	231	31
Safeguarding enquiries involved strangers who were unknown to the victim	Concluded safeguarding enquiries listed the source of risk as an individual known to the victim	Safeguarding allegations involved abuse by social care staff

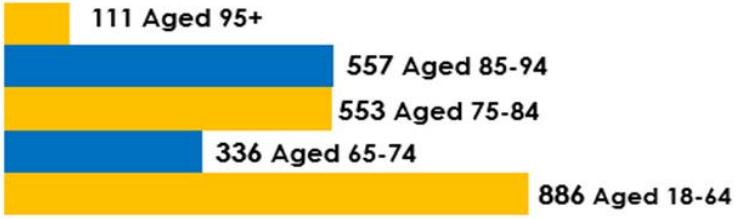
Individuals involved in Safeguarding Concerns

DEMOGRAPHICS

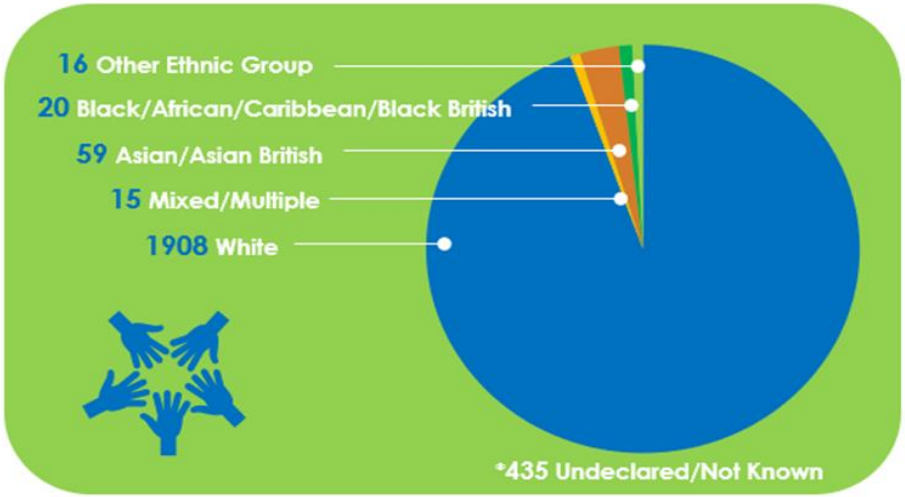
966 Male

1482 Female

*5 Unknown



*10 Unknown



Key Facts (Children)

Warwickshire Safeguarding

Warwickshire has a resident population of approximately **117,720** children ages **0-17 years**, who make up around a fifth of the total population of the county

18,081
CONTACTS RECEIVED
(19,878 in 2018/19)

5,046
SAFEGUARDING REFERRALS RECEIVED
(5,351 in 2018/19)

- **754** Looked After Children (722 in 2018/19)
- **673** LAC Missing Episodes (822 in 2018/19)
- **120** Missing Looked After Children (128 in 2018/19)
- **295** Children subject to a CP Plan (345 in 2018/19)

Open to Child Sexual Exploitation Team
68
(59 in 2018/19)

Domestic Violence most prevalent risk factor in children
2728
(2269 in 2018/19)

Referrals received for children with a disability
1.2%
(1.3% in 2018/19)

Largest proportion of children subject to a child protection plan were aged **0 to 5**. This is a change to the previous year when the largest cohort was aged **10 to 15**.

In January 2020, **19%** of the school population were classified as being of an ethnic group other than White British, the largest minority ethnic group being 'Any Other White Background' **(6%)** followed by 'Indian' **(4%)**.

Top 3 types of abuse for children subject to Child Protection Plans:

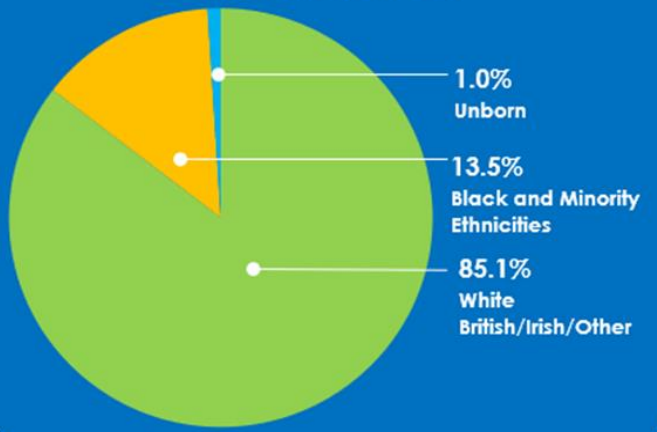
Emotional Abuse	Neglect	Multiple
46%	25%	22%

Referrals to Children's Social Care

25.1% Received from Police

22.8% Received from Schools

Referrals by Ethnicity

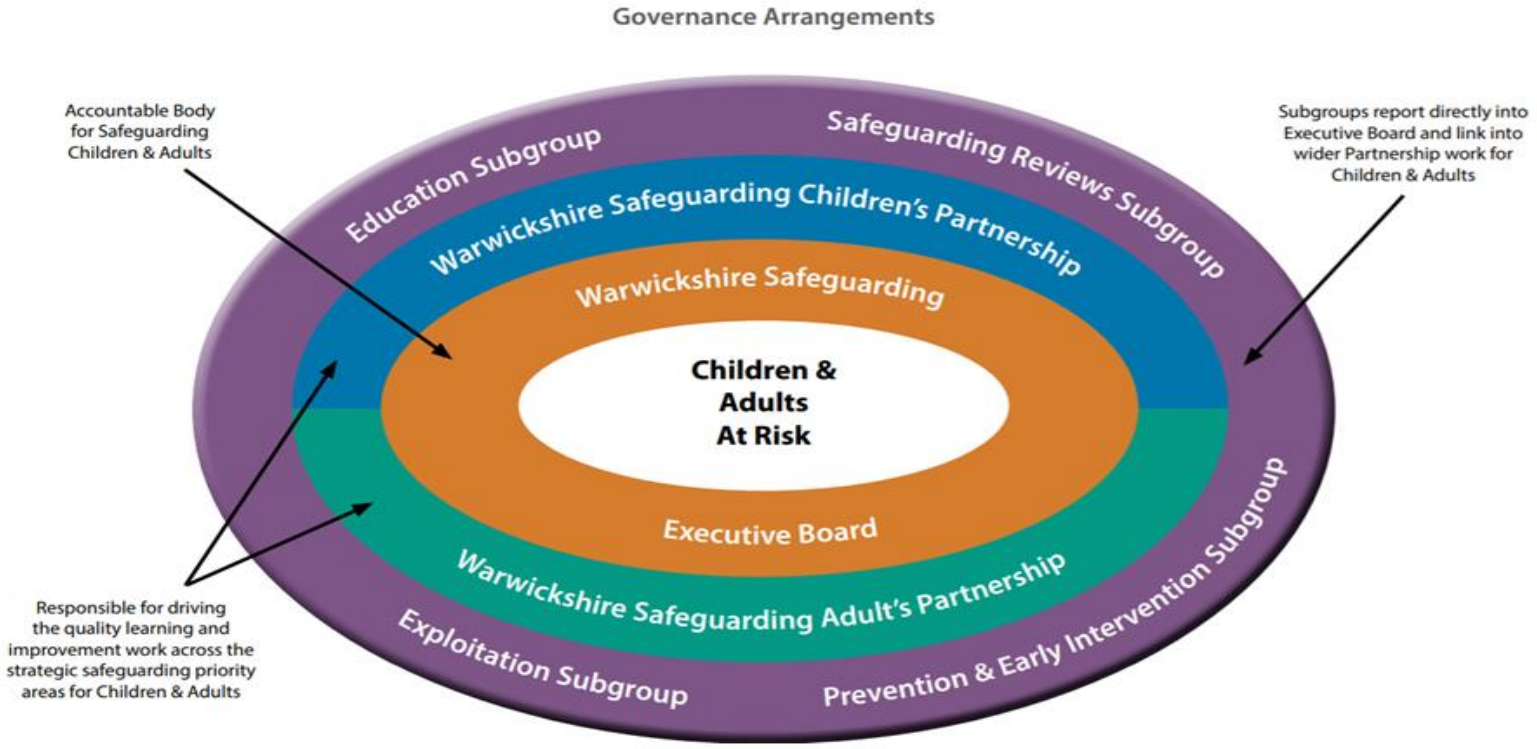


*0.4% Not Recorded

Governance Arrangements

Warwickshire Safeguarding replaced both former safeguarding partnerships (Warwickshire Safeguarding Children's Board (WSCB) and Warwickshire Safeguarding Adults Board (WSAB)) with effect from 29th September 2019 and established its new governance arrangements to combine the responsibility for safeguarding children and adults under the guidance of Working Together 2018 and the Care Act 2014.

The illustration below provides details of this new structure:



During the course of 2019-2020 the newly formed Warwickshire Safeguarding Executive Board continued to meet on a monthly basis to guide and approve new ways of partnership working and discharging their safeguarding duties. The Warwickshire Safeguarding Children's Partnership Group and Warwickshire Safeguarding Adult's Partnership Group held two meetings and were engaged to participate in the implementation of the new quality assurance framework and evaluation of findings from assurance activities. The Subgroups continued to meet on a regular basis to drive the agenda against each of their remits in respect of safeguarding adults, children, young people and families. The Prevention & Early Intervention Subgroup is yet to be established and work is underway to develop a clear remit for this subgroup, which builds on other prevention and early intervention activities underway across other partnership groups operating across the county.

Strategic Priorities

Warwickshire Safeguarding's new strategic priorities were agreed as part of the consultation and engagement on the new partnership arrangements replacing the two former safeguarding boards (Warwickshire Safeguarding Children's Board and Warwickshire Safeguarding Adults Board). The focus of the partnership's work has centred around these priorities which are overarching across both adults and children's safeguarding. Warwickshire Safeguarding will seek to gain assurances that safeguarding arrangements across the partnership are effective in helping to keep children, young people and adults with care and support needs safe from abuse and neglect and achieving positive outcomes:

Strategic Priority	What we did..
Effective Safeguarding	• Warwickshire introduced a new integrated governance model for safeguarding children and adults that allows the partnership to develop a family focused approach to working across the wider policy and partnership landscape. • Introduced new Pathway to Change model to develop shared language and understanding with families and partners agencies, which is in line with the Restorative Practice approach. This approach encourages practitioners to build relationships which should be child centred but also engage and work with the whole family. Recognising that to achieve and sustain change, parents need to be supported to care for their children. Practitioners need to provide practical support and recognise that families are the experts in their lives and their strengths and goals will be central to our approach.

	• Delivered a series of workshops to help broaden awareness and understanding of the new 'Pathway to Change' model across the wider partnership.
	• The MASH introduced new ways to manage incoming demand as part of the MASH Re-design, including the integration of improved advice/information and early support pathways.
	• Ongoing work with partner agencies to ensure consistent understanding and application of thresholds, pathways for support and interventions, including improving the quality of referrals.
	• Warwickshire health services have continued to work closely with partners to both identify children , young people and adults at risk and contribute to any ongoing support to reduce harm.
	• Warwickshire Police established a new Child Abuse, Trafficking and Exploitation Team Working with statutory and voluntary agencies to:
	  ○ *Manage risk to children*
	  ○ *Investigate offences and prosecute offenders*
	  ○ *Safeguard and protect children and young people from abuse and exploitation*
	  ○ *Work with the Missing team and partners to identify links between missing young people, exploitation and abuse.*
	• Warwickshire Police continued to work with partners, to seek to identify and investigate incidents of Child Sexual Exploitation and Child Criminal Exploitation which support the development and introduction of new practices to prevent exploitation and develop the links with missing children by increasing early identification of those most at risk of harm.
	• The Missing team, working in partnership with Warwickshire County Council Missing Practitioners continued to work together to identify children who are at risk of going missing and manage those who have multiple missing episodes to reduce risk to them. In Warwickshire last year, 113 children went missing repeatedly, accounting for 643 missing children investigations. The Missing team worked closely with partners to:
	  ○ *Gather intelligence in relation to the missing episode*
	  ○ *Reduce the duration of the episode*
	  ○ *Provide a return home interview for the child to increase knowledge of the causes of the episode*
	  ○ *Share information between agencies*
	• A Statutory & Major Crime Review Unit has been established to:
	  ○ *oversee Statutory reviews (DHR, Local Child Safeguarding Practice reviews, Safeguarding Adult reviews, MAPPA Serious Case Reviews)*

	○ *Identify good practice and organisational learning for cascading in the most relevant format to the wider workforce.* ○ *Improve the quality of investigations and working practices that will provide better outcomes and increase the trust and confidence of the community in Warwickshire Police and our Statutory partners.*

Strategic Priority	**What we did..**
Prevention & Early Intervention	• Warwickshire introduced new Early Help Pathway Assessment to make it easier for practitioners to complete the Early Help Assessment with families in line the new Restorative Practice approach. • Warwickshire has developed a stepped approach to Early Help services. This means that families and practitioners can identify what support is available to them at the level that best meets their needs. The help offered to a family can range from signposting to an informative website, right through to working with the family to complete an assessment called the Early Help Pathway to Change Plan. This helps ensure that families receive support from the right service at the right time.

Strategic Priority	**What we did..**
Exploitation	• Warwickshire Safeguarding has integrated the safeguarding arrangements for children and adults within a single governance model which enables the operational arrangements on the ground to be integrated. Under the new arrangements an all age Exploitation Sub Group was created to provide strategic oversight in relation to the protection of children and adults from harm as a result of criminal and sexual exploitation and abuse, people trafficking, modern slavery and children missing from home, school and care. • The Executive Board decided that the theme of Exploitation would be the subject of the partnership's first strategic thematic review. • Warwickshire commissioned Research in Practice to support the development of Warwickshire Safeguarding's new 'Exploitation Strategy'. Two workshops were held which involved partner representation from across

	Warwickshire's Public, Voluntary and Community sectors the learning gathered from these is helping to inform the new strategy and work plan moving forward. • Warwickshire has established a dedicated multi agency Child Exploitation Team (CET) which includes members from Warwickshire Police, Social Care & Barnardo's and have a campaign called "Somethings Not Right" which is a positive and well-regarded campaign raising awareness around child exploitation. • New strategic arrangements have increased partnership working between the exploitation team with Youth Justice, voluntary organisation ROSA who provide victims with counselling and three Cyber Crime Advisors. • The CCG has worked closely with the missing from education team to identify those young people most at risk. • Warwickshire continued to support victims of modern slavery and human trafficking. During 2019-2020 **a total of 110 referrals were made into the National Referral Mechanism (NRM)**. This is a framework for identifying and referring potential victims of modern slavery and human trafficking and ensuring they receive the appropriate support. The breakdown of this total number is: ○ **89** Child referrals ○ **21** Adult referrals • A total of **250 child cases of Child Sexual Exploitation and 32 human trafficking cases** were supported through the safeguarding partnership and a total of 2 adult safeguarding cases related to modern slavery were concluded under s42 Enquiries, as per the criteria in the Care Act 2014. • A total of **15 County Lines have been identified as operating across Warwickshire**. Work continues to increase awareness of this issue and finding ways to combat the problem working with safeguarding partners from across neighbouring local authority areas and partners from within Warwickshire.

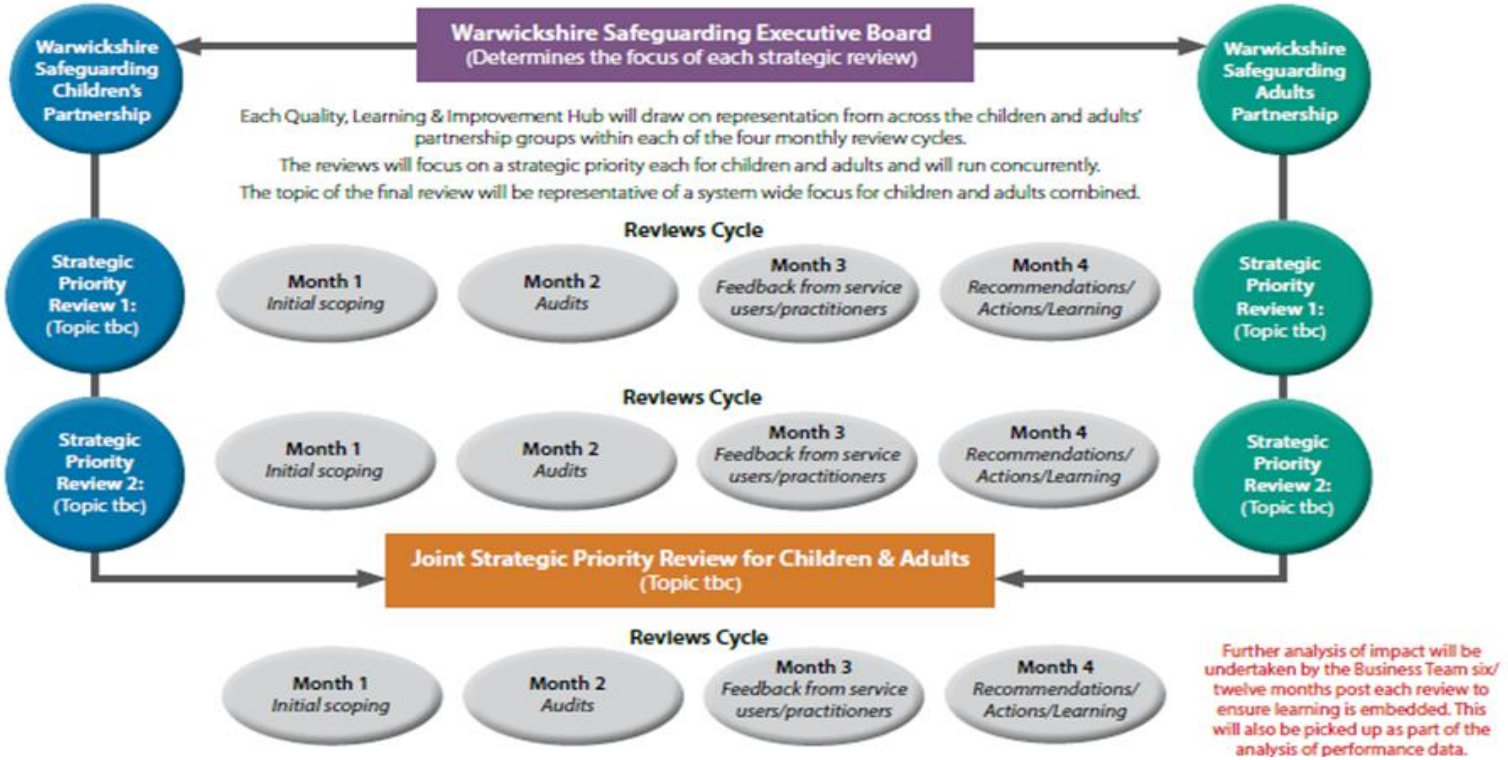
Quality Assurance Framework

As part of its new ways of working, Warwickshire Safeguarding implemented a new Quality Assurance Framework *(see illustration below)* introducing quality learning and improvement hubs to provide independent scrutiny and assurance of safeguarding practices being adopted across the partnership. A series of tools were developed to support single agency self-evaluations, case file audits, professionals' surveys and conversations with professionals and service users.

Warwickshire Safeguarding

Warwickshire Safeguarding Quality Learning and Improvement Hubs

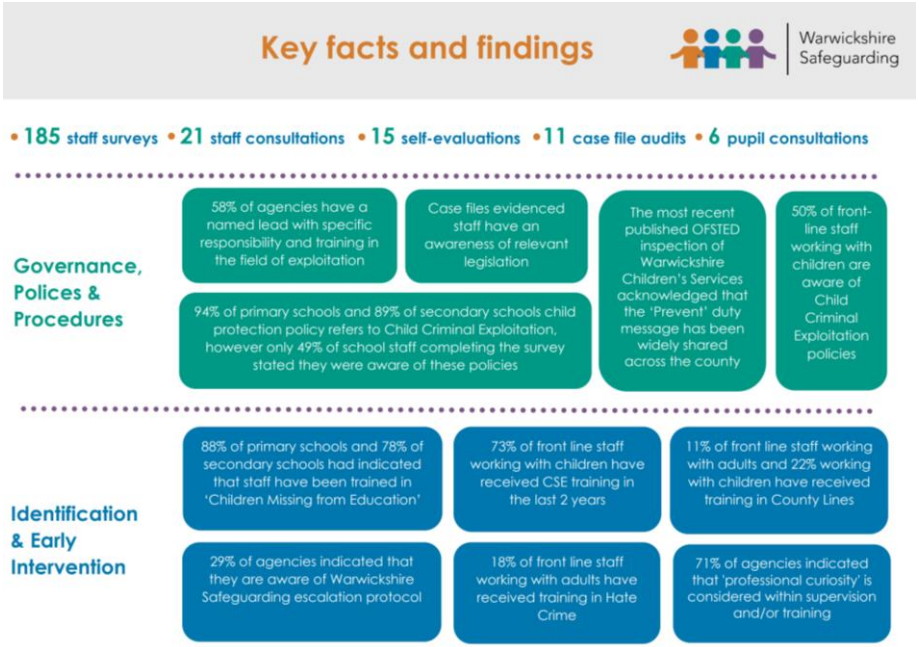
(Designed to drive the delivery of the Quality Learning and Improvement Framework. The hubs will be convened to examine a range of information from a variety of sources relating to multi-agency practice issues aligned to one of the safeguarding Board's strategic priorities for Children or Adults)

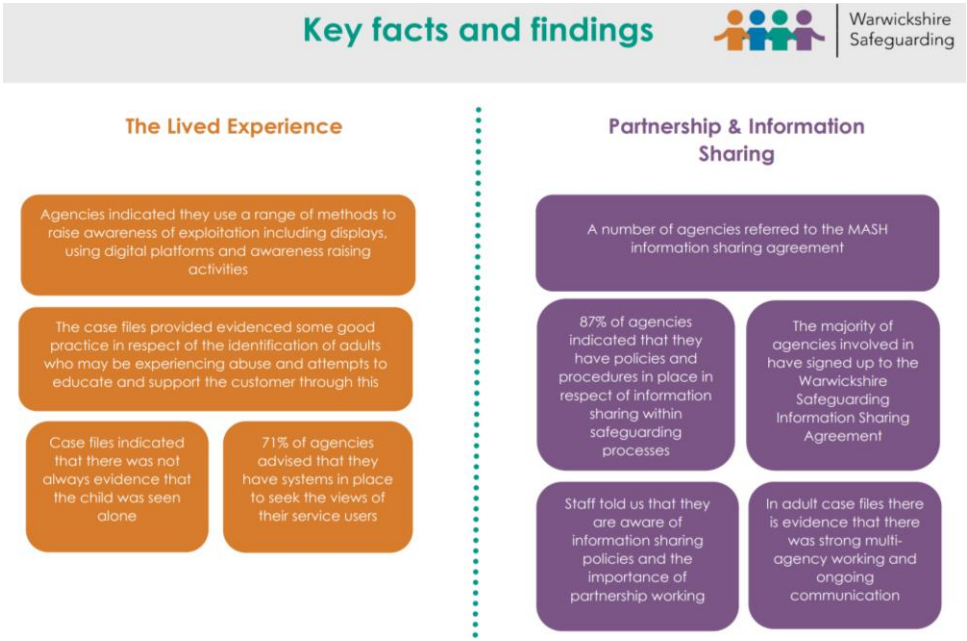


The key lines of enquiry for each thematic review will look to scrutinise the effectiveness of practice across the following four key areas:

- *Governance, Policies & Procedures*
- *Identification & Early Intervention*
- *The Lived Experience*
- *Partnership & Information Sharing*

Warwickshire Safeguarding Executive Board (WSEB) determined that the focus of the first thematic review would be 'The Exploitation of Children and Adults', in line with the partnership's strategic priorities. This thematic review was completed in January 2020 and the final full report and an executive summary of the findings were published on the website. The report captured learning identified from single agency self-evaluations, case file audits, professionals' surveys, conversations with professionals and service users. This proved to be a very insightful and valuable exercise which helped the partnership to consider successes and challenges, identify learning, make suggestions and recommendations for improvements, both at multi-agency and single agency levels. Detailed below are some of the key findings from this thematic review:





The responsibility for the delivery and oversight of the multi-agency summary action plan developed in response to this thematic review sits with the Exploitation Subgroup, who provide WSEB with regular updates on performance against these actions.

Learning and Improvement

Over the course of 2019-2020 Warwickshire Safeguarding introduced a number of new initiatives to help to improve the pace of learning and improvement across the safeguarding agenda for both adults and children, young people and families. Provided below are the details of how this has been achieved.

Safeguarding Reviews

Adults	Children
The Care Act 2014 places a statutory duty on local Safeguarding Adults Boards (SABs) to arrange Safeguarding Adults Reviews (SARs) ***• When an adult, with needs for care and support, (whether or not the local authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; OR*** ***• If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult. 'Serious Abuse' is considered to be life threatening which requires intervention to prevent death and/or where there is significant psychological impact of the abuse on the individual.***	***The Children and Social Work Act 2017 places a duty on safeguarding partners to make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.*** ***Serious child safeguarding cases are those in which:*** ***• Abuse or neglect of a child is known or suspected; and*** ***• The child has died or been seriously harmed.*** ***Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health.***

Warwickshire Safeguarding has continued to receive a high volume of referrals from across the partnership in respect of both adults and children's cases where the referrer considers the circumstances of the abuse or neglect caused to the individual could have potentially been managed differently and where lessons can be learned and improvements to practices identified and implemented.

Working Together 2018 introduced a new requirement for undertaking Rapid Reviews. The aim of the rapid review being to enable safeguarding partners to:

- *Gather the facts about the case, as far as they can be readily established at the time*
- *Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately*
- *Consider the potential for identifying improvements to safeguard and promote the welfare of children; and*
- *Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.*

Warwickshire Safeguarding decided to extend this process to the management and overview of safeguarding adult's referrals to ensure a consistent approach to the consideration of Safeguarding Adults Review referrals.

Warwickshire Safeguarding's Safeguarding Reviews Subgroup is responsible for ensuring that Safeguarding Adult Reviews and Local Child Safeguarding Practice Reviews in Warwickshire are carried out appropriately and effectively so that issues and lessons are identified, disseminated and acted upon.

The table below provides an overview of the number of safeguarding reviews referrals received during 2019-2020 and how many of these converted into formal reviews, or progressed as alternative learning reviews:

Safeguarding Adults Reviews (SARs)	**Serious Case Reviews (SCRs) / Child Safeguarding Practice Reviews (CSPRs)**
No. of referrals received = ***11***	*No. of referrals received =* ***10***
No. of Rapid Reviews conducted = ***8***	*No. of Rapid Reviews conducted =* ***6***
No. of referrals progressed as a full review = ***1, plus 1 joint with Children's***	*No. of referrals progressed as a full review =* ***2, plus 1 joint with adults***
No. of referrals progressed as alternative learning reviews = Nil	*No. of referrals progressed as alternative learning reviews =* ***2***
Types of abuse reported in referrals = ***Organisation Abuse, Self-Neglect and Physical Abuse***	*Types of abuse reported in referrals =* ***Organisational Abuse, Neglect, Sexual Abuse, Physical Abuse, Exploitation***
No. of reports published = ***Nil***	*No. of reports published =* ***2 (Amy and Child:K)***
No. of lessons learned briefings published = ***3 (Rose, Noel and Chris)***	*No. of lessons learned briefings published =* ***1 (Amy)***

Alternative Learning Reviews

Warwickshire Safeguarding conducted two alternative learning reviews for cases which did not meet the statutory criteria for a Child Safeguarding Practice Review however, presented areas of key learning which would benefit partner organisations working with children in similar circumstances in the future. Partner agencies were invited to participate in tabletop reviews to identify any learning or improvements to practice in order to better safeguard children and young people with a focus on the following topics:

- *Communications*
- *Information Sharing*
- *MASH Processes*
- *The Voice of the Child*
- *Escalations*
- *Partnership Working*

Joint Learning Events across Children and Adults (AMY)

To reflect its new ways of working, Warwickshire Safeguarding introduced opportunities for reviewing safeguarding review referrals which offered cross cutting learning across the children's and adults partnership landscape. In March 2019 a joint learning event was commissioned to provide the partnership with the reassurance that if given a similar set of circumstance the current response from the relevant services would be robust enough to prevent a similarly poor outcome for the child and family concerned.

The case of AMY highlighted a number of failings in terms of:

- *Recognising and respond to the issue of coercive and controlling behaviour*
- *Putting the child first*
- *Recognising anger as an appropriate and healthy response to trauma*
- *Providing effective advocacy for children*

Agencies were asked to focus on the frequently faced challenge of controlling and coercive men joining vulnerable families. Amy's voice was captured as part of the learning event through statements provided by her during a visit to her home by the Independent Reviewer and Business

Manager. This provided a powerful presentation of her own feelings about the way agencies managed her safeguarding situation and how this could be improved when dealing with similar cases in the future.

Although Adult Social Care were not directly involved in this case, it provided an opportunity for them to identify learning from this case that could be applied to the services they deliver.

Both the full report and Lessons Learned Briefing were published on Warwickshire Safeguarding's website and cascaded to the wider partnership to support improvement in practice.

Lessons Learned Briefings

Warwickshire Safeguarding introduced new Lessons Learned Briefings to help improve the communication of lessons being drawn from safeguarding reviews, which help to ensure the learning is being shared widely and more rapidly so that it can impact positively on future case management. These are produced following the completion of a Local Child Safeguarding Practice Review (LCSPR) or a Safeguarding Adults Review (SAR), or in those cases where the criteria for a formal review was not met however; the initial scoping process identified key areas of practice which highlighted the need to promote awareness.

The Lessons Learned briefings are structured to provide a summary overview of the story of the child or adult, what we learned and advice for professionals and the community. During the course of 2019-2020 Warwickshire Safeguarding published the following 4 Lessons Learned Briefings on its website:

- *Rose (Adult)*
- *Noel (Adult)*
- *Chris (Adult)*
- *Amy (Child)*

7 Minute Briefings

In order to encourage continuous learning and maintain a skilled workforce, Warwickshire Safeguarding introduced 7-Minute Briefings as a quick and simple way to share learning on a range of safeguarding topics. These are often related to areas of key learning identified through reviews work, or

the introduction of new changes to local/national policy, procedures and practice. The briefings act as a catalyst to help teams and their managers to discuss and reflect on their practice and systems.

Warwickshire Safeguarding encourages all agencies to record or evidence how they have used the 7-Minute Briefings on the 7-Minute Briefing Action Plan Template, which will be reviewed as part of Warwickshire Safeguarding's regular quality assurance audits. During 2019-2020 Warwickshire Safeguarding published briefings on the following topics:

- *Joint Target Area Inspections (JTAI)*
- *Local Child Safeguarding Practice Reviews*
- *New Partnership Arrangements - Warwickshire Safeguarding*
- *Rapid Reviews*
- *Children moving across Local Authority boundaries*
- *Financial and material abuse*
- *Reporting an adult safeguarding concern*
- *Role of Special Guardians*
- *Safeguarding Adult Review (SAR)*
- *Section 42 Adult Safeguarding Enquiry*

Schools Annual Audit – 2018/2019

Warwickshire schools/education settings completed their annual audit of their safeguarding arrangements to enable the partnership to gather structured information to facilitate effective monitoring of safeguarding practice in the education sector. As part of the 2018/2019 academic year, **280** schools/education settings submitted a return of their safeguarding audit. Initial analysis of the returns has provided the following overview of findings:

- *There was evidence of significant progress in arrangements for DSLs to receive reflective supervision*
- *The audit provided an encouraging picture of movement towards more trauma informed practice in response to children's behaviour in most schools/settings.*
- *A number of primary schools highlighted the lack of suitable curriculum materials for engaging children about issues such as exploitation, grooming and radicalisation.*

- *There is growing evidence from successive audits of increasingly robust governance arrangements in relation to safeguarding. However, this audit highlighted vulnerability when there are changes of governance arrangements including moves to multi-academy trusts, federations, de-federating, temporary governance arrangements and departure of experienced governors.*
- *The audit highlighted that a great deal more work was needed to raise the education sector's awareness of child criminal exploitation.*
- *The number of reported uses of the escalation process was surprisingly very low. Warwickshire Safeguarding should monitor closely whether its updated escalation process improves the recorded evidence of the process being used.*
- *Self-harm in education settings is clearly a safeguarding issue. This was the first year that the audit included questions about self-harm. The overall number of incidents was high but again a large number of schools reported no incidents at all, which could suggest the need for greater vigilance and reporting and more robust recording.*
- *Another theme was children's mental health and self-harm and the associated challenges of ensuring that teachers and other staff working directly with children are confident and equipped to deal with children experiencing these difficulties and to support other children who may witness distressing incidents.*
- *There were many references to the expectations upon schools and education settings to safeguard children from serious risks such as domestic abuse, homelessness and parental mental ill-health and drug misuse by means of early help, often without engagement by services working with adults in respect of those issues.*

Voice of the Adult/Child

MSP

Making Safeguarding Personal requires agencies to ask individuals and/or their representatives what outcomes they would like to achieve from their safeguarding intervention. During the course of 2019-2020 Warwickshire concluded **284** s42 safeguarding enquiries of these **184** individuals/their representatives were asked for their views and desired outcomes, out of which

- ***178*** *individuals/their representatives* ***expressed their views and desired outcomes***
- ***6*** *individuals/their representatives* ***did not wish to express their views and desired outcomes***
- ***100*** *of the concluded s42 enquires recorded that* ***the individual's outcomes had been fully achieved***

- ***69*** *of the concluded s42 enquiries recorded that* ***the individual's outcomes had been partially achieved***
- ***9*** *of the concluded s42 enquiries recorded that* ***the individual's outcomes had not been achieved***

Advocacy Support/Views of the Child

local authorities have a duty to arrange for an independent advocate to be available to represent and support certain persons (Children and adults) for the purpose of facilitating those persons' involvement in the exercise of functions by local authorities. Advocacy is a process of supporting and enabling people to:

- *Express their views and concerns*
- *Access information and services*
- *Defend and promote their rights and responsibilities; and*
- *Explore choices and options*

During 2019-2020 a total of **52 adults with care and support needs** were supported by an advocate to help them with their safeguarding issues.

A further **197 referrals for Children's Advocacy** service were supported by Barnardo's which involved:

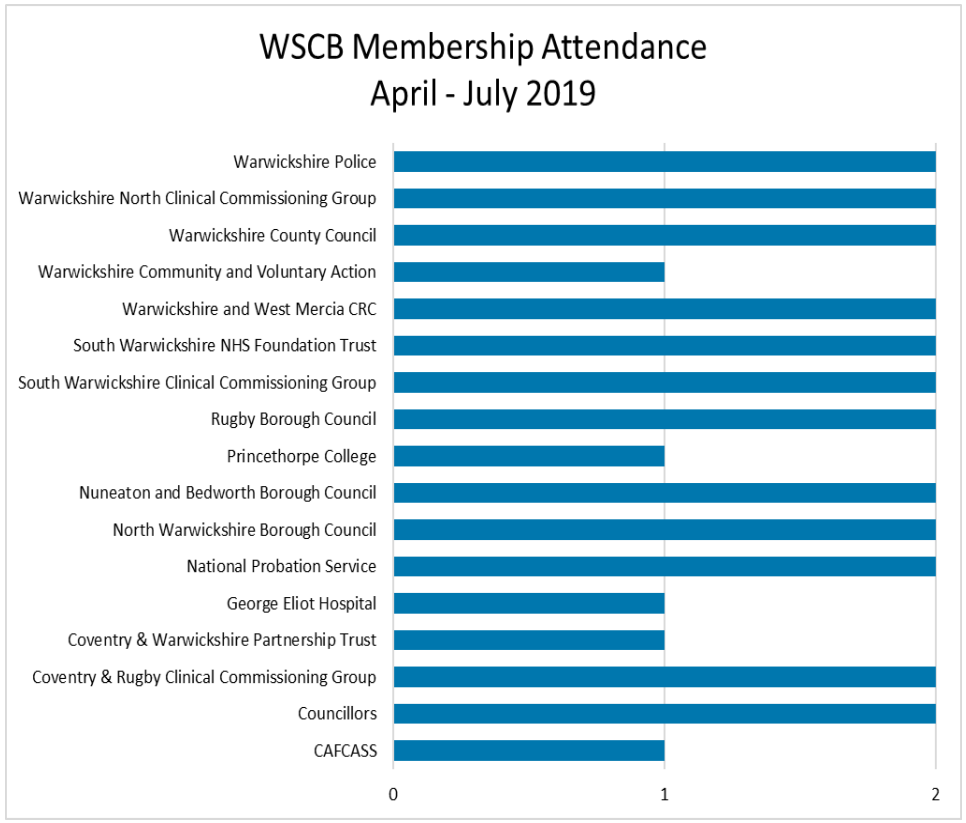
- *going to meetings with a young person where decisions are made – for example, meetings about foster placements*
- *writing letters on their behalf*
- *helping to get all the information the young person might need and help them understand what their rights are*

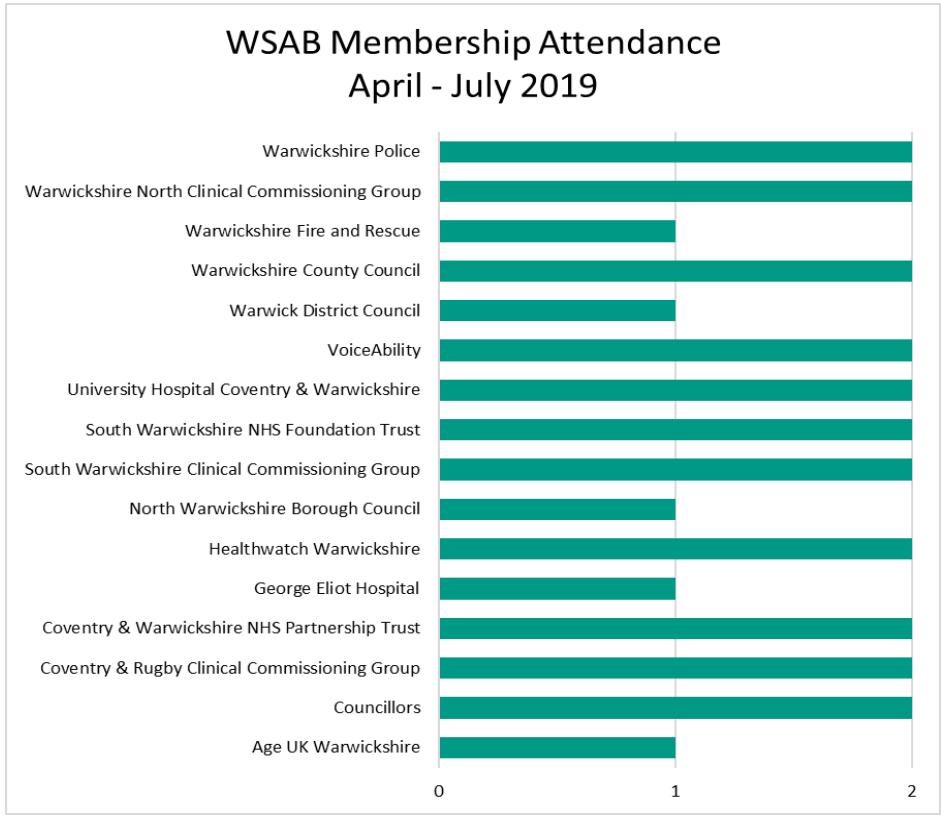
Partnership Funding

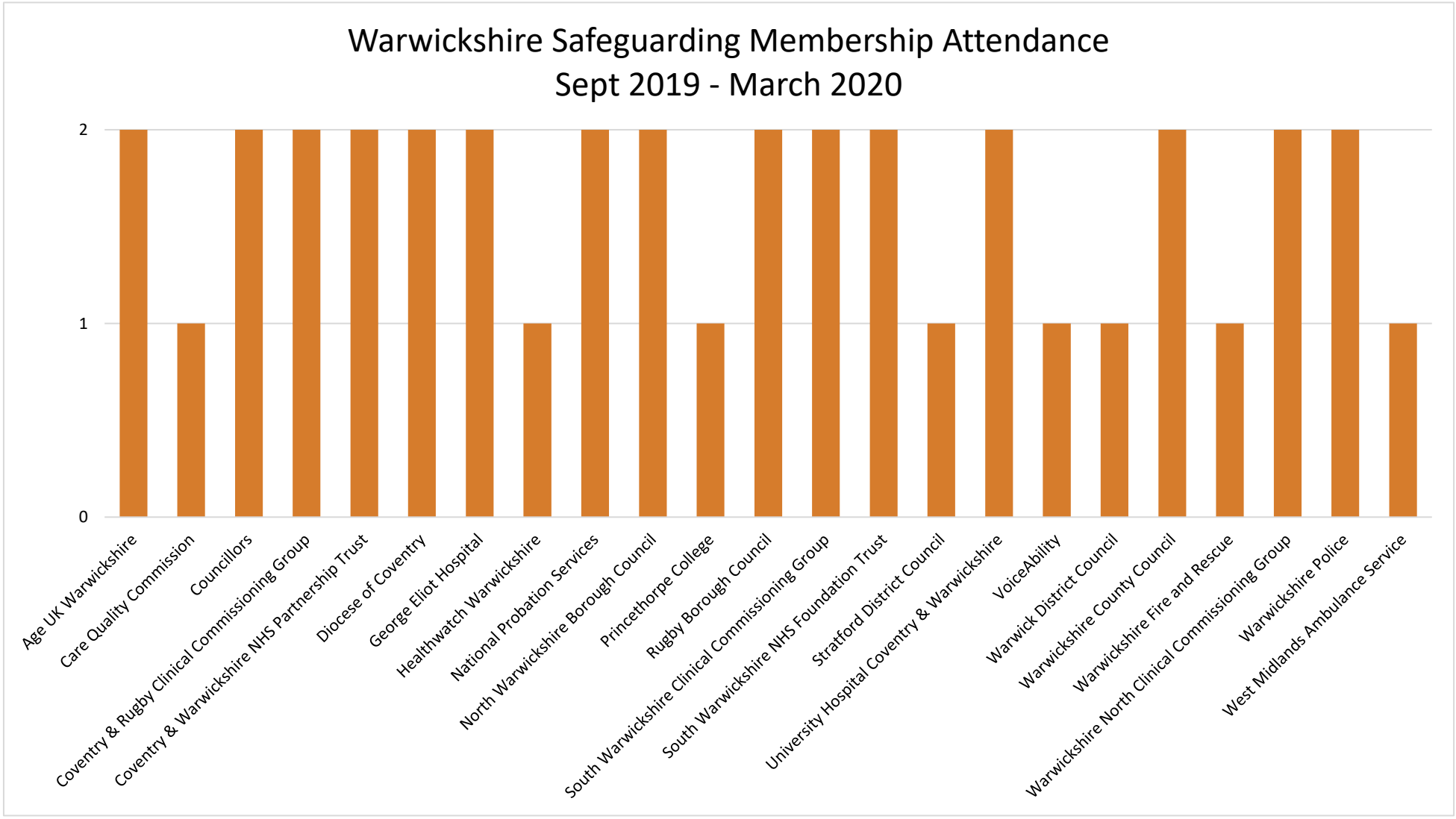
Warwickshire Safeguarding has been funded through a pooled budget from across the partnership including the County Council, District and Borough Councils, CCGs, Police and others which covers all aspects of the partnership's work and commitments, including the cost of the Business Team, commissioning of independent reviewers for safeguarding reviews, maintenance of procedures platforms and website development. The budget for 2019-20 was £371,161.

Member Attendance

The following tables provide an illustration of partners' attendance at meetings throughout 2019-2020. During April to July 2019, the partnership operated under the former governance of two separate safeguarding boards namely Warwickshire Safeguarding Children's Boards and Warwickshire Safeguarding Adults Board. The first two tables below illustrate member attendance at either of these two former boards. The third table provides an illustration of partner attendance under the new Warwickshire Safeguarding governance structures which came into effect from 29 September 2019.






Warwickshire Safeguarding Membership Attendance
Sept 2019 - March 2020
2
1
0
Age UK Warwickshire
Care Quality Commission
Councillors
Coventry & Rugby Clinical Commissioning Group
Coventry & Warwickshire NHS Partnership Trust
Diocese of Coventry
George Eliot Hospital
Healthwatch Warwickshire
National Probation Services
North Warwickshire Borough Council
Princethorpe College
Rugby Borough Council
South Warwickshire Clinical Commissioning Group
South Warwickshire NHS Foundation Trust
Stratford District Council
University Hospital Coventry & Warwickshire
VoiceAbility
Warwick District Council
Warwickshire County Council
Warwickshire Fire and Rescue
Warwickshire North Clinical Commissioning Group
Warwickshire Police
West Midlands Ambulance Service

Conclusion

In conclusion, this report demonstrates the continued development and increased awareness of safeguarding children and safeguarding adults' issues within the partnership. The year has provided an opportunity to develop the innovative new arrangements currently being introduced which has supported Warwickshire Safeguarding's 'Think Family' approach.

Warwickshire Safeguarding has continued to respond to the rapid national and local pace of change whilst maintaining focus on the delivery of its strategic priorities. A lot of groundwork has been undertaken to ensure the right infrastructures are in place to support the management of known and emerging safeguarding risks such as Modern Slavery, Human Trafficking, County Lines, Cuckooing and Domestic Violence . The partnership has opened itself to external challenge to ensure its approach to handling exploitation of children and adults is focused and deliverable.

The introduction of the new strategic thematic reviews as part of the partnership's new Quality Assurance Framework has enabled much broader partner engagement in assurance activities. The voice of the professionals working with vulnerable children and adults and the service users themselves has been a welcomed addition and has helped the partnership to understand the impact of its work, policy and practices from the frontline.

Moving forward, Warwickshire Safeguarding will continue to build on the work it has started in 2019-2020 and ensure new safeguarding practices are fully embedded and support the achievement of positive outcomes for children, young people and adults.

Warwickshire Safeguarding

This page is intentionally left blank

Item X

Health and Wellbeing Board

15 September 2020

Healthwatch Annual Report

Recommendation(s)

1. To note and receive the Report

1.0 Key Issues

1.1 Changes in Service Delivery

1.2 Future Priorities

2.0 Annual Report

2.1 The Healthwatch Annual Report was completed and circulated on 30th June 2020 to all key stakeholders including WCC, Healthwatch England, the CQC, and to NHS organisations. The Report included details of all activities undertaken between 1st April 2019 and 31st March 2020 and will be taken as being read by Members

2.2 Changes in Service Delivery

2.2.1 On 23rd March 2020 Healthwatch Warwickshire (HWW) received guidance from Healthwatch England that face to face activities, such as Engagement events and Enter and View, should be discontinued due to the Covid-19 pandemic. HWW therefore took the decision to close the offices at 4-6 Clemens Street on 24th March, and to discontinue face to face working with effect from that date.

2.2.2 The first priority was to restore services to the public as quickly as possible. By the 1st April HWW had:

- Set up Home Offices for all staff, including IT facilities. Risk assessments were conducted and arrangement for the support and wellbeing of staff had been put in place
- Restored the telephone-based signposting and advice service for the public
- Restored the facility on the website for the public to express concerns

- Established a space on the website to give the current advice and information from the Government, WCC and NHS providers. The information on the website is updated on a daily basis

- Contacted all key partners to advise them of the changes in operational arrangements

2.2.3 HWW also conducted a survey of the lived experiences of patients and the public between May and June 2020. The survey sought to gauge public sentiment about the impact that Covid-19 had on the services they were using. The survey received over 1,100 responses in 4 weeks and draft findings indicate that the primary concerns were around mental health and access to services.

HWW was also chosen as a pilot site for an in-depth qualitative report on the accelerated discharge process in operation during the pandemic. That report is now with Healthwatch England and will be available for distribution imminently.

2.2.4 All regulatory requirements such as the Annual Accounts, GDPR compliance, and Companies House Returns have been completed ahead of time

2.3 Future Priorities

2.3.1 HWW set up a Lockdown Task Group which explored the ways in which services can be delivered in the future, including arrangements for staff wellbeing, how engagement and outreach services can be safely delivered, and the processes for the restoration of services such as Enter and View.

2.3.2 HWW has submitted a Recovery and Restoration Plan to WCC which is still being considered.

2.3.3 HWW is currently preparing proposals for several projects including:

- Patient Voice arrangements in Integrated Care Systems, with a focus on seldom heard communities and individuals

- The future of Patient Groups post pandemic

- Patient sentiment on the proposals for digital by default services, assistive technology and patient portals

- Several streams of work around discharge arrangements for various patient groups

- A response to the Covid-19 survey finding on mental health

NB The impact on health inequalities is to form a key part of each proposal

2.9 The findings of the Covid-19 survey and the Accelerated Discharge Reports will be shared with key partners by the end of September

3.0 Financial Implications

3.1 None

4.0 Environmental Implications

4.1 None.

5.0 Timescales associated with the decision and next steps

5.1 Paragraph 1.

Background papers

1. Presentation

	Name	**Contact Information**
Report Author	Chris Bain	chris@healthwatchwarwickshire.co.uk Tel: 01926 453964
Assistant Director		
Strategic Director		
Portfolio Holder		

The report was circulated to the following members prior to publication:

Local Member(s):
Other members:

This page is intentionally left blank

Annual report 2019-20

Guided by you

healthwatch Warwickshire

Contents

Message from our Chair

Liz Hancock, Healthwatch Warwickshire Chair

> Healthwatch Warwickshire's aim is "to be an accessible, trusted, independent source of advice – listening, and responding effectively, to express your voice on local health and social care issues."

This is my second year as the Chair of Healthwatch Warwickshire and I am immensely proud of the team for the way they have managed their day to day work due to the impact of COVID-19. Like many they have had to adapt their ways of working, to help ensure the safety of the public, staff and volunteers, by stopping all face-to-face work. However, they have worked hard, in different ways, to continue to gather health and care experiences and report on these. The survey, produced with Healthwatch Coventry, asking people to share their experiences during the pandemic is a good example of how the team continues to ensure the voice of the local community is heard. We then ensure your voice is heard by the decision makers within the local council, primary and secondary care settings and that it helps to shape future services and developments. Through Healthwatch England we also work to ensure the people of Warwickshire's voice is heard at a national level.

In this Annual Report you will learn more about the work Healthwatch has carried out during the year and how we have helped to influence change.

Last year I ended by saying, "With the ever changing health and social care landscape and the continuing political uncertainty I am very proud of our small team of staff and volunteers who work hard to encourage and engage with local people to help local services to meet their needs. It is often a complex world they are working in but I have noticed that they never lose focus of the end result – making care better for people." I hope you will excuse me for repeating these words which seem to me to remain very apt.

Please keep safe during these difficult times,

Liz Hancock
Healthwatch Warwickshire Chair

Governance

Board of Directors

Our Board Directors volunteer to ensure that Healthwatch Warwickshire meets its legal requirements as a Community Interest Company. The Board sets out a strategic vision for Healthwatch Warwickshire and measures its effectiveness against the current contract with Warwickshire County Council to provide a Healthwatch service locally.

Our Board Directors meet every two months to monitor, support, and challenge the Chief Executive and Healthwatch Warwickshire Staff. They consider everything from the strategic direction of travel for the organisation as well as ensuring that we are financially stable and following all relevant policies and procedures relating to HR. They also represent Healthwatch Warwickshire externally.

During the period of April 2019-2020, we had nine Board Directors, including the Chair of the Board. Bob Malloy resigned from the Board of Directors in December 2019, we would like to wish him all the best, he made a valuable contribution to the Board especially in his work as Chair of the HR subgroup.

If you would like to find out more information about how we are set up, look at our Board minutes or find out how to become a Board Director please visit our website.

"……Healthwatch Warwickshire seeks to recruit to the Board members offering between them the full range of professional skills desirable…"
John Copping, Board Director

Seven of our Board Directors who attended the AGM and Annual Conference in October 2019

Accountability

How we are held accountable

There are a number of ways that we are held accountable and we continually look at how we are open and transparent in the work that we undertake and how this is communicated with the public and key stakeholders.

This year, alongside our Annual Conference, we introduced for the first year an Annual General Meeting (AGM) which was a public event where members of the public could attend and comment on what we do as an organisation.

Annually we make formal reports which are presented at the Health Overview and Scrutiny Committee and the Health and Wellbeing Board in Warwickshire. We also produce an Annual Report and Return to Healthwatch England. Every year we are audited to ensure that we are spending the money we receive correctly and this year we have chosen Burgis & Bullock as our auditors, as agreed at our AGM.

Each quarter we are measured against the contract that we have with Warwickshire County Council to provide a Healthwatch locally and have close contact with our Commissioner.

> Commissioning oversight and management of our local Healthwatch provision has only been within my portfolio for 6 months however within this time I have seen a breadth of work undertaken. The service has effectively transitioned from a predominantly face to face provision to a virtual offer with COVID-19 and this has continued to enable people to voice their concerns and views on local health and social care services. The service has good working relationships with a large number of local partners, providers and stakeholders and it is continuously striving to maximise its reach.
> ***Lisa Lissaman, Commissioner***

Picture taken at our AGM and Annual Conference 2019

Our priorities

As a result of the COVID-19 pandemic we have had to adapt our services and the way we work to ensure the safety of the public, volunteers, and staff. This has resulted in us suspending all face-to-face engagement and visits until it is safe for us to do so and in accordance with Government guidelines.

Our engagement objectives during this period:

1. To develop and maintain consistent and pro-active two-way channels of communication with key stakeholders
2. To provide appropriate channels for patients and the public to continue to inform HWW about their lived experiences
3. To communicate up to date COVID-19 guidance as provided by Public Health Warwickshire, Warwickshire County Council and other stakeholders to patients and the public
4. To communicate changes in service provision from key stakeholders to patients and the public
5. To signpost individuals to the most appropriate service or information source

Gathering your views about your experiences of health and social care during the pandemic

The NHS and Social Care services have had to adapt the support they offer the public in response to COVID-19. It is important that we understand how these changes are working for people. We launched a survey, at the beginning of May 2020 which will run until the end of June 2020, and out of this work we expect to understand:

- Access to services during COVID-19 and any subsequent changes
- Mental health – how it has been affected and access to services
- Communication issues – if there have been any barriers to those with additional communication requirements

This should then inform our future work and priorities moving forward. The full COVID-19 workplan is available on our website.

Contact us for more information about our work:

Telephone: 01926 422823
Email: info@healthwatchwarwickshire.co.uk

Healthwatch Network

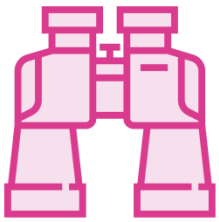
Here to make care better

The network's collaborative effort around the NHS Long Term Plan shows the power of the Healthwatch network in giving people that find it hardest to be heard a chance to speak up. The #WhatWouldYouDo campaign saw national movement, engaging with people all over the country to see how the Long Term Plan should be implemented locally. Thanks to the thousands of views shared with Healthwatch we were also able to highlight the issue of patient transport not being included in the NHS Long Term Plan review – sparking a national review of patient transport from NHS England.

We simply could not do this without the dedicated work and efforts from our staff and volunteers and, of course, we couldn't have done it without you. Whether it's working with your local Healthwatch to raise awareness of local issues, or sharing your views and experiences, I'd like to thank you all. It's important that services continue to listen, so please do keep talking to your local Healthwatch. Let's strive to make the NHS and social care services the best that they can be.

> I've now been Chair of Healthwatch England for over a year and I'm extremely proud to see it go from strength to strength, highlighting the importance of listening to people's views to decision makers at a national and local level.

Sir Robert Francis, Healthwatch England Chair

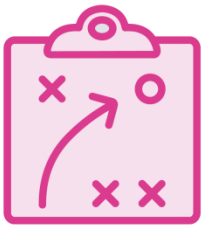


Our vision is simple

Health and care that works for you.
People want health and social care support that works – helping them to stay well, get the best out of services and manage any conditions they face.

Our purpose

To find out what matters to you and to help make sure your views shape the support you need.



Our approach

People's views come first – especially those who find it hardest to be heard.
We champion what matters to you and work with others to find solutions. We are independent and committed to making the biggest difference to you.

How we find out what matters to you

People are at the heart of everything we do. Our staff and volunteers identify what matters most to people by:

- Visiting services to see how they work
- Running surveys and focus groups
- Going out in the community and working with other organisations

Find out more about us and the work we do

Website: www.healthwatchwarwickshire.co.uk
Twitter: @Healthwatchwarw
Facebook: @Healthwatchwarw

Highlights from our year

Find out about our resources and the way we have engaged and supported more people in 2019-20.

Health and care that works for you

11 volunteers

Helping to carry out our work. They have helped with our Enter and View programme, our surveys we have conducted throughout the year, and recruitment.

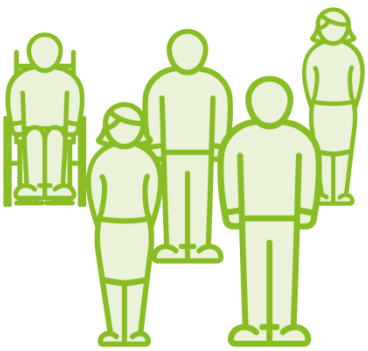
8 staff

Most staff work part-time hours, with only the Chief Executive working full-time. In total, we have 4.9 full-time equivalent staff.

£222,100 in funding

That we received from our local authority in 2019-20, 9.5% (£21,150) less than the previous year.

Providing support



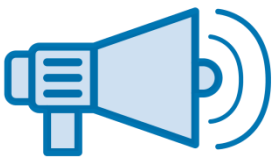
2115 pieces of feedback

We received 234 enquiries and feedback about services from individuals and a further 1881 comments on health and social care through responses to surveys.

1875 advice and information

Of these enquiries we signposted people 197 times. On our website advice and information page views totalled 1678.

Reaching out



50% more online activity

5,778 users visited our website, there were 4,824 engagements on social media posts, and a further 1,940 people engaged with us at nearly 100 community events.

Making a difference to care

6 reports published

About the improvements people would like to see with their health and social care. 3 of these were 'enter and view' care home reports and 3 were on our projects.

How we've made a difference

Speaking up about your experiences of health and social care services is the first step to change.

Take a look at how your views have helped make a difference to care and support for people who are experiencing homelessness.

Rights to Access Project: Helping homeless people understand their rights to access treatment

This project was created as a result of engagement work carried out throughout the County – talking to homeless support agencies, homeless individuals and from reports about homelessness in Warwickshire.

We worked with 37 local organisations around the County to raise awareness of peoples rights to access primary care treatment (GPs, community pharmacy, dental and eye health).

In the duration of the project we:

- Delivered 40 workshops locally with 289 attendees
- We gave out over 1,646 rights to access cards to organisations and individuals
- We distributed 530 booklets to GPs and organisations

Workshops delivered throughout Warwickshire
Picture taken in Stratford-Upon-Avon

In order to gain feedback from people experiencing homelessness we held a luncheon in each of the areas we visited*.

Over the festive period (2019) we gave organisations working with the homeless bags of sweets which included a rights to access card and resulted in numerous calls to us for help in gaining access to GPs.

*Two luncheons were postponed due to the COVID-19 pandemic

We think the RAP Project is great! The workshop was really interesting and informative. We have given out 4 cards to people. I know 2 young people managed to get an appointment and were very grateful for having the card. One young person said it saved him, he got important mental health help thanks to a simple card. It is definitely so much more than just a card. Thank you for helping to improve people's health and voices.

Emma Jones, Doorway Nuneaton

Volunteer Jackie Prestwich (centre) attending one of the workshops

CASE STUDY: Helping a homeless man exercise his right to register with a local GP

Volunteer Jackie Prestwich attended one of the RAP workshops, taking some cards and booklets away with her. She then took these to her local Church, where she discussed the project.

One of the attendees of the discussion later met a homeless person, John*, who was struggling to walk, and she told him about the project. Subsequently John went to the Church to learn more and receive one of our cards. He then went to his GP and was able to access an appointment the same day.

The GP referred him to Warwick hospital for x-rays and physiotherapy. John was supported by the Church to attend these appointments and was given crutches by a member of the congregation.

He said that having our card had given him the confidence to go and see the GP. With help from the Church, he applied for an NHS number and an HC1, and was able to open a bank account, obtain a birth certificate and was found some temporary accommodation.

However, during the course of his treatment John was diagnosed with cancer, which was too advanced for treatment. He passed away in hospital, under the care of a dedicated ICU team who treated him with dignity and respect, and in the company of his new friends from the Church. It is a tragic end to the story but it highlights the importance of the project.

*(*Not his real name)*

Healthwatch Warwickshire - Authorised Representatives who volunteer to provide a comprehensive enter and view programme based on intelligence received by you.

Enter and View: Following up on your concerns about health and social care providers

We actively encourage members of the public and staff to talk to us when they have concerns and we are happy to receive information anonymously.

This year we had a number of concerns raised about care homes in Warwickshire. We have made further investigations to every concern that has been raised and shared this information with relevant partners such as the Care Quality Commission (CQC), Safeguarding (MASH) and the Quality Assurance Team. The CQC have responded quickly to inspect services when we have raised serious concerns with them. We have subsequently received feedback from members of the public that services have improved as a result.

This year we have visited three Care Homes in Warwickshire:

- Park View, Warwick
- Sycamores, Leamington Spa
- Town Thorns, Rugby

We made ten recommendations in total which in each instance was given to the registered manager with opportunity to respond.

All the reports to health and social care providers are available on our website.

Share your views with us

If you have a query about a health and social care service, or need help with where you can go to access further support, get in touch. Don't struggle alone. Healthwatch is here for you.

Website: www.healthwatchwarwickshire.co.uk

Telephone: 01926 422823

Email: info@healthwatchwarwickshire.co.uk

Speaking up about your experiences of health and social care services is the first step to change.

Take a look at how your views have helped make a difference to people living in care homes.

Enter and View : A typical visit to a care home in Warwickshire

We have a team of trained and experienced Authorised Representatives who volunteer with us because they want to improve the lives of people living in care homes.

As part of our Enter and View programme we can make unannounced visits to care homes to observe activities being carried out in the home and talk to residents, relatives, staff and visiting professionals about what it is like to live, visit and work in the home. We find out what it is like to live there, how relatives feel about the home and what it is like for the staff to work there.

A typical visit to a care home would involve six authorised representatives and a trained member of staff. We usually arrive in the morning and stay until after lunch. One question we always ask ourselves is 'would I put my mum in here?'

At the end of each visit we meet with the Manager and discuss what we have seen and heard that day.

We then go away and decide our recommendations and write a report which is published on our website and read by, amongst others, Care Quality Commission Inspectors and families looking for care homes for their relatives.

This year Healthwatch Warwickshire have made three unannounced visits to Care Homes.

We have seen good practice in Dementia training and care, and made a total of ten recommendations including better access to transport, to allow for more outings for residents, routinely checking call bells are plugged in and pull cords are accessible, and for programmes of refurbishment and redecoration to be carried out. On one visit we recruited a new volunteer to be an Authorised Representative.

If you would like to learn more about volunteering [contact us]

"We hear from members of the public that the CQC have responded quickly to inspect services when we have raised serious concerns with them."
Robyn Dorling, Enter and View Lead, Healthwatch Warwickshire

Standing Conference July 2019 – bringing together Patient Participation Groups to discuss changes to the local health and care system

STANDING CONFERENCE: This year we hosted two standing conferences bringing together Patient Participation Groups (PPGs) from around Warwickshire

This year we brought together 167 people to discuss the NHS Long Term Plan, and what that would mean locally, as well as the introduction of Primary Care Networks (PCNs). The events allow participants to hear from both national and local figures, on what changes or strategies are to be introduced, whilst always having a local speaker to give perspective on what changes mean for them.

The Standing Conference in May resulted in us launching a piece of work to understand the local understanding of PPGs and PCNs.

We went to outpatient departments and community groups and asked three questions, we also put them online:

- Do you know that your GP practice has a Patient Participation Group?
- How would you feel about going to another practice for care?
- What are the best ways for your GP to tell you about changes that are happening?

We received 905 responses. The full report is available on our website.

"... I thought the ratio of presentations to discussions was much better – there was a good amount of time for delegates to discuss the issues – and it was excellent having Chris Ham there to listen and to respond."
Catherine White Lay Member for Patient and Public Involvement, SWCCG

Healthwatch Warwickshire – We asked local people who used health services in South Warwickshire for their views on the development of a patient portal

Patient Portal: We were asked by South Warwickshire Foundation Trust to engage with the public.

We asked people what they thought of an online portal to manage healthcare, what functions might be useful and what the potential barriers to accessing such a portal might be.

We received a total of 428 responses in a 4 week period using two methods:
Online survey (226 respondents)
Engagement work (202 respondents).

Key findings from our work:

- Respondents felt it could save a lot of time and effort. Favourite functions of a portal were for booking appointments and viewing test results.
- It would need to be accessible and easy to use for all. There is a need to consider accessibility and those who are less technology savvy.
- Largest barrier for adoption was perceptions of data security.
- We received positive comments from participants about being included in the design of the portal- at the early stages of it's development.

We will continue to work with those respondents who told us they would like to be involved in the development of the patient portal and with South Warwickshire Foundation Trust.

The full report and recommendations are available on our website.

"South Warwickshire Foundation Trust are committed to providing a portal to allow patients and communities in the area to digitally interact with our services. The work that Healthwatch have done for us engaging with patients, understanding requirements and priorities has been invaluable in helping to shape our work and provide the best possible support for our patients."
Adam Carson, Associate Director of ICT – Programme Delivery, South Warwickshire Foundation Trust

Long Term Plan

#WhatWouldYouDo

Highlights

More than 795 people shared their views with Healthwatch Warwickshire and Coventry.

We held over 7 focus groups reaching different communities across Warwickshire and Coventry.

The surveys and engagement work ran throughout March and April 2019.

NHS Long Term Plan

Following a commitment from the Government to increase investment in the NHS, the NHS published the 'Long Term Plan' in January 2019, setting out its' key ambitions over the next 10 years. Healthwatch launched a countrywide campaign to give people a say in how the plan should be implemented in their communities.

Working with Healthwatch Coventry we asked people #WhatWouldYouDo to improve the NHS locally. The top issues that people told us they wanted services to focus on were:

- Shorter waiting times for GPs, to see specialists and access support
- A more holistic approach to care
- Better transport (especially in rural areas)
- Communication – better management of health records, receiving timely and clear communications from health professionals, and better communication between services.

Our full report is available on our website.

The Coventry and Warwickshire Health and Care Partnership told us:

> …The insights and feedback gained through this engagement are a valuable resource to help inform and shape the future health and care system in a variety of ways…'
>
> (Full response available in our report)

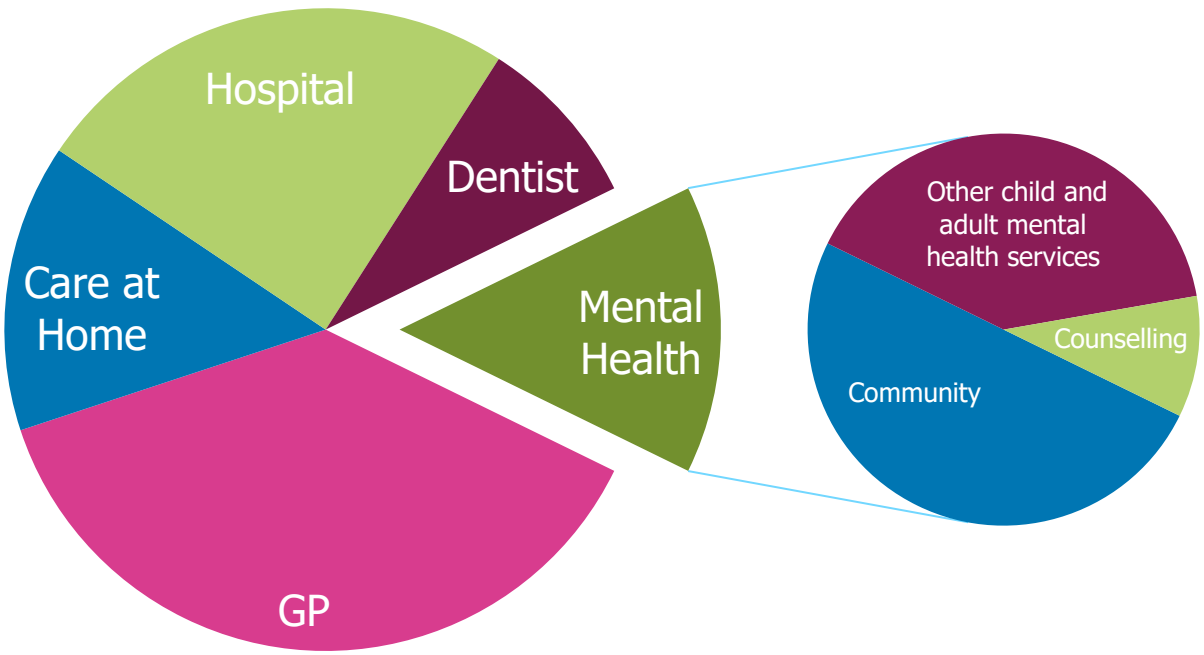
Helping you find the answers

Finding the right service can be worrying and stressful. Healthwatch plays an important role in helping people to get the information they need to take control of their health and care and find services that will provide them with the right support.

This year we helped people get the advice and information they need by:

- Providing advice and information articles on our website.
- Answering people's queries about services over the phone, by email, or online.
- Talking to people at community events.
- Promoting services and information that can help people on our social media.

Not only does Healthwatch help give advice but we are also there to listen. The next two graphics give an indication of the types of things people have told us about.



The main issues that people wanted to talk to us about included:

Access to Services

Quality of Care

Service organisation

Staff attitudes

Patient records

Communication between patients and staff

Case study: What happens when you are removed from your GP surgery and placed on a Special Allocation Scheme

A local man with long term health conditions and a disability had been removed from his GP list and assigned to the Special Allocation Scheme (SAS). He was now having to travel on two buses to see a Doctor. He accepted the reasons he had been removed from the GP surgery but said he had changed and wanted to know how he could get to see a local GP again.

We explained that patients have a right to appeal within 28 days of being removed from their practice but after this there is no set time period that a person remains on the scheme. The procedure for his local Clinical Commissioning Group (CCG) was to ask the Special Allocation Service Provider to review each patient approximately six monthly, or more frequently as required, and complete a report which is then considered by the CCGs SAS panel.

Unfortunately, if the provider has had insufficient or no contact with the patient it can be difficult for them to make an assessment as to whether the patient has been rehabilitated to the point that they are ready to return to a mainstream GP practice. In that scenario the GP would not be able to make a recommendation to the panel to discharge the patient from the scheme.

*Stock image

By understanding how the system works we were able to inform the patient that in order to demonstrate that he had been rehabilitated he would need to have contact with his Special Allocation Service GP and, where possible, seek support from the organisations he has engaged with during his rehabilitation to demonstrate to the GP that he was now fit to be seen by a local GP. By understanding how the system works this man was informed of the steps he needed to take to see a local GP again.

> As a team we work hard to understand health and social care systems, in order to help support local people access information, services and support when they need them
> **Claire Jackson, Head of Operations, Healthwatch Warwickshire**

Contact us to get the information you need

If you have a query about a health or social care service, or need help with where you can go to access further support, get in touch. Don't struggle alone. Healthwatch is here for you.

Website: www.healthwatchwarwickshire.co.uk
Telephone: 01926 422823
Email: info@healthwatchwarwickshire.co.uk

Care at home:

Over the year we have receive a number of calls on issues relating to home care services. These issues concerned treatment and attitudes, such as carers not attending for the required time or not attending to hygiene needs. One case resulted in a safeguarding concern being raised after broken home equipment meant that an individual was confined to a single room. A significant health issue arose which then brought to light some concerns for the care at home service. In this and several other cases we directly contacted, or referred them to, adult social care and the CQC.

Whistleblowing:

A healthcare assistant called us with concerns about a hospital she had been working in where they had witnessed patients call buttons going unanswered. The caller had tried to access the Free to Speak Up team but the email had bounced back. Healthwatch Warwickshire identified the problem with the email address and forwarded the concerns to the Free to Speak Up Guardian. We received a supportive response and were told there would be a full investigation. We later received a ten point action plan from the Director of Nursing.

Getting support when you need it:

A disabled man who was moving house in a few days time needed a hospital bed in his home on the day he moved in. Because he was moving from one council to another he was really struggling to find out who could arrange this. The only alternative he could see at the time was to turn up at his local Hospital and stay in a bed there until the situation was sorted. By making a few enquiries we were able to establish that he needed to register with a GP in the area he was moving to and then contact the District Nurses. Once he knew what to do he was able to take the right steps straight away in time for his move.

Volunteers

At Healthwatch Warwickshire we are supported by 11 volunteers to help us find out what people think is working, and what people would like to improve, to services in their communities.

This year our volunteers:

- Raised awareness of the work we do at events, in the community and with health and care services.
- Visited services to make sure they are providing people with the right support.
- Helped support our day-to-day running and recruitment.
- Listened to people's experiences to help us know which areas we need to focus on.

Volunteers are essential in the work we are trying to achieve: Meet Sue

I used to work in retail but was made redundant. A customer that used to come into the shop had said 'why don't you try working as a carer.' To cut a long story short I tried it and absolutely loved it. I carried on working at the care home long after I retired as a bank worker and only finished when they closed the Care home.

I was missing the elderly people from the home when I heard about Befriending with Age UK, so I became a befriender, which I still do.

Then someone mentioned that Healthwatch needed Volunteers to go in to Care homes if there had been a concern from a member of the public.

Sue Roodhouse, trained Authorised Representative

I have been a Volunteer with Healthwatch for four years now and really enjoy our care home visits. Healthwatch is very supportive of its Volunteers and training is very good.

Volunteer with us

Are you feeling inspired? We are always on the lookout for new volunteers. If you are interested in volunteering, please get in touch at Healthwatch Warwickshire.

Website: www.healthwatchwarwickshire.co.uk

Telephone: 01926 422823

Email: info@healthwatchwarwickshire.co.uk

Our volunteers

We could not do what we do without the support of our amazing volunteers. Meet some of the team and hear what they get up to.

David

I decided to volunteer for Healthwatch Warwickshire after retiring from a career in Social Work. I am interested in the welfare and quality of life of older people in Residential Care, having had experience of Social Care as a relative of someone in a Care Home.

Dilys

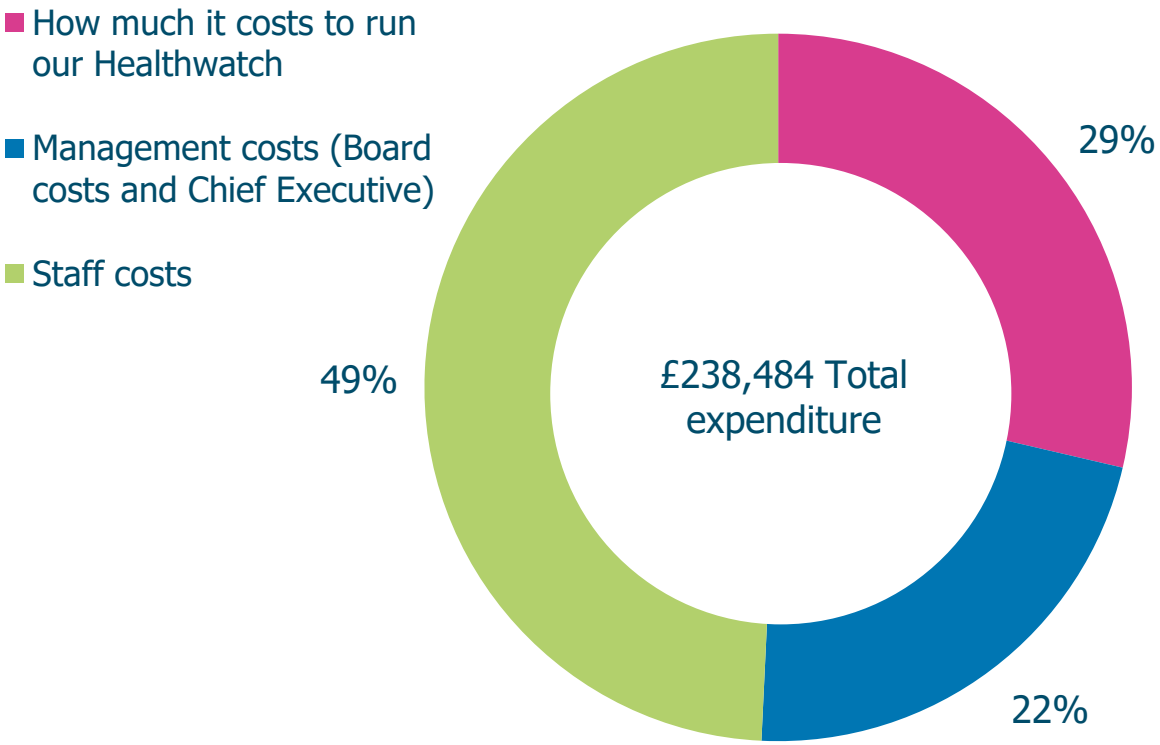
I am a retired Speech and Language Therapist and used to work in Coventry. My clinical work was mainly with children with special needs and their families. In retirement I have continued my interest in both Health and Education. I volunteer with Healthwatch as I am interested in learning about and being involved with Health Services in Warwickshire. My partner of 50 years is now a transgender woman so I also have particular interest in LGBT issues.

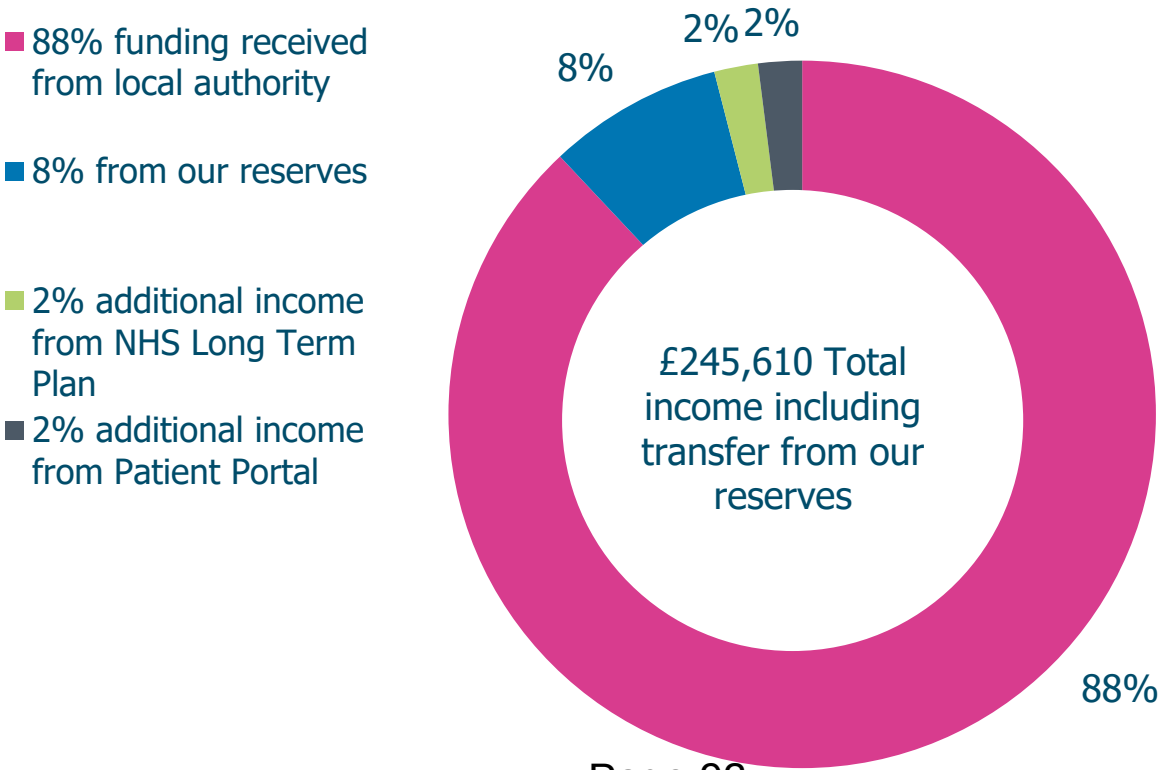
Sue

I am a former mathematics teacher and pastoral head who became involved in the Arden Cancer Network, following the death of my husband. This also led to me becoming involved with Macmillan Cancer Support, Dying Matters, CWPT and Rethink. For many years I represented patients and carers on the NHS groups delivering End of Life Care, and I have participated in research projects at the University of Warwick. I am an advocate for good care for all.

Finances

We are funded by our local authority under the Health and Social Care Act (2012). In 2019-20 we spent £238,484. *NB: All figures subject to audit.*





Our plans for next year

Message from our Chief Executive

Chris Bain, Chief Executive

2019/20 will be remembered as an extraordinary year for health and social care across the UK, and Warwickshire has been no different. The impact of the Covid-19 pandemic has been felt right across the County and is driving a re-assessment and re-set of the way in which all services are designed and delivered.

This has inevitably had a huge impact on the ways in which patients and public receive and experience care services. This has also in turn affected the ways in which Healthwatch Warwickshire is working and responding to these new challenges. I have been extremely proud of the way in which our staff, volunteers, and Board Members have all pulled together and enabled us to completely change the ways in which we work without any significant disruption to the services we provide.

Our priorities were to ensure that the voices and views of patients and public continued to be heard, and that people had the best and most up to date information to base their decisions on. We very quickly restored our telephone service for members of the public to get information and signposting, our online services to receive queries from the public, we put a lot of effort into keeping our website fully updated with information about service changes, and we have made extensive use of social media to hear from people and to keep them informed.

We have also ramped up our partnership working with statutory and voluntary sector partners, and I put on record my thanks to them. Healthwatch Warwickshire could not succeed without your help and guidance.

In addition to totally changing our ways of working we have continued with business as usual. Many of the projects begun prior to the impact of Covid-19 have continued apace, including our project working with homeless people, digital medicine, and citizen engagement. New projects such as our survey on patient experience of Covid-19 have been launched. We are looking forward to the re-launch of our Standing Conference on Patient Voice and Health & Social Care Forum using digital platforms.

As we look forward, we will be committing ourselves to work with health and social partners as a "Critical Friend" on the restoration and re-set of services across the County. We will work hard to ensure that patient perspectives are fully considered as services are planned, and patient and public engagement are hard wired into the new structures that are put in place as we gradually emerge from the pandemic.

We will continue to review and refine the ways in which we working to adapt to the 'new normal' that we will all be experiencing, and look forward to being of even greater service in the future.

Chris Bain, Chief Executive

Thank you

Thank you to everyone that is helping us put people at the heart of social care, including:

- Members of the public who shared their views and experience with us.
- All of our amazing staff and volunteers.
- The voluntary organisations that have contributed to our work.

Contact us

4-6 Clemens Street, Leamington Spa, CV31 2DL

Contact number: 01926 422 823
Email address: info@healthwatchwarwickshire.co.uk
Social media: @healthwatchwarw
Website: www.healthwatchwarwickshire.co.uk

You can send us your feedback using our freepost address:

FREEPOST

HEALTHWATCH WARWICKSHIRE

Address and contact details of the organisation holding the local Healthwatch contract as of 31/03/2020.

Warwickshire County Council
Saltisford Office Park, Ansell Way
Warwick, CV34 4UL
01926 745118
lisalissaman@warwickshire.gov.uk

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you need this in an alternative format please contact us.

Company number 8181496

This page is intentionally left blank

Agenda Item 6

Health and Wellbeing Board

COVID-19 Health Impact Assessment

15 September 2020

Recommendations

The Health and Wellbeing Board is asked to:

1. Note the findings of the COVID-19 Health Impact Assessment

2. Endorse the COVID-19 Health Impact Assessment for publication on the Warwickshire County Council website

3. Utilise findings from the COVID-19 Health Impact Assessment when engaging in reset and recovery planning

1. Background

1.1 On 12th May the Warwickshire County Council Joint Strategic Needs Assessment (JSNA) Strategic Group agreed to initiate a COVID-19 Health Impact Assessment (HIA).

1.2 The aim of the HIA was: *to identify key factors that may affect the population's health and wellbeing as a direct result of the COVID-19 outbreak. This assessment will be available to both internal and external stakeholders to support their planning for recovery*.

1.3 Although initially proposed as a WCC piece of work, Coventry City Council and CCG colleagues were engaged to ensure that the HIA represents a system wide view across the Health and Care Partnership.

1.4 A project team was created which included officers from WCC Public Health and Business Intelligence; Coventry City Council Public Health and Insight Team; and Coventry and Warwickshire CCG Business Intelligence Teams.

1.5 The HIA is structured using the Kings Fund population health model. This highlights four interacting areas that influence the health and wellbeing of people in Coventry and Warwickshire:

- The wider determinants of health
- Our health behaviours and lifestyles
- The places and communities we live in and with
- An integrated health and care system

2. Findings

2.1 The connection between the four pillars of population health is important, and underpins two key high-level findings from the report:

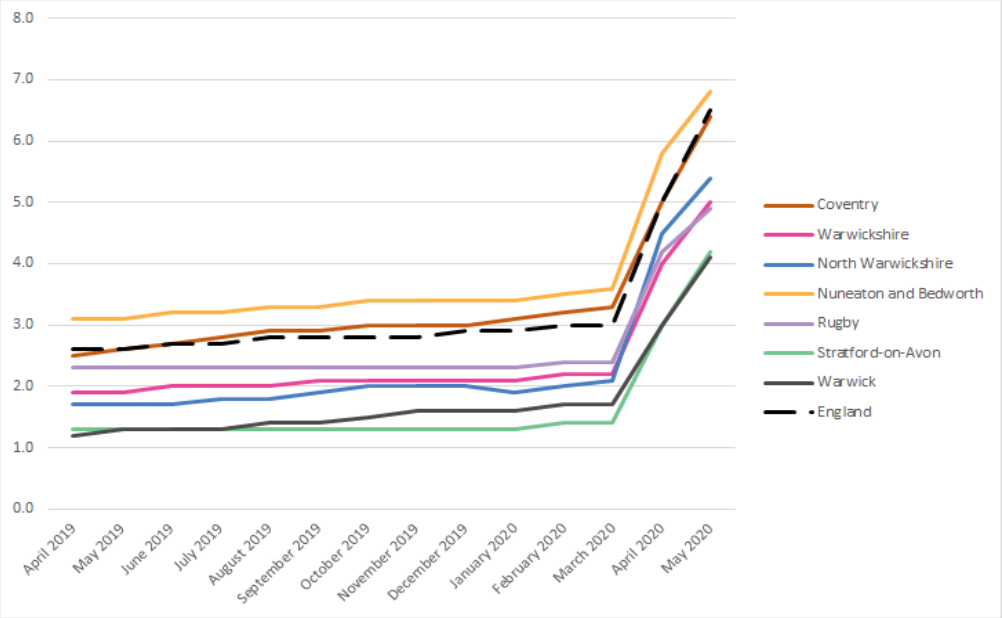
- **An integrated recovery:** This analysis shows that health and wellbeing has been deeply impacted on by changes across all four quadrants of the model. The implication is that recovery cannot just be contained to one sector and has to be connected across all four to have the biggest chance of success. An integrated recovery is one where we look across traditional boundaries to understand the wider impact of services.

- **The double impact:** The HIA references that the harm from COVID-19 has been unequally distributed across the population and is likely to continue to be so whilst still circulating. This analysis shows that the wider impacts from the pandemic and lockdown will fall more heavily on communities most directly affected by the disease itself. This analysis shows the potential harm for more deprived areas of Coventry and Warwickshire and, as more evidence develops, it will be important to understand the impact on Black, Asian and Minority Ethnic (BAME) groups and on the most vulnerable individuals facing multiple deprivation.

2.2 Key findings within the wider determinants of health and wellbeing pillar include:

- Mass Unemployment Events have a significant direct and indirect impact on health and wellbeing.
- Across Coventry and Warwickshire there are 17,000 new claimants of Job Seekers Allowance or Universal Credit with a requirement to look for work. An additional 85,000 people are furloughed.
- Areas such as Nuneaton and Bedworth, and Coventry which have had a relatively higher claimant count before COVID-19 are the same ones with higher rates afterwards. The area locally with the largest relative increase was North Warwickshire (see Figure 1 below).
- Stratford-on-Avon, North Warwickshire, and Rugby identified as potentially large decreases in economic output, predominantly because of manufacturing trade.
- Household spending has dropped by 22% during the lockdown.

2.3 Figure 1. Claimants in Coventry and Warwickshire aged 16+ as a proportion of residents aged 16 – 64



2.4 Key findings within the health behaviours and lifestyles pillar include:

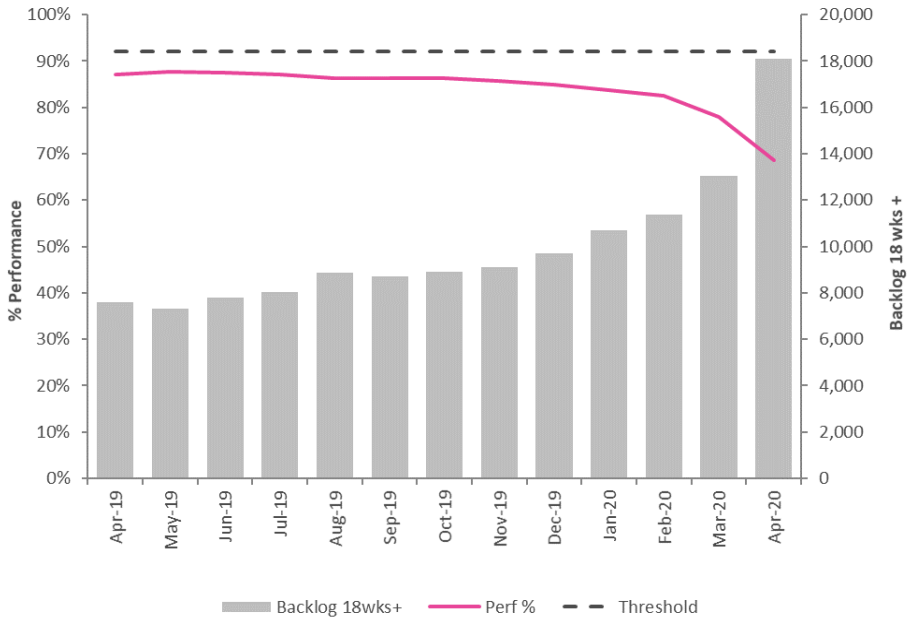
- Much of the evidence we use to understand health behaviours locally is drawn from national surveys or other data sources that have not been available. There is an evidence gap identified in this report, which prevents us from truly understanding the impact on healthy behaviours in Coventry and Warwickshire. Local surveys would be needed to fill that gap.
- Evidence that pandemics can increase alcohol use, particularly in healthcare staff. Supermarkets saw a 10.3% increase in alcohol sales in March.
- One in 500 adults started gambling in the first four weeks of lockdown. Active gamblers are more likely to use products with faster play cycles.
- Physical activity has increased for some and decreased for others in equal measures – but affluent groups are more likely to increase.
- There has been a drop in referrals to Stop Smoking in Pregnancy services.

2.5 Key findings within the integrated health and care system pillar include:

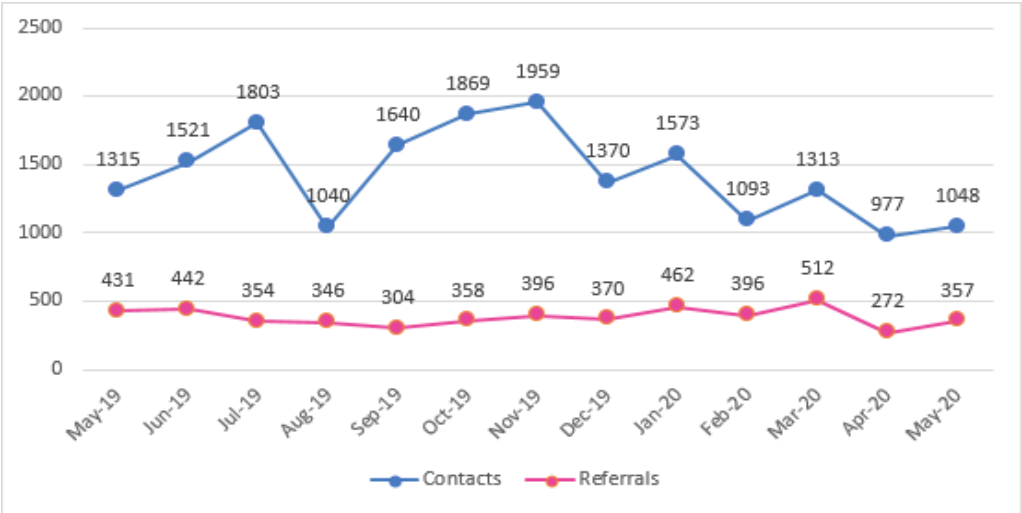
- Compared to April 2019, April 2020 saw:
  - A 62% reduction in A&E attendances. The biggest reduction was in Coventry and Rugby at 66.1%.
  - A 25.8% reduction in unplanned hospital admissions. The biggest reduction was 37.5% in South Warwickshire.
  - An 81% reduction in planned admissions. The biggest reduction was 89.7% in North Warwickshire.
  - A 74% reduction in outpatient activity.

- The total Referral to Treatment Waiting List moved to its lowest level during the 12 months between April 2019 and April 2020. There is also an increase in the backlog of referrals (see Figure 2).
- There were drops in the number of GP referrals into acute care over the same time period, including a 59.1% reduction in two week waits.
- Compared to previous months, in April and May there were 150 to 200 fewer child safeguarding referrals per month in Warwickshire (see Figure 3), and 100 to 150 fewer in Coventry.
- Each week that screening programmes were paused there were 679 missed bowel cancer screenings, 811 missed cervical cancer screenings and 538 missed breast cancer screenings.
- There is evidence of a drop in childhood immunisation coverage.

2.6 Figure 2. Waiting lists: 18+ week waits



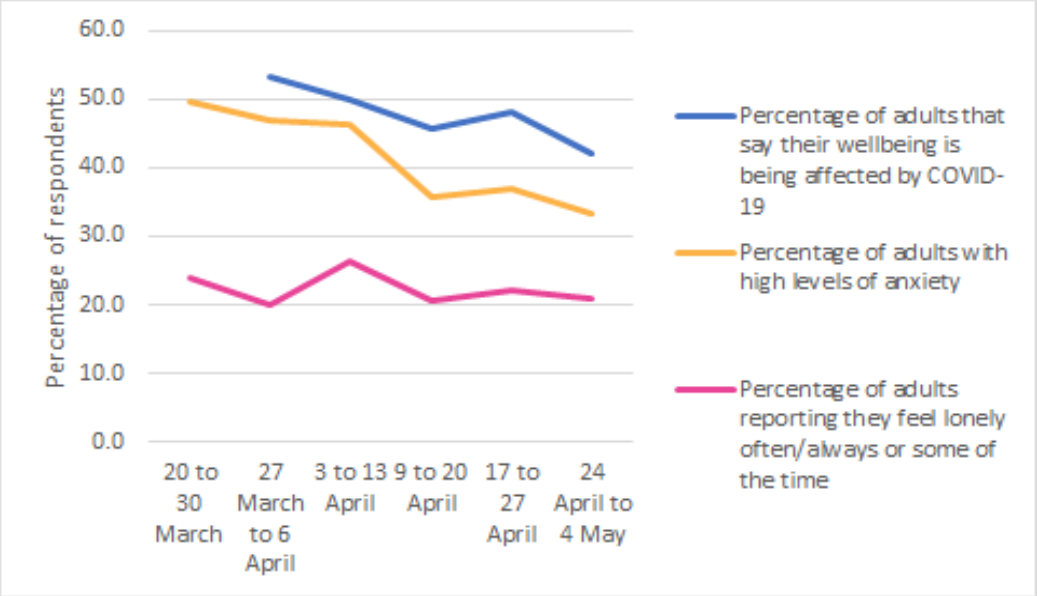
2.7 Figure 3. Child safeguarding referrals in Warwickshire



2.8 Key findings within the places and communities we live in pillar include:

- At the point of lockdown, half of adults reported a high level of anxiety and that COVID-19 had impacted on their health (see Figure 4).
- Between three to four percent of the population were on shielding lists, including over ten percent of over 70 year olds. There were more calls for social support the longer lockdown went on.
- There were increases in foodbank activity including packages to families with children.
- Reports of anti-social behaviour and domestic abuse increased. Theft and robbery reduced significantly.
- Over 200 homeless people were provided with temporary accommodation under the 'Everybody In' initiative.

2.9 Figure 4. ONS survey and feelings of wellbeing, anxiety and loneliness



3. Report recommendations

3.1 Recommendations relating to the wider determinants of health and wellbeing:

- Approaches to economic recovery can consider how 'Inclusive Growth' concepts that track the pattern as well as pace of growth can mitigate against a double impact in more deprived communities.
- The evidence presented here on areas and sectors most at risk can be used to better target and design interventions to support economic recovery.
- The health sector can play a role in identifying individuals who have become unemployed and explore preventative actions to mitigate any impact on health behaviours and wellbeing.

3.2 Recommendations relating to health behaviours and lifestyles:

- Local evidence needs to be collected on health behaviours through both planned and bespoke questionnaires and other engagement to understand the impact on health behaviours.
- There is an opportunity to encourage those who have adopted more healthy behaviours to maintain them. This needs to specifically consider the need to reduce health inequalities and how to address the barriers that prevented people in more deprived areas or lower paid professions from becoming more physically active.
- Health and social care organisations need to consider how to support front line staff to prevent increases in alcohol use seen following other pandemics.

3.3 Recommendations relating to an integrated health and social care system:

- More detailed analysis with clinical input needs to be carried out to understand the patient groups and conditions that have contributed to the decrease in hospital use, and their relative acuity. This will help to identify actions that mitigate the impact.
- The figures presented in this report on patients awaiting treatment, or who have missed screening and immunisation appointment should be used to support recovery planning. An integrated approach to recovery is needed across NHS organisations to prevent attempts to reduce the backlog from overwhelming parts of the system.

3.4 Recommendations relating to the places and communities we live in, and with:

- COVID-19 has had a broad impact on mental wellbeing and social isolation that needs to be addressed by all sectors as part of the recovery.
- Although there are plans to reduce the services available from shielding hubs, there are still health needs and anxieties in that group.
- Improvements in air quality have shown the potential to protect the public from this harm and opportunities to maintain some of the behaviours that have led to the reduction need to be considered, alongside additional work to support a shift onto more active forms of travel.

As well as the work to support rough sleepers housed during COVID-19 into more permanent accommodation, there need to be appropriate services in place.

4. Financial Implications

4.1 There are no financial implications arising from this update.

5. Environmental Implications

5.1 There are no environmental implications arising from this update.

6. Timescales associated with the decision and next steps

6.1 The COVID-19 Health Impact Assessment will be published to the WCC website following endorsement of this paper by the Health and Wellbeing Board.

Appendices

1. None

Background Papers

1. COVID-19 Health Impact Assessment

	Name	Contact Information
Report Author	Duncan Vernon, Catherine Shuttleworth	duncanvernon@warwickshire.gov.uk, catherineshuttleworth@warwickshire.gov.uk
Director of Public Health	Dr Shade Agboola	shadeagboola@warwickshire.gov.uk
Lead Director	Strategic Director, People, Nigel Minns	nigelminns@warwickshire.gov.uk
Lead Member	Portfolio Holder for Adult Social Care & Health, Cllr Caborn	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication: WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

This page is intentionally left blank

Coventry and Warwickshire COVID-19 Health Impact Assessment

Coventry and Warwickshire Joint Strategic Needs Assessment

July 2020

Coventry City Council

NHS

Warwickshire County Council

Many thanks are given to colleagues that contributed their time to creating this report. It was created within a short timeframe, across two local authorities and demonstrated the commitment of staff to work positively across the Coventry and Warwickshire patch to support recovery following COVID-19. Thanks is also given to local partner and commissioned organisations that provided data for input into this report which enabled us to demonstrate the wide impacts that COVID-19 has had upon our local population.

Report Project Team:

Coventry City Council

INSIGHT TEAM:

- Debbie Cashmore, Senior Analyst
- Si Chun Lam, Insight Development Manager (Place and Public Sector Transformation)
- Yolanda Chegwidden, Analyst

PUBLIC HEALTH:

- Tessa Hewitt, Public Health Speciality Registrar

Warwickshire County Council

BUSINESS INTELLIGENCE TEAM:

- Caroline McKenzie, Insight Analyst
- Kate Rushall, Business Intelligence Lead (Population Health & Economy)

PUBLIC HEALTH:

- Catherine Shuttleworth, Public Health Principal
- Duncan Vernon, Consultant in Public Health (project lead)
- Emily van de Venter, Associate Director of Public Health
- Harpal Aujla, Public Health Speciality Registrar

Coventry and Warwickshire CCG Business Intelligence Teams

PARTNER AND COMMISSIONED ORGANISATIONS

Big White Wall, Carer's Emergency Response Support Service, Change Grow Live, Citizen's Advice Bureau, Coventry and Warwickshire Mind, Coventry and Warwickshire Partnership NHS Trust, Edible Links, Healthwatch Warwickshire CIC, Mental Health Matters, Sport England, Trussell Trust, Warwickshire Police.

Contents

Foreword

Councillor Caborn

Portfolio Holder for Adult Social Care & Health (Warwickshire)

I am pleased to introduce this COVID-19 Health Impact Assessment which demonstrates the impacts of the pandemic across Coventry and Warwickshire.

Our thoughts and sympathies are with those people in our region and around the world have lost loved ones to COVID-19 and many others who have experienced indirect impacts of the outbreak.

This impact assessment outlines a number of different indicators across different sectors that have been negatively affected by the COVID-19 outbreak. Some of these impacts are just as big an issue for health and wellbeing as the impact of the virus itself. It is also clear that COVID-19 has highlighted, and in some cases exacerbated, health inequalities and that the wider impacts of the pandemic and lockdown will fall more heavily on communities most directly affected by the disease itself.

Working together is particularly important as we start to think about the resetting of health and wellbeing and recovery and the role that we can all play in helping to create healthy communities and tackle health inequalities. Please join us across Coventry and Warwickshire in utilising this impact assessment and its recommendations as we move forward to a reset and recovery phase, and reduce the future impact that the pandemic has on residents' health and wellbeing.

Councillor Kamran Caan

Cabinet Member for Public Health and Sport (Coventry)

Welcome to the COVID-19 Health Impact Assessment for Coventry and Warwickshire. This report focuses on the impact the outbreak has had on us locally and the steps we will be looking to take to improve our resilience to COVID-19.

Coronavirus has been tough on most of us, we have all been impacted in some way; whether that has been losing friends, family members and colleagues, being out of work, businesses struggling, or our key workers working tirelessly around the clock. Our thoughts and sympathies are with everyone that has been affected by the virus.

This assessment highlights the areas across our respective communities that have been negatively impacted by the pandemic and lockdown, but also demonstrates the shared understanding of factors needed to support and sustain the recovery across the patch. We know that existing health inequalities have only been intensified, especially in areas struck more directly by the virus and this is likely to continue while coronavirus is still circulating. The population health indicators in this report will enable an understanding of the potential harm for more deprived areas of Coventry and Warwickshire, and the developing impact on ethnic minority groups and on the most vulnerable individuals facing multiple deprivation.

We will continue to work closely together and with our partners in our reset and recovery journey. It is vital that we work to develop a level of trust within our communities and build healthy, active and resilient city-wide partnerships as a priority, especially in the absence of a COVID-19 vaccine.

By coming together and using this impact assessment and its recommendations as an integral part of the Coventry and Warwickshire reset and recovery approach, we can help support our communities to restore

Executive Summary

It is no understatement to say that the COVID-19 pandemic and response to prevent and mitigate the harm that it can cause radically changed how society functions. On the 23rd March a series of lockdown measures were announced in the UK which restricted most travel and shut down non-essential businesses and schools.

These actions successfully interrupted the spread of the disease. In Coventry and Warwickshire, a peak in the number of hospital beds occupied by patients with COVID-19 was reached in early April and the overall trend since then has been an ongoing reduction.

Whilst much harm from COVID-19 has been prevented, it is important to develop a shared understanding of the impact of the events over the last few months to support and sustain a recovery.

This report has been written to do just that. It is part of the Joint Strategic Needs Assessment (JSNA) programme in Coventry and Warwickshire and has been overseen by a project group including members from both Warwickshire and Coventry Business Intelligence and Public Health teams, as well as members from the NHS Clinical Commissioning Groups (CCG).

Key findings

This report has been structured using the Kings Fund 'population health' model. This highlights four interacting areas that influence the health and wellbeing of people in Coventry and Warwickshire.

- Wider determinants of health
- Our health behaviours and lifestyles
- An integrated health and care system
- The places and communities we live in, and with

The connection between these four pillars of population health is important, and underpins two key high-level findings from this report:

1) An integrated recovery: This analysis shows that health and wellbeing has been deeply impacted on by changes across all four quadrants of the model. The implication is that recovery cannot just be contained to one sector and has to be connected across all four to have the biggest chance of success. An integrated recovery is one where we look across traditional boundaries to understand the wider impact of services.

2) The double impact: This report references that the harm from COVID-19 has been unequally distributed across the population and is likely to continue to be so whilst still circulating. This analysis shows that the wider impacts from the pandemic and lockdown will fall more heavily on communities most directly affected by the disease itself. This analysis shows the potential harm for more deprived areas of Coventry and Warwickshire and, as more evidence develops, it will be important to understand the impact on Black, Asian and Minority Ethnic (BAME) groups and on most vulnerable individuals facing multiple deprivation.

The Wider Determinants of Health

This analysis has looked most closely at the economic impact of COVID-19. Mass unemployment events can have a wide and negative impact on health and wellbeing, as alongside the reduction in security it leads to increases in smoking and alcohol use, and puts wider strain on the mental wellbeing of the whole household and relationships.

Across Coventry and Warwickshire there are 17,000 new claimants of either Jobseeker's Allowance, or Universal Credit with a requirement to look for work. This may be an underestimate as there are additionally around 85,000 people locally currently furloughed, and national surveys have shown large amounts of financial concern in that group.

Areas such as Nuneaton and Bedworth, and Coventry which have had a relatively higher claimant count before COVID-19 are the same ones with higher rates afterwards. The area locally with the largest relative increase was North Warwickshire.

Some national studies have assessed the potential impact of COVID on employment sectors, and used that to rank all 383 English local authority areas to see where might have the largest decrease in economic output. Three authorities locally were in the top 15 most impacted: Stratford-on-Avon, North Warwickshire, and Rugby. Decreased outputs from the manufacturing sector were behind that estimated impact, although in North Warwickshire the logistics sector and the construction sector in Rugby also played a large part.

Health Behaviours

Much of the evidence we use to understand health behaviours locally is drawn from national surveys or other data sources that have not been available. There is an evidence gap identified in this report, which prevents us from truly understanding the impact on healthy behaviours in Coventry and Warwickshire. Local surveys would be needed to fill that gap.

Nationally there has been evidence of changes in health behaviours. March saw a 10% increase in supermarket alcohol sales – although national surveys have shown that some people are drinking less than before the lockdown. Others are drinking more, and this is potentially depending on how acutely they perceived the threat of COVID-19. To truly understand the impact on different groups, it is important to identify the groups that have increased alcohol consumption. There is evidence that health care workers are more likely to increase alcohol consumption after a pandemic. Services for people with substance misuse issues, including those who use alcohol, have been maintained over the last few months with some reductions in referrals.

Around one in every 500 adults are estimated to have tried gambling for the first-time during lockdown. Although there has been a reduction in gambling overall, some of the national evidence tells us that 1 in 3 people who gamble have tried new products during lockdown.

Physical activity was one of the exemptions of the lockdown and people could leave the house once-a-day to be active. Walking became one of the most common ways to be active in April. Overall there appears to be an equal split between people doing more, less and the same amount of physical activity although some evidence tells us that people in managerial professions were more likely to be more active than workers who do skilled or unskilled manual work, which may further exacerbate health inequalities.

Google's community mobility reports, that is, reports that chart movement trends over time and place, show that parks were used less during April than prior to lockdown, however there were large increases in access in May – especially during both half-term and the two Bank Holiday weekends.

There was a reduction in the number of referrals to the Stop Smoking in Pregnancy service in Warwickshire, and again, women in more deprived areas are more likely to smoke during pregnancy.

All in all, these trends may serve to exacerbate health inequalities, with people in more deprived communities, in lower-paid employment, or with pre-existing health conditions, may be more likely to experience further deprivation as a result of lockdown.

Integrated Health and Care System

Large reductions in health service contact have been seen across both primary and secondary care. This has the risk of manifesting as a late presentation or increased numbers of preventable deaths. A key challenge for the health service will be to identify, manage, and prioritise, individuals at risk within the capacity available.

There were large reductions in hospital use, even with the increases in the number of COVID-19 patients. For A&E departments across the region, the number of attendances were 40% of what would have been expected based on previous years – not accounting for any expected year-on-year increases from population change.

The reduction in unplanned hospital admissions was not as large and was roughly 75% of previous years. This gives us some early evidence on the changes in casemix, that is, the groupings of patients and treatments; and that attendances may have been for more severe illness on average.

Many planned hospital appointments were cancelled during the pandemic with over an 80% reduction in non-elective admissions. This has led to an increase in 5,000 patients waiting over 18 weeks for an appointment in April alone.

There is some evidence that patients stayed away from general practice. Surveys such as the national flu survey have shown the shift away from face to face contact and towards telephone consultations. There were reductions in referrals from General Practice into acute care, with the largest reduction from routine appointments, however we also saw the number of urgent cancer referrals halve in April compared to previous years.

There has also been a drop in preventative activity in the health service. Pausing screening programmes has led to a weekly total of 679 missed bowel screenings, 811 cervical screenings and 538 breast cancer screenings, across Coventry and Warwickshire. There have also been drops in the dementia diagnosis rate, with a 4% drop in April 2020 compared to the same month in the previous year. This drop was greater than seen nationally. There is some evidence locally and nationally that there has also been a decrease in the coverage of childhood vaccinations.

Referrals to mental health services have dropped. In some instances, this may have been due to changes in circumstances, with fewer patients seen due to educational stressors as a result of school closures, and increases in eating disorder referrals which may reflect more parents identifying this as the referral reason.

Safeguarding has also been impacted and there have been drops in around 100 to 150 referrals each month in Coventry in April and May, compared to the months prior, and in Warwickshire there have been drops of 150 to 200 each month. Analysis by referral source confirms that this is due to a lower proportion of referrals from schools.

The places and communities we live in, and with

Communities and human contact are important for wellbeing. A national Office for National Statistics (ONS) survey found that at the point of lockdown half of adults reported high levels of anxiety, with larger numbers reporting that COVID-19 had impacted on their health. This correlates closely with findings in previous sections showing financial worries amongst furloughed staff, and the Community Mental Health Team seeing isolation as the reason for people accessing support during lockdown.

Nationally, a programme of shielding was introduced to protect people who are clinically extremely vulnerable to COVID-19. Local authorities were responsible for supporting these people with food, medicine, safety checks and essential contact during the lockdown. The number of residents on the Ministry of Housing, Communities and Local Government (MHCLG) and NHS shielding list across Warwickshire and

Coventry has varied from around 3% of the population in Rugby to close to 4% of the population in North Warwickshire.

In Coventry, some 14,282 individuals had been identified as needing shielding, and in Warwickshire, the figure was 20,960. The vast majority of people did not require additional support – however, around 10-15% of those contacted required support to acquire food, medication, or regular social contact calls. In addition to the national shielding programme, Coventry also adopted a population health approach to identify and contact some 2,000 additional households locally identified as potentially vulnerable through its own and partner datasets such as council tax and priority services registers, due to multiple risk factors including age, disability, mobility, income or living alone.

Foodbank use increased during lockdown. Data from the Trussell Trust showed an increase of 95% and 125% in food parcels given out overall in Coventry and Warwickshire respectively compared to the equivalent month a year ago. There was also an increase in food parcels given to families with children.

There were changes in the types of crime reported. Comparing April 2020 with the previous year, antisocial behaviour more than doubled in Coventry and Warwickshire. Conversely, other than antisocial behaviour there was a 30% reduction in crimes in Coventry and 13% reduction in Warwickshire. Some of the largest falls were related to burglary, theft or robbery. However, there were an additional 250 domestic abuse incidents in Warwickshire in April and May compared to previous years.

Places and communities affect health and health inequalities, and lockdown and social distancing measures as a result of COVID-19 have had substantial impact on the wellbeing of individuals and communities, from mental health, to financial concerns; to access to important sources of support from family and friends. This is particularly true for more vulnerable individuals who are shielding, people facing domestic abuse, and people facing financial difficulties. The longer-term effect of this on health and wellbeing is yet to be fully known.

Health and wellbeing has been significantly impacted by changes across a number of different areas

An integrated recovery is required across all four sectors (i.e. wider determinants of health, our health behaviours etc)

There is a double impact meaning that the wider impacts from the pandemic and lockdown will fall more heavily on communities most directly by the disease itself.

- Wider determinants of health
- Our health behaviours and lifestyles
- An integrated health and care system
- The places and communities we live in, and with

In April there were (25.8%)

2,818

fewer unplanned hospital admissions compared with the previous year

142 Coventry

139 Warwickshire

People were provided with emergency accommodation during the COVID-19 pandemic

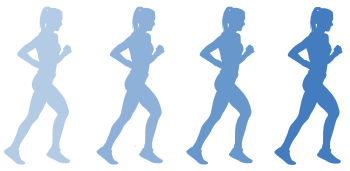
Increase of food parcels given out in April 2020 compared to April 2019:

- **95%** Increase in food parcels given out in Coventry.
- **63%** Increase in the Warwickshire North and Rugby.
- **87%** Increase in South Warwickshire.

In April 2020

- **18%** of men reduced their risky alcohol use
- **11%** of women reduced their risky alcohol use
- **5%** of people increased their risky alcohol use

% Increase in claimant count



Nearly **37%** of survey respondents in the West Midlands felt they were doing more physical activity during lockdown

Nearly **31%** of survey respondents in the West Midlands felt they were doing less physical activity during lockdown

people from manual or routine occupations were less likely to increase their physical acivity

Referrals for mental health services dropped between February 2020 and May 2020

Drop in the percentage of new referrals:

- 52% — Children and young people
- 33% — Early intervention psychosis
- 70% — Adult eating disorder
- 48% — Community mental health teams (CMHT)

Over all crime levels, excluding anti-social behaviour, dropped

- 30% — Coventry
- 25% — Warwickshire

However incidences of anti-social behaviour rose

- 105% — Coventry
- 150% — Warwickshire

Areas most at risk of GVA reductions

a measure of the value of goods and services produced in an area

Stratford-on-Avon	North Warwickshire	Rugby	Coventry	Nuneaton & Bedworth	Warwick
£ 46%	£ 45%	£ 45%	£ 37%	£ 36%	£ 34%

Referrals to children's social care

April	May	April	May
38%	22%	32%	10%
Coventry		Warwickshire	

When screening programmes were on hold, across Coventry and Warwickshire there were...

- 679 — Bowel Cancer
- 811 — Cervical Cancer
- 538 — Breast Cancer

...screenings missed per week

The pandemic resulted in high levels of anxiety in adults

49.6 % 20th to 30th March

The pandemic impacted 57.1% of adults' wellbeing

53.1 % 27th March to 6th April

The Lockdown saw a general decrease in gambling however.

- 1 in 3 — people who gamble have tried new products since lockdown
- 1 in 500 — people started gambling for the first time

Introduction

The COVID-19 pandemic and response has radically changed how society functions. Social distancing and isolation measures have resulted in significant changes to daily living for the majority of the population. As both society and the health and social care system work towards recovering from the pandemic, we need to have a shared understanding of what this impact has been. This rapid impact assessment highlights many of the areas that have been immediately impacted by the pandemic, and therefore some of the impacts on health that may need to be addressed in the recovery to meet the needs of the population.

The Coventry and Warwickshire Health and Care Partnership[i] started moving towards a population health model prior to the COVID-19 pandemic. Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population[ii]. The local approach, promoted by the King's Fund, uses a framework of the four pillars of population health and this report is structured to reflect these pillars:

- Wider determinants of health
- Our health behaviours and lifestyles
- The places and communities we live in, and with
- An integrated health and care system

The report also highlights health inequalities which have been brought to the fore in discussion of the COVID-19 outbreak and response.

It should be noted that this health impact assessment does not contain all indicators that were originally proposed to be included by the project group. This is due to the timeliness and availability of data. However, the assessment will be updated 6 months following publication to include longer term data to provide further insights into the impact of COVID-19.

This report has been written by a project group including members from both Warwickshire and Coventry Business Intelligence and Public Health teams, as well as members from the CCG. It has been written to cover the whole of the Coventry and Warwickshire health and care partnership (HCP) geography.

Health Inequalities

In February 2020, the Institute for Health Equity published the Marmot Review: 10 Years On[iii] which highlighted that health inequalities are large and have been growing over the past 10 years. Key findings include: life expectancy improvements have stalled and declined for the poorest 10% of women; people can expect to spend more of their lives in poor health; and the health gap between wealthy and deprived areas has grown.

As the COVID-19 outbreak has progressed it has highlighted existing inequalities and in some cases has increased them. PHE has published the report Disparities in the risk and outcomes of COVID-19[iv] which highlights the following findings:

- **Age and sex –** COVID-19 diagnosis rates increased with age for both males and females. Working age males diagnosed with COVID-19 were twice as likely to die as females. Among people with a positive test, those who were aged 80 or over were 70 times more likely to die when compared to those under the age of 40.
- **Geography –** Diagnoses rates and death rates in confirmed cases among males were highest in London followed by the North West, the North East and the West Midlands. The South West had the lowest rates. For females the North East and the North West had higher diagnosis rates than London, while London had the highest death rate. Local authorities with the highest diagnoses and death rates are mostly urban. Death rates in London from COVID-19 were more than three times higher than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequalities in all-cause mortality rates in previous years.
- **Deprivation –** mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females.
- **Ethnicity –** People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. This is the opposite of mortality rates in previous years when the mortality rates were lower in Asian and Black ethnic groups than White ethnic groups. 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. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced. A further PHE report has been published to understand the impact of COVID-19 specifically on BAME groups[v].
- **Occupation -** ONS reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. This analysis expands on this and shows that nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 to 2018.
- **Inclusion health groups -** When compared to previous years, there has been a larger increase in deaths among people born outside the UK and Ireland. The biggest relative increase was for people born in Central and Western Africa, the Caribbean, South East Asia, the Middle East and South and Eastern Africa. This may be one of the drivers behind the differences in mortality rates seen between ethnic groups. Data on rough sleepers suggested a higher diagnosis rate when compared to the general population.

- **People in care homes -** Data from the Office for National Statistics (ONS) shows that deaths in care homes accounted for 27% of deaths from COVID-19 up to 8 May 2020. The number of deaths in care homes peaked later than those in hospital, in week ending 24 April. Analysis shows that there have been 2.3 times the number of deaths in care homes than expected between 20 March and 7 May when compared to previous years, which equates to around 20,457 excess deaths. The number of COVID-19 deaths over this period is equivalent to 46.4% of the excess suggesting that there are many excess deaths from other causes or an under-reporting of deaths from COVID-19.
- **Comorbidities –** 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 mentioned on 21% of death certificates where COVID-19 was also mentioned. This finding is consistent with other studies that have reported a higher risk of death from COVID-19 among patients with diabetes. This proportion was higher in all BAME groups when compared to White ethnic groups and was 43% in the Asian group and 45% in the Black group. The same disparities were seen for hypertensive disease. Several studies, although measuring the different outcomes from COVID-19, report an increased risk of adverse outcomes in obese or morbidly obese people.

Due to the rapid nature of this assessment and the limited availability of more detailed data, some of the analysis in this report has not looked at many of these factors in detail. The inequalities of the impact of the COVID-19 pandemic need to be borne in mind and the local demographics detail presented can support this.

Local Demographics

Locally, the Joint Strategic Needs Assessment (JSNA) analyses the current and future health and wellbeing needs of the population. Demographic information of the local population is collected as part of this. The data below highlights key demographics where the inequalities highlighted above may impact on local communities. Consideration should be given to this information when recovery planning.

Further demographic information can be found on the Coventry and Warwickshire JSNA webpages:

- **https://www.coventry.gov.uk/jsna**
- **https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1**

Age and Gender

COVENTRY

Figure 1 highlights that the population in Coventry is relatively young, with largest numbers between the ages of 20 – 24. Compared to Warwickshire there is a lower number of people aged over 65, who are at increased risk of dying from COVID-19.

WARWICKSHIRE

In comparison the spread of age across the Warwickshire population is relatively uniform with small peaks between the ages 45 – 59 (Figure 2). A significant proportion of the population is aged over 65 and at increased risk of death from COVID-19.

Ethnicity

Ethnicity figures are taken from the 2011 Census. These numbers are expected to have changed in the recent years and should be interpreted with some caution.

Table 1 demonstrates that Coventry has a larger percentage of people who are BAME compared to Warwickshire (26.2% and 7.3% respectively). This indicates that a higher proportion of the Coventry population are at risk of dying from COVID-19 due to the additional risk factors associated with ethnicity.

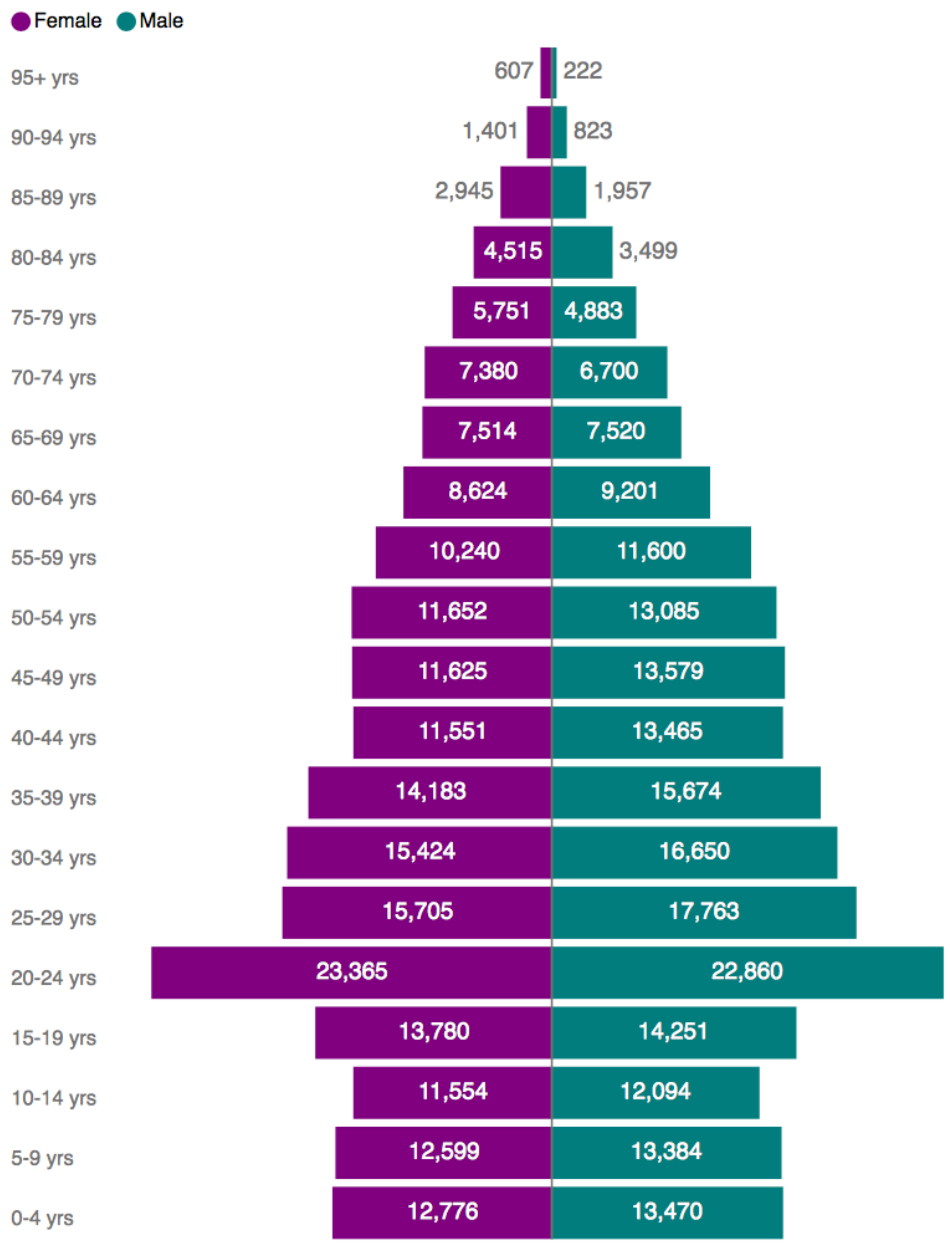
Deprivation

The following figures highlight areas of deprivation in Coventry and Warwickshire. Higher levels of deprivation have been associated with an increased risk of mortality due to COVID-19.

COVENTRY

In 2019 14.4% of Coventry's Lower Super Output Areas (LSOA) were amongst the 10% most deprived in England and 26.7% of LSOAs were amongst the 30% most deprived in England. Figure 3 highlights areas of higher deprivation where residents are at higher risk of contracting of dying of COVID-19. The majority of areas with high deprivation are in the central north east and north east of the city with pockets in the south west and south east.

FIGURE 1 The number of male and female persons in Coventry broken down by age and gender



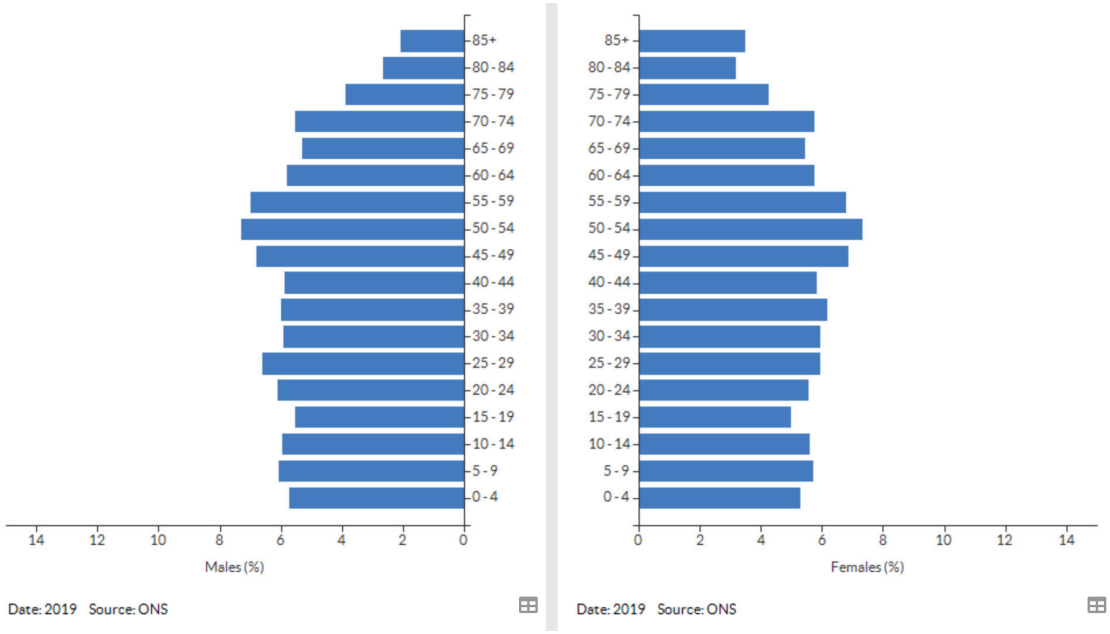
The number of male and female persons in Coventry broken down by age and gender

Source: Office for National Statistics mid-year population estimates / Insight Team, Coventry City Council

WARWICKSHIRE

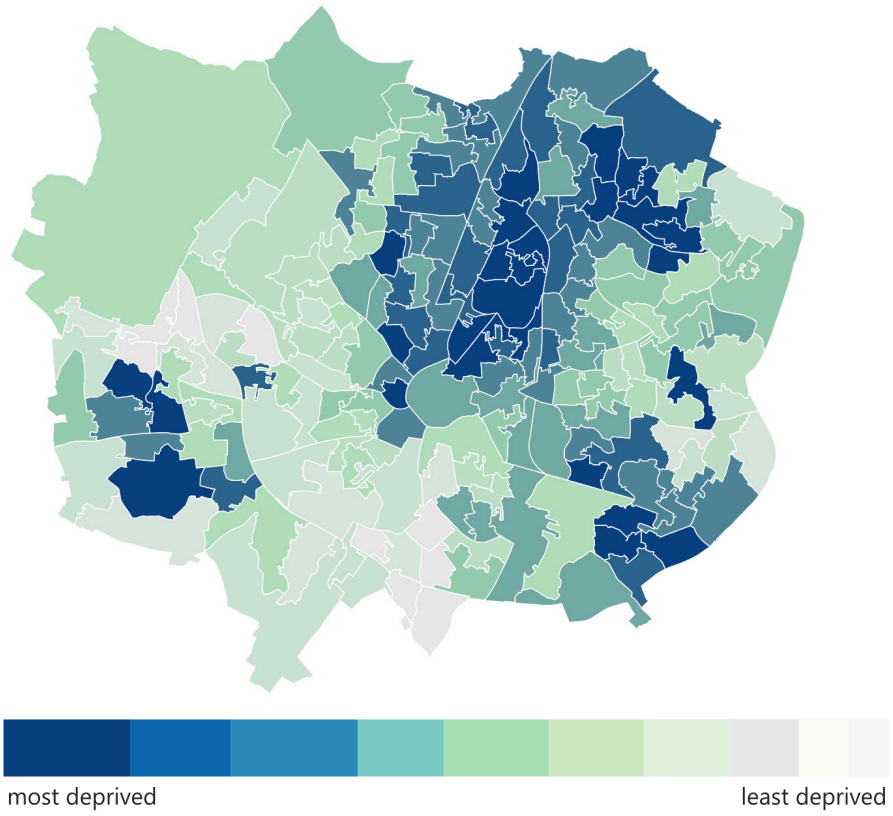
In 2019 Warwickshire ranked 121 out of 151 local authorities for deprivation, with 151 being least deprived. However, there are areas of deprivation across the county and each district or borough contains at least one LSOA amongst the 30% most deprived in England. As illustrated in Figure 4, five LSOAS in Nuneaton & Bedworth Borough and one in North Warwickshire Borough are in the 10% most deprived nationally. Given the national picture, these are areas where residents are at increased risk of contracting and dying from COVID-19.

FIGURE 2 The percentage of male and female persons in Warwickshire broken down by age and gender



Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

FIGURE 3 Heat map illustrating deprivation in Coventry



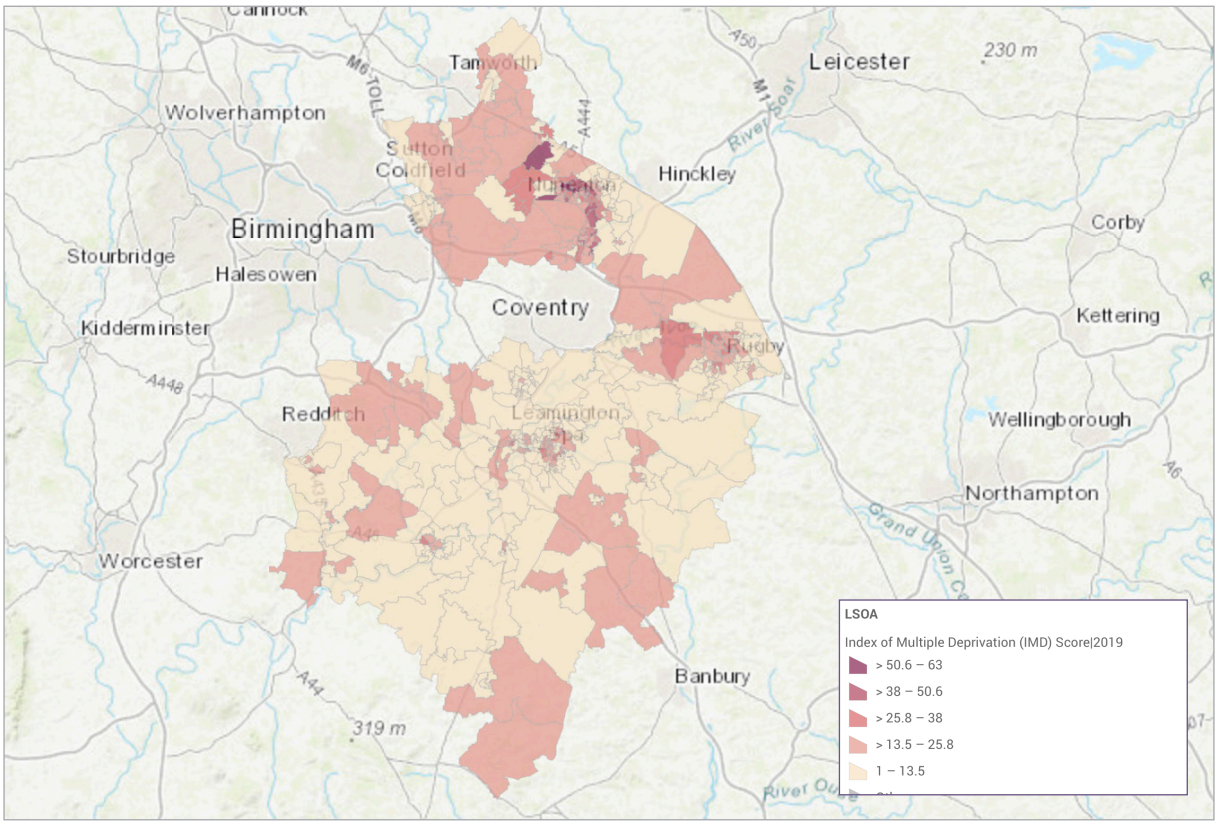
Source: Ministry of Housing, Communities and Local Government / Insight Team, Coventry City Council

TABLE 1 Population ethnicity estimates for Coventry and Warwickshire

	Stratford-on-Avon	North Warwickshire	Rugby
Population Size	55,977,200	366,785	577,933
White English / Welsh / Scottish / Northern Irish / British	79.8%	67%	88.5%
White Irish	1.0%	2.3%	1.0%
White Gypsy or Irish Traveller	0.1%	0.0%	0.1%
White Other	4.6%	4.9%	3.2%
Mixed	2.3%	2.6%	1.5%
Asian	7.8%	16.3%	4.6%
Black	3.5%	5.6%	0.8%
Other	1.0%	1.7%	0.4%

Sources: Office for National Statistics mid-year population estimates / Insight Team, Coventry City Council; Business Intelligence Team, Warwickshire County Council

FIGURE 4 Heat map illustrating deprivation in Warwickshire



Source: Ministry of Housing, Communities and Local Government / Business Intelligence Team, Warwickshire County Council

The Wider Determinants of Health

Claimant Count

What was the previous picture:

The Claimant Count is a measure of those receiving Job Seeker's Allowance, plus those receiving Universal Credit who are required to look for work. Across both Coventry and Warwickshire, the percentage of working age people counted in this group has been gradually rising since April 2019: in Coventry it increased from 2.5% in April 2019 to 3.3% in March 2020, and in Warwickshire from 1.9% in April 2019 to 2.2% in March 2020. Across Warwickshire, the highest rates were in Nuneaton and Bedworth Borough, which were consistently higher than the England rate, and the lowest in Warwick and Stratford Districts.

What does the literature say:

It is well documented that the health of populations is shaped by the socioeconomic context, welfare systems, labour markets, public policies and demographic characteristics of countries. Changes in these key determinants may be reflected in the wellbeing of populations. The original Marmot Review in 2010 shone a light on the importance of good employment for health and wellbeing, and the strong connection between unemployment and mortality[vi].

The impact of mass unemployment events has also been studied. Job loss can lead to increases in alcohol use, smoking, overweight and drug misuse, as well as mental health. There are wider impacts on the families of people who become unemployed including poor mental health and relationship stress[vii].

A systematic review focusing on mental health outcomes concluded that during periods of economic recession, an increase in unemployment can subsequently lead to a higher prevalence of mental health problems, including common mental disorders, substance disorders, and ultimately suicidal behaviour[viii].

What is the current data saying:

In Coventry the Claimant Count numbers increased from 8,030 in March to 15,700 in May (increase of 95.5%); which is lower than the England increase. When compared to May 2019, the percentage of the population who were claimants has more than doubled, from 2.6% in May 2019 to 6.4% in May 2020.

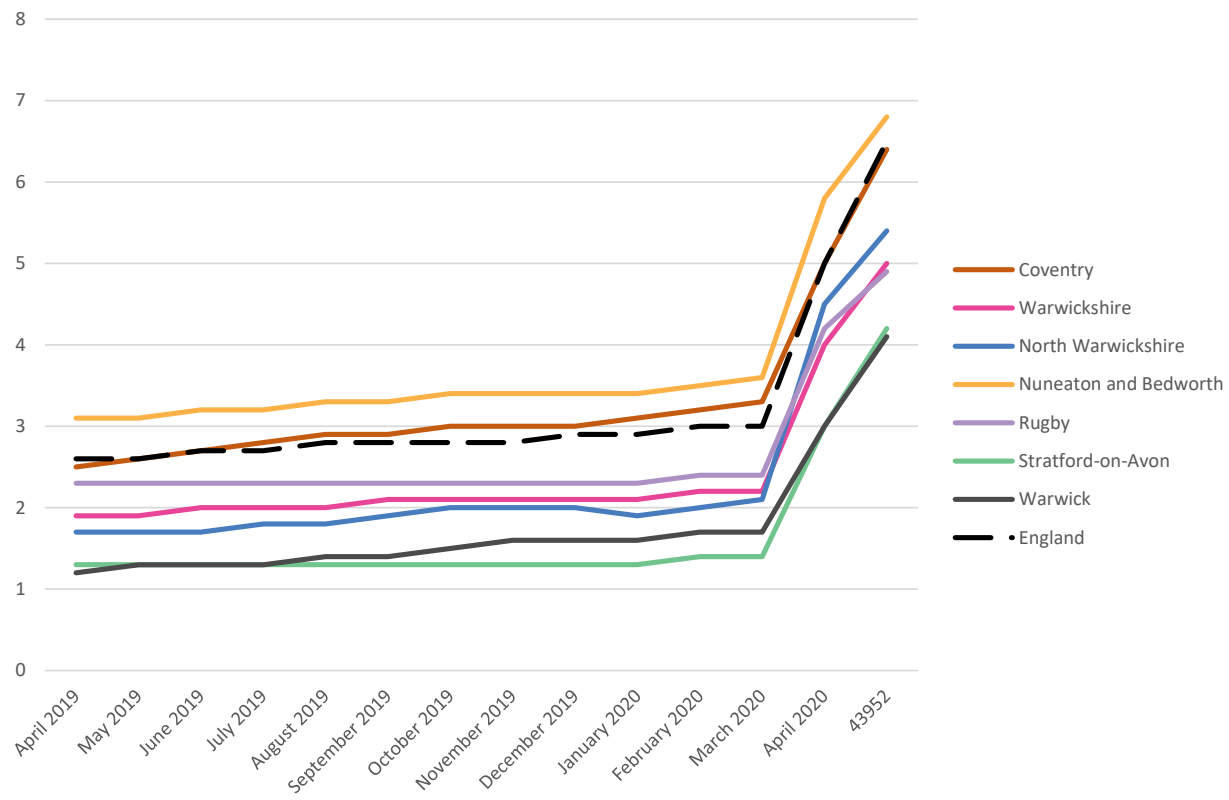
Across Warwickshire the numbers have more than doubled from 7,830 in March to 17,625 in May (increase of 125.1%). This is higher than the England increase of 114.1%. There have been large increases seen across each district and borough, with Stratford-on-Avon District seeing almost three times the number of claimants in May than in March, with more than twice the number in every other district and borough except Nuneaton and Bedworth, which saw an increase of 89.9%.

When compared to May 2019, the percentage of the population who were claimants across Warwickshire has more than doubled, from 1.9% in May 2019 to 5.0% in May 2020. The highest percentage in Warwickshire remains in Nuneaton and Bedworth (6.8%, Warwickshire average 5.0%).

It is important to note that the Government furlough scheme is to some extent masking the extent of the impact of COVID-19 on employment as people currently on furlough are not included in these figures. As such, the impact of COVID-19 on employment may be greater than these figures suggest.

It can be seen from Figure 5 and Table 2 that North Warwickshire has seen the biggest percentage increase in claimants. When comparing May 2019 to May 2020, there are over three times as many claimants. However, Coventry and every district and borough within Warwickshire have at least twice as many claimants in May 2020 as in May 2019.

FIGURE 5 Claimants in Coventry and Warwickshire aged 16+ as a proportion of residents aged 16-64



Source: NOMIS https://www.nomisweb.co.uk/

TABLE 2 Percentage increases in Claimant Count across Coventry and Warwickshire

Area	Percentage increase April 2019 to April 2020	Percentage increase May 2019 to May 2020
North Warwickshire	171.0%	222.6%
Nuneaton and Bedworth	88.0%	118.5%
Rugby	85.7%	119.4%
Stratford-on-Avon	138.5%	198.6%
Warwick	138.2%	138.5%
Warwickshire	111.4%	125.1%
Coventry	95.4%	142.8%
Coventry and Warwickshire	103.7%	153.4%
England	93.2%	114.1%

Source: NOMIS https://www.nomisweb.co.uk/

Value of goods and services, Gross Value Added

What was the previous picture:

The economies of Coventry and Warwickshire are seen as robust and in the past few years have bucked national trends, helped by a strengthening service sector, which has shown growth in domestic orders[ix]. The biggest concern was the manufacturing sector where confidence had fallen following a fall in domestic and overseas orders, and the uncertainty around the future trading relationship between the UK and EU.

What does the literature say:

A study published in April 2020 predicted severe adverse effects on employees, customers, supply chains and financial markets will most likely lead to a global economic recession.[x] Evidence has shown that employment protects against social exclusion through the provision of income, social interaction, a core role, identity and purpose. Evidence related to economic recovery based on the 2008 financial crisis may not be a suitable proxy measure due to the uncertainty around the end of this pandemic; both the length and scale are not predictable.

What is the current data saying:

Analysis undertaken by the Centre for Progressive Policy (CPP) provided a rank listing of all local district and unitary authorities in the UK in terms of most to least negatively affected by the pandemic. Gross Value Added (GVA) is a measure of the value of goods and services produced in an area. Out of 383 local authority areas, our local areas ranks are shown in Table 3. The main sector causing this decline across Coventry and Warwickshire is manufacturing (see Table 4); this is overwhelmingly the case in Stratford District, where manufacturing is expected to drop by 41%.

A national study by the Institute of Social & Economic Research (ISER), estimated the likely reductions in the workforce from lockdown by sector. While it is hoped that most of these reductions will be furloughed staff (as a result of the Job Retention Scheme), a concern is that this may lead to unemployment in the longer term and also the impact on reduced household income. Using the estimated sectoral percentage reductions in employment from the ISER analysis, we can explore what the potential impact may be locally, and how this may differ from area to area depending on the make-up of the local economy.

In Coventry, of 162,000 jobs, 34,000 (21%) are considered to be at risk, with most affected areas being wholesale and retail trade, and accommodation and food services. This is shown in Figure 6.

Warwickshire could see approximately 70,400 furloughed jobs taken from the local economy as a result of the lockdown measures (approximately 23% of total employment). (14,900 or 30% in North Warwickshire, 9,600 or 20% in Nuneaton and Bedworth, 12,500 or 26% in Rugby, 15,500 or 23% in Stratford and 17,900 or 21% in Warwick) The most affected sectors across Warwickshire would be the Wholesale and retail trade (-23,000) and Accommodation and Food Services (-15,000). This is in line with the sectors most impacted at a national level. This is shown in the Figure 7.

At a national level, according to the Joseph Rowntree Foundation, more than a third of furloughed private renters (37%) are worried about being able to pay their rent when the Coronavirus lockdown ends and there is the potential that they may be made redundant. Additionally, 40% of mortgage holders have suffered reduced income due to Coronavirus, and one in five worried about meeting their housing costs once lockdown lifts.

Nationally, according to the ONS on 12th June 2020, 22% of usual household spending has been prevented by the lockdown (£182 per week).

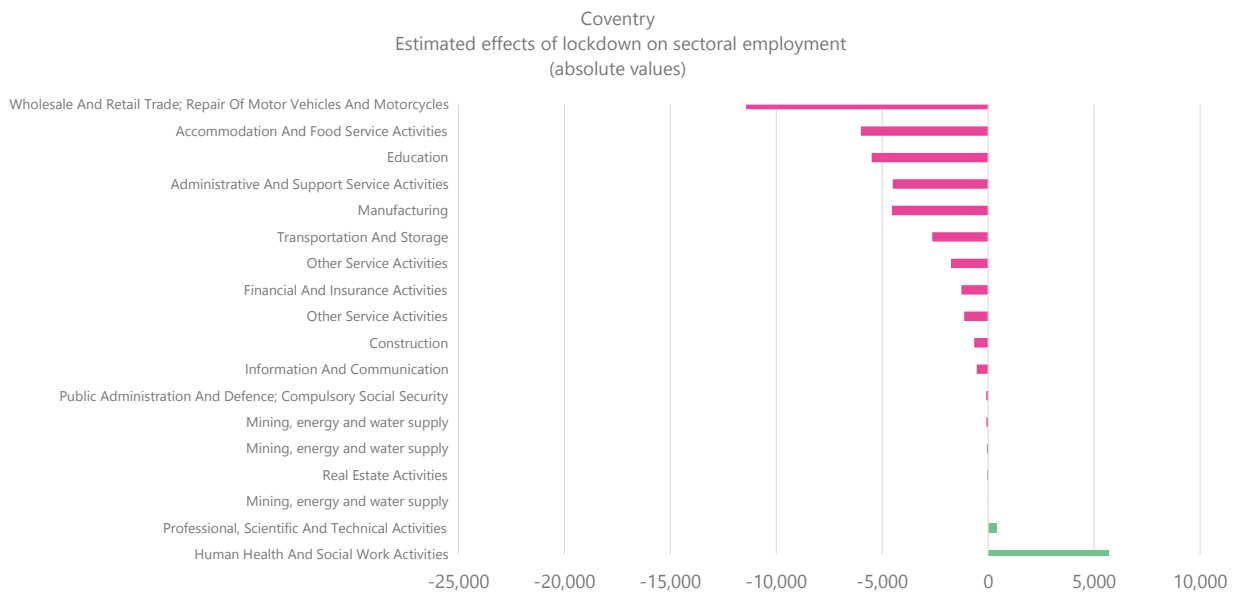
TABLE 3 Rankings of GVA for Coventry and Warwickshire				
Local Authority	**Rank**	**Total GVA (2018) (£m)**	**Reduction (%)**	**Main sectors for decline**
Stratford-on-Avon	4th	440	46%	Manufacturing
North Warwickshire	12th	531	45%	Manufacturing, Transport and Storage
Rugby	13th	249	45%	Professional, scientific and technical activities, Construction
Coventry	205th	992	37%	Manufacturing
Nuneaton & Bedworth	244th	299	36%	Manufacturing
Warwick	281st	774	34%	Agriculture, mining, electricity, gas, water and waste

Source: Centre for Progressive Policy (CPP) https://www.progressive-policy.net/publications/which-local-authorities-face-biggest-immediate-economic-hit

TABLE 4 Expected reduction in GVA by sector across Coventry and Warwickshire						
	Stratford-on-Avon	**North Warwickshire**	**Rugby**	**Coventry**	**Nuneaton and Bedworth**	**Warwick**
Accommodation and food service activities	3.3%	2.7%	1.8%	1.9%	1.7%	1.9%
Administrative and support service activities	3.0%	4.0%	3.7%	3.5%	3.5%	7.3%
Agriculture, mining, electricity, gas, water and waste	2.4%	3.8%	1.1%	8.6%	2.4%	22.4%
Construction	5.6%	8.6%	14.4%	2.7%	3.7%	4.2%
Education	3.7%	3.0%	5.2%	9.5%	7.8%	3.0%
Financial and insurance activities	0.7%	4.3%	0.3%	6.9%	0.6%	1.7%
Human health and social work activities	2.9%	1.0%	2.8%	7.4%	11.8%	4.9%
Information and communication	2.9%	2.5%	7.2%	5.1%	1.7%	7.3%
Manufacturing	40.7%	19.3%	11.8%	18.4%	21.7%	7.5%
Other service activities	3.6%	1.6%	2.9%	2.2%	2.4%	4.4%
Professional, scientific and technical activities	4.4%	7.6%	16.3%	4.4%	2.8%	6.3%
Public administration and defence	1.1%	0.8%	2.1%	4.6%	5.5%	3.5%
Real estate activities	15.1%	6.4%	12.4%	10.3%	13.0%	10.7%
Transportation and storage	1.2%	15.7%	9.8%	3.7%	7.4%	2.3%
Wholesale and retail trade; repair of motor vehicles	9.3%	18.6%	8.2%	10.8%	14.1%	12.6%

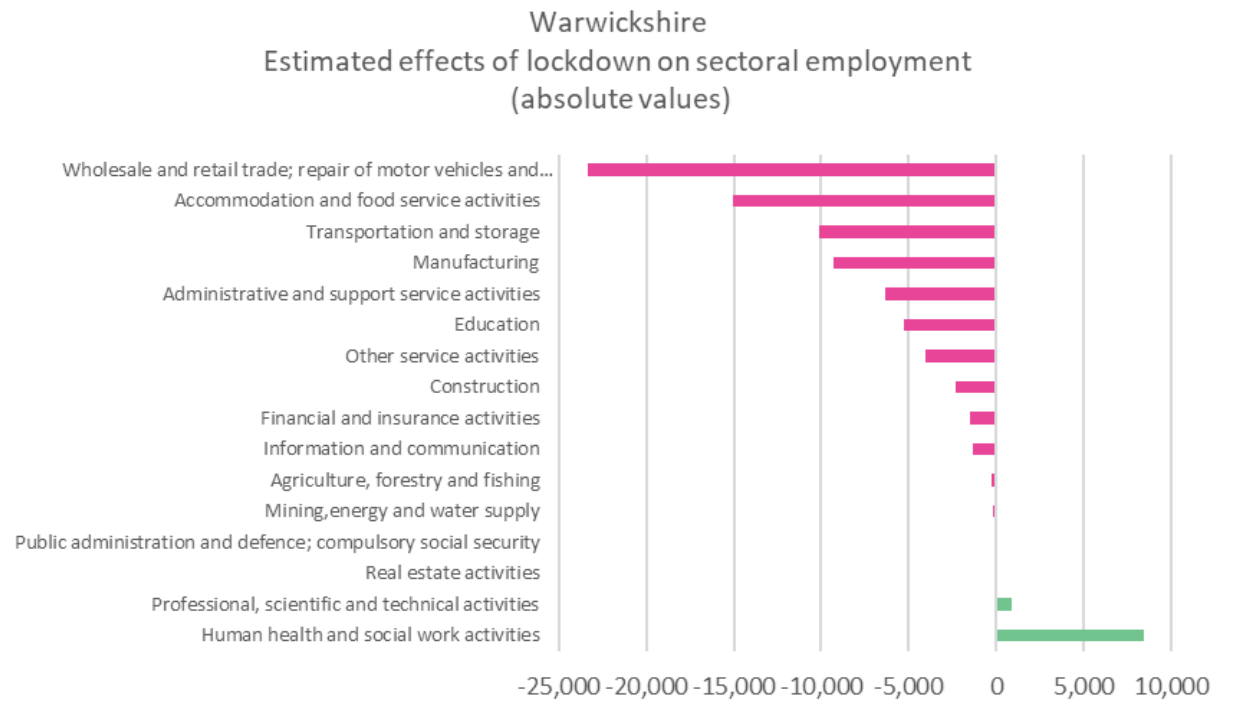
Source: NOMIS https://www.nomisweb.co.uk/

FIGURE 6 Estimated effects of lockdown on sectoral employment – Coventry



Source: Institute of Social & Economic Research (ISER)

FIGURE 7 Estimated effects of lockdown on sectoral employment – Warwickshire



Source: Economy team, Warwickshire County Council (Institute of Social & Economic Research (ISER))

Businesses applying for Government initiatives

4TH MAY TO 17TH MAY

The ONS Business impacts of a COVID-19 survey suggests that when considering all industries, 79.4% of businesses applied for the Coronavirus Job Retention Scheme, 15.8% applied for Government-backed accredited loans or finance agreements, and 16.5% applied for business grants funded by the UK and devolved governments. However, this did vary by industry. The sector where the highest percentage of businesses applied to government schemes was Accommodation and Food Service Activities, where 97.1% applied for the Coronavirus job retention scheme, 28.8% applied for Government-backed accredited loans or finance agreements, and 34.0% applied for business grants funded by the UK and devolved governments. When asked what proportion of the workforce was furloughed in the previous 2 weeks, on average 29.7% of the workforce was furloughed. However, this rises to 63.8% for Accommodation and Food Service Activities and 56.4% for Arts, Entertainment and Recreation.

The number of businesses applying for government initiatives in Coventry and Warwickshire is shown in Table 5 and is increasing.

TABLE 5 Government Initiatives accessed in Coventry and the Districts and Boroughs in Warwickshire (correct as of 28/05/2020)

	Stratford-on-Avon	Warwick	Rugby	North Warwickshire	Nuneaton & Bedworth	Coventry
Total Business Rate Relief	1,141	1,276	582	312	624	1,471
Value	£24,114,867.56	£27,996,711.72	£13,156,826.83	£8,371,335	£16,718,321	£49,193,309
Retail Business Rate Relief	1,115	1,239	562	303	610	1423
Value	£23,896,616.77	£27,572,565.75	£12,991,828.38	£8,302,504	£16,609,566	£48,700,000
Nursery Business Rate Relief	26	37	20	9	14	48
Value	£218,250.79	£424,145.97	£164,998.45	£68,831	£108,755	£493,309
Business Cash Grant Total	2,360	2,246	1,291	1,087	1,471	3,772
Value	£29,255,000.00	£29,125,000.00	£15,022,000.00	£12,460,000.00	£18,070,000	£44,920,000
Small Business Grant Fund	1,783	1,563	987	869	1125	2253
Value	£17,935,000.00	£15,630,000	£9,870,000	£8,690,000	£11,250,000	£22,530,000
15,000 rv >	207	238	102	112	122	1039
Value	£2,070,000.00	£2,380,000.00	£102,000.00	£1,120,000	£1,220,000	£10,390,000
15,000 - 51,000 rv	370	445	202	106	224	480
Value	£9,250,000.00	£11,115,000.00	£5,050,000.00	£2,650,000	£5,600,000	£12,000,000

Source: Coventry City Council, North Warwickshire Borough Council, Nuneaton and Bedworth Borough Council, Rugby Borough Council, Stratford-on-Avon District Council, Warwick District Council

TABLE 6 The take up of the Self-Employment Income Support Scheme (SEISS) across Coventry and Warwickshire

	Total potentially eligible population[1]	Total no. of claims made to 31/5/20[2]	Total value of claims made to 31/5/20[2] (£)	Average value of claims made to 31/5/20[2] (£)	Take-Up Rate[5]
United Kingdom	3,397,000	2,380,000	6,974,000,000	2,900	70%
West Midlands	262,000	185,000	521,000,000	2,800	70%
Warwickshire County	25,500	17,800	53,500,000	3,000	69%
North Warwickshire	3,200	2,300	6,900,000	3,000	72%
Nuneaton and Bedworth	4,900	3,500	10,100,000	2,900	71%
Rugby	4,400	2,900	8,800,000	3,000	67%
Stratford-on-Avon	7,500	5,200	16,200,000	3,100	69%
Warwick	5,600	3,800	11,500,000	3,000	69%
West Midlands Metropolitan County	117,500	82,600	221,200,000	2,700	70%
Coventry	13,100	9,100	24,500,000	2,700	69%

Source: https://www.gov.uk/government/statistics/self-employment-income-support-scheme-statistics-june-2020

Self-Employment Income Support Scheme (SEISS) claims made up to 31 May 2020 show that Warwickshire has about twice the number of potentially eligible people as Coventry. Within Warwickshire, Stratford District has the highest number of eligible people. However, take up is relatively similar across areas, varying slightly within Warwickshire between 67% in Rugby Borough and 72% in North Warwickshire Borough, and 69% in Coventry. This is in line with the West Midlands regional take up (70%) as well as national figures (70%). This is demonstrated in Table 6.

Free School Meals (FSM)

Free School Meals are provided to those who are in receipt of qualifying benefits, which include Income Support and Universal Credit, and apply through their local authority. If a child is eligible for free school meals, they will remain eligible until they finish the phase of schooling (primary or secondary) that they are in on 31st March 2022. In addition, all children in Reception, Year 1 and Year 2 currently receive a free school meal regardless of whether they are eligible. This section considers only those who are eligible due to being in receipt of qualifying benefits.

What was the previous picture:

The numbers of pupils eligible for and claiming free school meals in Warwickshire and Coventry at the school census undertaken in January 2020 are shown in the tables and figures below.

What is the current data saying:

In Coventry, as at 15 June 2020, numbers receiving free school meals through their school is around 5% higher than reported eligible in the Spring 2020 school census (11,600 or 10.7% of child population compared with 11,000 or 10.1% of child population), although in total, when you include further education students, around 12,500 free school meals are being received routinely each day (11.5% of child population).

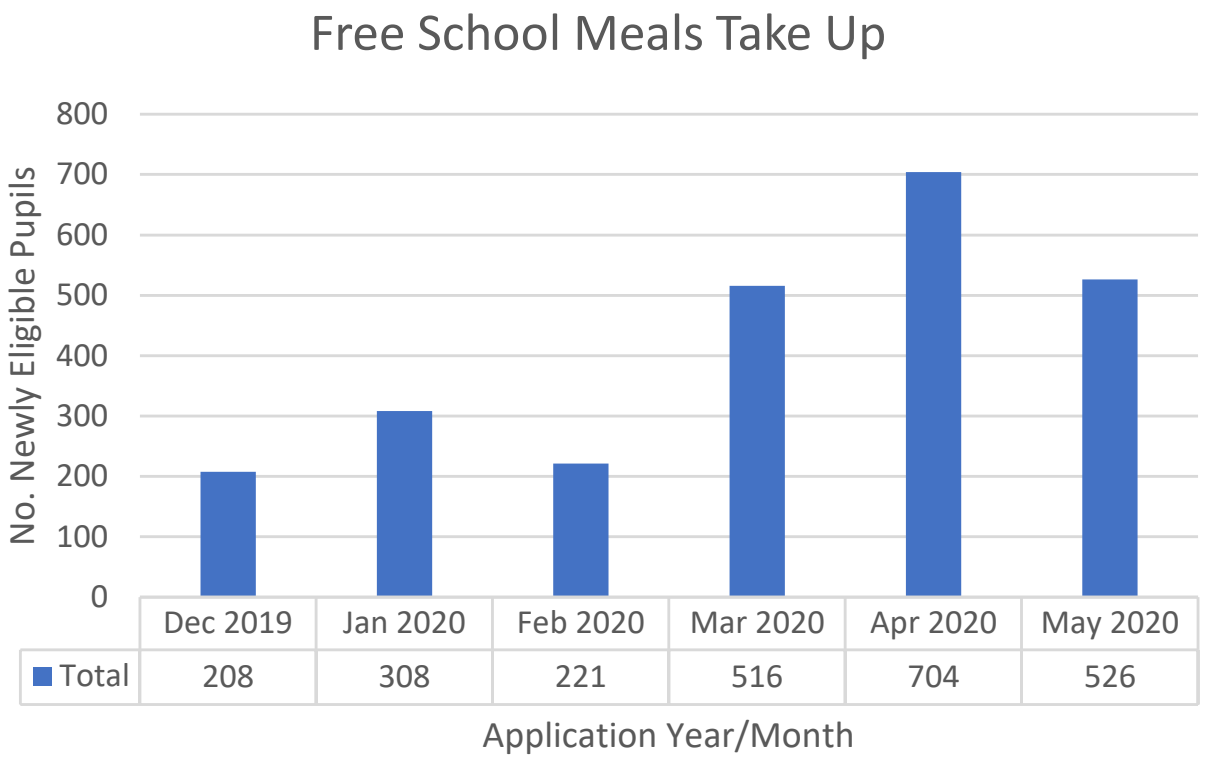
TABLE 7 Pupils eligible for FSM, January 2020 School Census, Coventry		
Area	**Total number of school age children eligible and claiming FSM (Nursery to Y13+)**	**Proportion of children %**
Pathways	1974	8.2
Park Edge	1515	11.5
Mosaic	1470	6.7
The Moat	1429	10.1
Harmony	1263	13.6
Families for All	1156	14.0
Aspire	1107	9.2
Wood Side	934	16.2
Coventry (including blank)	11012	10.1
Coventry	13,100	9,100
Source: Insight Team, Coventry City Council		

TABLE 8 Pupils eligible for FSM, January 2020 School Census, Warwickshire		
Area	**Total number of school age children eligible and claiming FSM (Nursery to Y13+)**	**Proportion of children %**
North Warwickshire Borough	1628	14.7
Nuneaton and Bedworth Borough	3478	18.6
Rugby Borough	2546	15.0
Stratford-on-Avon District	1864	9.3
Warwick District	1811	9.9
Warwickshire	11327	13.3

The number of children newly eligible for a free school meal in Warwickshire was 704 in April 2020, over twice as many as those who became eligible in January (308). This dropped to 526 in May, however still way above pre-lockdown numbers. These families receive a weekly shopping voucher worth £15.

In June the government extended the voucher scheme over the school summer holidays. Both Coventry and Warwickshire County Councils also plan to provide support to children who would normally receive free school meals during the holidays (in Warwickshire through the Warwickshire local welfare scheme).

FIGURE 8 FSM eligibility in Warwickshire, December 2019 – May 2020



Source: Education Team, Warwickshire County Council

Our Health Behaviours and Lifestyles

Drug and Alcohol Services

What does the literature say:

Evidence related to previous severe coronavirus outbreaks suggests there is likely to be an increase of alcohol dependence in the population, a study of hospital employees found alcohol dependence to be positively associated with an epidemic even up to 3 years after an outbreak.[xi]

In addition a study in the US on the current situation found that perceived threat from COVID-19 was linked with increased alcohol use as a coping mechanism. In the study group this was particularly pronounced in women. Alcohol contributes to a wide range of conditions including cardiovascular disease, cancer and liver disease, as well as harm from accidents, violence and self-harm.[xiii]

What is the current data saying:

According to a survey by Alcohol Change UK in April 2020, 22% of people stated they were drinking on more days than before lockdown, 22% stated they were drinking on fewer days, 43% stated they were drinking on about the same number of days and 12% had given up drinking altogether.

The Understanding Society study by the Institute for Social and Economic Research showed that, using the Alcohol Use Disorders Identification Test, 5% of people had increased their risky alcohol use in April (since 2018/19), whereas 18% of men and 11% of women reduced their risky alcohol use. The reduction in risky alcohol use occurred to the greatest extent in the youngest age group (16 – 34).[xiv]

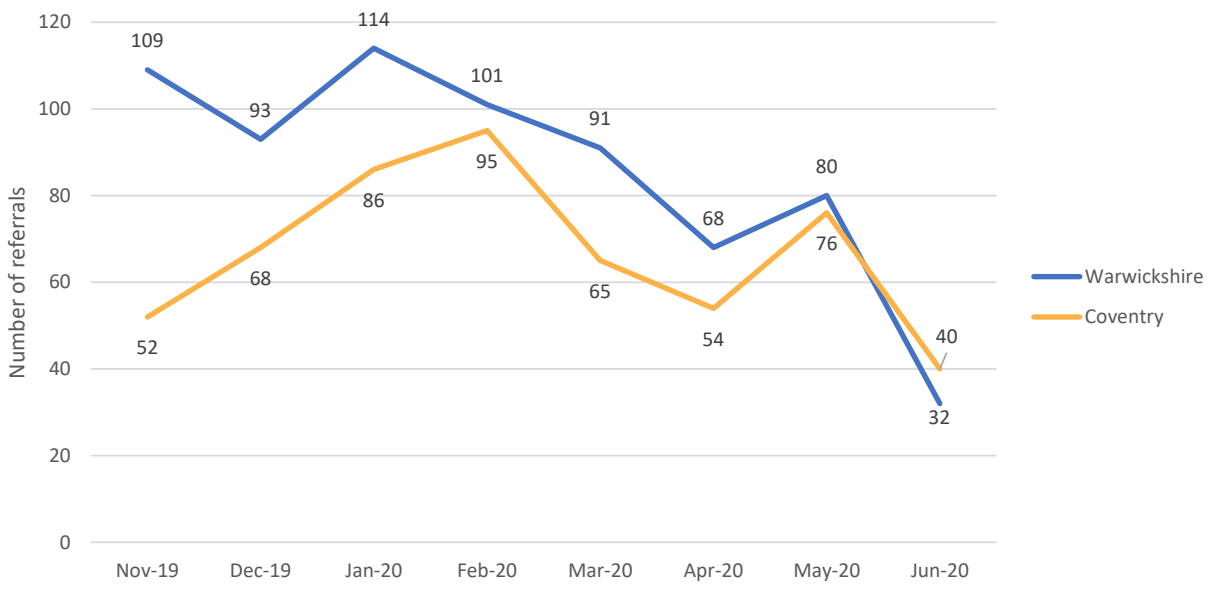
Supermarkets reported a strong increase in volume sales at 10.3% in March 2020 compared with February 2020, while off-licence alcohol sales increased by 31.4% in volume. Off-licenses, however make up less than 1% of total alcohol sales. Online shopping made up 22% of all alcohol purchases, a record high for e-commerce in the UK. Volume of alcohol sales can be more volatile month-on-month; it is likely that there was some stockpiling of alcohol during March, and therefore consumers may not need to replenish their wine, beer or spirits supplies for another couple of months (ONS[xv]).

Change Grow Live (CGL), the service commissioned to provide drugs and alcohol treatment services across Coventry and Warwickshire, has seen a decline in the number of referrals received in since February 2020, though it started rising again in May 2020. The CGL team, in discussion with other professionals, believes that this is mainly due to new potential service users knowing that they are no longer offering any face-to-face appointments at present (though they are offering telephone/web chats and groups via Zoom). They also believe that potential service users' health concerns around COVID-19 have also affected the numbers (data correct up to 18 June 2020).

Naloxone use: Naloxone is a lifesaving drug given to opiate using service users in case of overdose. Since COVID-19, there has been a dramatic increase in these kits given out by CGL to opiate service users in order to try to minimise risk as they are not being seen on a face to face basis unless absolutely vital. All opiate using service users are offered Naloxone on presentation to the service and the lower numbers previously would be due to new service users or re-issue (the majority of service users carry this), extra was offered to all service users.

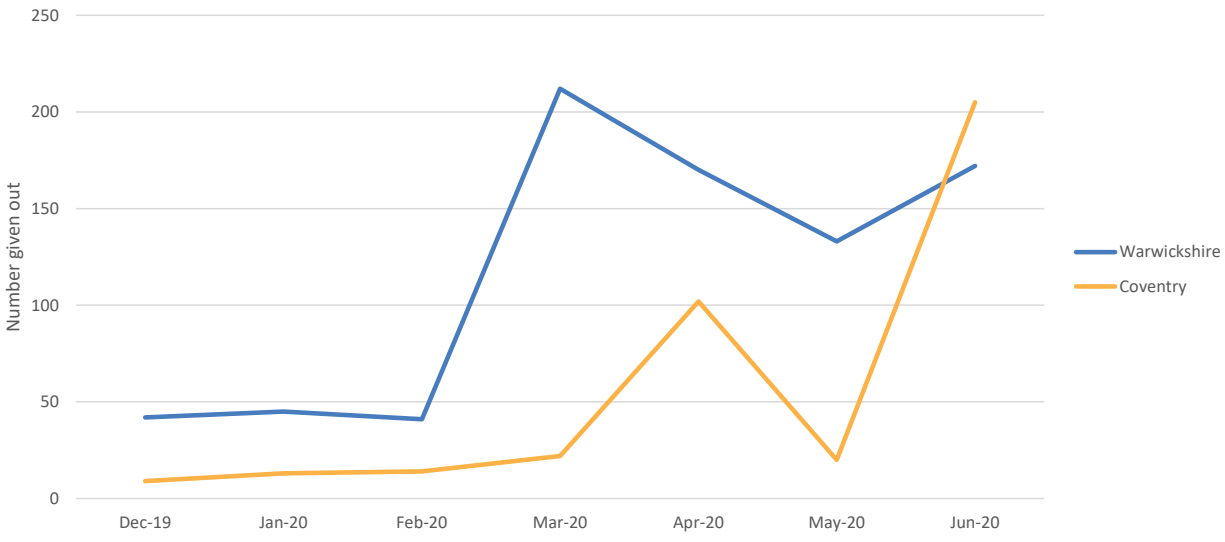
Triage by drug category: Triages take place following a referral, and they mark the beginning of a client's treatment journey.

FIGURE 9 Referrals made to Change Grow Live for alcohol consumption in Coventry and Warwickshire



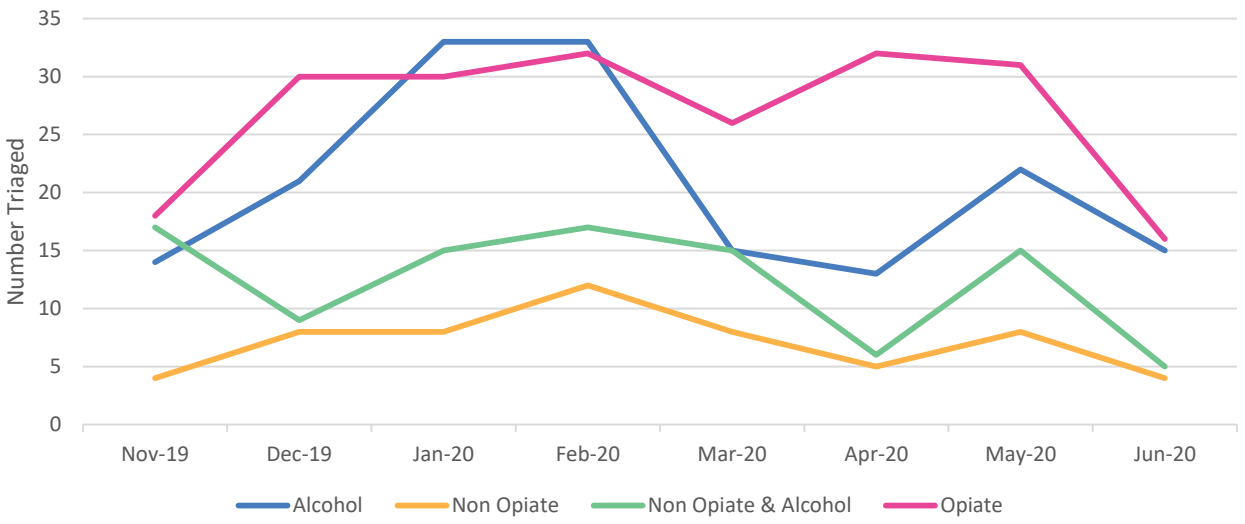
Source: CGL

FIGURE 10 The number of Naloxone kits provided to opiate service users in Coventry and Warwickshire



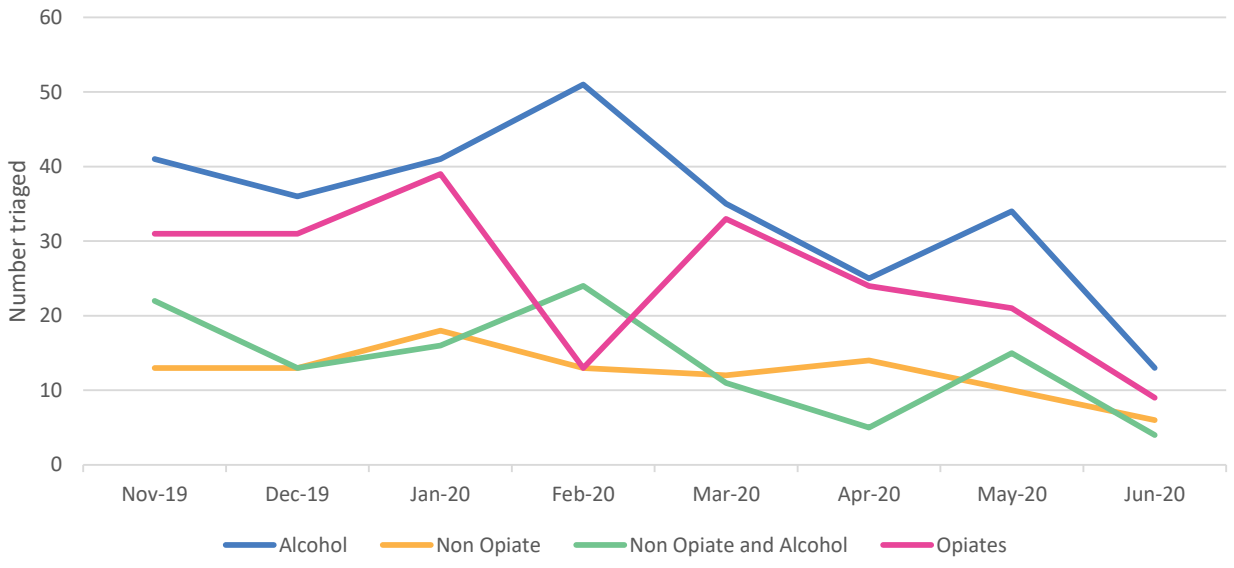
Source: CGL

FIGURE 11 The number of service users triaged by CGL by drug type in Coventry



Source: CGL

FIGURE 12 The number of service users triaged by CGL by drug type in Warwickshire



Source: CGL

COVENTRY

CGL saw a drop in opiate triages in March 2020, going back up to steady figures in April and May and dropping off again in June 2020 (although data for June is only partial, to 16 June 2020). Alcohol triages peaked in January and February 2020 and substantially decreased at the beginning of lockdown in March 2020. As discussed above, this may be due to potential service users being unaware that the service was still available or health concerns around COVID-19. Non opiate and non-opiate & alcohol triage numbers remained steady.

WARWICKSHIRE

There are no specific trends in drug types in new triages that have increased or decreased on a notable scale except alcohol (which increased dramatically in February 2020 and has slowly decreased over the following months) and heroin triages (dropping to 8 in February at the start of the outbreak and back up to an average figure in March).

Trend by Contact Type: There has been a substantial increase in the number of Recovery Worker contacts (i.e. where service users have been contacted within the last 4 weeks by text, call and video call) in both Coventry and Warwickshire. Recovery Worker contacts is a new measure that CGL introduced in March.

Anecdotally within Warwickshire, there appears to be crystal meth use in Nuneaton, which is not normally reported in Nuneaton. In South Warwickshire, drugs are still easily available, though purity has dropped and there is a slight increase in cost. In Rugby, ease of obtaining drugs varies, however there are also reports of reduced purity.

Gambling

Prior to the COVID-19 pandemic, there is evidence that gambling is easier to access in more deprived areas[xvi]. Since the pandemic, fewer consumers are gambling but some people, who are gambling already, are trying new products.

The crisis does not appear to have attracted many new consumers to gambling. According to YouGov research from 16-17 April, only 0.2% of all adults surveyed stated that they had started gambling for the first time during the last four weeks. For comparison, research by the Gambling Commission in 2019 found that 47% of respondents participated in gambling in the past four weeks[xvii].

Operator data on overall active player accounts indicates a 3% decrease, driven in part by real event betting (active players down 11%), where clearly the chance to bet on top quality sport has disappeared.

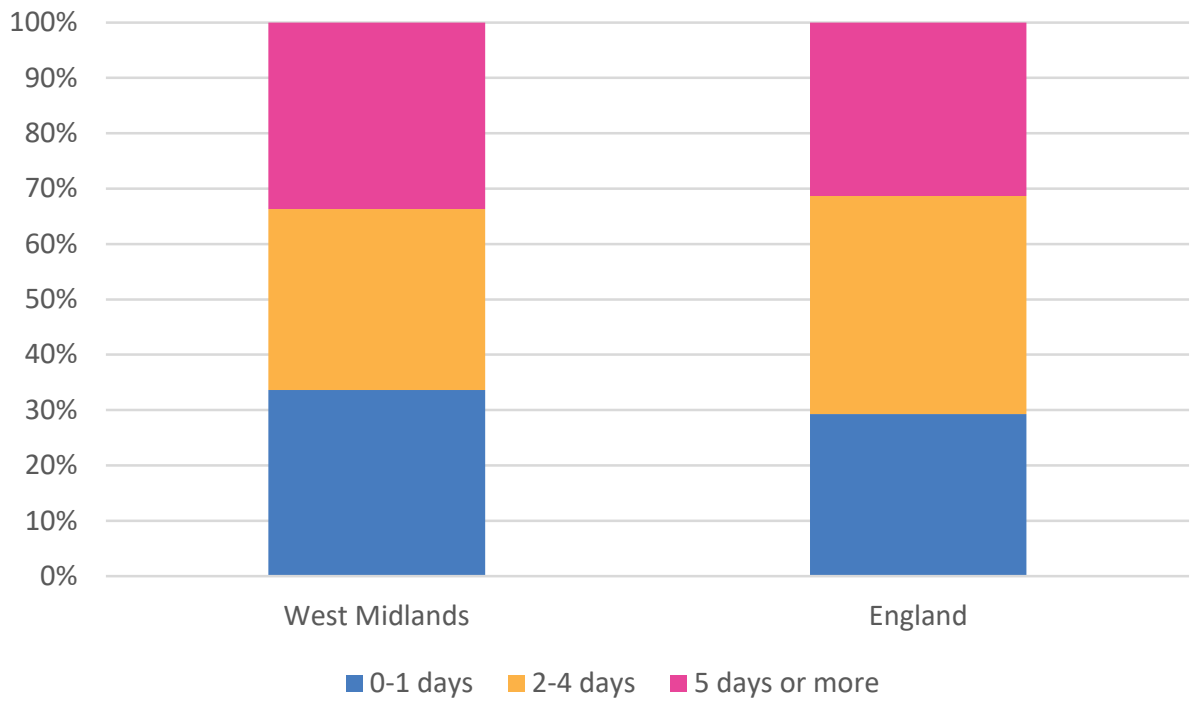
The YouGov research shows that a third of past four-week gamblers say they have tried one or more gambling activities for the first-time during lockdown. Operator data shows that certain products are seeing active player increases compared to this time last year (some from low comparative bases of players), which are generally those with a faster play cycle, such as slots (The Gambling Commission[xviii]).

TABLE 9 Physical activity undertaken during the COVID-19 lockdown restrictions compared to before restrictions were introduced in the West Midlands and England

Area	More	Neither more nor less	Less
West Midlands	34.5%	35.0%	30.6%
England	35.9%	29.5%	34.6%

Source: Sport England

FIGURE 13 Days of physical activity undertaken during the COVID-19 lockdown restrictions in the West Midlands and England



Source: Sport England

TABLE 10 Physical activity undertaken during the COVID-19 lockdown restrictions compared to before restrictions were introduced in ABC1 and C2DE grouping

Activity undertaken	ABC1	C2DE	All
More	39.5%	30.0%	35.0%
Neither more nor less	27.8%	35.3%	31.3%
Less	31.9%	32.1%	32.0%

Source: Comres Global and Sport England

TABLE 11 Physical activity undertaken during the COVID-19 lockdown restrictions by age group

Activity undertaken	16-17	18-24	25-34	35-44	45-54	55-64	65+
More	36.9%	47.5%	42.6%	39.7%	31.5%	28.8%	17.1%
Neither more nor less	17.9%	19.3%	20.3%	27.9%	40.7%	35.6%	50.5%
Less	40.5%	31.8%	34.8%	30.7%	27.0%	34.8%	30.6%

Source: Comres Global and Sport England

Physical Activity

In a survey for Sport England[xix], from 24th to 27th April 2020, 2,006 adults aged 16+ were asked about their physical activity. These results are split by region. In the West Midlands, 34.5% of respondents were doing more physical activity than before the lockdown restrictions, and 35.0% were doing the same amount. This is compared with 35.9% of respondents in England doing more physical activity, and 29.5% doing the same amount.

When asked, "On how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?", 34% stated on none or only one day, compared to 29% for England, whereas 34% stated 5 or more days, compared to 31% in England (Figure 13).

When asked about the type of activity, in the West Midlands the most common activity is walking, which 62% of people had done in the last week (England 61%). Home activities such as online workouts or DVDs (16%), running or jogging (15%) and cycling (12%) were also common activities, although all of these were slightly less popular in the West Midlands than in England as a whole[xx].

Looking at data collected between 3 April and 25 May, there were 1722 people surveyed in the West Midlands and there are some differences when looking at National Statistics Socio-economic classification social grade (NS-SEC) and age of respondents. ABC1 is roughly "middle class" and C2DE is roughly "working class" based on the occupation of the head of the household. Table 10 shows that a higher percentage of people in the ABC1 classification (broadly people in managerial and professional occupations) responded as having undertaken more physical activity during lockdown than those in the C2DE classification (broadly skilled or unskilled manual workers or people who are unemployed).

Table 11 illustrates whether respondents felt they had undertaken more, less or similar activity during the COVID-19 lockdown restrictions compared to before the restrictions were introduced. 18 – 24 year olds were the group reporting the highest percentage of respondents doing more activity during lockdown (47.5%) with those aged 65+ reporting the lowest percentage (17.1%). 16 – 17 year olds were the group reporting the highest percentage of respondents doing less activity during lockdown (40.5%) with those aged 45 – 54 reporting the lowest percentage (27%).

A survey of gym members conducted by Leisure-net solutions showed that 52% of respondents stated that they have been less active since the lockdown, and only 22% said they have been more active[xxi].

WARWICKSHIRE

In Warwickshire, support packs have been produced containing links and ideas for physical activity during lockdown. These have been sent to partners and providers across all districts and boroughs. Referrals for weight management, having been at between 1052 and 1360 for the previous four quarters, are at 43 referrals for Q1 of 2020/21 (data up to 11th June 2020).

Many of the local leisure centres have moved classes online since March 2020, offering reduced rates for access to online workouts and training plans.

Those on the Fitter Futures program have been contacted to offer advice and support on accessing exercise online. Of the 252 people contacted, 130 (51.6%) were completing no exercise at all. While it is not possible to link this data, it is likely that these people are doing less physical activity than before the lockdown.

Google Community Mobility Reports

The Google Community Mobility Reports chart movement trends over time by geography, across different categories of places such as retail and recreation, groceries and pharmacies, parks, transit stations, workplaces, and residential. This report is based on the location of users' phones.

MAY REPORT

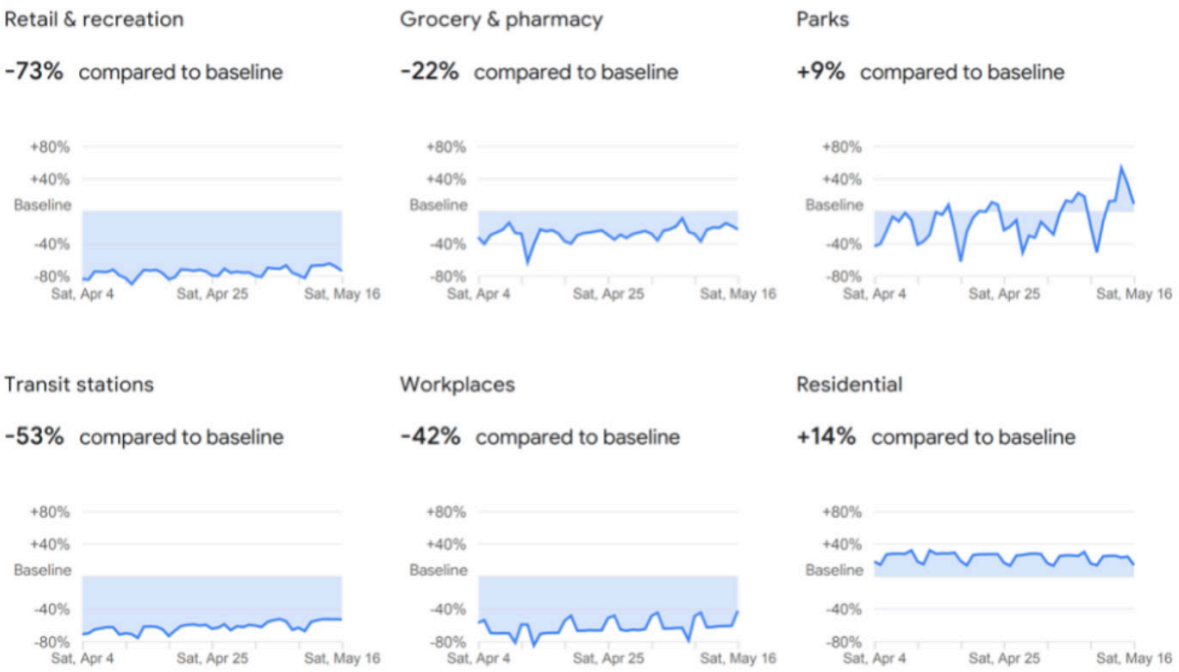
As expected, the reports for May show large reductions (-73%) in population mobility. There has been a 9% increase in visits to parks in Warwickshire compared to the baseline, which is notably less than the 33% increase across the West Midlands Metropolitan Area (including Coventry).

JUNE REPORT

There is a large increase in visits to parks for both Coventry and Warwickshire in this data, perhaps most noticeably over the half term and bank holiday at the end of May. Residential is still higher than baseline, but not as high as in the previous report. These changes perhaps reflect people's return to work, being allowed out for exercise more than once a day and being able to relax in parks.

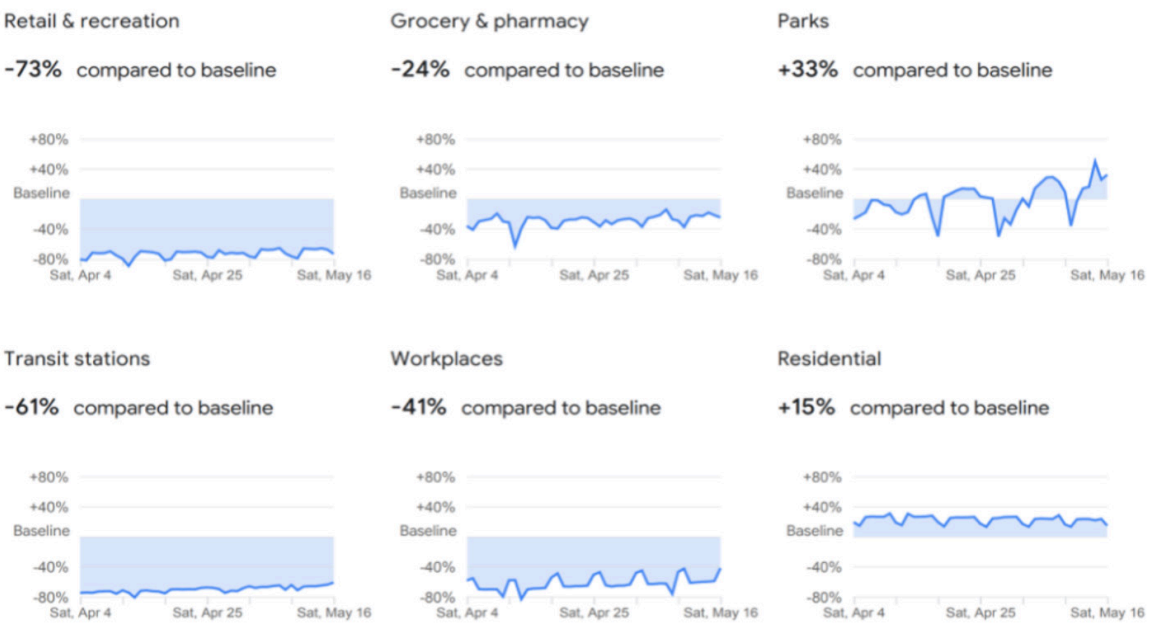
WARWICKSHIRE

FIGURE 14 Community mobility across Warwickshire, 4 April – 16 May



WEST MIDLAND METROPOLITAN AREA (INCLUDING COVENTRY)

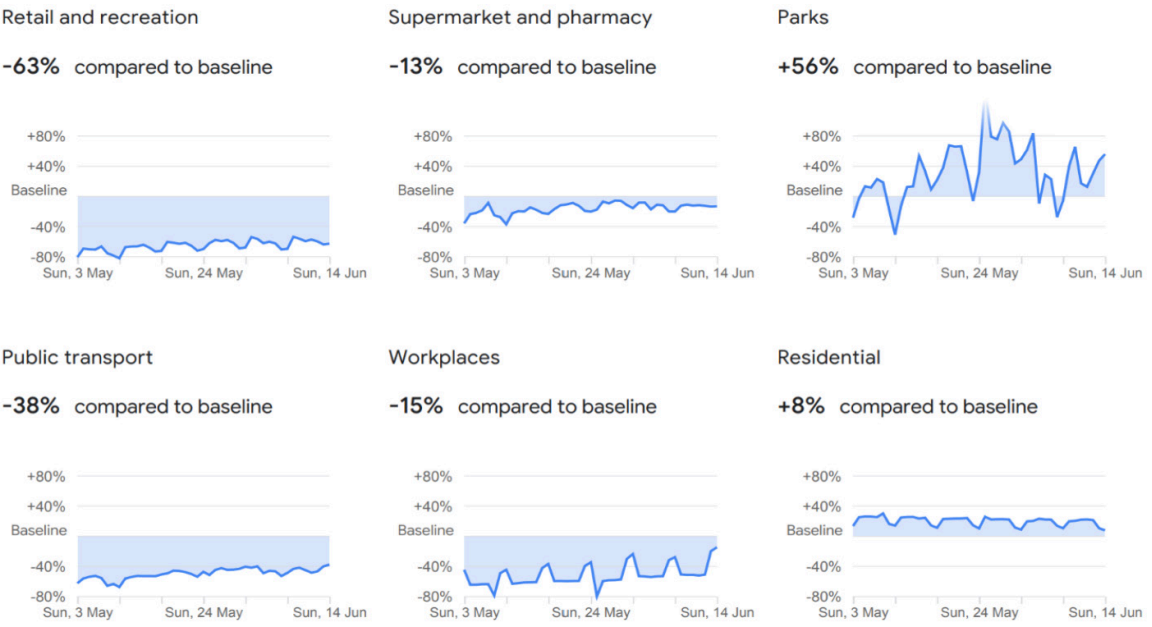
FIGURE 15 Community mobility across the West Midlands (including Coventry), 3 May – 14 June



Source: Google

WARWICKSHIRE

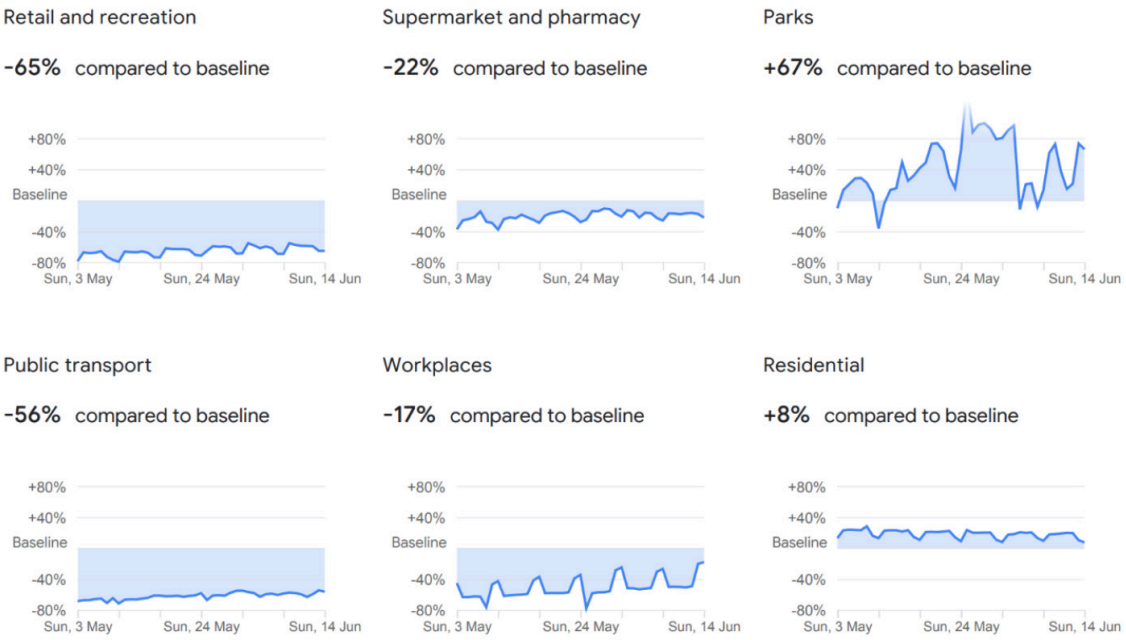
FIGURE 16 Community mobility across Warwickshire, 3 May – 14 June



Source: Google

WEST MIDLAND METROPOLITAN AREA (INCLUDING COVENTRY)

FIGURE 17 Community mobility across the West Midlands (including Coventry), 3 May – 14 June



Source: Google

Stop Smoking in Pregnancy Service

Smoking during pregnancy was associated with exposure to the UK 2008-2010 economic recession during pregnancy and this relationship is partly mediated by financial stress.[xxii] Health inequalities in smoking during pregnancy are affected by economic recession, as those who are most likely to smoke are also most likely to experience the financial stress resulting from economic recession.

WARWICKSHIRE

There were 191 referrals between 1st April 2019 and 16th June 2019, of which 66% set a quit date and 53% had quit at 4 weeks. The number of referrals to the Stop Smoking in Pregnancy Service in Warwickshire has dropped to 139 for the same period in 2020, with the biggest drop in Rugby Borough. The number setting quit dates is 83% and may rise for those who have been referred towards the end of this period, showing a big improvement on the 2019 figures. Engagement levels are said to be higher overall. It is not yet possible to compare quit rates as not enough time has elapsed, however the picture is a positive one. At present equivalent data is not available for Coventry.

An Integrated Health and Care System

The health and care sector in Coventry and Warwickshire saw large changes during the pandemic as services were directed towards preparing for and responding to increasing numbers of patients with COVID-19. Locally a peak in the number of hospitalised patients diagnosed with COVID-19 occurred in early April.

This analysis looks at how health service use for other reasons has changed.

A&E Attendances

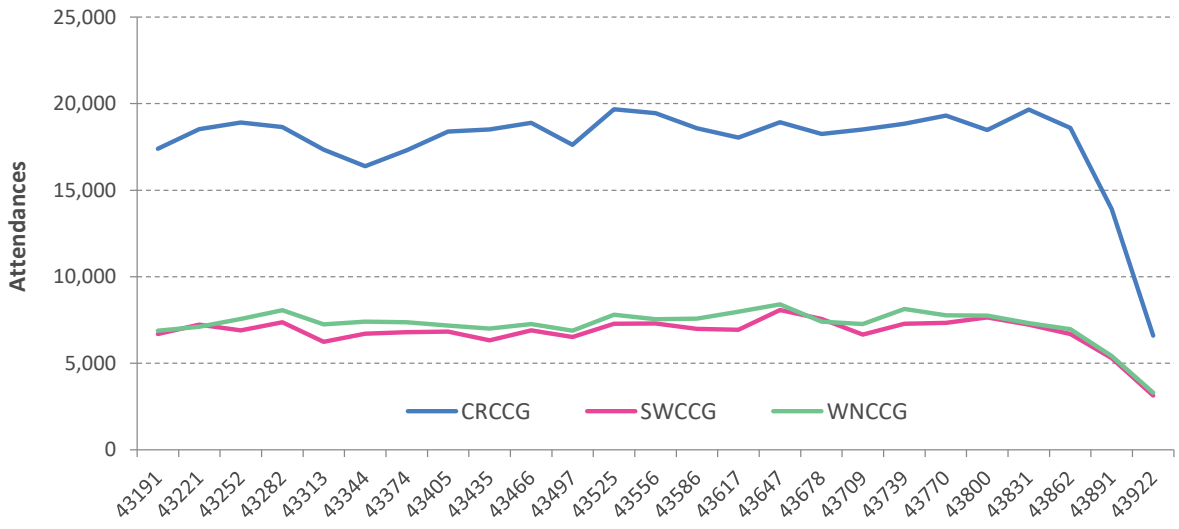
Overall, A&E attendances in April 2020 reduced by 62.0% compared with April 2019 across the Coventry & Warwickshire HCP footprint. All 3 CCGs have seen a reduction in A&E attendances, with South Warwickshire and Warwickshire North similarly so at 56.2% and 57.1% respectively. Coventry and Rugby saw a slightly higher reduction of 66.1%. This is illustrated in Figure 18.

Non-Elective (Unplanned) Admissions

Non-elective activity reduced in April and there were 2,818 fewer unplanned admissions compared with the previous year. This is a reduction of 25.8%. The reduction was made up of a 30.7% reduction in emergency admissions, and 8.8% reduction in non-emergencies. All 3 CCGs have seen a reduction in emergencies, with Coventry and Rugby and Warwickshire North similarly so at 27.4% and 30.0% respectively. South Warwickshire saw a larger reduction of 37.5%. This is illustrated in Figure 19.

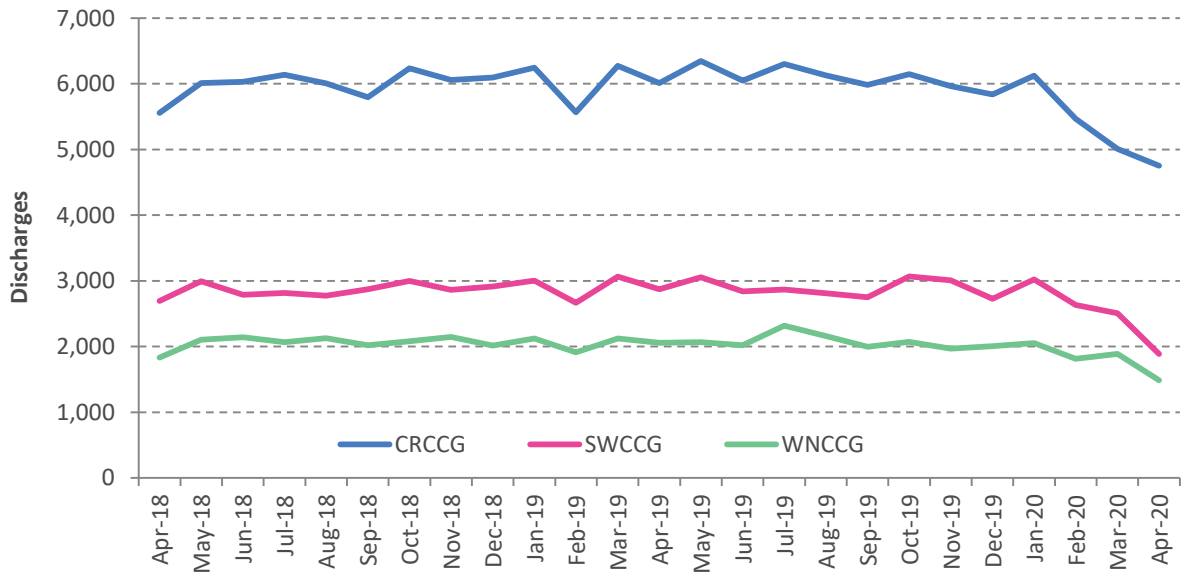
This percentage reduction in unplanned admissions is less than A&E attendances, where a large proportion of these patients would have been admitted from. This could therefore be early evidence of the change in case-mix of patients attending A&E, and that that patients attending A&E during lockdown were more likely to have severe illness requiring admission.

FIGURE 18 A&E attendances (all department types) in Coventry and Warwickshire CCGs, April 2018 – April 2020



Source: NHS

FIGURE 19 Non-elective admissions in Coventry and Warwickshire CCGs, April 2018 – April 2020

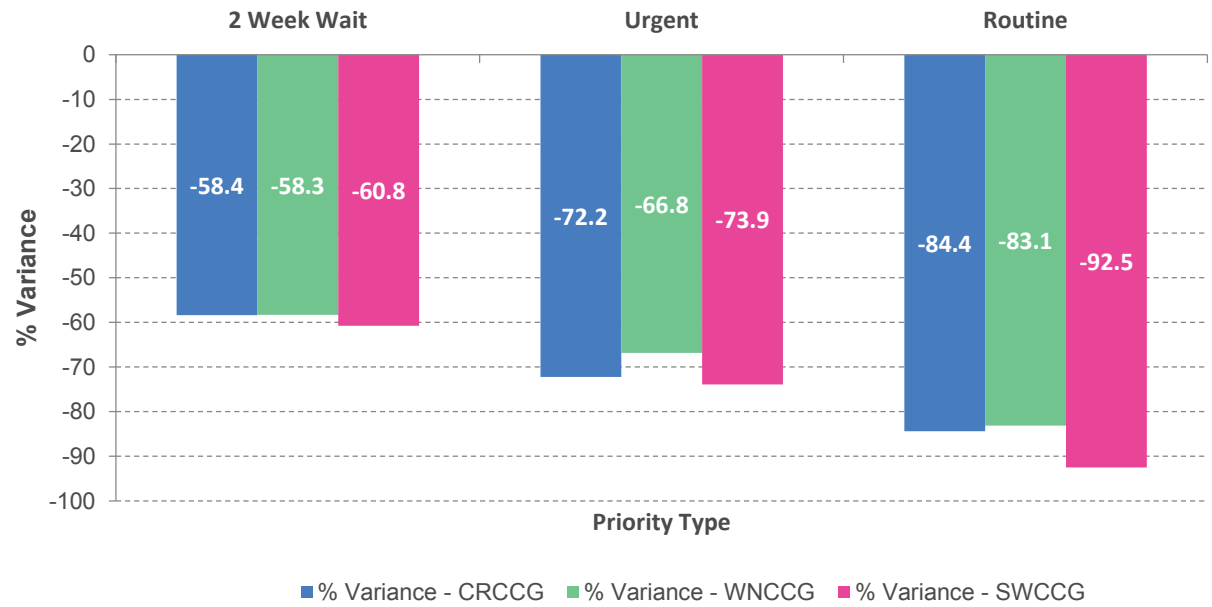


Source: NHS

GP Referrals (E-Referrals data)

Total referrals decreased by 80% across Coventry & Warwickshire CCGs in April 2020 compared with April 2019, with the biggest decrease seen in SWCCG (83.3%). Routine referrals have decreased by 85.9%, Urgent referrals by 71.8% and two week waits by 59.1% across Coventry & Warwickshire. This is illustrated in Figure 20.

FIGURE 20 GP referrals across Coventry and Warwickshire CCGs, April 2019 compared to April 2020



Source: NHS

Outpatient Attendances

Outpatient activity has decreased by 74% across the 3 CCGs when comparing April 2019 to 2020. Outpatient First attendances have decreased by 70% across Coventry & Warwickshire CCGs, with the biggest % decrease seen in CRCCG, with a reduction of 73.1% (11,000 attendances). Outpatient Follow up attendances have decreased by 64% across Coventry & Warwickshire CCGs, with the largest activity reduction seen at CRCCG, with a reduction of 73.3% (19,000 attendances). This is illustrated in Figure 21.

Elective (Planned) Admissions

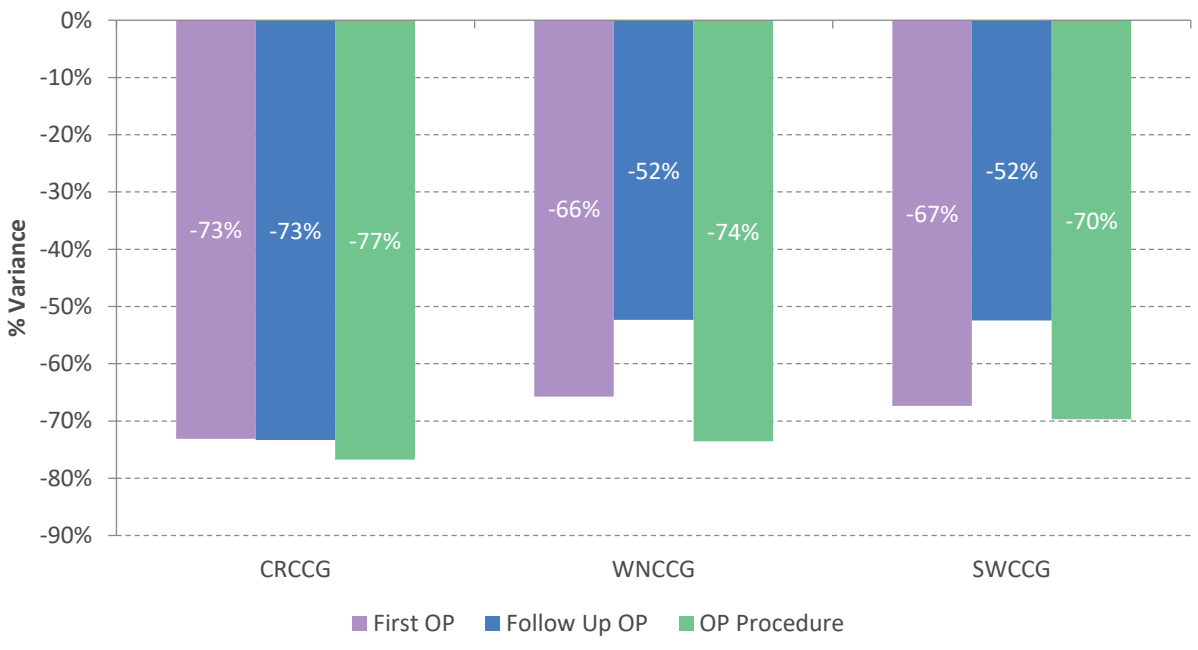
Day cases have decreased by 68% across Coventry & Warwickshire CCGs comparing April 20 to April 19, with the biggest decrease seen in WNCCG (81.2%). Electives have decreased by 81% across Coventry & Warwickshire CCGs, with the biggest decrease again seen in Warwickshire North CCG (89.7%). This is illustrated in Figure 22.

Waiting Lists

The total Referral to Treatment Waiting List (Incomplete Pathways) is at its lowest level during the last 12 months. However, this is due to the new clock starts (referrals) being extremely low due to the COVID-19 pandemic as outlined in the Referrals section. However, as referrals start to flow back into the system, this will extend waiting times and the total numbers on the waiting list. This can already be seen in the increase to the backlog (those patients waiting more than 18 weeks) in April 2020. This is illustrated in Figure 23.

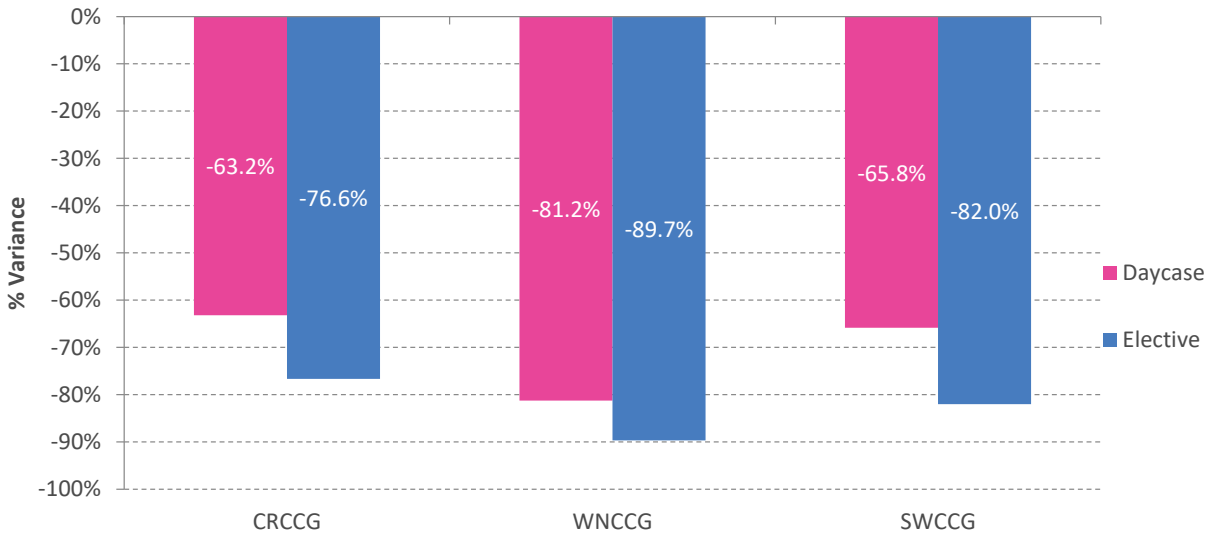
Performance of the 18-week target (which should be 92%) has decreased to 68.7% across the system with those patients waiting more than 18 weeks increasing from 7,610 in April 19 to 18,123 in April 20.

FIGURE 21 Outpatient attendances across Coventry and Warwickshire CCGs, April 2019 compared to April 2020



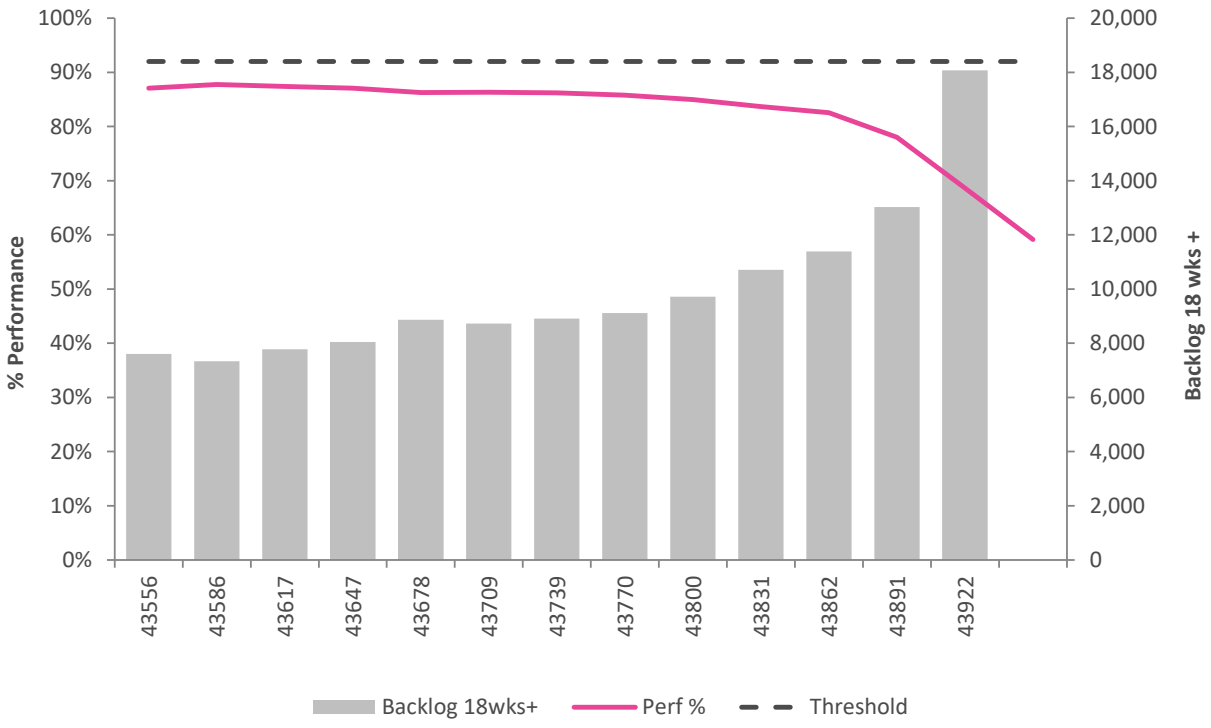
Source: NHS

FIGURE 22 Elective admissions across Coventry and Warwickshire CCGs, April 2019 compared to April 2020



Source: NHS

FIGURE 23 Waiting lists across Coventry and Warwickshire CCGs, April 2017 – April 2020
April 2019 compared to April 2020



Source: NHS

Referrals to the Multi-Agency Safeguarding Hub (MASH) and Children in Care

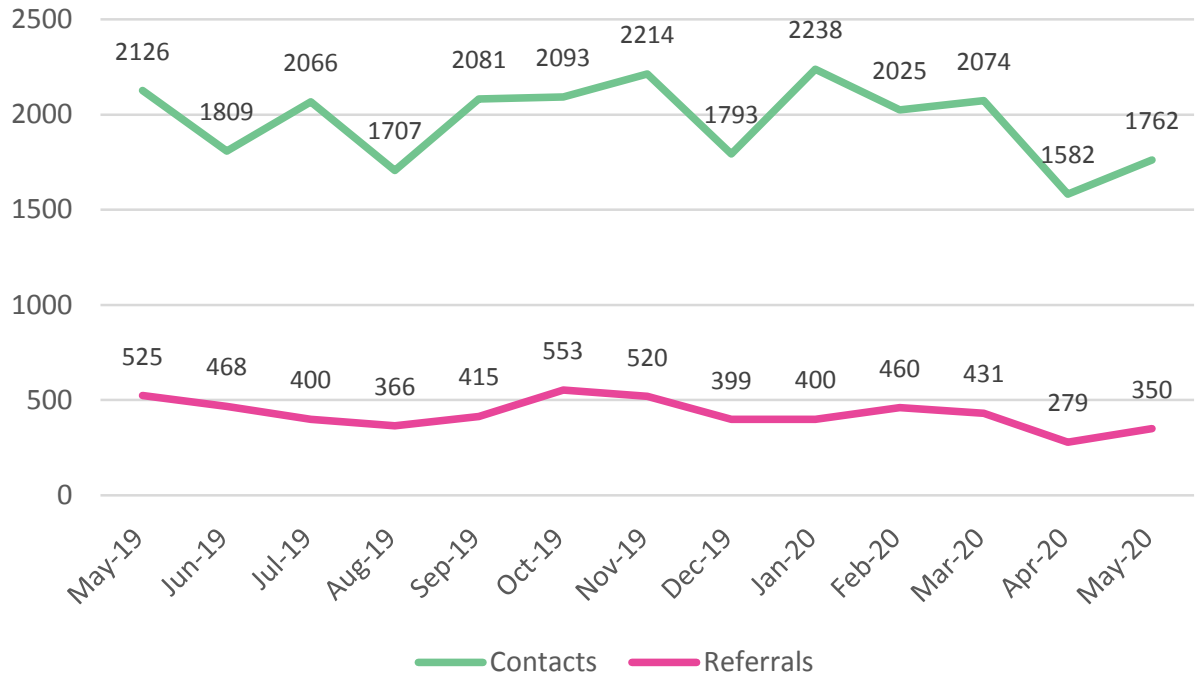
COVENTRY

In Coventry, the number of referrals to children's social care has decreased from an average of 448 per month over the period from May 2019 - March 2020 to 279 (a 38% decrease) in April 2020 and 350 (a 22% decrease) in May 2020 (around 100 –150 less than expected in a month for Coventry). The number of reported contacts has also trended down for these two months, around 1700 per month compared with over 2000 for the equivalent period in 2019.

The number and percentage profile by source of referral in April and May 2020 has also changed, reflecting school and other public sector closures at the end of March, and with referrals made by the police accounting for a relatively larger proportion of all referrals in May 2020.

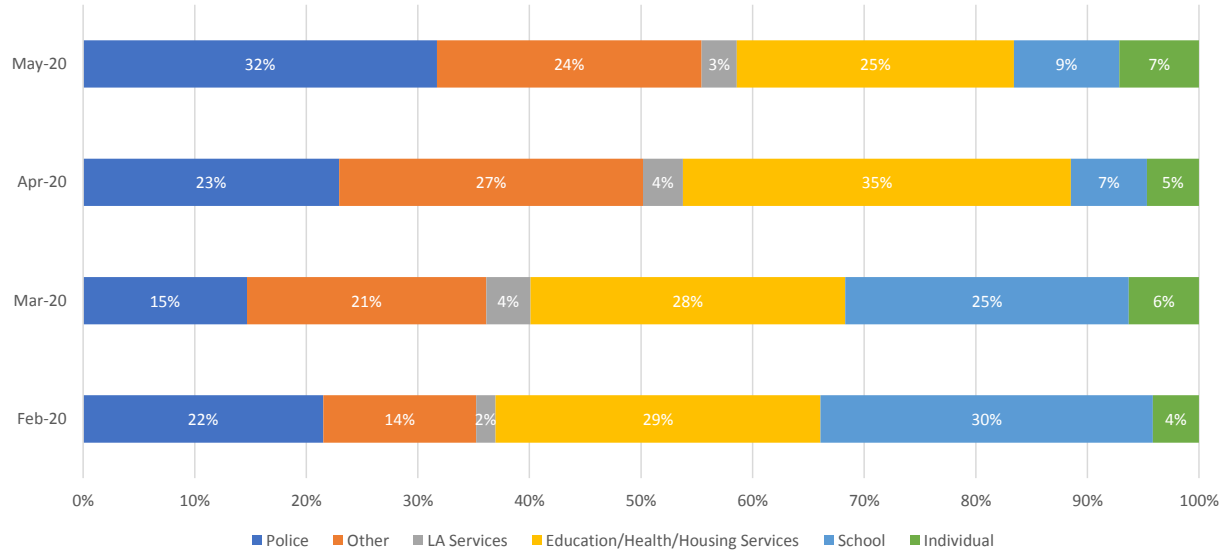
Reported data suggests actions taken following a referral have also shifted. In April and May 2020, only 70% of all referrals made were followed through with a Children and Families Assessment, compared with 85% routinely from May 2019 – Mar 2020; and Other Actions taken have grown from around 13% of all referral's pre-lockdown to 28% of all referrals in April/May 2020.

FIGURE 24 MASH referrals in Coventry between May 2019 and May 2020Source: NHS



Source: Insight Team, Coventry City Council

FIGURE 25 MASH contacts and referrals by source in Coventry between February and May 2020



Source: Insight Team, Coventry City Council

WARWICKSHIRE

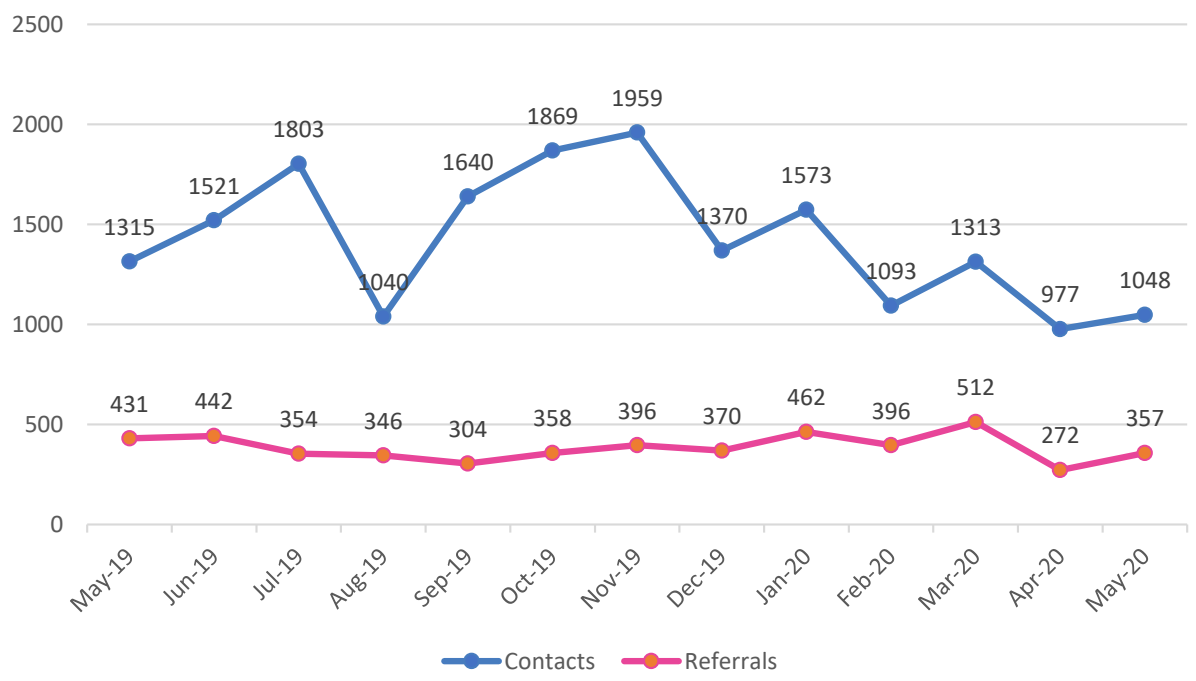
Total contacts to the Warwickshire MASH fell by 25.6% from March 2020 to April 2020, and total referrals fell by 46.9%. However, between April and May there was an increase of 7.3% in contacts and 31.3% in referrals (all contacts that have the next step of a single assessment are identified as a referral; all others are identified as a contact). Between the period May 2019 – March 2020 the Warwickshire MASH experienced a decrease in referrals from an average of 397 per month to 272 (a 31.5% decrease) and 357 (a 10.2% decrease) in April and May respectively.

In terms of the source of MASH contacts and referrals, the Police has become the top source, and the percentage of contacts and referrals from schools has fallen from 25% to 10%, although levels in May are slightly higher than in April.

At 31 May 2020, Warwickshire's looked after population was 772, whilst the number of looked after children excluding asylum seekers was 702, both numbers similar to the previous month. The number of children in care has risen significantly since March, this has been via court applications and the breakdown of family relationships with teenagers during the lockdown.

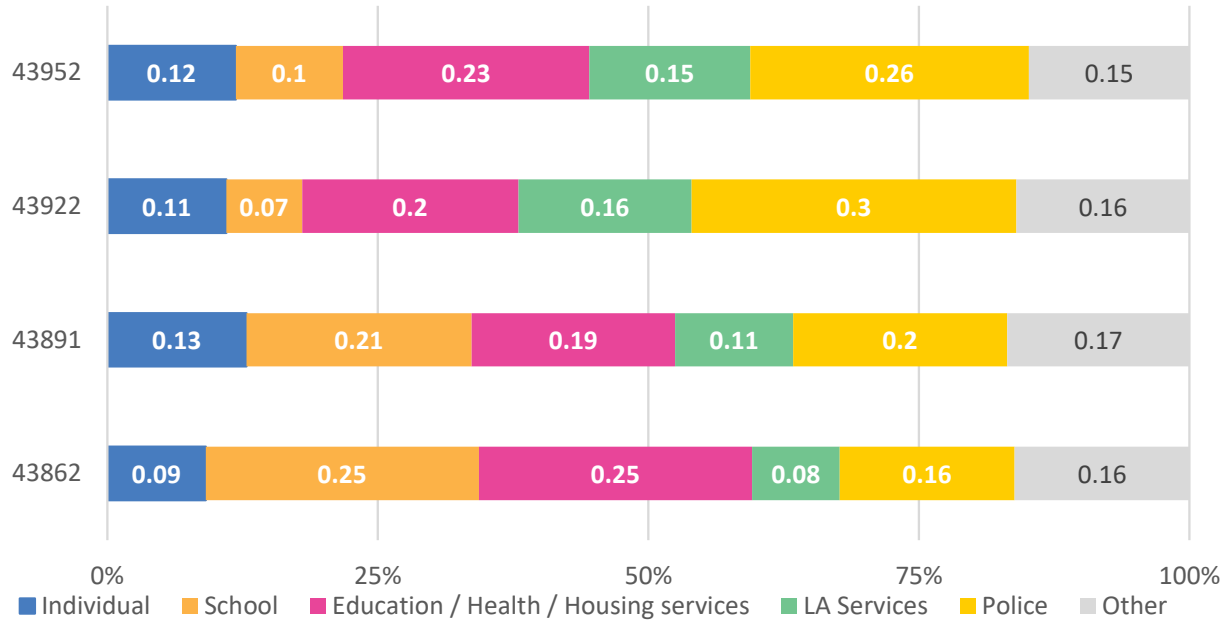
The largest cohort of children looked after continues to originate from North Warwickshire, Bedworth and Nuneaton. Across the district and borough teams the most notable increases in May were seen by Bedworth and North Warwickshire Children's Team (increase of 6 children) whilst the most notable reduction was seen by Warwick Children's Team who saw a reduction of 9 cases.

FIGURE 26 MASH referrals in Warwickshire between May 2019 and May 2020



Source: Business Intelligence Team, Warwickshire County Council

FIGURE 27 MASH contacts and referrals by source in Warwickshire between February and May 2020



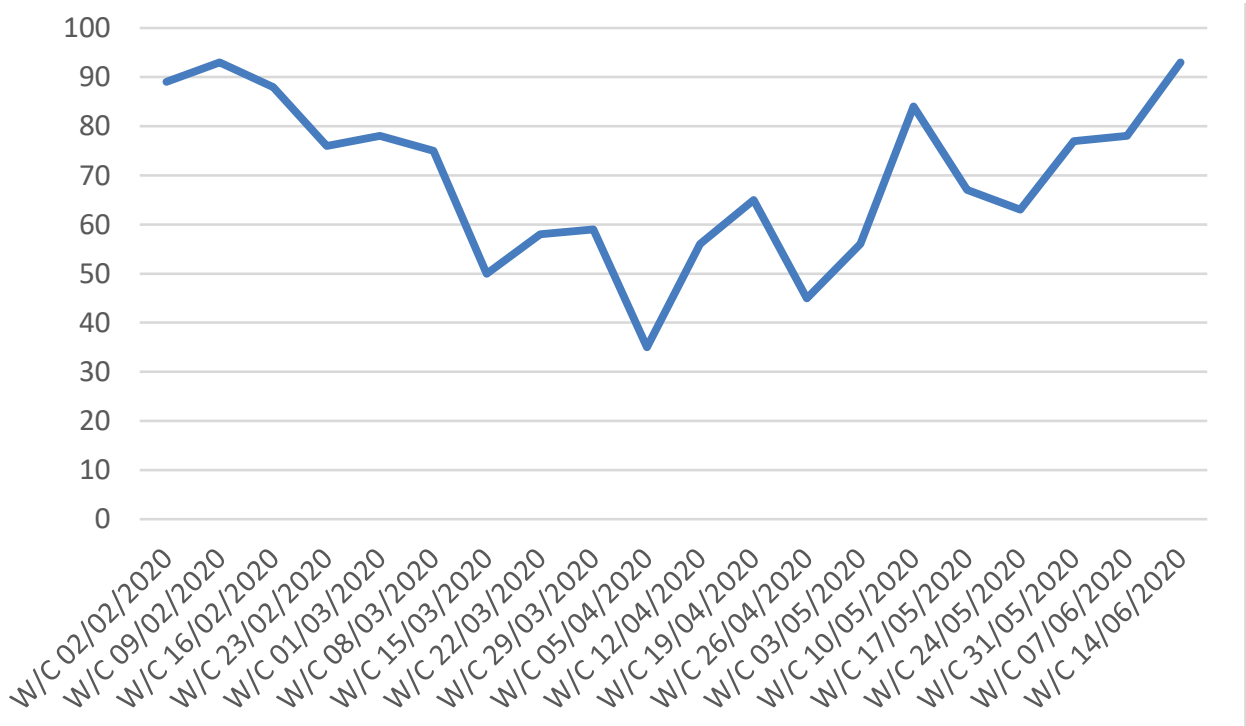
Source: Business Intelligence Team, Warwickshire County Council

The Department for Education are currently collecting data from local authorities on a fortnightly basis which includes figures on referrals and children entering care. Nationally, there are less referrals being received from schools (5.5% nationally) and a much larger proportion from the Police (38.5% nationally) although this is only based on referrals received over a week and has only been collected in one of the surveys so far. Interestingly, Warwickshire appear to be receiving a larger proportion of referrals from health services in a week than was seen nationally. However, this data is only based on a snapshot of a week so should be treated with caution.

From a looked after children perspective, the Department for Education are collecting data on the number of children who started to be looked after in the last week. This has been collected in each of the three surveys unlike the referrals by source which was only collected as part of Wave 3. On average Warwickshire are accommodating 3-4 children a week which is line with regional/national averages whilst our statistical neighbours have a slightly higher average of 4-5 children.

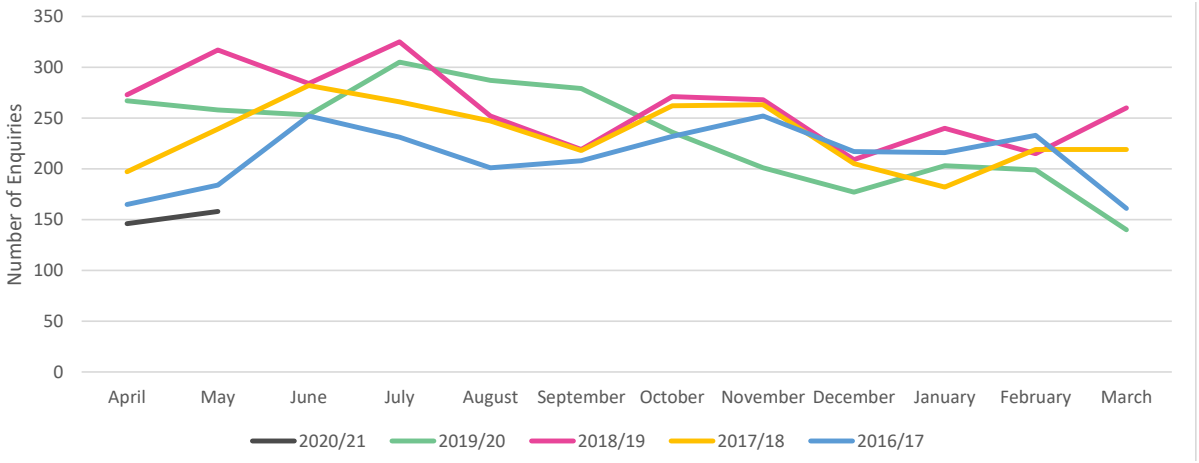
According to the charity Barnardos, the number of children needing foster care in England, Wales and Northern Ireland has increased 44%, to 2,349 in the period of 1 March to 23 April 2020, from 1,629 for the same period in the previous year[xxiii]. Meanwhile the number of enquiries from people looking to become foster parents for the charity fell from 302 to 161 - a 47% drop. The charity states that the coronavirus pandemic has increased pressure on vulnerable families, leading to family breakdown, which will impact more families as the crisis continues. At the same time, the change in circumstances that many people have experienced and uncertainty about the future has meant that fewer enquiries about fostering are being made.

FIGURE 28 New worker involvements received in Coventry between February 2020 and June 2020



Source: Insight Team, Coventry City Council

FIGURE 29 Adult safeguarding concerns received in Warwickshire between April 2016 and May 2020



Source: Business Intelligence Team, Warwickshire County Council

Adult Social Care

COVENTRY

The number of people in Residential and Nursing placements in Coventry saw a significant decrease in April and May 2020, from 1056 people in placement at the end of March 2020 to 963 at the end of May 2020. This is due both to a decrease in those starting placements (55 in March 2020, 37 in April 2020); and a high number of ended placements particularly in April 2020, including a high number of deaths in placement in April 2020. This has reduced to levels similar to 2019/20 in May 2020.

Numbers of people in placement for home support are higher than in 2019/20, at 1158 at the end of May 2020, compared to 1119 at the end of May 2019. Housing with care services have reduced from last year (394 May 2020, 413 May 2019), however this can be linked to a decline since January 2020. Numbers in placement for Supported Living have remained stable at around 190 clients.

Overall, initial contacts for new clients decreased significantly during March and April and have been steadily rising again since May as illustrated in Figure 28. Safeguarding assessments however, increased, from around 60 per week before COVID-19 to around 75 per week since 23 March (as of 22 June).

WARWICKSHIRE

The number of people in Residential and Nursing placements in Warwickshire saw a decrease from 1,862 in March 2020 to 1,788 in May 2020 (however, this figure is higher than the number for May 2019, which was 1,757). Between April and May 2020, admissions to permanent residential / nursing care dropped from 81 to 42. There have also been a high number of deaths in April 2020.

The total number of My Assessment Forms completed in the month had increased in April to 528 (from 451 in March 2020), however May saw a drop to 409. This is higher than the monthly average for 2019/20 (347). The number of planned reviews has dropped from 521 in March 2020 to 228 in April and 208 in May.

Safeguarding concerns received are at a low level, although rising slightly since March, they are much lower than in 2019 (May 2020 – 158, May 2019 – 258).

Cancer Screening

Screening services have all been paused across the UK. The implications of this will be that opportunities to identify cancers early may be missed. Looking at the total number of people eligible for screening the number who would attend each week can be calculated. Whilst screening programmes have been paused are a total of 679 missed bowel screenings, 811 cervical screenings and 538 breast cancer screenings, across Coventry and Warwickshire.

Overall, the number of urgent referrals has dropped to around 25% of usual levels in England. This is largely because fewer people are going to their GP, but in some instances GPs may have been reluctant to risk sending a patient to the local hospital. Every week that this goes on, over 2,300 cancer cases are likely to be going undiagnosed across the UK – and these will be stacking up over time (source: Cancer Research UK).

There have also been disruptions to cancer treatment. A large survey called Understanding Society COVID-19 had 17,450 Study participants. Of them, 3,414 respondents aged 16 and over from across the UK report one or more long-term health conditions, such as cancer or cardiovascular disease. The data shows that during April 2020, 63% of people with long-term health conditions, such as cancer or cardiovascular disease, who needed NHS treatment did not receive it. Around 10% of patients cancelled appointments themselves. The highest level of continued treatment was for those with cancer, but only 40% received treatment in this period. 56% of cancer patients had their treatment cancelled or postponed by the NHS and 4% postponed treatment themselves[xxiv].

However, certain hospitals in England have now been designated as 'cancer hubs' – such as in London, Manchester, Leeds and several other locations – and are creating 'COVID-free zones' for cancer treatment. However, this may mean a longer journey for residents of Coventry and Warwickshire to access treatment[xxv].

TABLE 12 Screenings missed per week in Coventry and Warwickshire

Area	Bowel Cancer	Cervical Cancer	Breast Cancer
Coventry and Rugby CCG	278	407	232
South Warwickshire CCG	247	249	184
Warwickshire North CCG	154	155	122
Total for Coventry and Warwickshire	679	811	538

Source: Business Intelligence Team, Warwickshire County Council

Child Immunisations

Early data indicates that in March 2020, there has been more of an impact on the early vaccinations than on the first dose of MMR which is usually administered after 12 months. In Warwickshire North CCG, it is likely that more than twice the percentage of eligible children have not been vaccinated for hexavalent in March 2020 than in March 2019. Anecdotal evidence suggests this increasing across all area in April and May, with an increase in the number not having the MMR vaccination. A four week campaign is being launched in Warwickshire on Monday 29th June (#CarryOnVaccinating) to help promote the importance of attending or re-booking scheduled vaccination appointments during the COVID-19 outbreak. This will focus on vaccinations during pregnancy, the MMR and preschool boosters.

Nationally, a study in Eurosurveillance journal, a medical journal covering epidemiology, showed that MMR vaccination counts fell across England from February 2020 but began to improve in mid-April[xxvi]. There has also been a gradual decline in hexavalent vaccination counts throughout 2020 which were not believed to be related to social distancing measures, however these have also improved from mid-April.

Dementia Diagnosis

What does the literature say:

Social restrictions have had a substantial impact on the management of outpatient clinics with cancelations or postponement of outpatient visits. Vulnerable patients, including elderly people with cognitive impairment (CI) or dementia, have an increased risk of serious morbidity, admission to intensive care units, and death when infected with COVID-19 because of their advanced age and frequent medical comorbidities. Consequently, they have been highly recommended to adhere to social distancing, increasing caregiver burden. Furthermore, these measures might lead patients with CI to a faster cognitive deterioration and to worsening of behavioural and psychological symptoms of dementia, inducing in turn higher caregiver distress.[xxvii]

What is the current data saying:

The estimated diagnosis rate for dementia in those aged 65+ was already showing a downward trend in Coventry and Warwickshire and has continued to fall between March and April 2020; across the HCP this has reduced from 59.4% to 57.8%; a reduction of 1.6 percentage points. This was slightly less than the national reduction, which was 2 percentage points. There was a further decrease in May 2020.

TABLE 13 Screenings missed per week in Coventry and Warwickshire

Area	Diagnosis rate March 2020	Diagnosis rate April 2020	Difference
England	67.4	65.4	-2.0
Coventry and Warwickshire	59.4	57.8	-1.6
NHS Coventry and Rugby CCG	60.6	59.5	-1.1
NHS Warwickshire North CCG	57.8	57.1	-0.7
NHS South Warwickshire CCG	58.9	56.1	-2.8

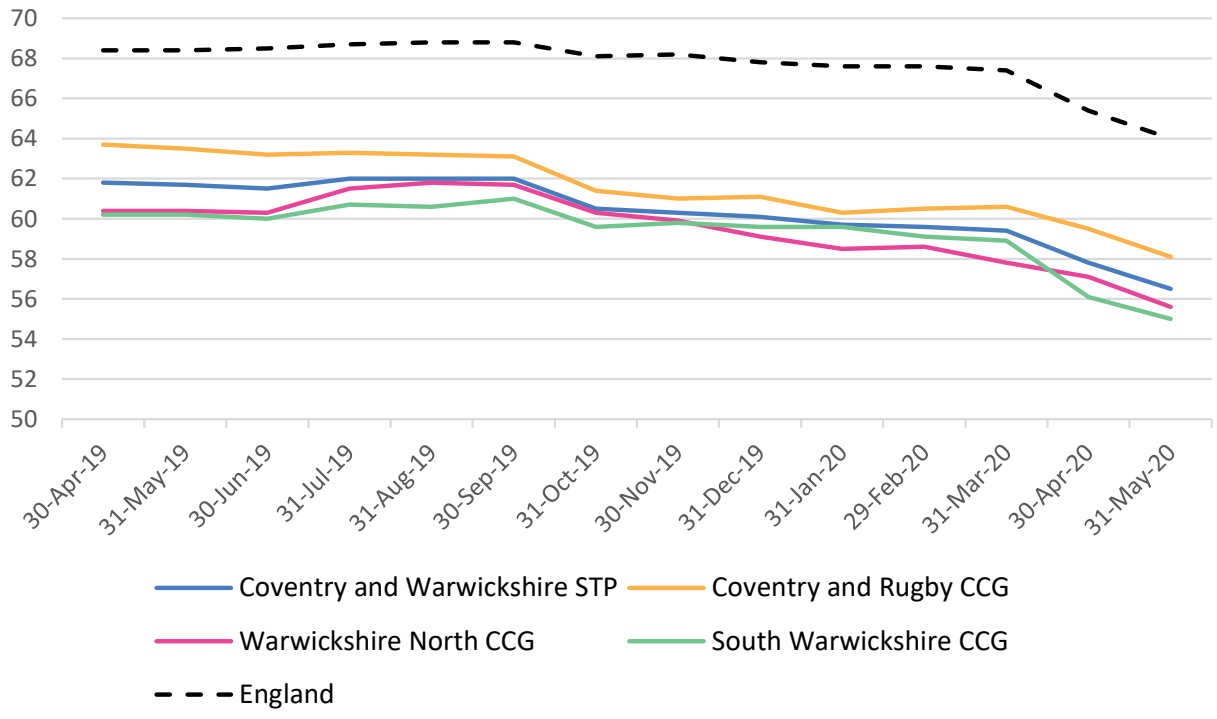
Source: NHS Digital [xxviii]

TABLE 14 The difference between dementia diagnosis rates in April 2019 and April 2020 across Coventry and Warwickshire

Area	Diagnosis rate April 2019	Diagnosis rate April 2020	Difference
England	68.4	65.4	-3.0
Coventry and Warwickshire	61.8	57.8	-4.0
NHS Coventry and Rugby CCG	63.7	59.5	-4.2
NHS Warwickshire North CCG	60.4	57.1	-3.3
NHS South Warwickshire CCG	60.2	56.1	-4.1

Source: NHS Digital

FIGURE 30 Dementia diagnosis rate from April 2019 to May 2020 across Coventry and Warwickshire



Source: NHS Digital

In South Warwickshire this figure showed a more significant change, from 58.9% to 56.1% - 2.8 percentage points; whereas in Coventry and Rugby and Warwickshire North, the difference was much smaller than the national figure.

Since April 2019, across Coventry and Warwickshire the diagnosis rate decreased by 4 points, compared to a national average of 3 points; with all three CCG seeing a bigger decline than the national figure, as demonstrated in the tables and figure below.

Mental Health Services

Referrals to Coventry and Warwickshire Partnership NHS Foundation Trust (CWPT) for mental health services dropped between the period February 2020 – May 2020, as illustrated in Table 15. The majority of attended care contacts were down for the majority of mental health services apart from the children and young people (CYP) service and adult eating disorder service.

It is felt that reductions in referrals to the CYP service reflect that the primary need of patients changed. The service often sees patients presenting with educational stressors, which were reduced during the COVID-19 outbreak period due to the school changes that were put in place. These changes have also provided people with more time to manage distress at home. It should be noted that eating disorder referrals have increased due to parents identifying disordered eating earlier.

In the adult eating disorder service the re-referral rate has increased from previously discharged patients and new presenting cases have been of a higher acuity.

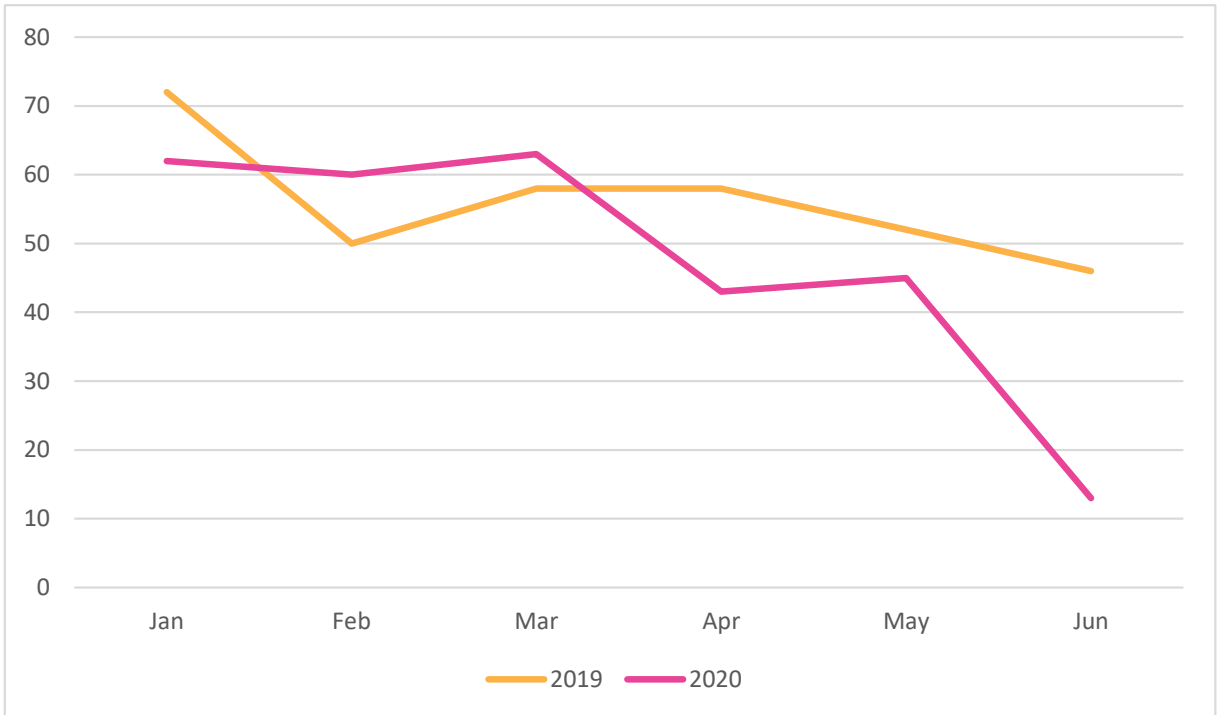
The Community mental health team service found that isolation has been described as a trigger for people accessing support.

TABLE 15 Percentage change in new referrals and attended care contacts in secondary mental health care services in Coventry and Warwickshire

Service Type		Estimated % change from February to April	Estimated % change from February to May
Children and young people	New referrals	-64%	-52%
	Attended care contacts	2%	-16%
Early intervention psychosis	New referrals	-31%	-33%
	Attended care contacts	-17%	-39%
Adult eating disorder	New referrals	-68%	-70%
	Attended care contacts	127%	59%
Community mental health teams (CMHT)	New referral	-60%	-48%
	Attended care contact	-14%	-29%

Source: Coventry and Warwickshire Partnership NHS Foundation Trust

FIGURE 31 New user registrations to the Big White Wall online e-mental health service in Warwickshire (correct as at 19 June 2020)



Source: People Strategy and Commissioning, Warwickshire County Council

COVENTRY

By contrast, Coventry Safe Haven, which provides out of hours crisis support and some medium-term support for adults suffering from mental health problems, has reported a substantial increase in service users since March.

Coventry Safe Haven offers initial support and some medium-term support to adults (18+) suffering from mental health problems in Coventry. They report that they had expected an influx of service users suffering

TABLE 16 Service user contacts made by the Warwickshire Safe Haven service (correct as at 19 June 2020)

Month (2020)	Number of service user contacts
January	-
February	51
March	35
April	19
May	17
June	7

from mental health problems when lockdown began, but in fact demand dropped considerably initially. The Service Manager suggested that this was because service users may have been unaware that the service was still available during the initial lockdown. Since then, demand has been rising substantially. It has continued to rise after lockdown restrictions have started to be lifted. There has been a change in the type of mental health problems reported by service users from what is typical, with a greater proportion now reporting high level anxiety, self-harm and suicidal ideation. There are also substantially more people calling where mental health support is their primary need.

Factors contributing to the increased demand for mental health support

Coventry Safe Haven have found that social isolation in particular has contributed to an increase in depression, self-harm and suicidal thoughts. Service users have often tried to stay in touch with family and/or friends virtually but are struggling with the lack of physical presence and contact, and have found that it has changed the dynamics of their relationships. Some service users are struggling with adjusting to lockdown then quickly having to adjust again now that lockdown is being eased. Coventry Safe Haven has found that many service users are experiencing anxiety around the lack of adherence to social distancing guidance. Some service users who have already recovered from COVID-19 have been suffering from ongoing panic attacks and anxiety as a result. The Service Manager noted that the lack of simple, easy to understand messaging around COVID-19 has also contributed to anxieties. In addition, service users have reported having to wait multiple days for a call back from their GP about their mental health concerns.

WARWICKSHIRE

Warwickshire County Council commissions a range of mental health services which have been available to support people via telephone and online during the coronavirus outbreak. Some services were already accessible in this way (e.g. e-mental health service, telephone helpline) but others have had to alter their methods of delivery from a face-to-face service (e.g. Wellbeing for Warwickshire, Safe Haven).

Some of these services have not been able to provide real-time data which demonstrates whether they have been impacted by COVID-19 but the e-mental health and safe haven services have been able to provide this data.

New user registrations to the Big White Wall online e-mental health service have not differed significantly from the same period in 2019, as illustrated in Figure 31. Table 16 highlights that the Safe Haven service, which provides face-to-face, phone, text and email support, has seen a reduced number of contacts since the COVID-19 outbreak started. It should be noted that this service changed providers on 1 April 2020 and this may have impacted residents' knowledge of the service.

Unpaid Caring

While studies about caregiving and COVID-19 are not yet available, it is highly likely that due to a combination of social distancing and lock down restrictions the disproportionate impact of the virus on older adults, caregivers of adults living both in community and long-term care are very likely to have been impacted.

According to the ONS Opinions and Lifestyle survey, the percentage stating that "I am spending more time caring for others" has fluctuated between 36% and 46% nationally for the period post COVID-19[xxix].

A UK-wide online platform, mobiliseonline.co.uk, was launched in March to provide online support for carers through the pandemic. The common challenges listed are financial (due to extra caring responsibilities and costs), the need for an emergency plan should a carer become ill and the need to keep a routine in order to cope well.

CRESS (Carer's Response Emergency Support Service) has been supporting carers in Coventry and Warwickshire; and have offered additional services during COVID-19 for carers who are vulnerable or caring for someone with a high level of caring needs, for example they cannot leave the person they are caring for alone. They have been offering a short break for the carer, for example to take exercise, go shopping or collect prescriptions; and have also supported carers with going shopping for essential supplies.

COVENTRY

Between March and May 2020 CRESS delivered 50.75 planned hours, and 335.25 emergency hours, in Coventry. They also saw an increase in the number of carers signposted to the service, suggesting more unpaid carers needed supported during COVID-19.

Coventry City Council data suggests that during April and May 2020 fewer clients received respite care and replacement care home support compared to 2019/20; however, the number of carers receiving direct payments remained relatively stable.

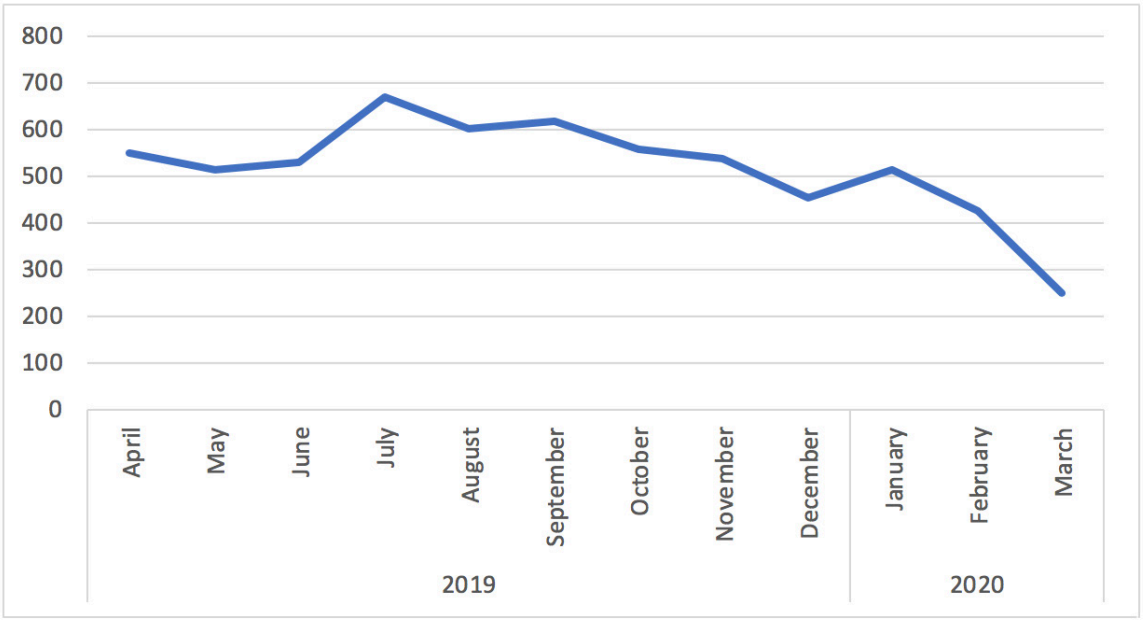
Health Checks

COVENTRY

In Coventry, the NHS health check programme has not been delivered during the COVID-19 outbreak. GPs deliver the majority of health checks and they stopped doing these in March. The Healthy Lifestyles Coventry service also deliver some on an outreach basis but, again, these were suspended in March as they cannot be delivered in a socially distanced way. Healthchecks also rely heavily on blood tests delivered by phlebotomy services / pharmacies which are more limited. This pause in services can be seen across the country.

From January to December 2019, there were 7,499 health checks completed in Coventry, which is an average of 625 per month. This includes those completed by GPs and the HLS service (90% are completed by GPs). We can therefore estimate that this is the number of health checks per month that have been missed during the COVID-19 pandemic. In the three months of April to June, taking the averages for health check findings for the UK from the NHS, there could have been between 47 and 63 people diagnosed with high blood pressure, between 9 and 23 people diagnosed with type 2 diabetes, and between 188 and 313 identified as being at high risk of cardiovascular disease[xxx].

FIGURE 32 The number of NHS Healthchecks completed by GPs in Warwickshire from April 2019 to March 2020



Source: Strategic Commissioning, Warwickshire County Council

WARWICKSHIRE

There has been a decline in the number of health checks completed in Warwickshire in the past year, with 551 health checks in April 2019 and 250 in March 2020. There have been none completed since the beginning of lockdown and increased social distancing in March may go some way to explaining the low numbers for that month.

Looking at the average number in the 11 months leading to March gives a monthly average of 544 health checks a month across Warwickshire (completed by GPs). This does not include a smaller number which are completed elsewhere. This is therefore the potential number of missing health checks. In the three months of April to June, taking the averages for the UK from the NHS, there could have been between 41 and 54 people diagnosed with high blood pressure, between 8 and 20 people diagnosed with type 2 diabetes and between 163 and 272 people identified as being at high risk of cardiovascular disease[xxxi].

The Places and Communities We Live In, and With

Communities and social contact are important components of maintaining good mental wellbeing, however measures to control the spread of COVID-19 depended on reducing social contact. This was achieved through lockdown measures and 'shielding lists' that identified those who were clinically vulnerable to severe infection and who would need additional support to successfully social distance.

The approach to supporting or working with communities is often 'asset based' and considers how communities can build on the assets and resources already available. Because of this the response to COVID-19 has looked different in each local authority.

Supporting vulnerable residents during and following lockdown

There has been a tremendous response by existing and newly formed third-party organisations and community groups to support vulnerable residents who are shielding or struggling to cope during lockdown.

Ring-fenced funding and additional support have been available especially to both sustain the third-party sector or help them to adapt to supporting changing needs.

To enable a rapid response, schemes have been funded and mobilised quickly (e.g. Heart of England Coronavirus Fund, National Lottery) and processes for delivering schemes and accessing them have been simplified (e.g. some foodbank schemes have not required a formal referral to them during COVID-19).

Funding gaps are being identified and attention is now moving from directly supporting people during lockdown to supporting them through the longer-term impacts that lockdown may have on the wider determinants of health.

Funding is also beginning to be made available to undertake research and evaluation of the impact of lockdown upon communities and to assess the effectiveness of initiatives which aim to support them. Emerging themes include: access to food and medicines, adapting access to routine support, befriending and advice services and tackling issues of anxiety, loneliness, relationship breakdowns, financial difficulties, crime, homelessness and health inequalities.

Shielding Hub Formal Lists and Activity

Many vulnerable residents have been identified by formal lists generated by for example the NHS, Local Authorities and private service providers, or more informally through charitable and community networks.

The number of residents on the MHCLG/NHS shielding list across Coventry and Warwickshire (as outlined in Tables 20 and 21) has varied from around 3% of the population in Rugby to close to 4% of the population in North Warwickshire, compared with close to 4% of the population nationally, and around 3.5 - 3.6% for both West Midlands and Warwickshire populations.

While there is some variation across the patch, reflecting the underlying demographic and general health of the population, the profile of residents on NHS shielding lists within Warwickshire and Coventry follow a similar trend to what has been reported nationally (< 1% of 0-18 years population, 3% of 19-69 years population, 11-13% 70+ years population).

Reported activity from local shielding hubs suggest that some but not all residents on NHS shielding lists required any immediate further additional support from the Local Authority when contacted. Additional residents (i.e. not on NHS shielding list) have been identified and added to local shielding lists.

TABLE 17 Numbers and percentages of people on the NHS shielding list across England, the West Midlands, Coventry and Warwickshire				
	England	**West Midlands**	**Warwickshire**	**Coventry**
All	2,229,797	207,940	20,370	13,445
% population	3.98%	3.52%	3.57%	3.67%
Male	1,051,407	98,300	9,725	6,165
% population	3.98%	3.36%	3.45%	3.31%
Female	1,178,338	109,635	10,650	7,270
% population	4.16%	2.92%	3.69%	4.02%
0- 18	93,969	8,755	675	640
% population	0.75%	0.64%	0.55%	0.77%
19-69	1,173,894	109,410	10,185	7,835
% population	3.26%	2.92%	2.81%	3.18%
70+	961,934	89,770	9,530	4,950
% population	13.08%	11.36%	10.99%	13.56%
Source: NHS Digital, accessed 4 June 2020[xvii]				

TABLE 18 Numbers and percentages of people on the NHS shielding list across England, the West Midlands, Coventry and Warwickshire					
	North Warwickshire	**Nuneaton & Bedworth**	**Rugby**	**Stratford-on-Avon**	**Warwick**
All	2570	4760	3,330	4,795	4,915
% population	3.96%	3.69%	3.11%	3.76%	3.45%
Male	1255	2200	1585	2370	2315
% population	3.92%	3.48%	2.97%	3.81%	3.25%
Female	1315	2560	1750	2425	2600
% population	4%	3.90%	3.25%	3.71%	3.65%
0- 18	85	210	115	115	150
% population	0.64%	0.72%	0.45%	0.45%	0.52%
19-69	1200	2625	1835	2135	2390
% population	2.90%	3.20%	2.75%	2.73%	2.54%
70+	1280	1930	1380	2550	2390
% population	12.36%	10.97%	9.15%	10.58%	12.19%
Source: NHS Digital, accessed 4 June 2020[xvii]					

COVENTRY

Operation Shield

Locally, as of 29 May, there were 14,282 individuals identified through the MHCLG/NHS vulnerable/shielded lists, of which 12,579 have been contacted.

Since end-March, 22,617 calls have been made, of which 12,649 were answered and 9,961 were not answered. The vast majority of people did not require additional support – however, a small proportion did.

The Council has been working with partners to compare the names on the NHS / MHCLG vulnerable / shielded lists with other datasets, including:

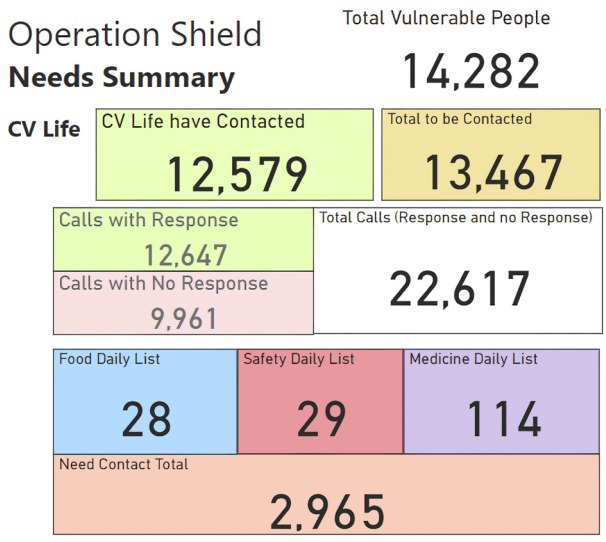
- Coventry City Council (adult social care);
- NHS Coventry and Warwickshire Partnership Trust;
- NHS Coventry & Rugby Clinical Commissioning Group (Primary Care Networks); and
- NHS University Hospitals Coventry and Warwickshire.

Shield+

In addition to Operation Shield, Coventry has embarked work to identify, contact, and support our most vulnerable residents including those not on the shielded lists; combining addresses of other residents who may be vulnerable or may become vulnerable because of the prolonged lockdown due to risk factors including age, mobility, income or living alone. This includes:

- waste services assisted collections – addresses where households are identified as having nobody with the level of mobility to move their wheelie bins to the designated pickup point;
- Council Tax single person discount – identifying older people aged 70+ who are living alone;

FIGURE 33 Summary of data for Coventry Operation Shield (as of 29 May 2020)



Source: Insight Team, Coventry City Council

- free school meals and early years pupil premium – children living in low-income families who may be struggling especially in light of difficulties with the roll out of the government voucher scheme;
- safe and well checks – list of residents who have had a safe and well visit and their frailty scores, held by the West Midlands Fire Service. Visits are focused on the most vulnerable people in our communities;
- self-presenting individuals – people presenting to the local authority, e.g. via telephone calls to the contact centre or emails to community resilience, asking for help or support; and
- priority services register – list of residents and addresses of various categories of vulnerable residents (disability, mobility, language difficulties, etc.) held by Western Power Distribution and compiled with other utilities including Cadent and Severn Trent.

After accounting for available resources this resulted in a list of just over 2,000 households across the city which have been contacted - 1,485 by phone (of which 10% required support) and 520 via door-knocking (of which 3% required support). Table 19 outlines the contacts made through Shield+:

TABLE 19 Contacts made through Shield+

Completed telephone contact	**Totals**
Total households contacted	1485
Total telephone contacts made	1989
Average telephone contact attempts per household	1.34
Total people requiring support	142
% of households requiring support	10%
Pre Door knocking	Totals
No of households awaiting door knocking	125
% requiring door knocking	6%
Telephone contact attempts made before door knocking	188
Average contact attempts per household	1.5
Completed door knocking	Totals
Total households 'knocked'	520
Total 'knocks' made	448
Average contact attempts per household	0.86
Total attempts to contact through neighbours	141
Total people requiring support following door knocking	14
% of households requiring support	3%
Telephone contact attempts made before door knocking	1022
Average contact attempts per household	1.97
Totals	
Customers contacted and completed	2005
Telephone contacts made	3199

Source: NHS Digital, accessed 4 June 2020[xvii]

FIGURE 34 Coventry City Council vulnerable people data set

Unique NHS Numbers 14544	Operation Shield	CCC Adult Social Care (Snapshot)	CWPT Forum Health Centre	Total CWPT	CWPT Walsgrave	GP Forum Health Centre	Total GP VPL	GP Walsgrave	UHCW	PCN Sowe Valley
Operation Shield	14259	880	30	34	4	354	431	77	2953	1108
CCC ASC	880	892	3	4	1	14	19	5	133	97
CWPT Forum HC_VPL	30	3	30	30	(Blank)	28	28	(Blank)	10	(Blank)
CWPT_VPL	34	4	30	34	4	28	31	3	11	(Blank)
CWPT Walsgrave VPL	4	1	(Blank)	4	4	(Blank)	3	3	1	(Blank)
GP Forum HC VPL	354	14	28	28	(Blank)	355	355	(Blank)	80	(Blank)
GP VPL	431	19	28	31	3	355	432	77	91	(Blank)
GP Walsgrave VPL	77	5	(Blank)	3	3	(Blank)	77	77	11	(Blank)
UHCW	2953	133	10	11	1	80	91	77	3212	197
PCN Sowe Valley	1108	97	(Blank)	(Blank)	(Blank)	(Blank)	(Blank)	(Blank)	197	1134

Number of People on Operation Shield without an NHS Number
64

Source: Insight Team, Coventry City Council

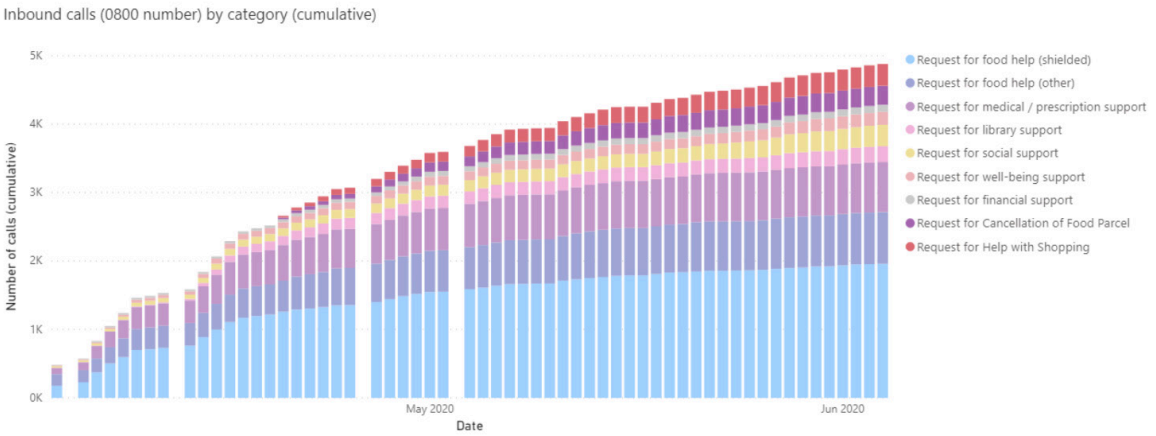
WARWICKSHIRE

As of 4th June 2020, there were a total of 20,960 on the shielded list in Warwickshire. Of these, 2,799 were requiring help to get essential supplies delivered.

As at 4th June, there have been 1959 requests for food help from those who are on the shielded list, 756 from those not on the shielded list, 733 requests for medical / prescription support, 230 requests for library support (Warwickshire Library staff have made contactless deliveries of books), 312 requests for social support, 191 for well-being support, 102 for financial support, 278 for cancellation of food parcel and 318 requests for help with shopping.

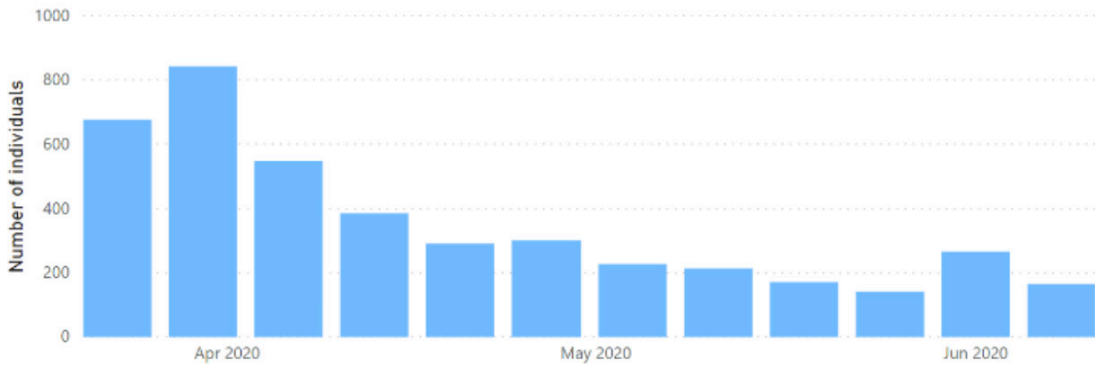
The main areas where people are requiring support are in the towns of Nuneaton, Bedworth, Rugby and Leamington.

FIGURE 35 Cumulative calls received by Warwickshire County Council for support broken down by request type



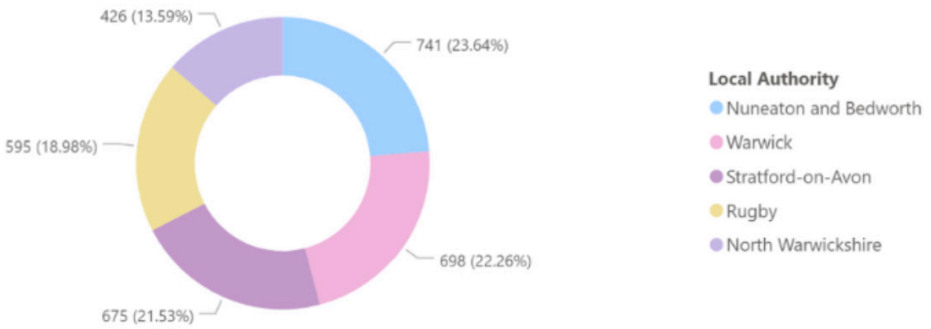
Source: Business Intelligence Team, Warwickshire County Council

FIGURE 36 New individuals indicating they potentially require support (essential supplies)



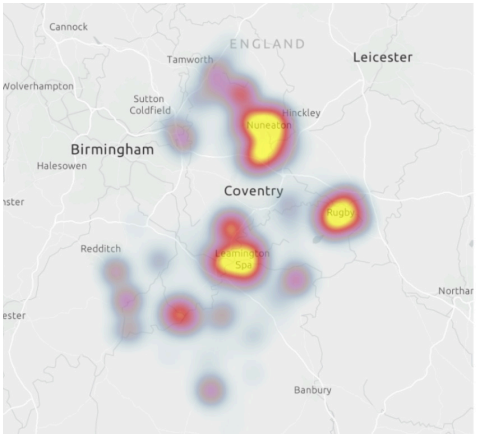
Source: Business Intelligence Team, Warwickshire County Council

FIGURE 37 People potentially requiring support by district / borough in Warwickshire



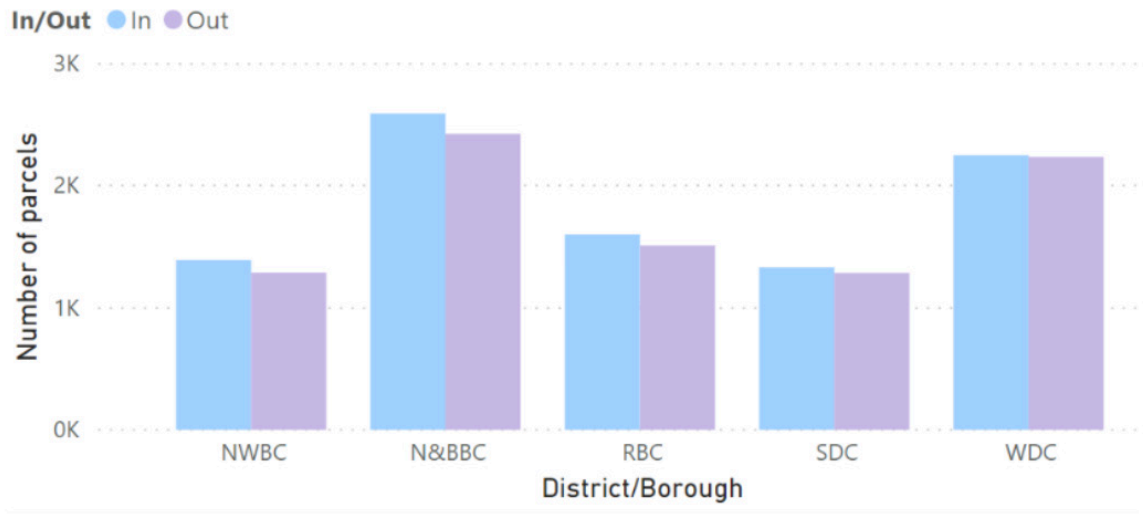
Source: Business Intelligence Team, Warwickshire County Council

FIGURE 38 Heatmap of people potentially requiring support in Warwickshire



Source: Business Intelligence Team, Warwickshire County Council

FIGURE 39 Food parcels received by and distributed by districts / boroughs in Warwickshire



Source: Business Intelligence Team, Warwickshire County Council

Food Bank Activity

Across the UK, food bank activity has significantly increased due to the COVID-19 pandemic. The Independent Food Aid Network (IFAN), which connects more than 300 food aid providers across the UK, reported a 175% increase in the number of emergency food parcels distributed by food banks in April 2020 compared with April 2019.

The outbreak of COVID-19 and subsequent lockdown have also changed how some food banks are operating; with 24% of organisations in a recent report by IFAN either seeing an increase in self-referrals or starting to accept self-referrals as a result of the COVID-19 outbreak. Before the outbreak, only 4% of organisations sampled ran a delivery service, this has increased to 57% in order to allow for social distancing[xxxii].

COVENTRY

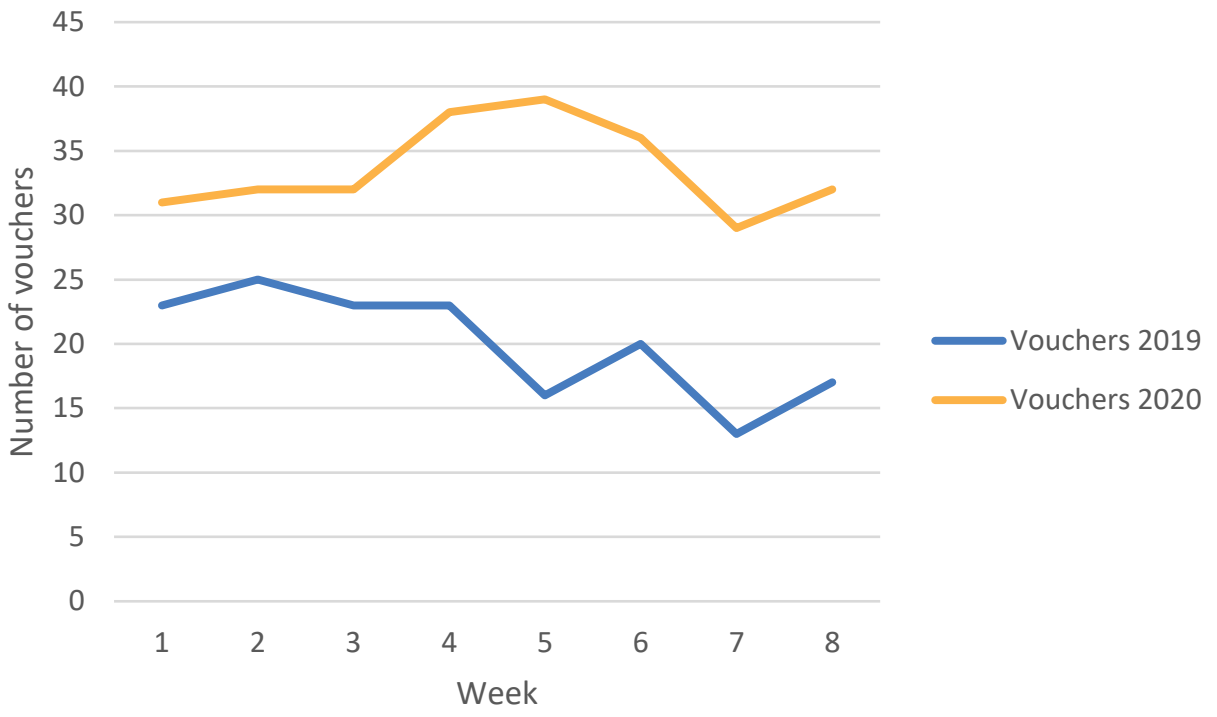
The Trussell Trust in Coventry saw a 95% increase in food parcels given out overall and an 106% increase in food parcels given out to children in April 2020 compared with April 2019.

This is supplemented by other food provision across the city: 10 emergency food hubs have been set up; 5 of which operate as social supermarkets. These have been providing food to many families in the city, for example the social supermarket in Foleshill ward is distributing around 250 parcels a week. Coventry City Council also supported 671 residents with food between 3 April and 4 June 2020 via calls into its contact centre.

WARWICKSHIRE

At the beginning of lockdown, the Trussell Trust in Warwickshire saw a 125% increase in food parcels given out overall and a 217% increase in food parcels given out to children in the last two weeks of March 2020 compared with the last two weeks of March in 2019.

FIGURE 40 Food vouchers received by Ediblelinks in Warwickshire between March and April 2019 and 2020



Source: Nuneaton and Bedworth Healthy Living Network

This increase continued in April 2020, where there was a 63% increase in food parcels given out to foodbanks in North Warwickshire (Includes foodbanks located in North Warwickshire, Nuneaton and Bedworth and Rugby Boroughs) an 87% increase in South Warwickshire (includes foodbanks located in Stratford-on-Avon and Warwick Districts).

Data from Ediblelinks, an independent foodbank in North Warwickshire Borough, shows a 68% increase in the 8 weeks commencing 16th March 2020, compared with the corresponding weeks in 2019, with 269 vouchers received from families or individuals needing to use the foodbank in this period in 2020 compared with 160 in 2019. There has been a 45% increase in the number of people helped (55% increase in adults and 34% in children). Figure 40 shows the number of vouchers received by Ediblelinks from families or individuals in the 8-week period commencing 16th March 2020 compared with the same weeks in 2019.

The increase in need is believed to be bigger but is not shown in these figures due to several “pop up” initiatives which have started since the beginning of lockdown. One of these is located at St John’s church in South Leamington, which was providing an average of 100 meals a week from April to both families and single people. They reported that some people have found it difficult to obtain vouchers for a food parcel as many of the usual suppliers are currently shut.

Citizens Advice Bureau (CAB) Activity

COVENTRY

The impact of COVID-19 on Coventry Citizens Advice has included a drop in the number of enquiries supported, and changes in the types of issues people have contacted CCA about. March 2020 saw a 25% fall in enquiry numbers compared with February, and the number of enquiries dealt with by CCA in April and May 2020 was lower than 2019; this corresponds to a decrease in advice capacity available, which was

around 75% of pre-COVID levels, due to the temporary suspension of two projects and the 'furloughing' of volunteer advisers.

Whilst this decline can be seen in most issue areas; there were some issues for which enquiries rose. In April 2020, CCA saw a 92% increase in enquiries about employment issues compared with April 2019, predominantly of concerns around 'pay and entitlements', terms and conditions' of employment', 'parental and carers rights' and questions around the government's Job Retention and SEIS Schemes. These declined in May 2020. Housing and Homelessness also saw an increase of 48% compared to April 2019, including actual or threatened homelessness and disputes with private sector landlords; and continued to be a common issue for enquiries in May 2020. CCA also saw a rise in new issues arising in April 2020, including credit card and personal loan debts, Council tax benefit eligibility and Job Seekers Allowance. In May 2020 enquiries around Universal Credit and Benefits shifted from a focus on making applications to coping with the wait for the first payment and dealing with award decisions.

In April 2020 CCA saw an increase in the number of younger adults (under 35s) accessing the service; although this declined in May it was still higher than usual. A higher proportion of clients were female (51%, April 2019, 54% April 2020), disabled (54% April 2019, 60% April 2020) and white (68% April 2019, 78% April 2020). Whilst the proportion of clients who were female and white decreased slightly in May 2020, BAME clients were still relatively under-represented in CCA's COVID-19 client base and the proportion of disabled clients increased again to 62%.

CCA note that some groups have fallen through the 'safety net' constructed around COVID-19. These groups include: the self-employed not covered by the SEISS, those with no recourse to public funds not covered by the Job Retention Scheme and the 'new homeless'.

As the lockdown is lifted in incremental steps, and temporary protections are withdrawn, CCA expect to see marked increases in demand for all their services, across all fronts; but particularly on debts, benefits, housing and employment.

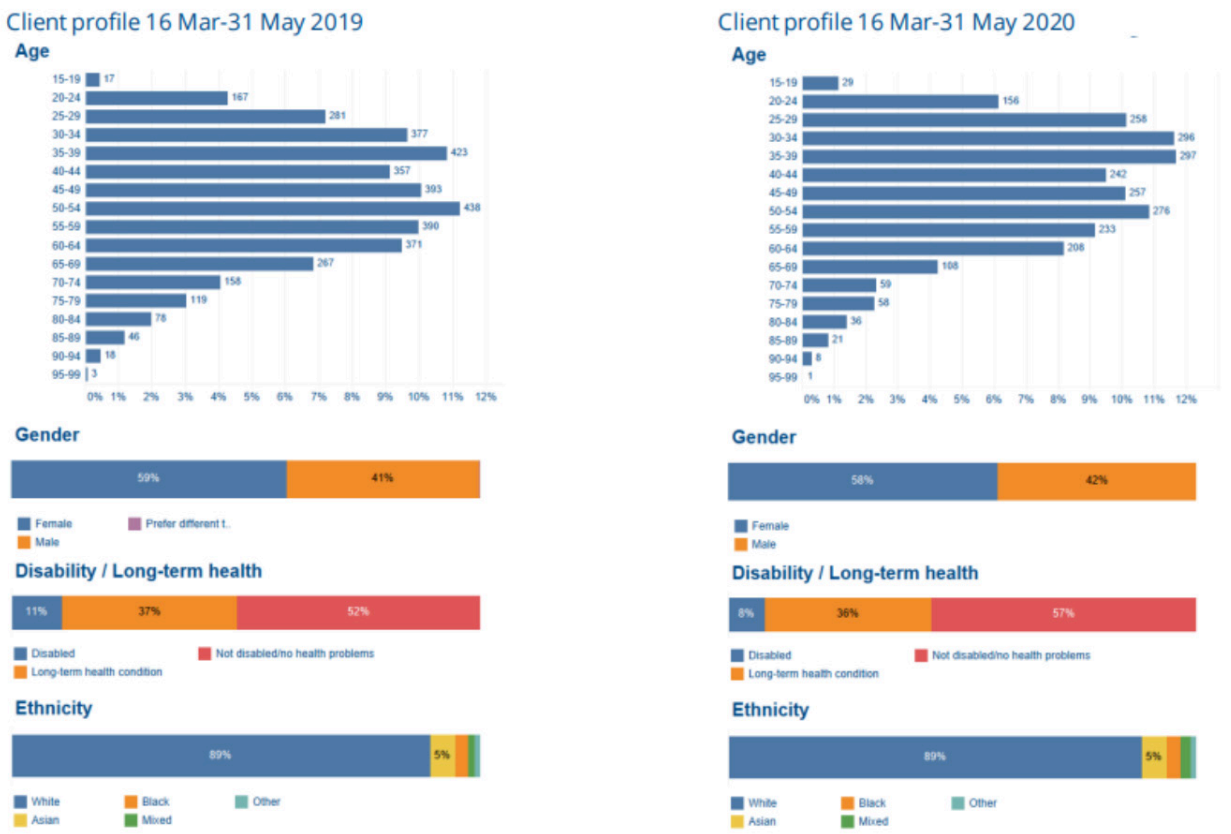
WARWICKSHIRE

Means of communication for Coventry Citizens Advice and the three CABs in Warwickshire (North Warwickshire, South Warwickshire and BRANCAB) had been about two thirds in person up to 20th March 2020, with most of the remainder being phone calls, and with very little online contact. In Warwickshire, there had been a small increase in the number of enquiries from 2018/19 to 2019/20, particularly those relating to Universal Credit.

Data across all Warwickshire Citizens advice from 16th March to 31st May 2020 shows a slight decrease in the number of clients and an increase in the complexity and number of issues per client (in line with national trends). Demand is expected to increase as lockdown lifts. Of those who have been in contact, a greater proportion are aged in their 20s and 30s and a smaller proportion are aged 55+. The increase of clients in their 20s and 30s may be down to a preference of using online contact methods, as well as an increased need in this age group. A greater proportion of contact has related to Universal Credit and Employment issues. There is expected to be an increase in clients with issues such as debt, financial capability, benefits, employment, and requests for welfare assistance. Face to face visits are likely to restart in June for the most vulnerable clients, those with English as a second language, and those where issues cannot be dealt with remotely.

In South Warwickshire, comparing the period 18th March 2020 to 30th April 2020 with the data for the year from 1st April 2019 to 31st March 2020, there were increases in the average number of clients per week, from 115.62 in the annual data, to 533.33 in the six week period in March and April 2020. In terms of the issues raised, there was an increase in employment and universal credit related queries, with debt related queries concerning debt relief orders and unsecured personal loans. There has been a proportional rise in queries from those in the 30-34 and 75-79 age groups. With the client being at home, they are able to

FIGURE 41 Client profiles across all Warwickshire Citizens advice – 2019 compared to 2020



Source: Warwickshire Citizens Advice Bureaus

focus on details which are readily at hand, and by homeworking staff are able to concentrate more on the allocated client (than they would in a busy office environment), and therefore the quality of advice given has risen markedly.

At BRANCAB (Bedworth, Rugby and Nuneaton CAB), there has been a particular increase in the number of queries relating to employment. At North Warwickshire Citizens Advice Bureau, there has been a particular increase in the number of queries relating to disability benefit.

Community Safety

CRIME AND DISORDER

With the notable exception of crimes associated with domestic abuse and anti-social behaviour, recorded crime numbers nationally during the initial 6 weeks following lockdown were notably lower than the same time last year (in total around 25% fewer crimes were recorded).

However, with the easing of lockdown, it is thought that recorded crime rates will at least bounce back to pre-lockdown levels and concern that gang related crimes, along with those relating to domestic violence and abuse, will spike, especially over the coming summer months.

Concern has also been raised about the longer-term impact of the lockdown on crime rates if long term economic difficulties and mental health issues are not addressed.

COVENTRY

Coventry saw a significant year on year rise in recorded crimes for anti-social behaviour (ASB) in April 2020 but an overall drop in recorded crime when those relating to ASB are excluded (drop of 30%). The drop in recorded crime can be explained by lockdown measures with more people staying at home and fewer people on the street. Trends in recorded crime relating to domestic abuse cannot be discerned from this dataset.

WARWICKSHIRE

Table 21 shows crime data in Warwickshire using categories available for Coventry, for the period available for Coventry (April 2020), so it can be compared. This dataset masks the increase in domestic abuse related crimes reported directly from the Warwickshire Police Crime Information System. Warwickshire saw a larger increase in ASB compared to Coventry (150% increase and 104% increase respectively). Warwickshire also saw an increase in incidents relating to drugs and possession of weapons for which Coventry saw a decrease.

Recorded crime data sourced from Warwickshire Police Crime Information System suggests Warwickshire is following the national trend. In April 2020, total recorded crimes were 25% fewer than the same month the previous year, but only 13% lower in May 2020. However, overall figures mask the true trends of specific types of crime, such as those relating to hate offences and domestic abuse, which, in line with the national picture, are all notably higher than the same time last year.

TABLE 20 Comparison of crime incidents in Coventry in April 2019 and April 2020

	April 2019	April 2020	% change
Anti-social behaviour	440	897	104%
All excluding anti-social behaviour	2441	1698	-30%
Other crime *	38	49	29%
Public order	125	151	21%
Violence and sexual offences	873	768	-12%
Possession of weapons *	27	22	-19%
Drugs *	41	30	-27%
Vehicle crime	284	178	-37%
Other theft	172	102	-41%
Criminal damage and arson	263	152	-42%
Burglary	253	126	-50%
Shoplifting	196	70	-64%
Robbery *	80	25	-69%
Theft from the person*	21	6	-71%
Bicycle theft *	68	19	-72%

Source: https://data.police.uk/
** indicates small numbers*

TABLE 21 Comparison of crime incidents in Coventry in April 2019 and April 2020

	April 2019	April 2020	% change
Anti-social behaviour	1019	2543	150%
All excluding anti-social behaviour	3517	2654	-25%
Drugs*	75	117	54%
Other Crime*	57	70	23%
Possession of Weapons*	36	42	17%
Public Order	182	183	1%
Violence and sexual offences	1257	1105	-12%
Criminal damage and arson	346	237	-32%
Vehicle crime	360	246	-46%
Shoplifting	296	186	-37%
Bicycle theft*	45	28	-38%
Other theft	405	216	-47%
Burglary	372	190	-49%

Source: https://data.police.uk/
** indicates small numbers*

From 16 March to 18 May 2020, there were 16 Road Traffic Collisions (RTCs) in Warwickshire where there were either fatalities or serious injuries. This compares with an average of 53 for the same period in 2019. The number involving a cyclist was 3 in 2020 and 4 in 2019. However, when looking at collisions where there were slight injuries, there were 12 in 2020 and 19 in 2019. (Source: Traffic & Road Safety Team, Warwickshire County Council) Attendances by the Fire Service at RTCs in the period 1st March to 3rd May 2020 were half the number in the same period in 2019 (28 compared with 56). (Source: Warwickshire Fire and Rescue)

Domestic Abuse

Nationally, information published by Refuge suggests the rise in domestic abuse incidents during lockdown is much higher than suggested by reported crimes recorded or referrals to services.

During the initial stages of the COVID-19 crisis, Refuge reported around a 50% increase in demand to its helpline call service, and a 300% increase in visits to its website. Refuge is now reporting an increase of 66% in calls to its helpline and a 950% rise in visits to its website compared with the period before lockdown, although this is partially offset by reported instances of domestic abuse tending to peak during the summer months.

COVENTRY

The level and pattern of domestic abuse reports have fluctuated significantly during the COVID-19 outbreak and the lockdown period. The number of crimes with a domestic abuse marker reported to police in

TABLE 22 Crime incidents in Warwickshire in April and May 2019 compared to April and May 2020

	April 2019	April 2020	% YOY	May 2019	May 2020	% YOY
Anti-social behaviour	1015	2543	151%	1195	2238	91%
All excluding anti-social behaviour	3485	2611	-25%	3509	3043	-13%
Hate Offences & Crimed Incidents	66	53	-20%	59	73	24%
Domestic Abuse (DA) Offences & Crimed Incidents	844	958	14%	894	1049	17%
Violence Against Person Without Injury – DA related	292	327	12%	311	355	14%
Violence Against Person With Injury – DA related	152	154	1%	135	142	5%
Rape	34	22	-35%	46	37	-20%
Other Sexual Offences	73	56	-23%	79	77	-3%
Violence With Injury	383	279	-27%	379	343	-10%
Violence Without Injury	744	707	-5%	757	867	-15%
Residential-Dwelling Burglary	158	74	-53%	131	78	-41%
Residential Non-Dwelling Burglary	265	134	-50%	203	133	-35%
Personal Robbery	45	19	-58%	27	25	-7%
Shoplifting	296	186	-37%	334	165	-51%
Total Vehicle Crime	359	245	-32%	364	261	-28%
Criminal Damage & Arson	348	236	-32%	366	278	-24%

Source: Warwickshire Police Crime Information System

Coventry up to and including March 2020 are shown below. Data for April is not yet available but police report that following an initial dip, the final two weeks of the month has seen a return to previous levels. Third party reporting (I.e. from neighbours) has increased.

As at 28 April 2020 there are approximately 70 individuals / families in temporary accommodation with domestic abuse as the primary reason for homelessness; this reflects a 10% increase in the first weekend following a national Home Office campaigned launched 11 April 2020.

The Council continues to work with the Regional Domestic Abuse Leads Group, which includes updates from the West Midlands Police and Crime Commissioner. Additional local partnership forums have been established to ensure communication between agencies and support mitigation of the risks; these include:

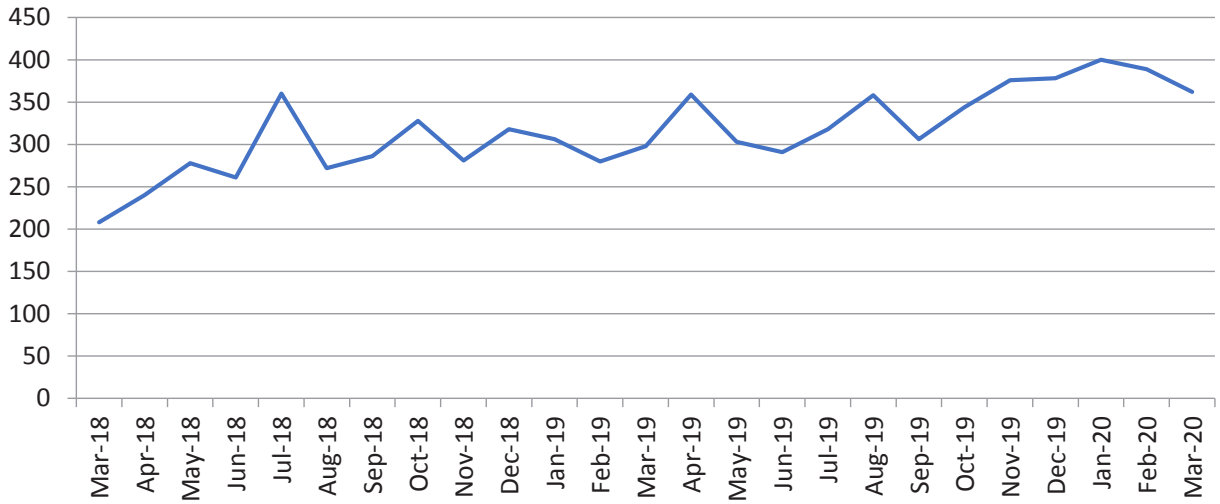
- fortnightly meetings of key stakeholders including WMP, C&R CCG, Children's Services, specialist providers and Housing, etc.
- weekly accommodation-focussed meeting including housing, providers, Children's services and police.

Discussions are underway to explore whether Coventry Haven can conduct 'safe and well' contacts with

households with a history of known domestic abuse supported by the Council's COVID-19 vulnerable residents' support scheme.

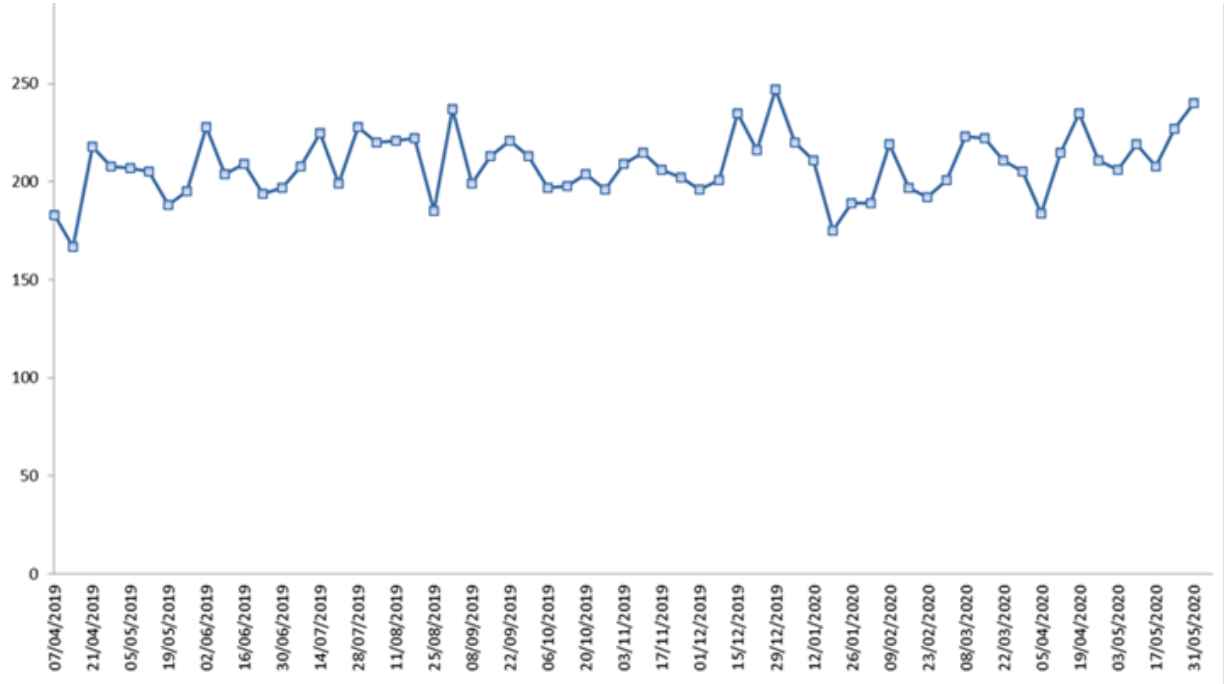
Local domestic abuse support providers report a significant fluctuation in the number of contacts to the Safe to Talk helpline. The average number of weekly calls to the helpline was 35-40 pre-COVID-19 and has fluctuated between 6 contacts (in the week immediately following lockdown) and 77 contacts (week commencing 4 May 2020).

FIGURE 42 Domestic abuse incidents recorded by Coventry Police



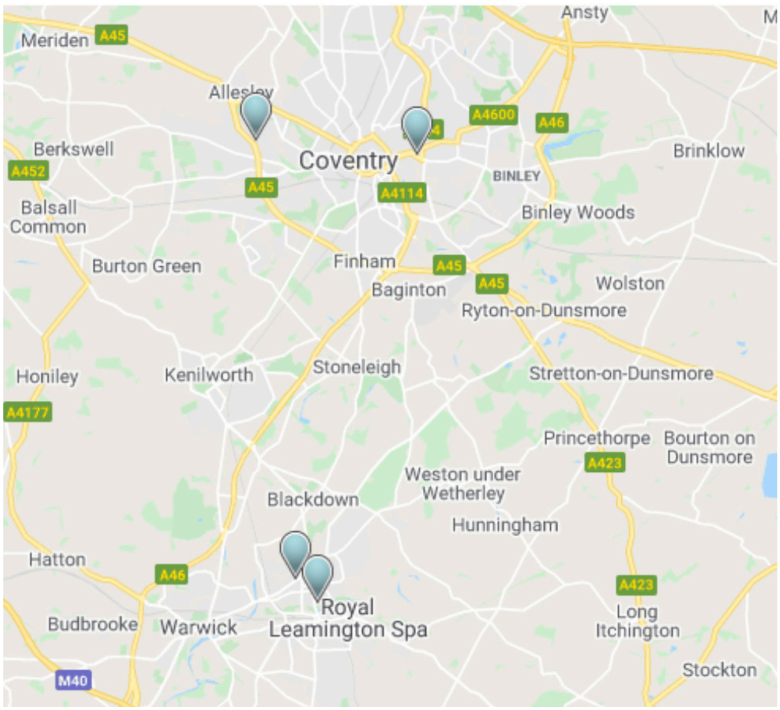
Source: Insight Team, Coventry City Council

FIGURE 43 Domestic abuse incidents recorded by Warwickshire Police



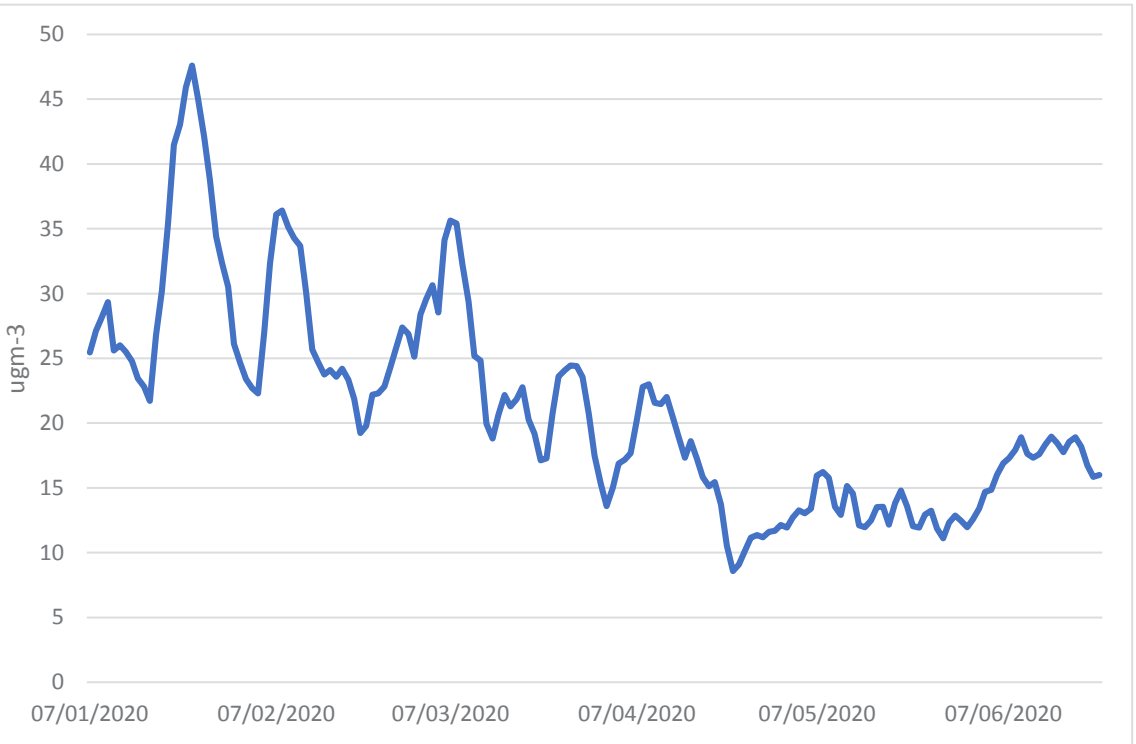
Source: Warwickshire Police Crime Information System

FIGURE 44 Location of Defra monitoring sites in Coventry and Warwickshire



Source: Defra

FIGURE 45 NO_2 recordings taken at the Binley Road Defra monitoring site between January and June 2020



Source: Defra

WARWICKSHIRE

Reported domestic abuse has increased during the 3 months of March, April and May 2020 (illustrated in Figure 43) to the highest levels seen since July 2018. It can be suggested that the increase in reports represents a willingness and ability of residents to report this type of behaviour despite the lockdown situation. In contrast though, it may also be the case that many more offences and incidents may currently be 'hidden' and only be noted and reported as residents are able to leave their homes and access support services in the coming months. It is likely that these raised levels will continue into July.

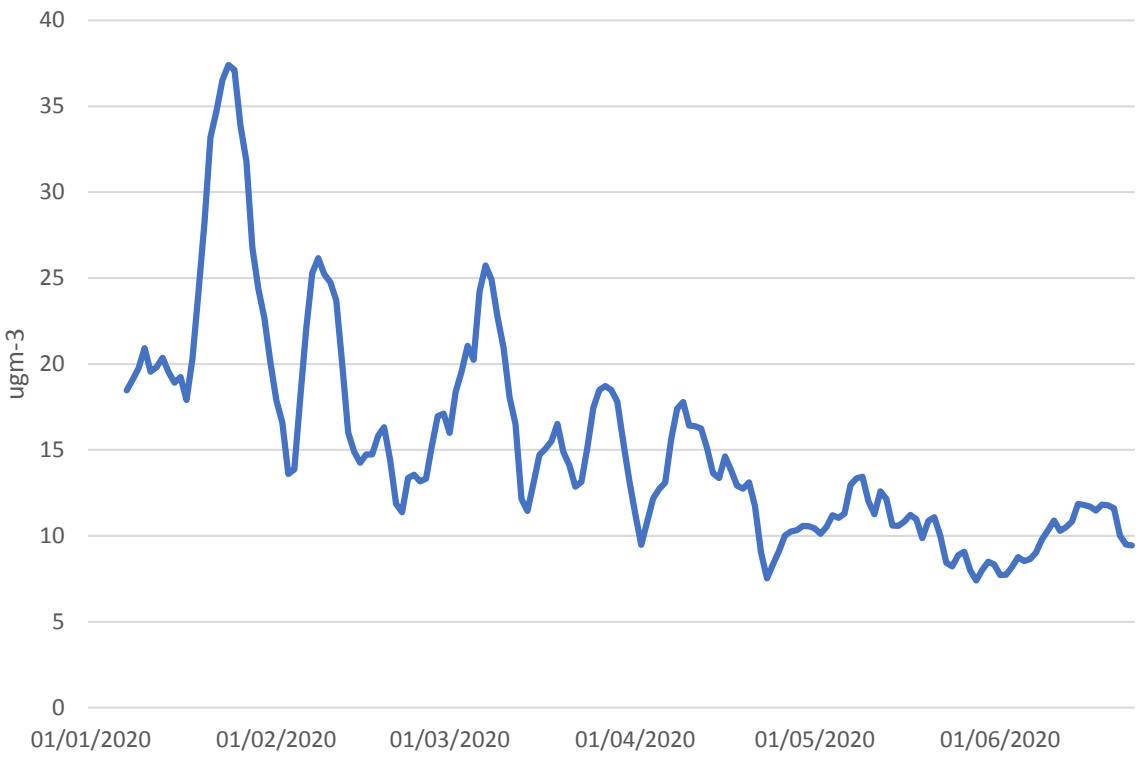
Referrals to Refuge in Warwickshire remained fairly constant throughout the lockdown.

Air Quality

The Air Quality Expert group, acting on a request from Defra, is calling for evidence from the research and air quality management user communities to address a set of urgent short-term questions related to recent and ongoing changes in UK air quality. This request for evidence is to provide focused and rapid scientific evidence that can support decision-making on air quality management in the coming weeks and months.

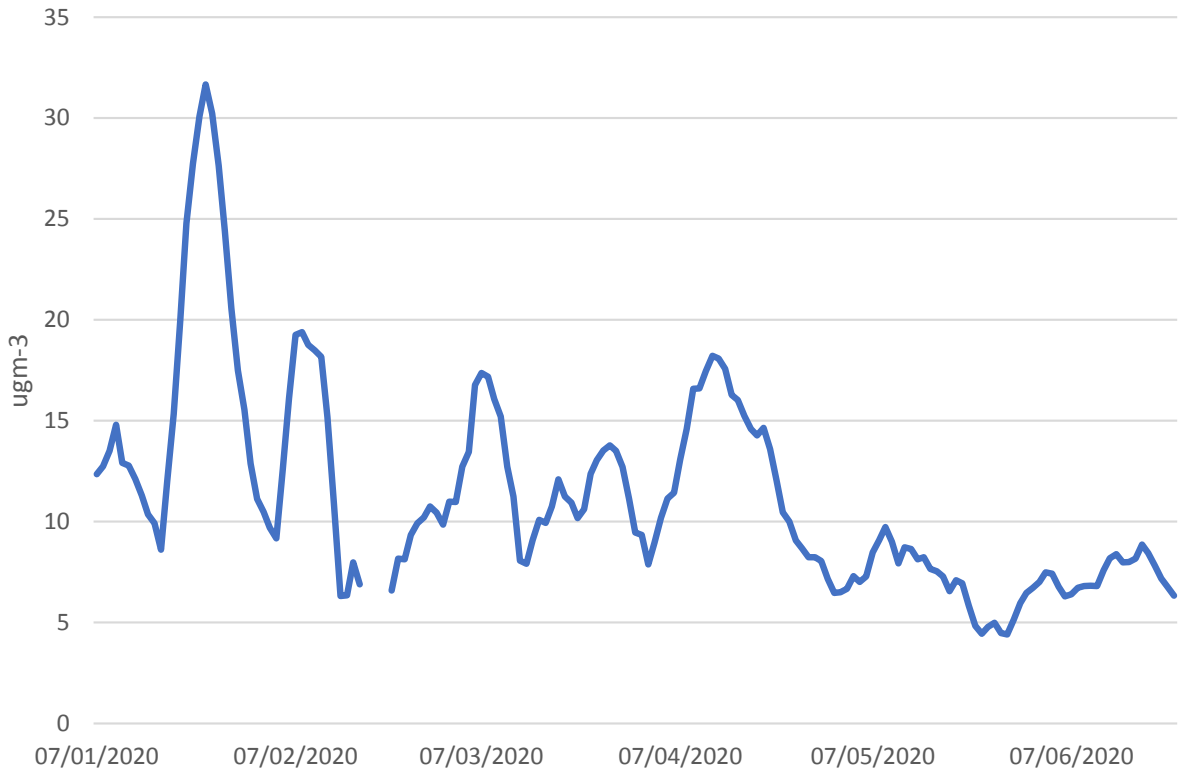
There are four Defra monitoring sites in Coventry and Warwickshire, two in each area as demonstrated in Figure 44. The four sites all monitor particulate matter PM10 (i.e. 10 micrometers or less in diameter) and nitrogen dioxide (NO_2) levels (microgram per cubic meter ugm-3).

FIGURE 46 NO_2 recordings taken at the Allesley Defra monitoring site between January and June



Source: Defra

FIGURE 47 NO_2 recordings taken at the Leamington Spa, Rugby Road Defra monitoring site between January and June



Source: Defra

COVENTRY

NO_2 levels at both Coventry Defra monitoring sites reduced significantly since lockdown measures were introduced in March, as demonstrated in Figures 45 and 46. The lowest recordings were towards the end of April and start of May. NO_2 levels have remained relatively low in June.

WARWICKSHIRE

NO_2 levels at both Leamington Defra monitoring sites reduced since lockdown measures were introduced in March, as demonstrated in Figures 47 and 48. Whilst there was some variation in March and April, May and June recordings have been particularly low at the Leamington Spa, Rugby Road site. The Leamington Spa site recorded a continued decline in NO_2 levels from early March with a small increase in June.

Rough Sleeping and Homelessness

In response to the Coronavirus pandemic, the Ministry for Housing, Community and Local Government (MHCLG) launched a scheme called "Everyone In" to provide emergency shelter for rough sleepers who had not been assessed formerly to be owed a statutory duty to accommodate.

Ring-fenced funding of £3.2m was allocated to local authorities to deliver the scheme (now ended), with the expectation by government (Ministry of Housing, Communities and Local Government MHCLG) that local authorities and the third party sector should try to continue to support recipients of the scheme, many having very complex health and care needs and not previously well engaged with statutory homeless services.

FIGURE 48 NO_2 recordings taken taken at the Leamington Spa Defra monitoring site between January and June

Source: Defra

TABLE 23 Numbers of people sleeping rough or at risk of sleeping rough who were provided with emergency accommodation during the COVID-19 outbreak

	Reported total number (1)	Households (1000's)	Per 1000 households	Snapshot as at 31st May 2020 (2)
England	14,610	/2,2595	0.64	
London	4,450	/3,545	1.25	
Rest Of England	10,160	/19,050	0.53	
Warwickshire	139	/242	0.31	139*
North Warwickshire	2	/27	0	2*
Nuneaton & Bedworth	42	/55	0.31	42*
Rugby	18	/45	0.42	18*
Stratford-on-Avon	50	/55	0.24	50*
Warwick	27	/60	0.43	27*
Coventry	142	/147	0.96	99

Source: MHCLG [xxxiii]
**Due to the data collection process moving to a monthly cycle these figures should be seen as an approximation and may change. Last updated 8/6/2020 - for May 2020 (London 15/05, ROE 7/05)*

TABLE 24 Numbers of people supported in accommodation under a statutory duty as at 31 December 2019					
	Households in temporary arranged by LA	With children	Per 1000 households	In temporary in another local authority	Duty owed but made own arrangements
England	88,330	62,580	3.78	24,430	6,350
London	58,680	43,920	16.55	21,440	1,860
Rest of England	29,650	18,660	1.49	2,990	4,490
West Midlands	4,900	3,720	2.03	3,510	2,720
Warwickshire	261	94	1.08	6	2
North Warwickshire	1	1	0.04	0	0
Nuneaton & Bedworth	69	29	1.25	6	0
Rugby	103	44	2.29	0	0
Stratford-on-Avon	71	18	1.30	0	0
Warwick	17	2	0.28	0	2
Coventry	672	367	4.57	0	8
Source: MHCLG					

On 14 May 2020 MHCLG announced £6m of emergency funding would be available to provide relief for frontline homelessness charitable organisations who are directly affected by the COVID-19 outbreak, whether that be to help alleviate the financial impact of COVID-19 on the organisation or to provide new or adapted services to homeless people affected by COVID-19.

A MHCLG survey estimates that over 14,500 rough sleepers have been supported with emergency accommodation nationally during the pandemic. Table 23 shows the total number of people sleeping rough or at risk of sleeping rough who have been provided with emergency accommodation in response to the COVID-19 pandemic (1), and Snapshot of number being supported as at 31st May 2020 (2)

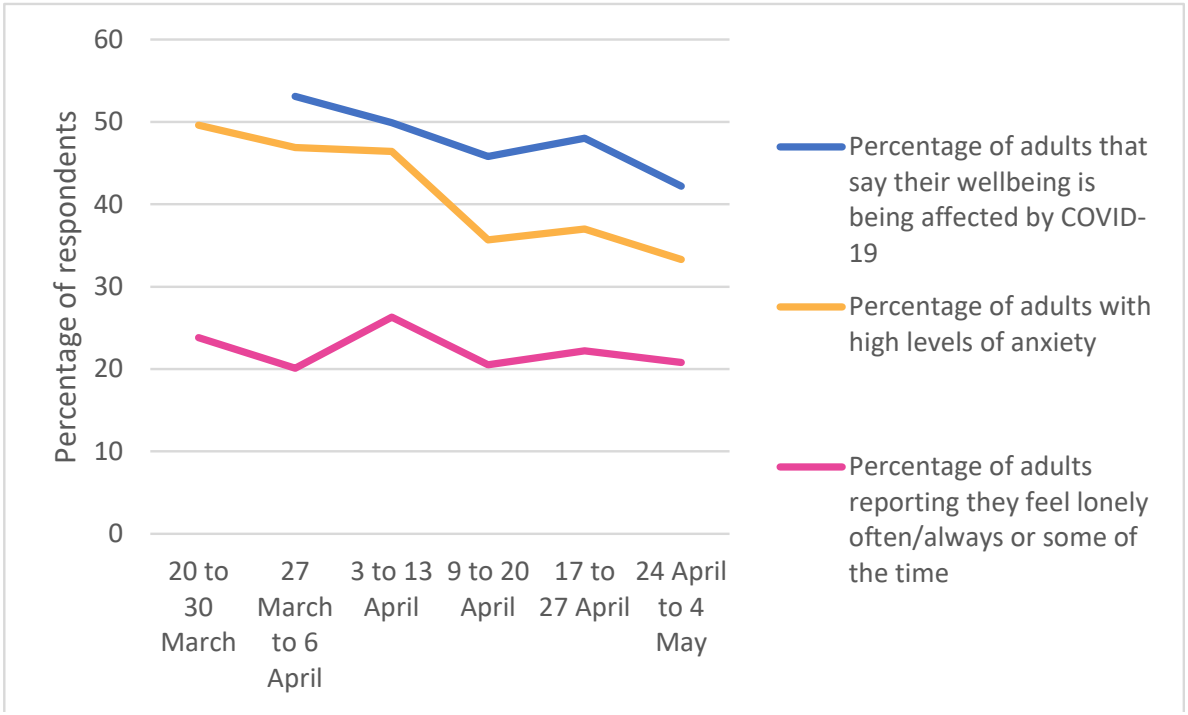
Whilst the long-term impact of the pandemic on levels of homelessness and the concomitant deterioration in health and well-being are acknowledged, they are poorly understood in terms of level of need and there is a very significant time lag of up to 9-12 months if relying on MHCLG quarterly data to measure this.

Further, the full impact of the pandemic on levels of homelessness (or risk of homelessness) will not be fully realised especially until the government suspension on Section 21 notices and evictions is lifted (currently until September 2020).

Whilst MHCLG quarterly published data is a good source for both establishing a baseline and for measuring the impact of the pandemic on levels of homelessness, it is recommended that in-house data be used to provide more timely information. For example, Coventry City Council are monitoring change in reasons why households are approaching housing and homeless services (e.g. threatened with eviction, fleeing domestic violence, relationship breakdown) and numbers being supported in temporary accommodation.

The most recent data available for numbers being supported in accommodation under a statutory duty from MHCLG is for 31 December 2019 (see Table 24).

FIGURE 49 ONS survey respondents' self-reported feelings of wellbeing, anxiety and loneliness between 20 March and 4 May 2020



Source: ONS

Mental Health – Anxiety and Loneliness

There are significant numbers of studies that suggest mental health will be a key issue that will have to be addressed after an epidemic. Survivors of previous coronavirus outbreaks (SARS & MERS) had considerable prevalence of psychological disorders such as post-traumatic stress disorder (PTSD) (38.80%, CI 30.93 to 47.31), depression (33.20%, CI 19.80 to 50.02) and anxiety (30.04%, CI 10.44 to 61.26) beyond 6 months[xxxiv]. However even those not directly affected by the virus are likely to experience mental health challenges. Studies also reported on general psychological symptoms emotional disturbance, depression, stress, low mood, irritability, insomnia, post-traumatic stress symptoms and anger amongst members of the public post quarantine.[xxxv]

What is the current data saying:

The Office for National Statistics (ONS) Opinions and Lifestyle Survey has an added COVID-19 module. This is not broken down into regions. However across Great Britain the percentage of adults with high levels of anxiety has reduced from 49.6% in the period 20th to 30th March to 33.3% in the period 24thApril to 4th May, as highlighted in Figure 49. The percentage of adults who say that their wellbeing is being affected by COVID-19 has also fallen from 53.1% in the period 27th March to 6th April to 42.2% in the period 24th April to 4th May.

Overall of those married or in a civil partnership, 39% reported feeling anxious, compared to 19% in the last quarter of 2019. In addition to this, those aged 75 and over were almost twice as likely as those aged 16 to 24 to report feeling anxious during lockdown. Before the pandemic, this age group was less likely to feel anxious.

The ONS also reported that older people (aged over 60) were worried about their access to groceries, medication and other essentials. Younger people (aged 16 to 29) were worried about the impact on their schooling and university courses, their work and their relationships. Coping strategies for older people included reading and gardening, and for younger people watching films, streaming services and socialising over the internet.

A further study found increased loneliness and anxiety during lockdown had particularly impacted people with disabilities. Almost three quarters (74%) of disabled people taking part in this study told us that they were feeling very or somewhat worried about the effect coronavirus was having on their lives and almost half (49%) said they had been lonely in the previous seven days.

The Understanding Society Study by Ipsos MORI and Kantar in April 2020 found that younger age groups reported the highest levels of loneliness (from the question "In the last four weeks, how often do you feel lonely?"), with 17% of 16 to 34 year olds saying they "often" feel lonely, compared to 4% of those aged 70 and over.

Health Watch Surveys

HEALTHWATCH WARWICKSHIRE AND HEALTHWATCH COVENTRY

During June there were 879 responses to a survey about people's experiences of health and social care during the pandemic. 388 (44%) people reported that they had used a healthcare service and experienced changes to services (changes included adjustments, postponements and cancellations).

72% of respondents reported that the COVID-19 pandemic had a negative effect on their wellbeing (either some impact or a great impact).

The majority of the responses related to health rather than social care services. This survey is ongoing and more detailed results will be available at a later date[xxxvi].

Recommendations

This report has been a comprehensive assessment of the immediate impacts of responding to the COVID-19 pandemic. There are two high level conclusions which will be critical as we look at recovery planning.

1) An integrated recovery: This analysis shows that health has been deeply impacted on by changes across all four quadrants of the model. The implication is that recovery cannot just be contained to one sector and has to be connected across all four to have the biggest chance of success. An integrated recovery is one where we look across traditional boundaries to understand where services have the potential to impact across all four quadrants of the Kings Fund model.

2) The double impact: This report references that the harm from COVID-19 has been unequally distributed across the population and is likely to continue to be so whilst still circulating. This analysis shows that the wider impacts from the pandemic and lockdown will fall more heavily on those communities directly affected by the disease itself. This analysis shows the potential harm for more deprived areas of Coventry and Warwickshire and as more evidence develops it will be important to understand the impact on BAME groups, and the most vulnerable individuals.

In addition there are a series of recommendations based on the analysis in each of the four quadrants of the Kings Fund model

- Approaches to economic recovery can consider how 'Inclusive Growth' concepts that track the pattern as well as pace of growth can mitigate against a double impact in more deprived communities.
- The evidence presented here on areas and sectors most at risk can be used to better target and design interventions to support economic recovery
- The health sector can play a role in identifying individuals who have become unemployed and explore preventative actions to mitigate any impact on health behaviours and wellbeing.
- Local evidence needs to be collected on health behaviours through both planned and bespoke questionnaires and other engagement to understand the impact on health behaviours.
- There is an opportunity to encourage those who have adopted more healthy behaviours to maintain them. This needs to specifically consider the need to reduce health inequalities and how to address the barriers that prevented people in more deprived areas or lower paid professions from becoming more physically active.
- Health and social care organisations need to consider how to support front line staff to prevent increases in alcohol use seen following other pandemics.
- More detailed analysis with clinical input needs to be carried out to understand the patient groups and conditions that have contributed to the decrease in hospital use, and their relative acuity. This will help to identify actions that mitigate the impact.
- The figures presented in this report on patients awaiting treatment, or who have missed screening and immunisation appointments should be used in recovery planning. An integrated approach to recovery is needed across NHS organisations to prevent attempts to reduce the backlog from overwhelming parts of the system.
- COVID-19 has had a broad impact on mental wellbeing and social isolation that needs to be addressed by all sectors as part of the recovery.
- Although there are plans to reduce the services available from shielding hubs, there are still health needs and anxieties in that group. The recovery phase must think about the ongoing support available to these groups.

- Improvements in air quality have shown the potential to protect the public from this harm and opportunities to maintain some of the behaviours that have led to the reduction need to be considered, alongside additional work to support a shift onto more active forms of travel.
- As well as the work to support rough sleepers housed during COVID-19 into more permanent accommodation, the role of services in supporting those individuals needs to be reviewed to ensure that appropriate services are in place.

This report describes the immediate impact of COVID-19 and a further review of evidence will need to be considered in order to understand the longer-term implications, especially on the groups at risk of a 'double impact'. In preparing for this Warwickshire County Council will carry out horizon scanning activities to identify new research and evidence which informs the later analysis.

Appendices

Appendix 1 – Claimant Count data including CCG data

Area	Percentage increase April 2019 to April 2020	Percentage increase May 2019 to May 2020
North Warwickshire	171.0%	222.6%
Nuneaton and Bedworth	88.0%	118.5%
Rugby	85.7%	119.4%
Stratford-on-Avon	138.5%	198.6%
Warwick	138.2%	138.5%
Warwickshire	111.4%	125.1%
Coventry	95.4%	142.8%
Warwickshire North CCG	105.5%	140.6%
Coventry and Rugby CCG	93.6%	138.5%
South Warwickshire CCG	138.3%	230.0%
Coventry and Warwickshire	103.7%	153.4%
England	**93.2%**	**114.1%**

Source: NOMIS https://www.nomisweb.co.uk/

Appendix 2 – Locations and details of Defra monitoring sites in Coventry and Warwickshire

Monitoring site	Location (Latitude/Longitude)	Type	Networks
Coventry Binley Road UK-AIR ID: UKA00634	52.407708,-1.490082	Traffic Urban	Automatic Urban and Rural Network UK Urban NO2 Network
Coventry Allesley UK-AIR ID: UKA00592	52.411563,-1.560228	Background Urban	Automatic Urban and Rural Network
Leamington Spa Rugby Road UK-AIR ID: UKA00564	52.294884,-1.542911	Traffic Urban	Automatic Urban and Rural Network UK Urban NO2 Network
Leamington Spa UK-AIR ID: UKA00265	52.288810,-1.533119	Traffic Urban	Automatic Urban and Rural Network Non-Automatic Hydrocarbon Network

Source: Defra, https://uk-air.defra.gov.uk/networks/find-sites

References

i **https://www.happyhealthylives.uk/** Accessed June 2020

ii **https://www.kingsfund.org.uk/publications/vision-population-health** Accessed June 2020

iii **https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on** Accessed June 2020

iv **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889195/disparities_review.pdf** Accessed June 2020

v **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf** Accessed June 2020

vi Marmot, M., & Bell, R. (2012). Fair society, healthy lives. Public health, 126 Suppl 1, S4–S10. https://doi.org/10.1016/j.puhe.2012.05.014http://www.wales.nhs.uk/sitesplus/documents/888/Watermarked%20PHW%20Mass%20Unemployment%20Report%20E%2815%29.pdf Accessed in June 2020

viii Bambra C, Gibson M, Sowden A, Wright K, Whitehead M, Petticrew M. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. J Epidemiol Community Health. 2010;64(4):284-291. doi:10.1136/jech.2008.082743

ix **https://www.cwgrowthhub.co.uk/news/economic-outlook-coventry-warwickshire-improves** Accessed June 2020

x Açikgöz Ö, Günay A. The early impact of the Covid-19 pandemic on the global and Turkish economy. Turk J Med Sci. 2020;50(SI-1):520-526. Published 2020 Apr 21. doi:10.3906/sag-2004-6

xi Wu P, Liu X, Fang Y, et al. Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak. Alcohol Alcohol. 2008;43(6):706-712. doi:10.1093/alcalc/agn073

xii L.M. Rodriguez, D.M. Litt, S.H. Stewart, Drinking to Cope with the Pandemic: The Unique Associations of COVID-19-Related Perceived Threat and Psychological Distress to Drinking Behaviors in American Men and Women, Addictive Behaviors Addictive Behaviors (2020)

xiii **https://www.england.nhs.uk/ltphimenu/prevention/alcohol-care-teams/**. Accessed in June 2020

xiv **https://www.understandingsociety.ac.uk/2020/06/08/the-health-impact-of-the-pandemic-nhs-hospital-treatments-for-long-term-health-conditions-fall-by** Accessed in June 2020

xv **https://www.ons.gov.uk/businessindustryandtrade/retailindustry/bulletins/retailsales/march2020** Accessed June 2020

xvi Wardle H, Keily R, Astbury G, Reith G, 'Risky places?': Mapping gambling machine density and socioeconomic deprivation. Journal of Gambling Studies. 2014;30(1):201-212

xvii **https://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-participation-in-2019-behaviour-awareness-and-attitudes.pdf** Accessed June 2020

xviii **https://www.gamblingcommission.gov.uk/news-action-and-statistics/Statistics-and-research/Covid-19-research/Covid-19-and-its-impact-on-gambling-%E2%80%93-what-we-know-so-far.aspx** Accessed June 2020

xix **https://www.sportengland.org/know-your-audience/demographic-knowledge/coronavirus#research** Accessed June 2020

xx **https://comresglobal.com/polls/sport-england-survey-into-adult-physical-activity-attitudes-and-behaviour-4/** Accessed June 2020

[xxi] **https://leisure-net.org/research-nearly-90-per-cent-of-brits-will-spend-the-same-or-more-on-being-active-after-lockdown-motivation-from-instructors-a-major-factor/** Accessed June 2020

[xxii] Uphoff EP, Small N, Pickett KE. Using Birth Cohort Data to Assess the Impact of the UK 2008-2010 Economic Recession on Smoking During Pregnancy. Nicotine Tob Res. 2019;21(8):1021-1026. doi:10.1093/ntr/nty083

[xxiii] **https://www.barnardos.org.uk/news/barnardos-declares-state-emergency-number-children-needing-foster-care-during-coronavirus** Accessed June 2020

[xxiv] **https://www.iser.essex.ac.uk/2020/06/04/60-of-cancer-patients-miss-treatment-during-first-month-of-the-pandemic** Accessed June 2020

[xxv] **https://www.cancerresearchuk.org/?_ga=2.191091055.439101329.1593189216-145690466.1593189216** Accessed June 2020

[xxvi] **https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.19.2000848** Accessed June 2020

[xxvii] Cuffaro, L., Di Lorenzo, F., Bonavita, S. et al. Dementia care and COVID-19 pandemic: a necessary digital revolution. Neurol Sci (2020). https://doi.org/10.1007/s10072-020-04512-4

[xxviii] **https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses** Accessed June 2020

[xix] **https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandthesocialimpactsongreatbritain/26june2020** Accessed June 2020

[xxx] **https://www.nhs.uk/conditions/nhs-health-check/what-is-an-nhs-health-check-new/** Accessed June 2020

[xxxi] **https://digital.nhs.uk/dashboards/shielded-patient-list-open-data-set** Accessed June 2020

[xxxii] **https://www.foodaidnetwork.org.uk/ifan-data-since-covid-19** Accessed June 2020

[xxxiii] **https://www.gov.uk/government/publications/coronavirus-covid-19-rough-sleeper-accommodation-survey-data-may-2020** Accessed June 2020

[xxiv] Ahmed,H; Patel, K; Darren, G; et al. Long-term clinical outcomes in survivors of coronavirus outbreaks after hospitalisation or icu admission: a systematic review and meta-analysis of follow-up studies (April 2020) doi: https://doi.org/10.1101/2020.04.16.20067975

[xxxv] Samantha K Brooks, S; Webster, R; Smith, L et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. (Feb 2020) DOI:https://doi.org/10.1016/S0140-6736(20)30460-8

[xxxvi] **https://www.healthwatchwarwickshire.co.uk/healthwatch-survey-patient-experiences-during-covid-19/** Accessed June 2020

This page is intentionally left blank

Agenda Item 7

Health and Wellbeing Board

Black and Minority Ethnic Communities and Covid-19

15 September 2020

Recommendation(s)

1. To note the main findings from the Public Health England (PHE) Review of the Impact of COVID19 on Black, Asian and Minority Ethnic (BAME) communities

2. To consider the recommendations included in the report, as outlined in the Appendix, and support their adoption for Warwickshire, where the Director of Public Health considers relevant.

3. To champion improvements in access, experiences and outcomes of NHS, local government and Health and Care Partnership commissioned services by BAME communities

4. To endorse, using place-based JSNA approaches, a review into the relationship between ethnicity and COVID-19 in North Warwickshire and Nuneaton and Bedworth.

1. Executive Summary

1.1 Evidence from the early stages of the COVID-19 pandemic suggested that a significant proportion of critically ill patients with COVID-19 were from Black, Asian and Minority Ethnic (BAME) communities. In addition, the first ten healthcare workers in the UK who died as a result of COVID-19 were all from BAME backgrounds. Rapid reviews of evidence have subsequently shown that in the UK, the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

1.2 Even after accounting for the effect of age, gender, deprivation and region, people from BAME backgrounds were significantly more likely to die from COVID-19 compared to White British counterparts.

1.3 Several explanations have been posited for this association. This includes the finding that risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups.

1.4 The unequal impact of COVID-19 on BAME communities may also be explained by a number of additional factors, ranging from social and economic

inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, cardiovascular disease and asthma.

1.5 Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure. They are more likely to use public transportation to travel to their essential work. Historic racism and poorer experiences of healthcare or at work 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.

1.6 Public Health England (PHE) subsequently completed and published a rapid review of the evidence. The review includes seven recommendations that are based on stakeholder requests for action across four domains – the need for research and data to deepen our understanding of the wider socio-economic determinants and improve data recording of ethnicity, policy change, communications with community leaders and the use of anchor institutions to scale up prevention services in a targeted way. (Appendix 1).

1.7 There is evidence that WCC recognises the importance of diversity in its workforce. A 2019 diversity and inclusion report shows that the ethnic profile of WCC staff is more diverse than the county profile. In response to the emerging evidence on COVID-19 and its relationship with ethnicity, there is ongoing work within WCC to include BAME status in organisational risk assessments.

1.8 Managers and employees will now be required to undertake individual risk assessments if one or more check list criteria is met. This includes a number of equality considerations, one of them being BAME, alongside other considerations (their role, health, household, journey etc.) and will ensure that, in addition to the general risk of infection when returning to the workplace, any potential specific risks to individual employees and their mental wellbeing has been considered and assessed.

2. Financial Implications

2.1 It is currently anticipated that any costs incurred as a result of the recommended actions will be managed within operational budgets.

3. Environmental Implications

3.1 None

4. Supporting Information

4.1 Without explicit consideration of the impact of ethnicity and structural disadvantage in our responses to COVID 19, there remains a risk that health inequalities will continue to worsen. Seven recommendations have been put forward by Public Health England and whilst there's a recognition that addressing the underlying determinants of the poor health outcomes in relation to COVID-19 is beyond the scope of one organisation to influence, The Health & Wellbeing Board needs to consider which of these are relevant, doable and achievable with employees from BAME backgrounds across Warwickshire.

4.2 There is also a need to explore the possible relationship between ethnicity and COVID-19 outcomes in North of the County (North Warwickshire and Nuneaton and Bedworth) where we have consistently observed a higher number of cases and deaths to date.

5. Timescales associated with the decision and next steps

5.1 N/A

Appendices

1. Appendix 1 - Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities - 10 Recommendations

Background Papers

1. Background paper 1 – Beyond the data: Understanding the impact of COVID-19 on BAME groups. A Public Health England Report. June 2020.

	Name	**Contact Information**
Report Author	Dr Shade Agboola	Shadeagboola@warwickshire.gov.uk Tel: 01926 731450
Assistant Director	Dr Shade Agboola	Shadeagboola@warwickshire.gov.uk Tel: 01926 731450
Lead Director	Nigel Minns	Nigelminns@warwickshire.gov.uk Tel: 01926 412 665
Lead Member	Cllr Les Caborn	Lescaborn@warwickshire.gov.uk Tel: 01926 412264

The report was circulated to the following members prior to publication:

Local Member(s): Councillor Les Caborn

Appendix 1 – Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities - 10 Recommendations

Throughout the stakeholder engagement exercise, it was both clearly and consistently expressed that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to COVID-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention. No work was done to review the evidence base behind stakeholders' comments.

The following recommendations arise from a range of requests for action from stakeholders and point to the areas where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities. This is crucially important as we emerge from the first phase of the COVID-19 pandemic and look toward rebuilding communities, restarting services and local economies, and creating resilient, engaged and cohesive communities capable of withstanding and thriving despite the upcoming challenges.

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, 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.

3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19. Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities.

5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild

trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

COVID-19: understanding the impact on BAME communities

This page is intentionally left blank

Public Health England

Protecting and improving the nation's health

Beyond the data: Understanding the impact of COVID-19 on BAME groups

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk

Facebook: www.facebook.com/PublicHealthEngland

Published June 2020
PHE publications
gateway number: GW-1307

PHE supports the UN
Sustainable Development Goals

Contents

Executive summary

There is clear evidence that COVID-19 does not affect all population groups equally. Many analyses have shown that older age, ethnicity, male sex and geographical area, for example, are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death. This work has been commissioned by the Chief Medical Officer for England to understand the extent that ethnicity impacts upon risk and outcomes.

The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. Genetics were not included in the scope of the review.

This review found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to 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.

Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all-cause mortality rates are lower in Asian and Black ethnic groups.

Comparing to previous years, all-cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

These analyses did not account for 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. Other evidence has shown that when comorbidities are included, the difference in risk of death between ethnic groups among hospitalised patients is greatly reduced.

This report builds upon the PHE epidemiological review by summarising a rapid literature review and external stakeholder engagement.

Review of the wider literature

A rapid review of the published literature was undertaken to identify if inequalities exist in how BAME groups are affected by COVID-19 infection when compared to the White British population.

The review also sought to understand the social and structural determinants of health that may impact disparities in COVID-19 incidence, treatment, morbidity, and mortality in BAME groups.

There is some evidence which supports the hypothesis that BAME groups are more likely to test positive for COVID-19 than those identifying as White British but more needs to be done for other minority ethnic groups, there is insufficient evidence to draw conclusions.

The evidence describing risk of severe COVID-19 is mixed. More, high quality research is needed before any conclusions can be reached. The emerging evidence suggests excess mortality due to COVID-19 in BAME populations. Individuals of Black African or Black Caribbean and Asian ethnic groups may have the highest increased risk.

The literature review and stakeholder feedback indicate that risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups. The most recent research from the UK suggests that both 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. They are more likely to use public transportation to travel to their essential work. Historic racism and poorer experiences of healthcare or at work 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.

Stakeholder engagement

We also carried out engagement with a broad range of stakeholders. In total 17 sessions were hosted involving over 4,000 people with a broad range of interests in BAME issues. These sessions provided further insights into the factors that may be influencing the relationship and impact of COVID-19 on BAME communities and strategies for addressing inequalities. PHEs role was to capture the feedback received and were not responsible for confirming the evidence base behind the points raised.

Stakeholders expressed deep dismay, anger, loss and fear in their communities about the emerging data and realities of BAME groups being harder hit by the COVID-19

pandemic than others, exacerbating existing inequalities. Many had lost colleagues or family members to the disease, and nearly all are experiencing the impact of the disease on their communities with the significant social, physical and mental health impacts and complications.

Stakeholders acknowledged that while actions are already being undertaken, the results of the PHE review and other studies should be used to strengthen and accelerate efforts moving forward. Clear, visible and tangible actions, provided at scale were called for now with a commitment to address the underlying factors. A summary of available resources available to support local action is provided in this report.

The main themes emerging from the stakeholder sessions were as follows.

Longstanding inequalities exacerbated by COVID-19

It is clear from discussions with stakeholders that COVID-19 in their view did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK. A wide variety of explanations for these have been examined, ranging from upstream social and economic factors to downstream biological factors (this review did not look at genetic factors). BAME groups tend to have poorer socioeconomic circumstances which lead to poorer health outcomes. Data from the ONS and the PHE analysis confirmed the strong association between economic disadvantage and COVID-19 diagnoses, incidence and severe disease. Economic disadvantage is also strongly associated with the prevalence of smoking, obesity, diabetes, hypertension and their cardio-metabolic complications, which all increase the risk of disease severity.

Stakeholders felt that the disproportionate impact of COVID-19 on BAME groups presented an opportunity to create fast but sustainable change and mitigate further impact. Change needs to be large scale and transformative. Action is needed to change the structural and societal environments such as the homes, neighbourhoods, work places - not solely focusing on individuals. There is a legal duty and moral responsibility to reduce inequalities.

Increased risk of exposure to and acquisition of COVID-19

The results of the PHE data review suggest that people of Black, Asian and other minority ethnic groups may be more exposed to COVID-19, and therefore are more likely to be diagnosed. This could be the result of factors associated with ethnicity such as occupation, population density, use of public transport, household composition and housing conditions, which the currently available data did not allow us to explore in this analysis.

Stakeholders highlighted the high proportion of BAME groups that were key workers and in occupations that placed them at risk by increasing the likelihood of social contact and increasing the risk of being exposed to those infected with COVID-19. Key actions recommended by stakeholders included the importance of valuing and respecting the work of key workers; provision of adequate protective equipment; stronger arrangements for workplace wellbeing and risk assessments; targeted education, awareness and support for key workers; occupational risk assessments; and tackling workplace bullying, racism and discrimination to create environments that allow workers to express and address concerns about risk.

Increased risk of complications and death from COVID-19

Once infected, many of the pre-existing health conditions that increase the risk of having severe infection (such as having underlying conditions like diabetes and obesity) are more common in BAME groups and many of these conditions are socio-economically patterned. For many BAME groups, especially in poor areas, there is a higher incidence of chronic diseases and multiple long-term conditions (MLTCs), with these conditions occurring at younger ages.

Stakeholders called for further efforts to strengthen health promotion programmes and improve early diagnosis and clinical management of chronic diseases as a strategy to improve overall health, increase resilience and reduce the risk of adverse COVID-19 associated health outcomes. The role of severe mental illness as a risk factor for COVID-19 disease severity and death was mentioned repeatedly and identified as an area that was at risk of being overlooked in the current response. Key strategies recommended by stakeholders included strengthening targeted programmes for chronic disease prevention; culturally competent and targeted health promotion to prevent chronic diseases and MLTCs; targeting the health check programme to improve identification and management of MLTCs in BAME groups; targeted messaging on smoking, obesity and improving management of common conditions including hypertension and diabetes. Culturally competent strategies to support better symptom recognition (eg hypoxia), early diagnosis and earlier presentation to clinical services for COVID-19 was also seen as critical to reducing complications from COVID-19.

Racism, discrimination, stigma, fear and trust

Stakeholders pointed to racism and discrimination experienced by communities and more specifically by BAME key workers as a root cause affecting health, and exposure risk and disease progression risk. Racial discrimination affects people’s life chances and the stress associated with being discriminated against based on race/ethnicity affects mental and physical health. Issues of stigma with COVID-19 were identified as negatively impacting health seeking behaviours. Fear of diagnosis and

death from COVID-19 was identified as negatively impacting how BAME groups took up opportunities to get tested and their likelihood of presenting early for treatment and care. For many BAME groups lack of trust of NHS services and health care treatment resulted in their reluctance to seek care on a timely basis, and late presentation with disease.

Despite these challenges, stakeholders reinforced the importance and need for communities to work with government and anchor institutions to create solutions. Faith communities played a vital role in engaging with communities and were a trusted source of information, leadership and engagement with many BAME groups and needed to be better engaged in future efforts to build community resilience and prepare communities for the immediate and long-term challenges of COVID-19. National and local government officials (including public health teams) have a unique opportunity to provide advocacy for vulnerable groups. Work to tackle racism and discrimination within the health and care system must continue at pace with a clear commitment for increasing diverse leadership at all levels in health and care system, reflecting the communities being served.

Strategies to create healthy and supportive workplaces (within and outside the health service) that have zero tolerance for discrimination and empower BAME staff to raise concerns about occupational risk and safety are essential. So too is work with local communities to rebuild trust and reduce fear of using health services in the aftermath of COVID19. Stakeholders acknowledged that there are lots of examples of work already underway at local, regional and national levels, however COVID-19 presents an opportunity to step-up commitments and accelerate the pace of change. There is a wariness and concern that the opportunity for lasting change will be missed alongside a willingness share good practice and co-produce the change required.

Moving forward

Stakeholders made numerous recommendations for further research to understand the impact of COVID-19 on BAME groups, the extent to which this is due to increased rates of infection and why, after being infected, such patients appear to have poorer outcomes. Given the limitations of the PHE review, work was especially called for on the socio-economic, occupational, cultural and structural factors (racism, discrimination, stigma) influencing COVID-19 outcomes in BAME groups within and outside the health sector. There was a consistent ask for all research on this issue to be done in partnership with communities, ideally embedding community participatory research principles and integrating mental and physical health. Further consideration needs to be given to factors such as diet, vitamin D and housing. Guidance currently recommends that individuals with limited sunlight exposure take a daily supplement of vitamin D. Learning from the experiences in other countries was thought to be essential in helping to understand why BAME groups in England were disproportionately affected. There is also a need for further research on the economic

impacts of COVID-19 on BAME groups, which will likely be very long term and severe, with lasting health and wellbeing impacts. There was a clear ask for improved data collection on ethnicity, occupation and faith in all routine clinical data and death certification.

The report sets out a number of stakeholder requests for action across the following domains.

Research and data: to deepen our understanding of the wider socio-economic determinants, improve data recording of faith and ethnicity and greater use of community participatory research.

Policy: ensuring long term sustainable change, establish cross government infrastructure to drive change, address occupational risk and act to mitigate the impact of race crime.

Communications: work with community leaders to enhance the depth of reach into BAME communities ensuring guidance and media is culturally appropriate and available in different languages use different approaches to mitigate fears and encourage improved uptake of vital prevention services.

Anchor institutions: scale up prevention services in a targeted and timely way, develop strategies to rebuild trust with health and care services, co-produce solutions with BAME groups and faith leaders, provide safeguards to mitigate risks for all front-line workers.

In conclusion, this report provides additional information and insights on the relationship between COVID-19 and BAME communities in England from a rapid review of the published literature and stakeholder engagement exercise. Although our understanding is evolving rapidly, it is difficult at this stage to provide a full explanation of the observed differences. Ethnic inequalities in health and wellbeing in the UK existed before COVID-19 and the pandemic has made these disparities more apparent and undoubtedly exacerbated them.

The unequal impact of COVID-19 on BAME communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, CVD and asthma. Unpacking the relative contributions made by different factors is challenging as they do not all act independently. The engagement sessions highlighted the BAME groups deep concern and anxiety that if lessons are not learnt from this initial phase of the epidemic, future waves of the disease could again have severe and disproportionate impacts. All were united in the commitment that urgent, collaborative and decisive action is required to avoid a repeat of this in the future.

Recommendations

Throughout the stakeholder engagement exercise, it was both clearly and consistently expressed that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to COVID-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention. No work was done to review the evidence base behind stakeholders comments.

The following recommendations arise from a range of requests for action from stakeholders and point to the areas where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities. This is crucially important as we emerge from the first phase of the COVID-19 pandemic and look toward rebuilding communities, restarting services and local economies, and creating resilient, engaged and cohesive communities capable of withstanding and thriving despite the upcoming challenges.

1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process, 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.

3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure that **COVID-19 recovery strategies** actively **reduce inequalities caused by the wider determinants of health** to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Acknowledgements

Professor Kevin Fenton

Emma Pawson

Leah de Souza-Thomas

Rooah Omer

Lina Toleikyte

Loretta Sollars

Angela Baker

Terry Blair-Stevens

Sally O’Brien

Hashum Mahmood

Cassandra Powers

Sheetal Burke

Elke Streit

Amy Halls

Sam Larkin

Bethany Walters

PHE KLS

Rachel X Clark

Ines Campos-Matos

We would like to thank all the stakeholders who contributed their time, knowledge and insights to the development of this report.

Impact of COVID-19 in BAME populations: a rapid literature review

Main messages

There is some evidence which supports the hypothesis that individuals identifying as Black African or Black Caribbean are more likely to test positive for COVID-19 than those identifying as white British. For other minority ethnic groups, there is insufficient evidence to draw conclusions.

The evidence describing risk of severe COVID-19 is very mixed. More, high quality research is needed before any conclusions can be reached.

The emerging evidence suggests excess mortality due to COVID-19 is higher in BAME populations. Individuals of Black African or Black Caribbean ethnicity may be of highest increased risk.

The risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups.

The most recent research from the UK suggests that both 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. They are more likely to use public transportation to travel to their essential work.

Historic negative experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff less likely to speak up when they have concerns about PPE or testing.

Background

Health disparities are differences in health across the population, some of which may be unfair and avoidable. There is emerging evidence from the United Kingdom and other countries that some population groups have an increased risk of adverse outcomes from COVID-19 including some ethnic groups, males, those with certain pre-existing conditions such as obesity, those in deprived communities, older people, some occupations, people living in care homes, and other vulnerable groups. This may exacerbate existing health inequalities in the population.

To support the review, PHE has undertaken a rapid literature review on disparities in the risk and outcomes of COVID-19 using available data sources.

Alongside this the National Institute for Health Research (NIHR) and UK Research and Innovation (UKRI) launched a rolling call for rapid research proposals that address emerging priorities and have potential to deliver public health impacts within 12 months.

There is emerging evidence of an association between those in an BAME group and increased risk of severe COVID-19 disease and mortality. Evidence is also emerging of an association between cardiovascular disease, diabetes, and severe obesity and increased risks of severe COVID-19 disease. These long term conditions are also found with increased prevalence among many UK BAME populations (2, 3). London and Birmingham, 'hot spots' for the COVID-19 epidemic in England, also have some of the highest BAME populations; London is home to 60% of black residents of England and Wales and 50% of the Bangladeshi population (4).

These underlying individual and population level associations confound the risk of COVID-19 disease severity and mortality. The existing literature was examined to determine if excess risk remained for individuals from BAME groups from COVID-19 after adjusting for social and structural determinants of health.

The purpose of this review was to identify if inequalities exist in how BAME populations are affected by COVID-19 infection when compared to the white British population. The review also seeks to understand the social and structural determinants of health that may impact disparities in COVID-19 incidence, treatment, morbidity, and mortality in BAME groups.

Methods (set out in detail in appendix 1)

The review questions were:

1. Are individuals in BAME groups more likely to be tested for and/or subsequently diagnosed with COVID-19 infection?

2. Are individuals in BAME groups more likely to develop severe clinical presentations of COVID-19 infection?

3. Is infection with COVID-19 more likely to lead to mortality within BAME groups?

4. What are the social and structural determinants of health that may impact disparities in COVID-19 incidence, treatment, morbidity, and mortality in BAME groups?

Notes

Ethnicity can be defined as shared culture and traditions that are distinctive, maintained between generations, and lead to a sense of identity and groupness. Minority ethnic groups are populations that differ in ethnicity from the dominant or majority ethnicity in a country. In the 2011 census, 7.9 million people identified themselves as being in a BAME groups equivalent to 14% of the UK population (1).

A scoping search was completed on 14/05/2020 to identify any existing reviews (systematic or rapid) related to the defined research questions. A number of COVID-19 review repositories and prospective review registers were searched and a summary paper was produced. Four completed, potentially relevant rapid reviews were identified, that broadly examined the impact of COVID-19 in BAME groups(4-7). One additional review was identified in the primary literature search described below (8).

Of the reviews identified, McQuillan et al (6) answered the key questions defined in the research protocol. An updated literature search, using the search terminology detailed in McQuillan et al, was undertaken specifically focused on papers published (or available as pre-print) between 25 April and 19 May 2020. See appendix 1 for details of the full methodology used. A full protocol is available on request. In summary, this was screening published evidence, extracting data, critically appraising studies and synthesising key points for inclusion. The narrative synthesis includes evidence from the primary literature as well as the four rapid reviews identified in the scoping search.

Evidence

The search returned 527 records; an additional 21 papers were sent to the team by public health colleagues, primarily potentially relevant papers awaiting publication. After removal of duplicates, 544 records were screened by title and abstract and 120 full texts. A PRISMA diagram is provided in appendix 2.

Thirty-one papers were identified for inclusion. Twenty studies looked at UK data with eight pulling from the large, Biobank Cohort study (9-16). While this cohort study has the benefit of including a large number of UK residents, over 500,000 participants, and has collected a significant amount of data about each individual to allow for adjustment of numerous confounders, the voluntary nature of enrolment in the cohort leads to a concern around selection bias and worries about the generalisability of the findings. Additionally, most of the information collected about socio-economic status and underlying health conditions were collected at the time of enrolment (between 2006-2010); these may have changed significantly in the following decade.

Four UK studies describe the COVID-19 epidemic at individual NHS trusts: two papers report findings from trusts in the West Midlands and two from trusts in London (17-20). These papers are valuable in describing the outbreaks in ‘hotspots’ affecting members

of the BAME community but may not be generalisable to other populations across England.

Eleven studies describe data from the United States (21-30). Due to the differing ethnic profile of the United States, the historical differences in the impacts of racism and slavery, and the radically different healthcare systems between the US and the UK, it is difficult to generalise the effects of social and structural impacts on health. The data, however, were included given the scarcity of data examining the impact of COVID-19 in BAME groups, nationally and internationally. Country of data origin will always be highlighted.

All the studies included in the review were observational and have a number of limitations such as lack of randomisation and heterogeneity of participants. Several included ecological studies which present additional limitations, including the inability to control for individual level confounding. In addition, all studies were conducted during a global pandemic, which could have resulted in possible incompleteness of data. Inconsistency of testing across settings and countries is another limitation.

Summary of rapid reviews

The rapid review of the literature conducted by McQuillan et al examined 54 papers and found the overall quality of the data to be very low (6). They found no data on testing rates in BAME populations. There was little data on severity of Covid-19 in black, Asian, and minority ethnic groups in the UK beyond demonstrating that BAME populations have higher rates of cardiovascular and diabetes, both of which lead to an increased risk of complications and mortality from Covid-19. Two very low-quality US studies found that BAME groups were more likely to make up the ICU population after the pandemic started (not all results were statistically significant) and that hospitalised patients were more likely to be from an BAME group than the underlying population would suggest. Evidence on mortality came from very low-quality papers. When looking at actual vs. expected hospital deaths, for all ethnic groups other than white British and white Irish, the number of deaths exceeded what would be expected for that age group. The mixed and Indian ethnic groups were more than twice as likely to die; Pakistani, Bangladeshi and black Caribbean nearly three times as likely to die, black African more than four times as likely and other ethnic group nearly eight times as likely to die from Covid-19 related complications. The review identified housing, occupational risk (health and social care and other “essential work”), and the low socioeconomic status as social and structural risks that could potentially impact BAME groups and lead to an increased risk of Covid-19 transmission, morbidity, and mortality.

Raznaq et al conducted a review for the Centre for Evidence based Medicine. The rapid review examined 46 papers and found that CVD had the highest prevalence among diseases that put patients at highest risk for complications with Covid-19. They also found that the most deprived were nearly twice as likely to be admitted to ICU than the

least deprived (this follows the pattern for other viral pneumonias) and proportionally more black patients required advanced respiratory support in ICU than during other viral pneumonias. The review also found higher excess deaths due to Covid-19 in BAME populations: 1.5 times higher in Indian populations, 2.8 times higher in Pakistani populations, 3 times higher in Bangladeshi populations, 4.3 times higher in black African populations, 2.5 times higher in black Caribbean populations, and 7.3 times higher in black other populations.

This review will build on the limited evidence from the McQuillen et al rapid synthesis.

Evidence on testing and test positivity for COVID-19 in BAME populations

Several studies reported that individuals in BAME groups, particularly those identifying as Black African and Black Caribbean, were more likely to test positive for COVID-19 (10, 12, 15, 27, 29, 31); however, only one study presented data on the proportion of participants, by ethnicity, that were tested for COVID-19 regardless of result (12). Both black and Asian participants of this Biobank study had a higher proportion of COVID-19 tests than expected when compared to white British participants (All tests: white 88.6%, Asian, 3.73%, black 4.8%; All participants: white 94.1%, Asian 2.4%, black 1.8%). Statistical significance was not reported.

Following the move into the second pandemic phase, ‘Delay,’ COVID-19 testing in England was prioritised for individuals admitted to hospital with respiratory symptoms, health and social care workers, and other key workers (32). The ethnicity of those tested has not been reported but the literature is clear that BAME groups are over-represented across a number of key-worker populations, which may have led to increased testing in these groups. The health and social care workforce is particularly well represented by BAME groups: Indians account for 14% of doctors and Black Africans make up 7% of the nursing workforce (4).

The likelihood of a positive test in certain BAME groups appears to be raised even after adjusting for confounding. These results, however, all come from studies with high risk of bias and should be interpreted with caution. Two Biobank studies report statistically significant increased relative risk of a positive COVID-19 test result for black participants when compared to white participants: aRR 2.66 (95% CI 2.03, 3.88) (15); aRR 2.07 (95% CI 1.16, 3.71) (10). Prats-Uribe et al also reported an increased relative risk of COVID-19 positivity for individuals in the ‘other ethnic groups’ category (aRR 1.67; 95% CI 1.04, 2.68) and those identifying as Asian (aRR 2.09; 95% CI 1.53, 2.84) (15).

The national Royal College General Practitioners surveillance programme found that those of a black ethnicity had 4.75 times the odds of a positive COVID-19 test than those of a white ethnicity (31). It should be noted, however, that the sample of BAME individuals in the RCGP database is small and ethnicity is missing for 27% of entries.

Internationally, two large cohort studies in the US and one US ecological study support the findings that individuals of a black ethnicity are at increased odds of a positive COVID-19 test (27-29).

Key findings

The current evidence around the likelihood of individuals in BAME populations being tested for COVID-19 at a higher or lower rate than those identifying as white British is very limited and conclusions cannot be drawn from the literature.

Low-level evidence from the studies included in the literature review supports the hypothesis that individuals identifying as Black African or Black Caribbean are more likely to test positive for COVID-19 than those identifying as white British. For other minority ethnic groups, there is insufficient evidence to draw conclusions.

Evidence on severe clinical presentations of COVID-19 in BAME populations

The picture is very mixed when examining the evidence around severe clinical presentations of COVID-19 across ethnic groups. In one UK Biobank study, researchers found that participants from black ethnic groups had three times the odds of hospitalisation and participants from Asian ethnic groups had twice the odds of hospitalisation when compared to participants from white ethnic groups (14) to note participants in the study were volunteers which may impact on results. In another UK Biobank study, however, the same groups were found to have similar odds of hospitalisation (12). One additional UK Biobank study, looked at risk of “severe COVID-19 ” and found that participants from black ethnic groups had over a three-fold increased risk and participants from Asian ethnic groups had a two-fold increased risk compared to participants from white ethnic groups ($p<0.001$) (11).

Studies focussing on NHS Foundation trusts had similarly mixed results: one Birmingham trust found those of South Asian descent more likely to have higher disease severity on admission to hospital and more likely to need ICU support ($p<0.001$) (19). Three other NHS Foundation trusts found no significant differences between any BAME groups when compared to the white British population on ICU admission (17, 18, 20). These studies had small sample sizes and high risk of bias but little additional UK data are available.

Other evidence reviews highlight the ICNARC ICU audit, which compared confirmed COVID-19 ICU patients with viral pneumonia patients from 2017-2019 (5, 7). The ICNARC ICU audit notes that 34% of critically ill COVID-19 patients were from an BAME groups background compared to 12% of admitted to ICU for viral pneumonia in previous years.

Co-morbid conditions

Certain co-morbidities have been linked in the literature to higher risks of severe clinical outcomes and/or mortality due to COVID-19. The key risk factors for poor outcomes is pre-existing cardiovascular disease (CVD); others include diabetes and hypertension (4, 8). A meta-analysis performed by Janowski et al found that multiple co-morbidities appear to confer cumulative risk (8). Rates of CVD and diabetes are particularly high in some BAME communities. Death rates from CVD are 50% higher than average among individuals of South Asian descent (2). Individuals of South Asian descent are four times more likely to have type 2 diabetes; individuals with a Black African or Black Caribbean ethnicity are three times more likely to develop type 2 diabetes than those of white British ethnicity (3, 33, 34).

Key finding

The evidence describing risk of severe COVID-19 among BAME populations is unclear; more, high quality research is needed before any conclusions can be reached.

Evidence on excess mortality due to COVID19 in BAME populations

The evidence emerging from the United Kingdom suggest excess mortality due to COVID-19 in BAME populations. Studies conducted at single hospital trusts found significantly greater odds of mortality for individuals of South Asian ethnicity (17, 19) sample size for these were over 2000. A national ICU retrospective audit found that BAME patients were more likely to die after being admitted to ICU with confirmed COVID-19 than those of white ethnicity (p=0.0001) (6).

Two groups used hospital mortality data to generate standardised mortality ratios (SMRs) by ethnicity (35, 36). Williamson et al used anonymised primary care data to further refine the SMR. They found that individuals recorded as black ethnicity or Asian ethnicity were at higher risk of COVID-19 related mortality, even after controlling for age, co-morbidity, and deprivation (black ethnicity: aHR 1.71, 95% CI 1.44, 2.02; Asian ethnicity aHR 1.62, 95% CI 1.43, 1.82; mixed ethnicity aHR 1.64, 95% CI 1.19, 2.26) (36).

The Institute for Fiscal Studies found in their analysis of the available hospital deaths data that there is a “higher per-capita mortality for all BAME groups than can be explained by age and geography alone” (4). Black Africans have 3.7 times the number of deaths than those of the white British ethnicity, Pakistanis have 2.9 times the deaths, and Black Caribbean’s have 1.8 times the deaths. White Irish have fewer deaths due to COVID-19 than the white British do.

The Office for National Statistics has examined data and reported that those of Black African or Black Caribbean ethnicity are 1.9 times more likely to die due to COVID-19; males of Bangladeshi and Pakistani ethnicity are 1.8 times more likely to die, and females of Bangladeshi and Pakistani ethnicity are 1.6 times more likely to die. All excess deaths are compared to those of a white British ethnicity (37). Those of a Chinese or mixed ethnicity have a similar risk of death to white British. Mortality data has primarily relied on hospital reported deaths; not including care home deaths could artificially inflate BAME deaths as more white British older adults reside in nursing and residential homes (4). The analysis presented by the ONS, however, includes deaths outside of hospital and adjusts for potential confounding through linkage to the 2011 census data.

Only one study reports mortality in healthcare workers in the UK by ethnicity (38). This study used data gathered from social media, news reports, and other publicly available “In memoriam” websites to gather outcome data, meaning it is high risk of bias. They found a higher proportion of BAME groups fatalities than expected considering the proportion of the NHS workforce that is from an BAME population. Of the deaths in healthcare workers reported, 63% were in BAME groups: 36% were of Asian ethnicity (compared to 10% of NHS workforce) and 27% were of black ethnicity (compared to 6% of the NHS workforce). Further analysis is urgently needed to understand the morbidity and mortality of health and social care workers due to COVID-19, with a particular focus on BAME groups.

The international literature is mixed. The data from the United States is primarily from ecological studies, which have a high risk of bias due to residual confounding. These studies show that the risk of death is higher for African-Americans (black ethnicity) when compared to the white population (5, 25, 26, 30). There is, however, substantial variation across and within states and some cohort studies found no significant difference between risk of mortality for those of a black ethnicity and those of a non-black ethnicity (24, 28).

Key finding

The available evidence suggests excess mortality due to COVID-19 in BAME populations in England. Individuals of Black African or Black Caribbean ethnicity may be of highest increased risk.

Evidence around the social and structural determinants of health in relation to COVID-19 and BAME groups

The social and structural determinants of health are defined as the wider influences to an individual’s health; these can be visualised as the outer layer of Dahlgren and

Whitehead's policy rainbow (39). The social and economic circumstances described can affect health throughout the life course and those that are most deprived have the highest risk of serious illness and premature death (39, 40). Disparities in health behaviours increase over time: those that are richer have even better health and those that are poorer lag further behind. It is important to find public health interventions that do not widen these health inequalities (41). More research is required to fully understand of the correlation between COVID-19 risks and outcomes, ethnicity and wider determinants of health.

There is substantial evidence on health inequalities that is relevant to COVID-19 Inequalities in health status and disease risk are associated with minority ethnic status; those in minority ethnic groups have poorer health outcomes compared to the majority of the population (42). Differences in cultural factors may play a role in disease risk, but it is more likely that the decreases in life expectancy and health outcomes are due to social, economic, and structural determinants of health (43).

Housing

The risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups.

While there is no direct evidence which directly correlates housing to COVID-19 outcomes there are studies which can be considered.

Overcrowding can lead to increased COVID-19 transmission as individuals within the household are unable to effectively self-isolate (20) This is a much larger problem in BAME households than in white British households, even after controlling for region (4). In London, 30% of Bangladeshi households, 16% of Black African households, and 18% of Pakistani households have more residents than rooms compared with only 2% of white British households (4). Soltan et al found that overcrowding was associated with increased rates of mortality in their hospital based cohort (20).

BAME households are more likely to be intergenerational: grandparents living alongside grandchildren. While this can have significant community and social benefits, there is a concern that socially active young people may be more likely to spread the virus associated with COVID-19 disease to the oldest population most at risk. Bangladeshi, Indian, and Chinese households are particularly likely to have people over the age of 65 living with children under the age of 16; 30% of BAME groups live with a child under the age of 16 compared with only 11% of the white British population (7).

Black, Asian, and other minority ethnic populations are also much less likely to be owner-occupiers of their current residence compared to the white British majority. This can lead to housing insecurity (7).

Financial vulnerabilities

Socioeconomic status has been linked to incidence and severity of viral pneumonia in recent years (5). This social gradient continues to be seen with COVID-19 disease: individuals in the most deprived quintiles are nearly twice as likely to be admitted to ICU as the least deprived. The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality (44).

The economic impact of the COVID-19 ‘shut-down’ may be felt differently across different ethnic groups in England. Platt et al found that Pakistani and Bangladeshi households were most likely to have men working in a ‘shut-down’ sector (restaurant work, taxi driving) as well as having a partner not currently in the labour market; this could lead to high levels of financial insecurity in this group (4). They also identified that the proportion of Black African and Black Caribbean households with dependent children and lone parents is high when compared to other groups; this may lead to difficulty arranging childcare in order to become economically active. Local and national policy initiatives will need to be sensitive to BAME communities to ensure existing health and economic inequalities are not widened due to the extraordinary measures taken during the pandemic.

Occupational risk

Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure, this includes the health and social care workforce, as well as cleaners, public transport workers, and retail workers (6). The health and care workforce in England are significantly over-represented by people from BAME groups: 40% of doctors, 20% of nurses, and 17% of social care workforce are from of BAME groups. In London, nearly 50% of the NHS and CCG staff come from a BAME group (44.9%) (5). Often, BAME workers are in lower paid roles within the NHS, which mean that these roles cannot be done remotely (5, 6); this leads to greater exposure with other members of the community.

It has also been noted by several research groups that individuals in BAME groups are more likely to use public transportation to travel to their essential work, leading to additional routes of exposure (5, 6, 22).

Experiences

Individuals that identify as being part of an BAME group may feel marginalised, have experienced racism, or have had previous experiences with a culturally insensitive health service that could create barriers to engagement. Research has shown that individuals from BAME backgrounds often have poorer access to healthcare services as

well as poor past experiences of care and treatment (45). This may mean they are less likely to seek care when needed or as NHS staff less likely to speak up when they have concerns about PPE or testing (5).

Key findings: drawn from direct and indirect evidence

The risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME community. Overcrowding can lead to increased COVID-19 transmission as individuals in the household are unable to effectively self-isolate. BAME households are more likely to be intergenerational, leading to risk of transmission between young children and older adults.

The most recent research from the UK suggests that both 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. They are more likely to use public transportation to travel to their essential work.

Historic racism and poorer experiences of healthcare or at work may mean that BAME individuals are less likely to seek care when needed or as NHS staff less likely to speak up when they have concerns about PPE or testing.

Limitations

The rapid review of primary studies is limited to evidence drawn from COVID-19. This evidence base has been generated during extremely difficult global pandemic circumstances that may have affected the completeness of the data sources. Furthermore, none of the data presented, including the previously conducted reviews, were of high quality. It is important to continue to monitor this rapidly expanding evidence base and update the literature review regularly.

Conclusions

The emerging evidence base suggests that individuals in black, Asian, and minority ethnic groups are at increased risk of mortality due to COVID-19. Those of Black African and Black Caribbean descent appear to be at greatest increased risk.

Health inequalities known to affect the BAME communities in England may be increasing the risk of transmission (overcrowded housing, reliance on transport, living in population centres) and the risk of mortality (high underlying risk of co-morbidities: CVD, diabetes, obesity). Furthermore, the measures to control the spread of the COVID-19

across the country may have led to further economic or housing instability. Local and national policy initiatives will need to be sensitive to BAME communities to ensure existing health and economic inequalities are not widened due to the extraordinary measures taken during the pandemic.

Looking beyond the data: stakeholder engagement

Main messages

In total, 17 sessions were hosted involving over 4,000 people with a broad range of interests in BAME group issues. These sessions provided further insights into the factors that may be influencing the relationship and impact of COVID-19 on BAME communities and strategies for addressing inequalities.

Stakeholders expressed deep dismay, anger, loss and fear in their communities about the emerging data and realities of BAME groups being harder hit by the COVID-19 pandemic than others, exacerbating existing inequalities.

In their view, COVID-19 did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting BAME communities in the UK.

Stakeholders acknowledged that while actions are already being undertaken, the results of the PHE review and other studies should be used to strengthen and accelerate efforts moving forward. Clear, visible and tangible actions, provided at scale were called for now with a commitment to address the underlying factors.

Stakeholders highlighted the high proportion of BAME communities that were key workers and in occupations that placed them at risk by increasing the likelihood of social contact and increasing the risk of being exposed to those infected with COVID-19.

Stakeholders called for further efforts to strengthen health promotion programmes and improve early diagnosis and clinical management of chronic diseases as a strategy to improve overall health, increase resilience and reduce the risk of adverse COVID-19 associated health outcomes.

Stakeholders pointed to racism and discrimination experienced by communities and more specifically by BAME key workers as a root cause affecting health, and exposure risk and disease progression risk.

Faith communities played a vital role in engaging with communities and were a trusted source of information, leadership and engagement and needed to be better engaged in future efforts to build community resilience and prepare communities for the immediate and long-term challenges of COVID-19.

Strategies to create healthy and supportive workplaces (within and outside the health service) that have zero tolerance for discrimination and empower BAME staff to raise concerns about occupational risk and safety are essential. So too is work with local communities to rebuild trust and reduce the fear of using health services in the aftermath of COVID19.

Introduction

The stakeholder engagement/ listening sessions had three objectives: (1) To provide clarity on the terms of reference for PHE's research review of COVID-19 and BAME communities; (2) To engage a broad cross-section of external partners on current concerns, activities, and priorities for work regarding the impact of COVID-19 on BAME communities' (3) To identify opportunities for individual and collective action, recognising that interventions to address these disparities must be multi-level, sustained, participatory and ideally place-based.

In this component of the work, data was gathered from a series of 17 stakeholder engagement events involving representatives from a wide and diverse range of constituencies. The events took place over a four week period (between 30 April 2020 and 27 May 2020) with participants from national, regional and local bodies including the Royal Colleges; the devolved nations; cross-government departments; local government leaders, chief executives of local government, directors of public health, faith groups, migrant health leaders, community and voluntary sector leaders and representatives, researchers and academics, pharmacist organisations, business leaders, political leaders and health and wellbeing board chairs. Many the events were co-chaired by senior leaders in the field. In total more than 4,000 individuals were involved in a stakeholder engagement events.

All engagement events took place online either by Skype, Zoom or Microsoft Teams. Key issues raised by participants were recorded and summarised for each session. PHE also received written feedback from other stakeholders, from which key themes were extracted and considered in the content of this report. Due to data protection we are not able to include a list of all the individuals who participated in the discussions. The stakeholder engagement events provided rich qualitative and contextual insight into a range of issues on COVID-19 and BAME groups. All acquired data were analysed using an iterative approach which incorporated deductive and inductive methods in identifying themes

Stakeholders expressed deep dismay, anger, loss and fear in their communities about the emerging data and realities of BAME communities being harder hit by the COVID-19 pandemic than others, exacerbating existing inequalities. Many had lost colleagues or family members to the disease, and nearly all are experiencing the impact of the

disease on their communities with the significant social, physical and mental health impacts and complications. The engagement sessions highlighted the deep concern and anxiety that if lessons are not learnt from this initial phase of the epidemic, future waves of the disease could again have severe and disproportionate impacts. All were united in the commitment that urgent clear action was taken to avoid a repeat of this in the future.

In general, the feedback from communities centred around four major areas: The impact of longstanding social and economic inequalities on BAME groups vulnerability to COVID-19; factors increasing the risk of exposure to and acquisition of COVID-19; factors increasing the risk of severe disease and death from COVID-19; the impact of racism, discrimination, stigma, fear and trust; and solutions for moving forward. These are described in more detail in the following section.

The information set out below represents feedback received from external stakeholders and are not the views of PHE.

Impact of longstanding social and economic inequalities

Stakeholders clearly articulated an understanding that COVID-19 did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK. A wide variety of explanations for these were discussed by participants, ranging from upstream social and economic factors to downstream biological factors (the PHE review did not look at genetic factors). BAME groups tend to have poorer socioeconomic circumstances which lead to poorer health outcomes. Participants highlighted data that they had seen from the ONS which confirmed the strong association between economic disadvantage and COVID-19 incidence and severe disease. Economic disadvantage is also strongly associated with risk factors for disease severity including smoking, obesity, asthma, diabetes, hypertension and cardio-metabolic complications.

Stakeholders felt that the severe and disproportionate impact of COVID-19 on BAME communities presented an opportunity to create fast but sustainable change and mitigate further impact. Change needs to be large scale and transformative. They noted that action is needed at multiple levels - everyone has an important role to play. They also felt that action is needed to change the structural and societal environments such as the homes, neighbourhoods, workplaces - not focusing on individuals. They also highlighted a legal duty and moral responsibility to reduce inequalities.

The need for taking a systems level approach

Stakeholders felt more could have been done to anticipate the unequal effect of COVID-19 on BAME communities and that many lessons from previous incidents were not drawn upon to prevent the excess mortality rates in BAME communities. Had this been done, this could have helped to prevent some of the disproportionate impact on BAME communities and loved ones.

There was recognition that socio-economic factors are often linked together and can combine to reinforce disadvantage in communities and across generations. This multiple disadvantage is often concentrated in specific geographical areas, particularly in inner city areas across the whole country. These in turn could increase risk of exposure to COVID-19 as well as risk of severe disease.

Participants felt that any conversation about a health issue must start from the wider societal challenges that we face; economic challenges, structural racism, quality of housing, among others. Many recognise that there are long-standing structural issues that need to be addressed at a systems level but hope that COVID-19 represents a tipping point for change.

> “We have deprivation that is not new. This is an ongoing issue within communities. From our organisational point of view, we are looking at what’s the action that the system has taken to address some of these challenges and which ones of them have been effective in trying to lift people out of these situations. Because I think there’s an opportunity to not get complacent and to think about how we can reshape a new normal. And I just wonder how we can capture some of that learning going forward.”

Further, there is also a wider anxiety that the organisations that support BAME groups and other communities may not exist due to the economic impact of the COVID-19.

> “The prediction is that 40% of SME community and voluntary sector will cease to exist in three months from now. Including those run by ethnic minorities supporting individuals with overlapping intersectionality eg BAME, woman, single parent, mental illness, not employed – these small organisations will cease to exist…my concern is that trust is diminished yet again for these communities but how do we sustain and strengthen a sector that doesn’t exist?”

Local government

Stakeholders recognised the critical role that local government played in ensuring services were available for the most vulnerable in society. However, there was deep concern for many that decades of cuts in local authority funding had diminished the ability of local authorities to truly address many of the wider social and structural issues

that may have placed BAME communities at risk. This includes the ability of a local authority to reduce poverty, social exclusion, and improving living and housing conditions for some of the most marginalised in our society including the homeless, migrants, gypsies and travellers. Similarly, stakeholders felt that the reductions in public health funding and capacity within local government reduced the ability to deliver targeted prevention programmes at scale in many local areas, critical in reducing COVID-19 risk and severity.

> “More needs to be done to recognise that adverse health impacts of this pandemic extend beyond the illness itself. It should include the health impacts from lockdown measures and increased economic vulnerability that disproportionately affect ethnic minority groups too.”

Despite these challenges, local government played a significant role in the first phase of the pandemic by engaging local communities, developing culturally appropriate outreach and programmes, working with local faith institutions and leaders, supporting and shielding vulnerable persons, and providing food, financial and social support to those who had been severely affected and isolated.

> “Our partnership have come together to support communities in ways that have never been done before – we are committed to building on this and ensuring we use this pandemic as a transformation opportunity – some good can come from this!”

There was a lot of innovation in how local government responded to the crisis that respondents felt should be taken forward. It was felt critical that resources were provided for local government to meet the growing and pervasive needs that will emerge post-COVID.

Income and poverty

Stakeholders expressed concerned about the role of economic deprivation and the risk of acquiring COVID-19 and having more severe disease. Their knowledge of the emerging data indicated that those who were more economically disadvantaged were more likely to be in occupations that involved greater exposure to risk or were less able to take up protective measures including isolation at home. Many of the BAME community make up a large percentage of frontline and key worker roles. COVID-19 is hitting deprived communities hardest.

Income inequality and poverty was also identified as a major concern for communities, reducing their capacity to be able to withstand the economic challenges resulting from

the COVID-19 pandemic. A number of stakeholders felt that more needed to be done to protect the economic stability of these communities.

> “A lot of people think this is just a ethnicity issue, but it’s not: it’s everybody’s business”

Housing, social and living conditions

Stakeholders repeatedly raised a number of social factors related to housing, accommodation, and living conditions that may have increased the risk of exposure to COVID-19. Poor housing conditions had a significant detrimental impact on health, with poor housing increasing the risk of cardiovascular disease, respiratory disease, depression and anxiety, as well as lack of sleep and restricted physical activity. All of these were mentioned as risk factors for worse outcomes with COVID-19 once infected.

Participants raised concerns that BAME communities were more likely to live in more densely populated urban areas where the virus has spread fastest, and are more likely to be key workers, especially in London. Some minority ethnic groups are more likely to live in over-crowded accommodation increasing risk of transmission within households.

> “Multiple generations living in one household mean elderly and vulnerable individuals may struggle, or be unable, to physically distance themselves in a safe manner. However, older people might have more support for essential activities”.

Legal and moral duty to act to prevent long term harm

Stakeholders feel that there is legal and moral duty to act, and that more must be done to comply and protect those most at risk. Stakeholders raised concerns that the long-term impacts of COVID-19 would likely significantly affect BAME communities particularly those living in areas of high deprivation.

> “We already had people who had existing problems, but we know that because of the post-COVID economic issues that there are going to be disproportionate effects on those people who are from lower socio-economic backgrounds and there is a predominance of people from black and Asian and minority ethnic groups in those lower socio-economic status backgrounds. So, this is like a triple whammy, adding the traumatic effects of COVID itself and then the economic effects.”

Voluntary and community sector organisations (VCS)

Stakeholders uniformly felt that voluntary sector organisations play such an essential role in engaging and supporting local BAME groups and ultimately help build community resilience to COVID-19 and other threats. Even before COVID-19, reductions in funding to this sector had resulted in a gradual and significant loss in the number, range and diversity of VCS organisations working in many localities. Stakeholders believed that this prevented or limited the extensive community mobilisation, preparedness and resilience building that could have helped limit the impact of COVID-19 on local communities and supported efforts by local and national government.

> "Volunteers have and are the backbone of our community – providing medicine, care and support to the most vulnerable – it's heart breaking to see so many forced to close or unable to support more because of a lack of resources"

As we move beyond the peak of the first phase, VCS organisations and the role they play in supporting communities was seen as critical for the months ahead when we will need to work with communities to observe COVID-19 prevention strategies including testing, contact tracing and ultimately preparation for a vaccine. Their role in communicating culturally sensitive and language appropriate messaging, as trusted allies, and as a bridge to statutory services was felt as essential for BAME communities.

Vulnerable groups and populations

Stakeholders consistently identified vulnerable groups, including the homeless, migrants, gypsies and traveller communities as being at increased risk throughout the COVID-19 outbreak and even more so in its aftermath. There were concerns about the ability of national and local government messages and programmes on COVID-19, for example regarding prevention, testing and contact tracing, to reach the most vulnerable and excluded within our society, especially when those groups may be wary or fearful of engaging with statutory services.

> "The announcement that people who cannot work from home should return to work has disproportionately affected BAME workers who are more likely to work in these roles, such as construction, process plants and cleaning. People were also advised that they should avoid public transport and commute by car, bicycle or walk wherever possible to minimise social contact. However, they are significantly more likely to be reliant on public transport than White people. More must be done to recognise, safeguard and protect our vital front-line workers –we must take greater care of those who take care of us and our loved ones"

Stakeholders recognised the good work that had been done locally to address some of these issues, for example providing temporary accommodation for the homeless, and that the lessons learnt should be built upon. Stakeholders felt that it would be

unacceptable to return to the status quo pre-COVID-19 and that every effort should be taken to avoid to the systematic disadvantage, social and economic exclusion and discrimination that these communities experienced. Key to this will be ensuring that all national, regional and local recovery plans actively account for and commit to building upon, the positive gains made in engaging and providing comprehensive services for these groups.

> “As the UK faces an historic economic recession as a consequence of COVID-19, ongoing financial and other additional support needs to be targeted at those who are living in poverty or insecure employment. Adequate financial support will also help ensure that people who should be shielding or isolating for their own and others’ health are not forced to work by economic necessity”

Faith community

Stakeholders emphasised the central role that faith plays in BAME communities. COVID -19 had significantly affected not only communities’ ability to recognise their religious practices but also to grieve for loved ones.

> “We cannot separate faith from people’s lived experiences – faith is part of the solution”

Faith leaders have shown great leadership throughout the pandemic response – engaging and educating local communities, providing support services, helping the most vulnerable, tackling myths and misinformation, supporting families and communities through trauma and bereavement, and helping to support some of the most vulnerable in our midst.

> “Communication of risk to communities is crucial and faith groups can be a key pillar to support dissemination of information “

It was felt by some that their unique contributions were not valued enough in the initial response to the pandemic and that moving forward opportunities to strengthen and support the role of faith communities in local responses should be reinforced. They also provide a way to support messages about infection control in faith settings.

> “The system does not engage with faith, and we know faith is a key part of BAME communities”

This is especially important as we move into the recovery phase of COVID-19 and will be imperative to help build community resilience. Stakeholders felt very strongly that faith leaders can have a key role to play in rebuilding trust with health, care and other statutory services. They can also help with engaging hard to reach communities, and

working with government to ensure that guidance and messaging is culturally appropriate.

> "We've seen so many faith-based organisations at the forefront of community efforts providing mental health and spiritual support, practical support by organising delivery of food medicine, essential supplies to elderly, vulnerable and isolated households – they provide a vital component of many communities"

Increased risk of exposure to and acquisition of COVID-19

Stakeholders highlighted the high proportion of BAME communities that were key workers and occupations that placed them at risk by increasing the likelihood of social contact and being exposed to those infected with COVID-19.

Key actions recommended by stakeholders included the importance of valuing, supporting and protecting key workers; provision of adequate personal protective equipment (PPE); stronger arrangements for workplace wellbeing and risk assessments; targeted education, awareness and support for key workers; occupational risk assessments; and tackling workplace bullying, racism and discrimination to create environments that allow workers to express and address concerns about risk.

Protection of BAME staff working in frontline roles in health and social care

Concerns were raised by stakeholders about the increased risk of exposure to COVID-19 among BAME staff in NHS and social care settings, and the high mortality rate they have reported to observe. Outside the health and care sector, many people from ethnic/racial minorities hold essential jobs in retail, public transport and other sectors putting them on the front line and at risk of exposure to COVID-19. Stakeholders felt that too little has been done to protect these staff, some were unaware of the work that the NHS has been doing and others felt this was too little too late. Some reported that they had personally experienced or received reports from colleagues about racism, bullying and harassment at work. This meant that they were reluctant to speak up about issues (such as PPE shortages), which placed them at higher risk.

Others believe that BAME front line workers were sometimes given substandard quality or inadequate PPE given the nature of their roles and the risk of exposure. Numerous examples were given of staff not able to access appropriate PPE to protect themselves adequately in line with national guidance and being afraid to speak up about this.

> "Requests for risk assessments or additional PPE by BAME workers are more likely to be refused, or whether those requests are less likely to be made because of fear of adverse treatment"

Differential treatment in the workplace

Many feel this is a long-standing issue which existed prior to COVID-19. BAME staff are concerned about raising issues because of past experiences and fear of consequences for speaking up. Others raised issues about fairness in the workplace. Staff want support and an environment for staff to express their concerns and have these met effectively.

> "Reports we have received since the outbreak of the pandemic suggest that there have been a significant number of instances of direct and indirect discrimination based on ethnicity.
>
> A high number of our BAME members have felt concerned about raising issues because of either previous instances of poor treatment, or a fear that they will face adverse consequences if they speak up."

Support for key workers with high levels of social contact

There are even greater concerns about other frontline staff outside of health and care settings such as transport workers, security staff and carers. Some stakeholders felt that there was initial confusion on risk and the levels of PPE required for those working outside of health and care settings which may have led to BAME key workers being poorly protected. Stakeholders recognised that occupational risk is out of scope of the PHE review but wanted action to be taken by NHS and government to clarify the risk for those working in roles with high exposures to members of the public and, where appropriate, effective workplace risks assessments being made. This was seen as important to ensure that those who did some of the most important and essential roles were adequately protected.

> "We must take care of those who take care of us"

Valuing and protecting key staff

Stakeholders repeatedly returned to a theme of how we as a society value those who occupy key worker roles, largely filled by BAME individuals in many parts of the country. Many of these roles cannot be done at home forcing people to place themselves in positions of higher risk. More should be done to recognise, value and protect key workers (outside of the NHS). Steps should be taken to ensure that women are equally represented in all engagement and communications.

> "Media should do a lot more in balancing the appreciation of such bravery, commitments, and sacrifices, made by our community key workers to appreciate what they have achieved for us today"

People who are still working and leaving the household during this period have an increased risk of exposure to COVID-19. Those in informal employment are also less likely to have access to adequate, or any, PPE.

Migrant workers are more likely to be employed in key worker roles, making up approximately 1 in 5 of the health and social care workforce and more than 40 per cent of workers in food manufacturing.

Risk assessments

The issue of occupational risk assessments came up repeatedly in engagement sessions involving professionals as well as community representatives. It was felt that evidence-based tools that could help employees to understand risk and to identify employees who may be at increased risk of acquiring or transmitting infection would be helpful. Many participants called for an evidence informed standardised risk assessment tools. However, it was also recognised that support and guidance must accompany the use of these tools to ensure that workers do not feel discriminated against and ensure that they feel safe to identify risks and issues without fear of losing their job.

Other factors increasing exposure risk

Stakeholders highlighted other factors that may be contributing to the increased risk of exposure including the important role of culture, including places of worship, multigenerational households, and variation in social interactions. Some BAME groups have been segregated in overcrowded urban housing centres and workplaces, the conditions of which can make physical distancing and self-isolation difficult, leading to increasing risks for the spread of COVID-19. Stakeholders were also concerned that BAME groups exposed in crowded places and becoming seriously ill might be infected from multiple sources and a comparatively large infectious dose of COVID-19, further driving onward transmission and influencing the severity of their disease. These complicated social determinants of health might explain the increased risk of infection, but not necessarily worse outcomes and all these factors need deeper examination before we can draw valid conclusions.

Increased risk of complications and death from COVID-19

Stakeholders felt that once infected, many of the pre-existing health conditions that increase the risk of having severe infection (such as having underlying conditions like diabetes and obesity) are more common in BAME groups and many of these conditions are both socio-economically patterned. For many BAME communities, especially in economically deprived areas there is a higher risk of having high incidence of chronic diseases and multiple long-term conditions (MLTC), with these conditions occurring at younger ages.

Stakeholders highlighted concerns about the high burden of MLTC among BAME communities and called for efforts to improve early diagnosis, better clinical management and improve health outcomes. The role of severe mental illness as a risk factor for COVID-19 disease severity and death was mentioned repeatedly as an area that was at risk of being overlooked in the current response. Key strategies recommended by stakeholders included strengthening targeted programmes for chronic disease prevention; culturally competent and targeted health promotion to prevent chronic diseases and MLTCs; targeting the health check programme to improve identification and management of MLTCs in BAME communities; targeted messaging on smoking, obesity and improving management of common conditions including CVD and diabetes. Culturally competent strategies to support better symptom recognition (eg hypoxia), early diagnosis and earlier presentation to clinical services for COVID-19 was also seen as critical to reducing complications from COVID-19.

Timely access to services

Stakeholders reflected on the challenges of differential access, experiences and outcomes of such services for BAME groups across a range of settings which pre-dated COVID-19. Equitable and timely access to services extends beyond simple service uptake and includes access to appropriate information, services that are timely, appropriate and sensitive to needs.

Some BAME communities feel that they receive different treatment when compared with white patients – this has further exacerbated fear within BAME communities and reluctance to seek medical care.

> “Why are black people who go into hospital with other medical conditions being put on COVID-19 wards when they do not have corona virus, particularly when they have known underlying conditions, eg diabetes, which clearly makes them at higher risk?”

Fear of contracting COVID-19 and misunderstanding about availability of vital services results in late and more acute presentations. This needs to be addressed to ensure that further risk is mitigated.

> “Our communities are more likely to have health conditions which make them more vulnerable to COVID-19, such as diabetes and CVD. Many didn’t even know their GP was open, while others were afraid to go in case they caught COVID -19”

Improved management of multiple long-term conditions (MTLC)

BAME communities are disproportionally affected by MLTC and associated life style risk factors. Uptake of prevention services in these communities needs to improve. Services

need to target their resources and ensure that they offer culturally appropriate care. Stakeholders mentioned that there is poor engagement of BAME communities with health services for chronic diseases, especially for cardiovascular disease – a condition that is known to increase disease severity with COVID-19. Requests were made to review shielding criteria to take account of these issues.

Stakeholders were also concerned about ethnic differences in engagement with health promotion initiatives and uptake of preventive interventions, which may have exacerbated the risk of severe disease due to smoking, obesity, cardiovascular disease, asthma and diabetes. Moreover, the heterogeneity of BAME groups, whether African, Caribbean, South Asian (Indian, Pakistani, or Bangladeshi in the UK), Chinese, or other ethnicities, have diverse risk factor profiles, which might be important for COVID-19 outcomes.

> “For too long we have known that ethnic minorities are at higher risk of CVD, diabetes and obesity and that prevention services are not accessed in time by high risk groups – more must be done.”

Mental illness and COVID-19 severity

Stakeholders highlighted their knowledge of emerging evidence of increased acquisition risk and poorer health outcomes for people with mental illness. This was especially compounded for BAME communities for whom problematic access to primary mental healthcare and mental health promotion have been well described. There were concerns that the importance of mental ill health as a risk factor for COVID-19 was not adequately acknowledged and therefore poorly managed, with many missed opportunities for early intervention and support.

Many feel that lockdown restrictions will significantly impact those with mild, moderate and severe mental illness (SMI) and those who are caring for them. Social distancing measures place restrictions on access to social support networks which are a fundamental part of BAME communities’ infrastructure and culture.

> “Ethnic minority groups also face particular risks of social isolation and loneliness, linked to higher levels of deprivation and potential exclusion from structures and processes that promote social connectedness and a sense of belonging.”

Community engagement and mobilisation

Issues were raised that COVID -19 communications and their method of cascade were not always appropriate for all BAME groups. Community participatory engagement with BAME groups could be used to produce communication materials which have a bigger impact and raise awareness of risk factors and improve the uptake of prevention

services. These should also be translated into different languages and recognising the central role that faith plays in many BAME groups.

Several participants felt that official guidance and messages about COVID-19 were conflicting and difficult to interpret. This was further complicated by false theories circulating across social media, ‘fake news’ and a misunderstanding about the effectiveness of using home remedies to treat COVID-19.

People receive and process national messages differently, and not all have the means to apply these messages in the same way. Some BAME communities, can only be reached through non-traditional methods. Digital communication is efficient and easy to use but does not reach all vulnerable groups. Certain groups such as the elderly, those with mental health issues, and certain cultural or faith-based communities including Orthodox Jews may be excluded.

> “People who struggle to access, understand, appraise and apply health information, or who face barriers in navigating the complexity of the NHS, may not be able to adhere to public health messages or advice.”

> “Messages must be delivered with clarity, with locally created messages likely to have greater uptake /impact “

Racism, discrimination, stigma, fear and trust

Stakeholders pointed to racism and discrimination experienced by communities and more specifically by BAME key workers as a root cause affecting health, and exposure risk and disease progression risk. In addition, the stress associated with being discriminated against based on race/ethnicity affects mental and physical health through physiological pathways. Issues of stigma with COVID-19 were identified as negatively impacting health seeking behaviours.

Fear of diagnosis and death from COVID-19 was identified as negatively impacting how BAME communities took up opportunities to test for COVID-19 and their likelihood of presenting early for treatment and care. The effects of hostile environments against immigrants, particularly failed asylum seekers and undocumented immigrants, might affect settled BAME populations adversely through heightened prejudice and societal tensions. For many BAME communities, lack of trust of NHS services and treatment resulted in their reluctance to seek care on a timely basis, again resulting in late presentation with disease. Others were also fearful of being deported if they presented to hospital.

> “People in the asylum system and those with no recourse to public funds, who can often face additional barriers to accessing healthcare”.

Despite these challenges, stakeholders reinforced the importance and need for communities to work with government and anchor institutions to create solutions. Faith leaders are a trusted source of information for many BAME communities and needed to be better engaged in future efforts to build community resilience and prepare communities for the immediate and long-term challenges of COVID-19. National and local government officials (including public health teams) have a unique opportunity to provide advocacy for vulnerable groups. Work to tackle racism and discrimination within the health service must continue at pace with a clear commitment for increasing diverse leadership at all levels in health and care system, reflecting the communities being served.

Strategies to create healthy and supportive workplaces (within and outside the health service) that have zero tolerance for discrimination and empower BAME staff to raise concerns about occupational risk and safety are essential. So too is work with local communities to rebuild trust and reduce fear of using health services in the aftermath of COVID19. Stakeholders acknowledged that there are lots of examples of work already underway at local, regional and national levels. However, COVID-19 presents an opportunity to step-up commitments and accelerate the pace of change. There is a wariness and concern that the opportunity for lasting change will be missed alongside a willingness share good practice and co-produce the change required.

Cultural competence

The theme of cultural competence, defined as the ability of providers and organisations to effectively deliver services that meet the social, faith, cultural, and linguistic needs of service users, was raised repeatedly by stakeholders. This was especially important as interventions to reduce the disproportionate impact of COVID-19 and BAME communities would require a set of attitudes, perspectives, behaviours, and policies – both individually and organisationally – that would promote and value positive and effective interactions with diverse cultures.

> “This has contributed towards a lack of trust the health system and apathy among ethnic minorities towards health information, and consequential decisions among communities who didn’t trust the system and were apathetic about health messages”

The sustained, at scale action on the wider social and economic determinants of health required to effectively address and mitigate the societal (health, social, economic) impact of COVID-19 may inadvertently exacerbate ethnic health inequalities unless it adequately considers the ethnic patterning in residential, income, educational and occupational circumstances and empowers BAME communities to be part of creating

solutions. The central role of racism must be acknowledged, understood and addressed and there is an urgent need to build the evidence base around effective action and while taking effective action at every level in our society.

BAME staff working in health and care settings

Stakeholders felt strongly that more must be done to protect and support BAME staff working in health and care services (including pharmacies and domiciliary care). They play a vital role in our society, more should be done to recognise this and celebrate this. There are deep concerns raised about the support that BAME front line workers have received. This fundamental break in trust between employers and organisations should be a priority to address as we move into recovery phase of COVID-19.

It was recognised that a lot has been done since the start of the pandemic to improve access to PPE and mitigate risk, but concerns were expressed that these safeguards were not applied equally across ethnic groups. Staff should be made to feel comfortable and safe to voice concerns without fear of job loss or discrimination. There are good examples of occupational risk assessments providing an opportunity to ensure a standardised approach at scale to all health and care settings.

> “We are pleased that steps have been taken in NHS services to ensure risk assessments are carried out on a precautionary basis and that being of a non-white ethnicity has been included as a risk factor in the risk assessment frameworks and guidance. However, there is significant variation in how these are carried out”

Stigma and fear of COVID-19

Stakeholders felt that COVID-19 has exacerbated historic issues with discrimination, stigma, fear and trust by BAME communities with anchor institutions. There is a widespread stigma and fear associated with contracting COVID-19 for the individual involved, their family, and their community. Chinese communities reported experiencing racism and being subjected to violent crimes because of COVID -19.

More recently, as reports of increased risk of COVID-19 among BAME communities have become more widely reported, some BAME communities have increased experienced stigma and discrimination as they are viewed as being more likely to be infected with the disease. There are fears that this will also have negative effects on job and housing opportunities. Stakeholders therefore encouraged caution and care with how these issues were discussed and framed in media discussions.

> “Currently we have a Chinese mother with children. She’s suffered domestic violence and moved out of the home, but because of the racist comments due to COVID-19, people shouting at her, she’s so scared so she moved back to her

> husband. This happens a lot, we suffer a lot of racist comments in the Chinese community due to COVID19"
>
> "Black men are labelled as being four times more likely to have COVID-19 infection – what will mean for them in seeking employment, for example?"

Factors such as low health literacy, loss of trust and fear of discrimination have resulted in BAME groups not seeking health advice in a timely fashion. It has also reduced uptake of COVID-19 testing and fear of reporting COVID-19 symptoms. This has serious implications resulting in more acute symptoms and severity of condition.

Trust and fairness

Issues related to trust and fairness were raised repeatedly by stakeholders in the engagement sessions. For some BAME communities, longstanding challenges in the provision of high quality, culturally competent and compassionate health and care service provision meant that there was little trust or faith in healthcare providers and services. In addition, as so many communities had lost family or community members following often challenging interactions with the health service (NHS 111, emergency and clinical care) during the COVID-19 outbreak, this relationship was further strained. Lack of trust and a perception of the unfairness were seen as an additional burden faced by BAME communities, which negatively impacted people's willingness to engage with services. Stakeholders felt that work to rebuild trust with BAME communities in the aftermath of COVID-19 must be a key part of restoring local clinical and care services.

> "Fear and anxiety have increased not only with NHS staff but also in communities, with people nervous to use primary and secondary services. In my opinion this must be a priority of this review – this must not be a one size fits all solution – investing in this long-standing issue will need time and effort"

The role of the media

The media's critical role in supporting public messaging which can effective reach diverse populations was mentioned by numerous stakeholders. There was some concern that relevant public health messaging, on prevention, early diagnosis, and treatment of COVID-19 among BAME groups might be less effective, leading to later presentation.

Stakeholders stressed that portraying BAME communities in the media is important but this must be done fairly and appropriately. While welcoming the increased visibility of the BAME issues with COVID-19 there was concern that the disease would be seen as one primarily affecting BAME individuals leading to increased stigma and discrimination.

It was felt important to portray the range of risks faced by BAME communities as well as the assets within these communities. The media had an important role to play in highlighting the positive roles being played by many BAME individuals who lost their lives or were negatively impacted by COVID-19. Associated with this was the importance of the media portraying positive stories of the roles and importance of key workers within our society, ensuring the images and stories of NHS, care and other frontline workers truly reflected the diversity of people in these roles.

> “When people speak about our community they speak of low skilled, deprived communities. But many of us have professional jobs and are valuable members of society”.

Moving forward

Stakeholders made numerous recommendations for research needed to understand the impact of COVID-19 on BAME communities, the extent to which this is due to increased rates of infection and why, after being infected, such patients appear to have poorer outcomes. Given the limitations of the PHE review, work was especially called for on the socio-economic, occupational, cultural and structural factors (racism, discrimination, stigma) influencing COVID-19 outcomes in BAME communities within and outside the health sector. There was a consistent ask for all research on this issue to be done in partnership with communities, ideally embedding community participatory research principles and integrating mental and physical health.

Further consideration needs to be given to factors such as diet, vitamin D and housing. Guidance currently recommends that individuals with limited sunlight exposure take a daily supplement of vitamin D. Learning from the experiences in other countries was thought to be essential in helping to understand why BAME communities in England were disproportionately affected. There is also a need for further research on the economic impacts of COVID-19 on BAME communities, which will likely be very long term and severe, with lasting health and wellbeing impacts. There was a clear ask for improved data collection on ethnicity, occupation and faith in all routine clinical data and death certification.

Cross-government approaches are critical

Stakeholders recognised the vital role that policy and government can play in reducing inequalities during the COVID -19 pandemic and beyond. Truly addressing the long standing societal inequalities can only be achieved through united joined up leadership. Responsibility for policy on issues which widen inequalities such as housing, employment, health, social care, race crime is shared across government.

> "We need to come together to understand and address the impacts across the whole piece not just direct and indirect health impacts – such as education, employment, welfare, access/uptake of business support- focusing on changing the situations and environments that people live in not focusing on individuals"

Examples such as the joint work and health unit provide models which could be adopted further. Any future strategies and communications must be designed in partnership with BAME communities – there are many examples of community participatory working to learn from. To ensure success this work will require dedicated resources.

Discussions across government departments and across the devolved nations were welcomed with recognition that cross government infrastructure will be vital as we move into the recovery phase of COVID-19. Stakeholders felt that there is a need for pace and scale in tackling the disparities that exist in COVID -19, there are many ways in which further risks and impact can be mitigated. Prevention at scale which is tailored and targeted at the most vulnerable is required, that must be properly resourced.

Focus should be on immediate and long-term policy and legislation changes to ensure that risks can be mitigated, and lessons learnt for future situations. The passion and commitment to make bold and sustainable change is shared by all stakeholders. Government have an opportunity (and a legal duty) to tackle long standing inequalities which existed prior to COVID-19 but this requires leadership and collaboration by all.

> "This is a once in a lifetime chance we must come together to act – we are committed and want to work together"

Capturing the passion and commitment for change

The stakeholder engagement and listening sessions have provided an invaluable perspective to this review. Despite acknowledgement of wider structural and systems level issues which need to be addressed, there is an overarching sense of enthusiasm to work together from all sectors and across all spatial levels. Individuals and groups are keen to be involved in future work lead by PHE and other organisations, and there is much appetite for collaborative preparation for a second wave of COVID-19, should one occur.

> "What is important for all of us is that we don't let the data limitations and other issues get in the way of our ambition of what we need to do, in terms of joining up and thinking about what the impact of COVID-19 means for our communities."

Act now: share promising practices

While stakeholders were keen to have a thorough investigation of the impact of COVID-19 on BAME communities which would take time to conduct, it was universally felt that

action to engage, empower and protect communities could not and should not wait. The imperative to act now, at scale and in culturally appropriate ways was emphasised. It was felt that doing so could offer a significant opportunity to rebuild trust with BAME communities. There are many examples of good practice that can be celebrated and shared.

> "We must act now – COVID-19 did not create inequalities, these have been with us for a long time we don't need more data or research to act. We must prevent any more harm being done."

Improve ethnicity and faith data collection and recording

The accuracy, completeness and granularity of ethnicity recording continues to affect the quality and depth of research that can be carried out. This also impacts upon the ability to understand and respond to need. Some local areas have devised innovative methods to improve this such as contacting relatives of deceased COVID-19 residents to get ethnicity data retrospectively. This is resource intensive and a more systematic resolution is needed. Many participants also called for faith to be recorded in addition to ethnicity data, there are large differences within communities of the same ethnicity that are dictated by faith.

> "It makes me sad that 20+ years later in my career we are still talking about data being collected, which is the basics of science. Surely that has to be fixed forever going forward.
>
> Recording of ethnicity and occupation on death certificates has been an issue for too long – a change in legislation is urgently needed."

The current classification of ethnic groups is problematic for some BAME groups who feel that the grouping of ethnicities does not reflect the heterogeneity within each ethnic group. Smaller ethnic minority groups such as the Gypsy, Roma and Travellers, new migrants and asylum seekers communities are missed by current ethnicity recording.

Many of the most at-risk individuals are unable to access NHS services due to various reasons such as immigration status and therefore may be a hidden unmet need. Recording of lower level data can however also have unintended consequences which need to be considered.

> "We want to flag that communities don't always like or want granular data published about them. We are afraid of the public gaze and the hate that can arise from that."

Need for further research

Stakeholders recognise the complexity of why inequalities exist and that COVID-19 is a new challenge which has never been experienced at such scale before. Understanding the causes and risk factors which are driving the disparities in COVID-19 outcomes for BAME communities is vital to mitigating further risks and impacts.

There is substantial interest and support from academics and research bodies to help fill the gaps that exist. Many highlighted the need to better understand the complex relationships between MLTC and COVID-19 risk factors. The NIHR and UKRI calls are welcomed but concerns were raised that this will be too slow. Stakeholders are keen to adopt more agile and rapid ways of learning. Examples of researchers tapping into big data to provide real time intelligence are promising and offers insights into behaviours and opportunities to reach communities.

> “Lack of data is an impediment to the system’s ability to respond practically- delivering better, frequent and agile access to data would be a significant improvement- However, at this stage, people were not being allowed to access all the data needed, and a failure to tackle this would be a mistake”.

Many expressed concerns about the longstanding gaps in ethnicity and occupation recording in health and care data.

> “In the absence of some of the more textured data it would be difficult to drill down into a very local, community level, understanding and, therefore, would limit the ability to decide how best to target and allocate resources”

We have seen examples of innovative approaches to data collection, but this is not efficient or sustainable. Steps must be taken to ensure that government and services can work in an evidence informed way as we move into the recovery phase of the pandemic. Stakeholders were clear that long standing gaps in the recording of ethnicity must be addressed with legislation.

> “It’s important that we reframe how we work with communities. We shouldn’t wait for the data reports before taking action, but should be thinking now about what to do differently”

There are many areas for further research that were called for and it is recognised that this is a complex issue with multiple factors interacting. Many calls were made to develop a programme of community participatory research, involving BAME researchers and community representation - to inform the evidence, to help translate results and evidence into action.

> “Clear commitments should be given to expanding research on this topic beyond the bio-medical to include the social, cultural, economic and structural determinants of health and the intersectionality of different domains of inequalities.”

Using community assets – the role of culture and faith

More needs to be done to support and recognise culture and faith as an asset during the recovery phase of the pandemic. Faith provides an important foundation for communities’ resilience through recovery and bereavement. The importance of faith in BAME communities should be reflected better in COVID-19 guidance. Faith leaders can play an important role in increasing the adoption of guidance.

> “I have buried over 300 people as a leader in the Muslim community. I want faith data to be collected for COVID-19 deaths, so that our community can work to prevent this”

> “Community members turn to faith as a core component of their resilience and purpose, but it is often omitted in response to illness and thus individuals are unable to express themselves wholly”

> “face-mask guidance suggests men should shave their beards. For Muslim and Sikh communities, this can carry a tremendous compromise to their spiritual practice”

Learning from others

Stakeholders were keen to understand whether the patterns of disadvantage and disproportionality observed with COVID-19 and BAME communities in England were seen in the devolved nations and other western industrialised countries. While ethnic disparities in the U.S. COVID-19 epidemic were among the most frequently mentioned, stakeholders highlighted the situation in other European countries as potential exemplars and encouraged a more systematic enquiry to understand what lessons could be learnt where similarities and differences existed.

> “Previous studies have shown that natural disasters widen inequalities for people with chronic diseases or those who are more vulnerable – what can we learn from other countries. We need to do more faster to help prevent further harm”

For a number of stakeholders, signals of the potentially less severe impact of COVID-19 in many countries in the Caribbean, Africa and Indian sub-continent raised questions as to why BAME communities in England were so severely affected. They suggested that issues such as structural racism and discrimination, widening societal and economic inequalities, and failure to adequately protect key workers, many of whom are ethnic /

racial minority, while not unique to the U.K. may have contributed disproportionately to patterns observed here. There was recognition however that differences in population structures, patterns of social mixing, household structures, phasing and timing of epidemic responses all played a role in explaining these differences between geographic areas and more detailed research would be required. The recurring theme of vitamin D deficiency and diet was also postulated as a factor in explaining geographic differences, while recognised that research is underway this still remains an area that requires further evidence as a matter of urgency.

Limitations

The stakeholder engagement sessions provided an opportunity to engage a wider range of individuals working in various sectors, at national, regional and local levels, across multiple disciplines, and representing diverse demographic, social, cultural and economic characteristics. The data and insights from the sessions were further complemented by written submissions received by numerous stakeholders. We have attempted to summarise the major themes arising from these activities, while highlighting areas which were unique or distinctive to some constituencies. The data highlight opportunities for further, more detailed research to understand the nature, range and contexts of many of the issues identified. It will be important to understand how these factors vary between different racial/ethnic minority groups given the significant differences in their demographic and socio-economic characteristics and life experiences in England.

Stakeholders requests for action

The following section provides a summary of the requests for action from stakeholders and do not represent the views of PHE. These are not set out in order of priority. They have the potential to build on existing work and commitments and are not exhaustive.

These requests for action inform six main considerations to help guide short to medium term actions, which are included at the end of this section.

Data and research

Stakeholder requests on data and research include the following:

- clear commitments should be given to expanding research on this topic beyond the bio-medical to include the social, cultural, economic and structural determinants of health and the intersectionality of different domains of inequalities
- develop a programme of community participatory research, involving BAME researchers and community representation: to inform the evidence, to help translate results and translate evidence into action
- mandate the recording of ethnicity, faith and occupation for all mortality and morbidity data
- strengthen ethnicity and faith group data collection across all the COVID-19 response- including all testing pillars, morbidity and mortality data (including front line workers from all workplaces) and future data collections such as antibody testing and vaccinations
- build the evidence base to inform practice and policy ensuring this is rapid and uses real time information and optimises upon big data opportunities

Policy

Stakeholder requests on policy include the following:

- co-produce with communities ways to strengthen their resilience in the next phase of this pandemic, and for future pandemics, by using asset-based approaches
- scale up action across government to tackle structural root causes of inequalities such as housing and employment
- put in place cross government infrastructure to facilitate collective action across policy departments: this may require new structures or identifying a lead department to coordinate activity
- commission a rapid review or horizon scan to identify if, and how, policy and guidance should change as lock down measures are relaxed (for example shielding,

PPE, testing, guidance to employers and employees) in response to the emerging evidence of disproportionate impact of COVID-19 on BAME communities
- change legislation to mandate a duty to act upon the results of health impact assessments
- use the convening powers and leadership of metro mayors and devolution to create change
- work with violence reduction units, the police and community and faith leaders to a) mitigate escalation of race crime and b) reduce the risk of further discrimination in the community and workplace if COVID becomes mis-represented as an BAME disease
- develop an approach to reduce risk in occupational settings where workers feel disproportionality affected and ensure that these staff groups feel valued for their vital contribution to society

Anchor institutions

Stakeholder requests on anchor institutions include the following:

- scale up prevention support for risk factors such as CVD and diabetes and enhance data driven prevention to target those at highest risk, and ensure that this is appropriately tailored to different BAME communities
- work with behavioural insights team to review messaging to ensure reach into most at risk community groups is effective
- rebuild trust between services and BAME communities
- work with communities and faith leaders to address concerns about unequal treatment and institutional racism
- accelerate efforts to improve workplace race equality and promote, value and support diverse leadership across systems and institutions
- provide an evidence-based work place risk assessment for use across all work places settings. This should include clear guidance about their implementation to avoid any unforeseen perceived discrimination or widening of inequalities

Communications

Stakeholder requests on communications include the following:

- ensure that all communication and marketing include culturally specific imagery and content, using voices of communities with lived experiences to shape future public messaging
- work with community and faith leaders to develop a communication plan to mitigating the fears and stigma in communities arising from media headlines around BAME and COVID-19
- public bodies to continue to develop and strengthen their advocacy roles

- highlight and disseminate models of best and promising practice
- continue with proactive community engagement throughout the next phase of the pandemic

Recommendations

1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process, 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.

3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and

effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure that **COVID-19 recovery strategies** actively **reduce inequalities caused by the wider determinants of health** to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Resources

This section contains additional resources on health inequalities, including key data sources, tools and evidence collections. The resources include guidance which empowers organisations to systematically address health inequalities and equity at a local level, including guidance for local authorities, public health teams, CCG's and NHS providers. The resources focus on population level inequalities in health but includes specialist literature and sources for the experience of specific groups who are socially excluded, including minority ethnic groups. A wider set of literature can be found in The King's Fund Information and Knowledge Services health inequalities reading list.

A detailed description of place-based approaches to reducing health inequalities is included after the resources tables.

COVID-19 specific resources

The following table summarises resources available to support local action to reduce health inequalities as a direct result of COVID-19

COVID-19 specific resources		
Resource	**Description**	**Link**
Place-based approach to reducing health inequalities and COVID-19	Resources supporting place-based approaches to planning and responding to the pandemic.	COVID-19 place-based approach to reducing health inequalities overview COVID-19 Summary of Guidance and support for vulnerable groups COVID-19 Suggestions for mitigating the impact on health inequalities at a local level COVID-19 Health Equity Assessment Tool (HEAT) for local areas COVID-19 Data tools to support local areas COVID-19 Estimated population at risk by LA

General resources: tools and guides

The following table summarises resources available to support local action to reduce health inequalities which have not been specifically produced for COVID -19 but support local action to reduce inequalities.

General resources – tools and guides		
Resource	**Description**	**Link**
PHE place-based approaches on health inequalities	PHE has recently released its 'place-based approaches to health inequalities' tool. This draws together of a lot of the lessons of areas who have looked to reduce inequalities, including experience from the former National Inequalities Support Team. With checklists, examples and advice on approaches to take across the NHS, local authorities and wider partners.	https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities
Right Care – Equality and Health Inequalities Packs	This highlights health inequalities across some healthcare areas within Clinical Commissioning Groups and provides case studies to support improvement planning.	https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs/
PHE and NHS Right Care Atlases of Variation	These highlight unwarranted variation of activity and outcomes across the heath system.	https://fingertips.phe.org.uk/profile/atlas-of-variation https://www.england.nhs.uk/rightcare/products/atlas/
PHE LKIS Health Inequalities Packs	These show inequalities in high burden diseases and the correlation with income deprivation.	Available through your PHE Local Knowledge and Intelligence Service: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/supporting-information/contact-us

General resources – tools and guides		
Resource	**Description**	**Link**
Reducing Health Inequalities Through New Models of Care: A Resource for New Care Models	The Institute for Health Equity has developed a resource for NHS 'new care models' to support them in tackling health inequalities. The report assesses the potential and opportunities for new care models to drive a health system that focusses on population health, reduces health inequalities and takes action on the wider determinants of health.	http://www.instituteofhealthequity.org/resources-reports/reducing-health-inequalities-through-new-models-of-care-a-resource-for-new-care-models
Local wellbeing, local growth: adopting Health in All Policies	Resource to help local government improve local wellbeing and growth through its multiple functions, service areas and partnership working.	https://www.gov.uk/government/publications/local-wellbeing-local-growth-adopting-health-in-all-policies
National Conversation on Health Inequalities: Reducing health inequalities	A toolkit and guidance for starting local conversations.	https://www.gov.uk/government/collections/national-conversation-on-health-inequalities
Local action on health inequalities evidence papers	This research shows the evidence supporting action to reduce health inequalities.	https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers
Strategic Health Asset Planning and Evaluation	Maps location of healthcare services against population health metrics, includes travel time	Access by registration. https://shapeatlas.net/place/

General resources – tools and guides		
Resource	**Description**	**Link**
(SHAPE) Place Atlas	and impact analysis.	
Health and Environmental Impact Assessment	Provides a guide to health and environmental impact assessments for local teams.	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/629207/Health_and_environmental_impact_assessment.pdf
Health Equity Collection	The Health Equity Collections page contains over 30 resources that have been produced over the last few years. Some key documents included in the Collections page are: 1. Guidance for system wide approaches to reduce health inequalities 2. Children and young people 3. Community engagement and asset based approaches 4. Data and intelligence reports on health inequalities 5. Economics and health equity 6. Healthy places 7. Inclusion health 8. Prevention and early treatment 9. Public sector equality duty 10. Work, health and inclusive growth	https://publichealthmatters.blog.gov.uk/2018/01/16/a-guide-to-our-new-health-equity-collections-page/

General resources: specific groups – tools and guides

The following table summarises resources available to support local action to reduce health inequalities in specific population groups.

Specific groups – tools and guides		
Resource	**Description**	**Link**
Health inequalities: reducing ethnic inequalities	Guidance to support local and national action on ethnic inequalities in health.	https://www.gov.uk/government/publications/health-inequalities-reducing-ethnic-inequalities
Health inequalities in ageing in rural and coastal areas	An evidence summary of health inequalities among older people in coastal and rural areas.	https://www.gov.uk/government/publications/health-inequalities-in-ageing-in-rural-and-coastal-areas
Migrant Health Guide	A resource for primary care practitioners on NHS entitlements, disease topic areas and country-specific information.	https://www.gov.uk/topic/health-protection/migrant-health-guide
The Migrant Health Guide's NHS Entitlements page	Also includes translated advice and guidance for the public on COVID-19.	https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide
Mental Health: Migrant Health Guide	Provides advice and guidance on the health needs of migrant patients for healthcare practitioners.	https://www.gov.uk/guidance/mental-health-migrant-health-guide

Mental Health Data	Shows mental health data by protected characteristics.	https://fingertips.phe.org.uk/profile-group/mental-health
Health Inequalities tools for Scotland	While some of these are not relevant to England, some of them are. In particular, these tools assess the impacts of different policy options on the wider determinants of health and what impact they are likely to have.	https://www.scotpho.org.uk/comparative-health/health-inequalities-tools/introduction/

General resources: data sources and trends

The following table sets out the wide range of data sources which help to inform action and understand need

General resources - data sources and trends		
Resource	**Description**	**Link**
The Office for National Statistics Health Inequalities Dataset	The ONS holds a wide range of datasets on health inequalities, including on life expectancy, avoidable mortality and healthy life expectancy at a wide range of geographic areas.	https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/datalist
PHE Health Inequalities dashboard	This displays trends in health inequalities in England. Inequalities are considered across a range of dimensions,	https://fingertips.phe.org.uk/profile/inequality-tools

	including deprivation, ethnic group, sexual orientation and employment status.	
PHE Wider Determinants of Health	Describes wider determinants of health.	https://fingertips.phe.org.uk/profile/wider-determinants
PHE Public Health Outcomes Framework	Range of public health indicators and population health outcomes.	https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
PHE Segment Tool	This present causes of death and age groups driving life expectancy gap at a local area level.	https://fingertips.phe.org.uk/profile/inequality-tools
Institute for Health Metrics and Evaluation Global Burden of Disease Compare Tool	Compares diseases, injuries, and risk factors to show most important contributors to health loss.	https://vizhub.healthdata.org/gbd-compare/

References

1. National Institute for Health and Care Excellence (NICE). BMI: preventing ill health and premature death in black, Asian, and other minority ethnic groups. London: NICE; 2013.
2. National Institute for Health and Care Excellence (NICE). Cardiovascular disease prevention. London: NICE; 2010.
3. National Institute for Health and Care Excellence (NICE). Type 2 diabetes prevention: population and community-level interventions. London: NICE; 2011.
4. Platt L, Warwick R. Are some ethnic groups more vulnerable to COVID-19 than others? London: Institute for Fiscal Studies; 2020 01/05/2020.
5. NHS Confederation BME Leadership Network. The impact of COVID-19 on BME communities and health and care staff. London: NHS Confederation; 2020.
6. McQuillan R, Dozier M, Theodoratou E, Li X, McSwiggan E, Goodwin L, et al. What is the evidence on ethnic variations in COVID-19 incidence and outcomes? Edinburgh: UNCOVER (Usher Network for COVID-19 Evidence Reviews); 2020 29/04/2020.
7. Razaq A, Harrison D, Karunanithi S, Barr B, Asaria M, Khunti K. BAME COVID-19 Deaths - What do we know: Rapid data and Evidence Review: 'Hidden in Plain Sight'. Oxford: Oxford Centre for Evidence-Based Medicine; 2020.
8. Jankowski j, davies A, English P, Friedman E, mcKeown H, Rao M, et al. Risk Stratification for Healthcare workers during the COVID-19 Pandemic; using demographics, co-morbid disease and clinical domain in order to assign clinical duties. medRxiv. 2020:2020.05.05.20091967.
9. Hastie CE, Mackay DF, Ho F, Celis-Morales CA, Katikireddi SV, Niedzwiedz CL, et al. Vitamin D concentrations and COVID-19 infection in UK Biobank. Diabetes Metab Syndr. 2020;14(4):561-5.
10. Ho FK, Celis-Morales CA, Gray SR, Katikireddi SV, Niedzwiedz CL, Hastie C, et al. Modifiable and non-modifiable risk factors for COVID-19: results from UK Biobank. medRxiv. 2020:2020.04.28.20083295.
11. Khawaja AP, Warwick AN, Hysi PG, Kastner A, Dick A, Khaw PT, et al. Associations with COVID-19 hospitalisation amongst 406,793 adults: the UK Biobank prospective cohort study. medRxiv. 2020:2020.05.06.20092957.
12. Kolin DA, Kulm S, Elemento O. Clinical and Genetic Characteristics of COVID-19 Patients from UK Biobank. medRxiv. 2020:2020.05.05.20075507.
13. Niedzwiedz CL, O'Donnell CA, Jani BD, Demou E, Ho FK, Celis-Morales C, et al. Ethnic and socioeconomic differences in SARS-CoV-2 infection: prospective cohort study using UK Biobank. medRxiv. 2020:2020.04.22.20075663.
14. Patel AP, Paranjpe MD, Kathiresan NP, Rivas MA, Khera AV. Race, Socioeconomic Deprivation, and Hospitalization for COVID-19 in English participants of a National Biobank. medRxiv. 2020:2020.04.27.20082107.
15. Prats-Uribe A, Paredes R, PRIETO-ALHAMBRA D. Ethnicity, comorbidity, socioeconomic status, and their associations with COVID-19 infection in England: a cohort analysis of UK Biobank data. medRxiv. 2020:2020.05.06.20092676.

16. Raisi-Estabragh Z, McCracken C, Ardissino M, Bethell MS, Cooper J, Cooper C, et al. NON-WHITE ETHNICITY, MALE SEX, AND HIGHER BODY MASS INDEX, BUT NOT MEDICATIONS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM ARE ASSOCIATED WITH CORONAVIRUS DISEASE 2019 (COVID-19) HOSPITALISATION: REVIEW OF THE FIRST 669 CASES FROM THE UK BIOBANK. medRxiv. 2020:2020.05.10.20096925.
17. Fletcher RA, Matcham T, Tibúrcio M, Anisimovich A, Jovanović S, Albergante L, et al. Risk factors for clinical progression in patients with COVID-19: a retrospective study of electronic health record data in the United Kingdom. medRxiv. 2020:2020.05.11.20093096.
18. Perez-Guzman PN, Daunt A, Mukherjee S, Crook P, Forlano R, Kont MD, et al. Report 17: Clinical characteristics and predictors of outcomes of hospitalised patients with COVID-19 in a London NHS Trust: a retrospective cohort study. London; 2020 29/04/2020.
19. Sapey E, Gallier S, Mainey C, Nightingale P, McNulty D, Crothers H, et al. Ethnicity and risk of death in patients hospitalised for COVID-19 infection: an observational cohort study in an urban catchment area. medRxiv. 2020:2020.05.05.20092296.
20. Soltan MA, Crowley L, Melville C, Varney J, Cassidy S, Mahida R, et al. Socal determinants for health have a modulating role in predicting outcomes among hospitalised COVID positive patients. *pre-publication*. 2020.
21. CDC COVID-19 Response Team. Characteristics of Health Care Personnel with COVID-19 - United States, February 12-April 9, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(15):477-81.
22. Cutler D, Stantcheva S, Alsan M, Yang D. Disparities in COVID-19 Reported Incidence, Knowledge, and Behavior. medRxiv. 2020:2020.05.15.20095927.
23. DiMaggio C, Klein M, Berry C, Frangos S. Blacks/African Americans are 5 Times More Likely to Develop COVID-19: Spatial Modeling of New York City ZIP Code-level Testing Results. medRxiv. 2020:2020.05.14.20101691.
24. Gold JAW, Wong KK, Szablewski CM, Patel PR, Rossow J, da Silva J, et al. Characteristics and Clinical Outcomes of Adult Patients Hospitalized with COVID-19 - Georgia, March 2020. MMWR Morb Mortal Wkly Rep. 2020;69(18):545-50.
25. Gross CP, Essien UR, Pasha S, Gross JR, Wang S-y, Nunez-Smith M. Racial and Ethnic Disparities in Population Level COVID-19 Mortality. medRxiv. 2020:2020.05.07.20094250.
26. Khan A, Chatterjee A, Singh S. Comorbidities and Disparities in Outcomes of COVID-19 Among African American and White Patients. medRxiv. 2020:2020.05.10.20090167.
27. Millett GA, Jones AT, Benkeser D, Baral S, Mercer L, Beyrer C, et al. Assessing Differential Impacts of COVID-19 on Black Communities. Ann Epidemiol. 2020.
28. Rentsch CT, Kidwai-Khan F, Tate JP, Park LS, King JT, Skanderson M, et al. COVID-19 by Race and Ethnicity: A National Cohort Study of 6 Million United States Veterans. medRxiv. 2020:2020.05.12.20099135.
29. Vahidy FS, Nicolas JC, Meeks JR, Khan O, Jones SL, Masud F, et al. Racial and Ethnic Disparities in SARS-CoV-2 Pandemic: Analysis of a COVID-19 Observational Registry for a Diverse U.S. Metropolitan Population. medRxiv. 2020:2020.04.24.20073148.

30. Wadhera RK, Wadhera P, Gaba P, Figueroa JF, Joynt Maddox KE, Yeh RW, et al. Variation in COVID-19 Hospitalizations and Deaths Across New York City Boroughs. Jama. 2020.
31. de Lusignan S, Dorward J, Correa A, Jones N, Akinyemi O, Amirthalingam G, et al. Risk factors for SARS-CoV-2 among patients in the Oxford Royal College of General Practitioners Research and Surveillance Centre primary care network: a cross-sectional study. Lancet Infect Dis. 2020.
32. Department of Health and Social Care. Guidance - Coronavirus (COVID-19): getting tested 2020 [updated 19/05/2020. Available from: https://www.gov.uk/guidance/coronavirus-COVID-19-getting-tested#history.
33. Ntuk UE, Gill JMR, Mackay DF, Sattar N, Pell JP. Ethnic-specific obesity cutoffs for diabetes risk: cross-sectional study of 490,288 UK biobank participants. Diabetes Care. 2014;37(9):2500-7.
34. The Health and Social Care Information Centre. Health Survey for England 2004: The health of minority ethnic groups. Leeds: The Information Centre; 2006.
35. Aldridge R, Lewer D, Katikireddi S, Mathur R, Pathak N, Burns R, et al. Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data [version 1; peer review: 1 approved with reservations]. Wellcome Open Research. 2020;5(88).
36. Williamson E, Walker AJ, Bhaskaran KJ, Bacon S, Bates C, Morton CE, et al. OpenSAFELY: factors associated with COVID-19-related hospital death in the linked electronic health records of 17 million adult NHS patients. medRxiv. 2020:2020.05.06.20092999.
37. White C, Nafilyan V. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. Newport; 2020 07/05/2020.
38. Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from COVID-19 analysed. Health Services Journal. 2020.
39. Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm; 1991.
40. Wilkinson R, Marmot M. Social determinants of health: the solid facts. Copenhagen; 2003.
41. Mosdøl A, Lidal IB, Straumann GH, Vist GE. Targeted mass media interventions promoting healthy behaviours to reduce risk of non-communicable diseases in adult, ethnic minorities. The Cochrane database of systematic reviews. 2017;2(2):CD011683-CD.
42. Nielsen SS, Krasnik A. Poorer self-perceived health among migrants and ethnic minorities versus the majority population in Europe: a systematic review. International journal of public health. 2010;55(5):357-71.
43. Buck D, Frosini F. Clustering of Unhealthy Behaviours Over Time. Implications for Policy and Practice. London: The King's Fund; 2012.
44. Rose TC, Mason K, Pennington A, McHale P, Buchan I, Taylor-Robinson DC, et al. Inequalities in COVID19 mortality related to ethnicity and socioeconomic deprivation. medRxiv. 2020:2020.04.25.20079491.
45. Stead M, Angus K, Langley T, Katikireddi SV, Hinds K, Hilton S, et al. Mass media to communicate public health messages in six health topic areas: a systematic review and other reviews of the evidence. Southampton (UK): NIHR Journals Library; 2019.

Appendices

Appendix 1: methods

Literature search

This report employed a rapid review approach to address the following research questions:

Q1: Are BAME more likely to be tested for and/or subsequently diagnosed with COVID-19 infection?

Q2: Are BAME groups more likely to develop severe clinical presentations of COVID-19 infection?

Q3: Is infection with COVID-19 more likely to lead to mortality within BAME groups?

Q4: What are the social and structural determinants of health that may impact disparities in COVID-19 incidence, treatment, morbidity, and mortality in BAME communities?

Notes

Ethnicity can be defined as shared culture and traditions that are distinctive, maintained between generations, and lead to a sense of identity and groupness. Minority ethnic groups are populations that differ in ethnicity from the dominant or majority ethnicity in a country.

A preliminary scoping search identified 4 relevant reviews (4-7); one of these reviews (6) answered the key questions defined in our research protocol.

It was, therefore, agreed that an updated literature search, using the search terms defined in McQuillan et al (6) would be undertaken to provide the most up to date evidence.

Protocol

A protocol was produced by the project team before the literature search began, specifying the research question and the inclusion and exclusion criteria. The protocol is available on request. Due to there being limited available evidence, we included observational studies without control group.

Sources searched

- medline, medRxiv preprints

- we also searched a number of existing COVID-19 review repositories plus additional resources such as PROSPERO, TRIP database, PubMed Clinical Queries, LitCovid, NICE Evidence, an Endnote library containing COVID-19 citations, and Google

Search strategy

The original search from McQuillan et al included all papers published between 11 November 2019 and 26 April 2020. Searches were conducted for papers published between 25 April 2020 and 19 May 2020 to fully update the available literature.

Search terms covered key aspects of the research questions, including terms related to the specific population. The search strategy for Ovid Medline is presented below.

Search strategy Medline:

("Ethnic Groups"[Mesh] OR race OR racial OR ethnic* OR migrant* OR refugee* OR displaced OR minority* OR BAME OR BME) AND (("Betacoronavirus"[Mesh] OR "Coronavirus Infections"[MH] OR "spike protein, SARS-CoV-2"[Supplementary Concept] OR "COVID-19"[NM] OR "Coronavirus"[MH] OR "Severe Acute Respiratory Syndrome Coronavirus 2"[NM] OR 2019nCoV[ALL] OR Betacoronavirus*[ALL] OR Corona Virus*[ALL] OR Coronavirus*[ALL] OR Coronavirus*[ALL] OR CoV[ALL] OR CoV2[ALL] OR COVID[ALL] OR COVID19[ALL] OR COVID-19[ALL] OR HCoV-19[ALL] OR nCoV[ALL] OR "SARS CoV 2"[ALL] OR SARS2[ALL] OR SARSCoV[ALL] OR SARS-CoV[ALL] OR SARS-CoV-2[ALL] OR Severe Acute Respiratory Syndrome CoV*[ALL]) AND ((2020/04/25[EDAT] : 3000[EDAT] OR 2020/04/25[CRDT] : 3000[CRDT] OR 2020/04/25[PDAT] : 3000[PDAT])))

Inclusion and exclusion criteria

Table 1. Inclusion and exclusion criteria

	Included	Excluded
Population	All Black, Asian, and minority ethnic populations of all ages	Indigenous populations of the Americas and Australasia
Issue	Inequalities in how BAME groups are affected by COVID-19 infection	
Comparison	White British or other White majority populations	
Outcomes	• COVID-19 incidence • Morbidity and Mortality associated with COVID-19 infection	
Measurement type	Laboratory confirmed cases	Non-PCR confirmed COVID-19 cases

	Included	Excluded
Language	English	
Date of publication	17 November 2019 to present	
Study design	Reviews and experimental or observational studies	Editorials, comments
Publication type	Published and pre-print	
Setting	OECD countries	We may focus on literature from UK/Europe in the first instance due to the significant differences in BAME populations between the UK and the US, UK and Australasia

Screening

Title and abstract screening was done independently by 2 reviewers. In case of disagreement, the study was included for full-text consideration. Full text screening was completed by a one reviewer. Figure 1 illustrates this process.

Data extraction and quality assessment

Data extraction was done by 1 reviewer.

Due to the rapid nature of the work, a validated risk of bias tool was not used to assess study quality. However, major sources of bias were noted when reviewing the papers.

Summary of Analysis of literature

Quality Assessment Criteria (based on ROBINS-1 - www.bmj.com/content/355/bmj.i4919)

1. Is there potential for confounding of the effect of intervention in this study?
2. Is there a potential risk of bias due to selection bias?
3. Is there a potential risk of bias in the methods used to ascertain exposures and outcomes?
4. Were the data that produced the results analyses in accordance with a pre-specified outcome(s), or where they selected among multiple measurements?

Table 1: Quality Assessment of Included Papers

Paper	Confounding	Selection Bias	Bias in the Methods	Pre-specified Protocol
Aldridge et al	Yes	Yes	Yes	Yes
Brill et al	Yes	Yes	Yes	Unknown
CDC Covid-19 Response Team	Unknown	Yes	Yes	Unknown
Chow et al	Unknown	Yes	Unknown	Yes
Cook et al	Unknown	Yes	Yes	Unknown
Cutler et al	Yes	Yes	Yes	Yes
de Lusignan et al	Yes	Yes	Yes	Yes
DiMaggio et al	Unknown	Yes	Yes	Yes
Fletcher et al	Yes	Yes	No	Yes
Gold et al	Unknown	Yes	Yes	Unknown
Gross et al	Unknown	Yes	Yes	Yes
Hastie et al	Yes	Yes	No	Yes
Ho et al	Yes	Yes	No	Yes
Khan et al	Yes	Yes	No	Yes
Khawaja et al	Unknown	Yes	Yes	Yes
Kolin et al	Yes	Yes	No	Yes
Millett et al	Yes	Yes	Yes	No
Niedzwiedz et al	Yes	Yes	No	Yes
Patel et al	Yes	Yes	No	Yes

Perez-Guzman et al	Yes	Yes	No	Yes
Platt et al	Yes	Yes	No	Unknown
Prats-Uribe et al	Yes	Yes	No	Yes
Raisi-Estabragh et al	Yes	Yes	No	Yes
Rentsch et al	Yes	No	No	Yes
Rose et al	Yes	Yes	Yes	Yes
Sapey et al	Unknown	Yes	No	Yes
Soltan et al	Yes	Yes	No	Unknown
Vahidy et al	Yes	Yes	Yes	Yes
Wadhera et al	Yes	Yes	No	Yes
White et al	No	Yes	Yes	Yes
Williamson et al	Yes	Yes	Yes	Yes

Table 2: AMSTAR Scores for Systematic Reviews and Rapid Reviews

Paper	
Jankowski et al	2
McQuillan et al	4
NHS Confederation	0
Razaq et al	1

Appendix 2: PRISMA diagram

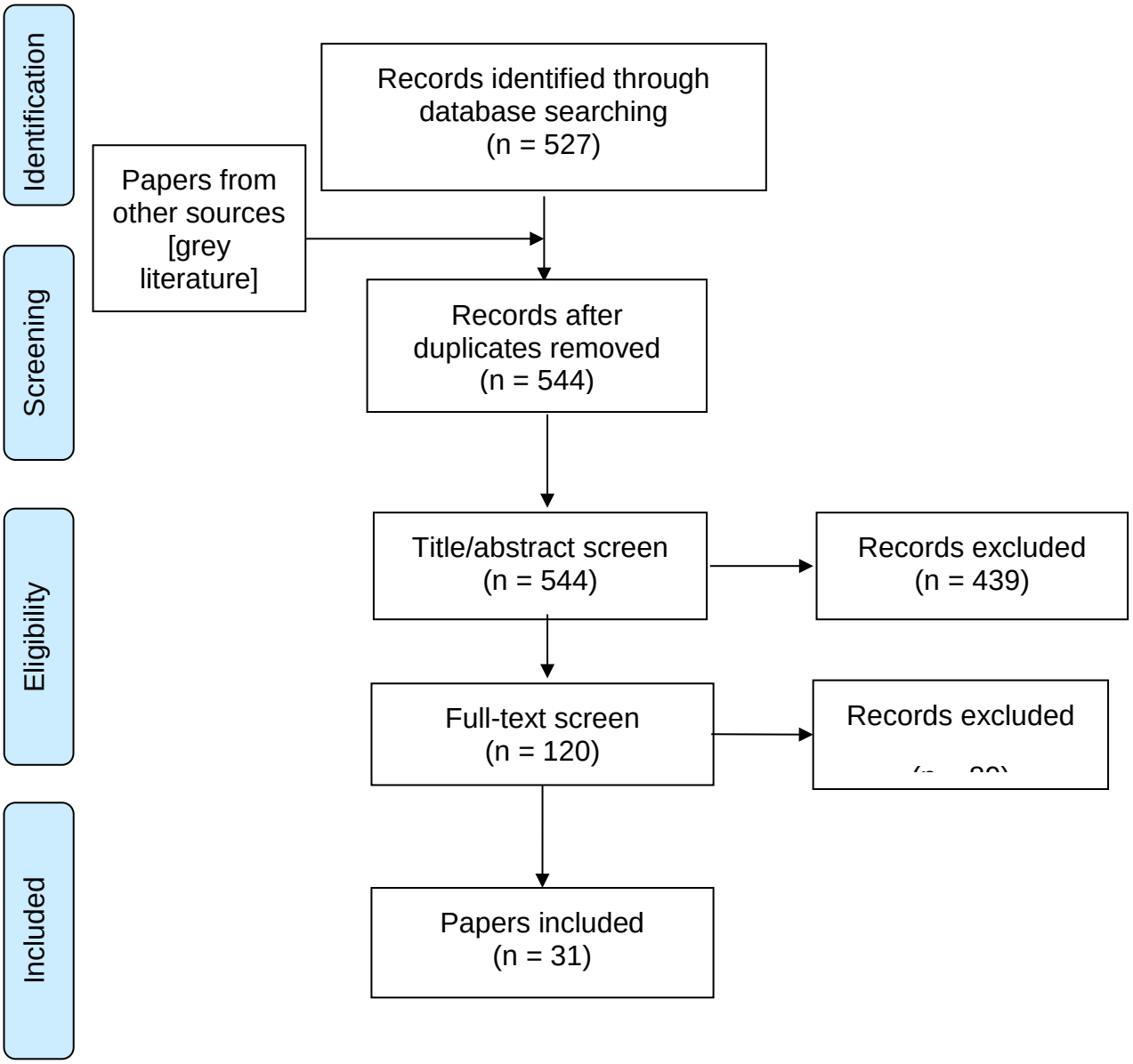


Figure 1. PRISMA diagram

Glossary

Acronyms

BAME- Black, Asian and Minority Ethnic (people)

CCG – Clinical Commissioning Group

CVD – Cardio-Vascular Disease

COVID-19 – Coronavirus Disease 2019

MLTC – Multiple Long-Term Conditions

NHS – National Health Service

ONS – Office for National Statistics

PPE – Personal Protective Equipment

Terminology

Acquisition – to contract (coronavirus)

Confounder – a variable other than the one being studied, which could be the cause of the results seen in a study.

Health promotion – the process of enabling people to improve their health and increase control over it. Health promotion programmes are often targeted at specific groups of people; for example, smokers.

Hypothesis – an idea that is put forward as an explanation for a situation but has not yet been proven. A hypothesis can be tested through carrying out research.

Incidence instances a number of new cases. An incidence rate divides this number by the denominator which needs to be accurate, possibly expressing it as a percentage or number of cases over person-years-of-observation depending on the study design.

Inequality – an inequality is an unfair and avoidable difference between people or groups of people. Inequalities exist in health, income, and other areas.

Intersectionality – the interconnectedness and overlap of social organisations such as race, gender and class, which can cause disadvantage and discrimination to the individual involved.

Morbidity – illness or degradation of health that results especially from long-term conditions and older age.

Mortality – death.

Risk assessment/occupational risk assessment – a process used to identify hazards that may negatively impact an individual. An occupational risk assessment assesses hazards in the workplace which may harm an employee.

Stakeholders – a person, group or organisation that has an interest or concern in a given topic.

Terms of reference – a specific description of what the purpose of a project/meeting is for people working together towards a shared goal.

This page is intentionally left blank

Agenda Item 8

Health and Wellbeing Board

Immunisation Update

15 September 2020

Recommendation(s)

1. To take note of the work being undertaken to increase the uptake of childhood immunisations in Warwickshire, and provide appropriate organisational support for actions proposed.

1. Executive Summary

1.1 A recent Coventry and Warwickshire Immunisation and Screening Review (2019) assessed the uptake of routine childhood and adult/older people's vaccinations against national targets. It identified that primary immunisation uptake had reduced across all 3 CCGs for certain vaccinations. In particular, we have seen reduced uptake of the pre-school immunisations, and at Quarter 3 2019/20 (single quarter data only), uptake of 2 doses of MMR at 5 years is at 78.3% for Coventry Rugby CCG, 83.7% for Warwickshire North CCG and 88.8% for South Warwickshire CCG. 12 of 16 West Midlands CCG areas have uptake rates below 90% - with Warwickshire North CCG and Coventry Rugby CCG at the lower end of the range. It should be noted that three local CCGs have an uptake of one dose of MMR (provides protection for 90% of children) of 93.2%, 96.3% and 96.6% respectively. However, an uptake rate of at least 95% is needed (both doses of the vaccine) to achieve herd immunity. A similar pattern is seen for the 4 in 1 pre-school booster. Currently uptake is below levels required for herd immunity.

1.2 An enhanced seasonal flu vaccination scheme will be running for 2020/21 flu season.

2. Supporting Information

2.1 **Childhood Immunisation Uptake**

2.2 Primary care and the school-based Immunisation and Vaccination Service (IVS) are responsible for delivery of the routine vaccination schedule.

2.3 A Task and Finish group has been convened with representatives from Public Health, Clinical Commissioning Groups and the regional Screening and Immunisations teams to increase uptake of vaccinations (a Flu Steering Group plans the delivery of the flu vaccinations). Work completed or in development includes:

- Detailed analysis, which has shown that the national COVER vaccination data is currently robust
- Development of a childhood vaccination uptake database by GP practice and the results of a GP Practice consultation, which will be used to gather good practice and offer support to relevant GP practices
- Public facing/stakeholder consultation has been developed, but is on hold during the COVID-19 pandemic
- An awareness-raising campaign emphasising the importance of vaccination has just been run. All three health and wellbeing partnerships will be engaged with work on this going forward.
- Over 40% of GP practices have signed up to an enhanced national MMR vaccination schedule which will target children who have not been vaccinated
- GP practices not signed up to data auto extraction are being encouraged to do so, this system improves the quality of the data reported

2.4 **Flu Vaccine**

2.5 The flu vaccine this year will be offered via a GP or Pharmacist to anyone aged 65 and over (rolling out to people aged 50-64yrs later in the flu season), pregnant women, children and adults with certain health conditions and children aged 2 and 3. The IVS provide the vaccination to primary school children and will also be vaccinating children in Year 7 for the first time this year. Frontline health and social care workers are eligible for the flu vaccine also (including an expanded list of social care workers).

2.6 The proportion of Warwickshire school aged children vaccinated for flu in 2019/20 exceeded the national and regional average rate and the proportion of over 65s in Coventry and Rugby receiving the flu vaccine exceeded 70% for the first time.

2.7 A Seasonal Flu Steering Group for Coventry and Warwickshire is leading the organisation of the vaccination programme for this year.

2.8 Please see Appendix 1 for seasonal flu vaccine uptake infographic. School based immunisation uptake rates in all groups exceeded the 65% target in Warwickshire. Uptake in all three CCGGs has fallen short of targets for 2 and 3 year olds, under 65s at risk, and pregnant women. Uptake has generally been lowest in the Warwickshire North CCG area for these groups, followed by Coventry Rugby CCG, with uptake highest in South Warwickshire CCG. Uptake is generally higher for 65 and overs for all CCGs, although only South Warwickshire hit the 75% target last year. South Warwickshire Foundation Trust and University Hospitals Coventry and Warwickshire hit the 75% staff immunisation target last year.

3. Financial Implications

3.1 It is currently anticipated that any costs incurred as a result of taking the recommended actions will be managed within operational budgets.

4. Environmental Implications

4.1 None

5. Timescales associated with the decision and next steps

5.1 The Immunisation Task and Finish group and Seasonal Flu Steering group will be working together to support actions outlined above over the next year/during the course of this year's flu season respectively.

Appendices

None

Background Papers

1. Infographic showing seasonal flu uptake for 2020/21

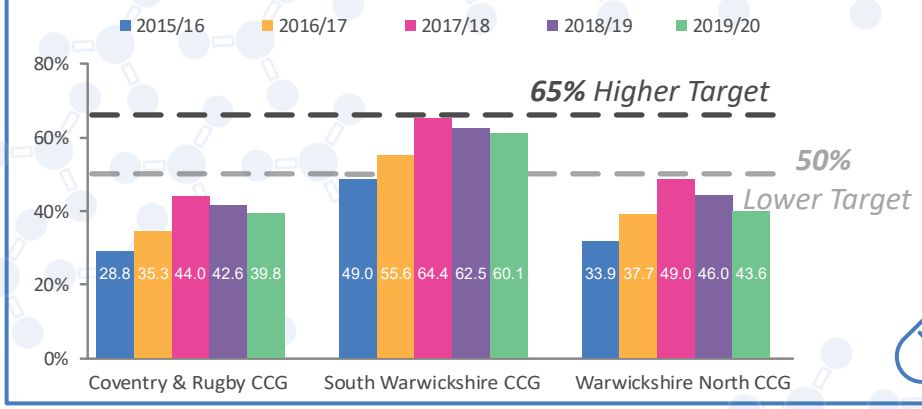
	Name	Contact Information
Report Author	Nadia Inglis	nadiainglis@warwickshire.gov.uk
Assistant Director	Shade Agboola (Director of Public Health)	shadeagboola@warwickshire.gov.uk
Lead Director	Strategic Director for People	nigelminns@warwickshire.gov.uk
Lead Member	Portfolio Holder for Adult Social Care & Health	lescaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication: WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

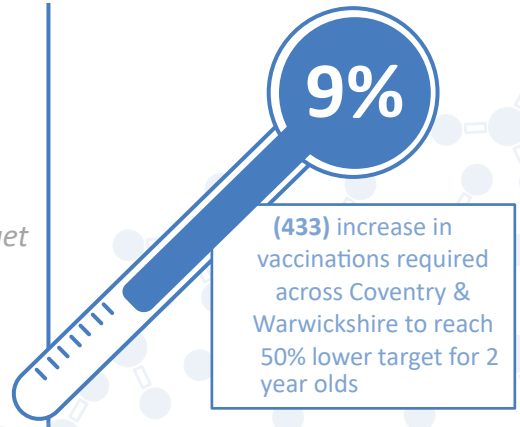
This page is intentionally left blank

Seasonal Flu Vaccination Children's Programme

2 year olds:

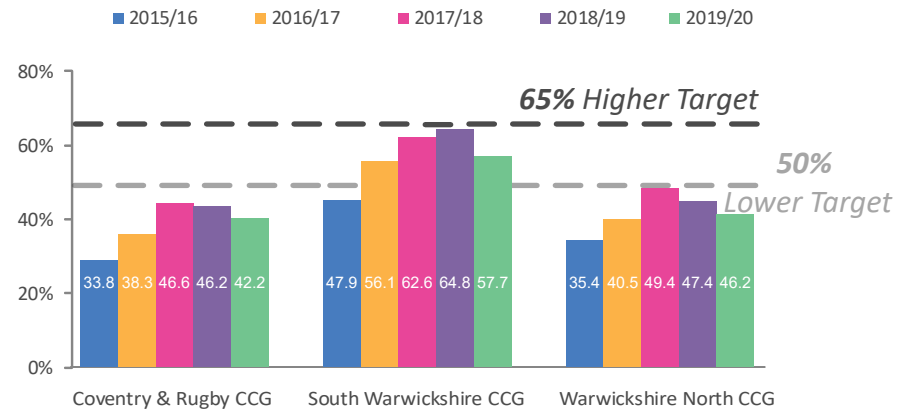


All 3 CCGs have seen a fall in uptake rates between 2017/18 and 2018/19

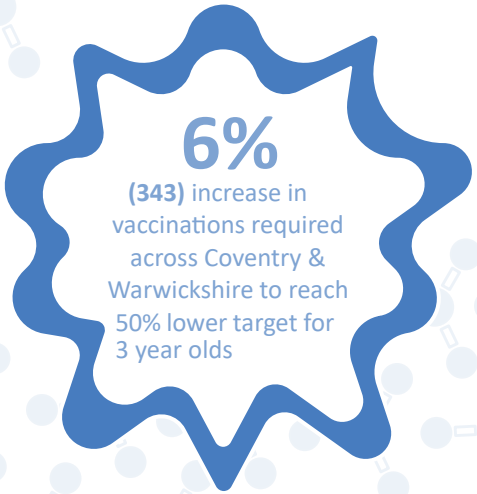


Don't hesitate, let's vaccinate

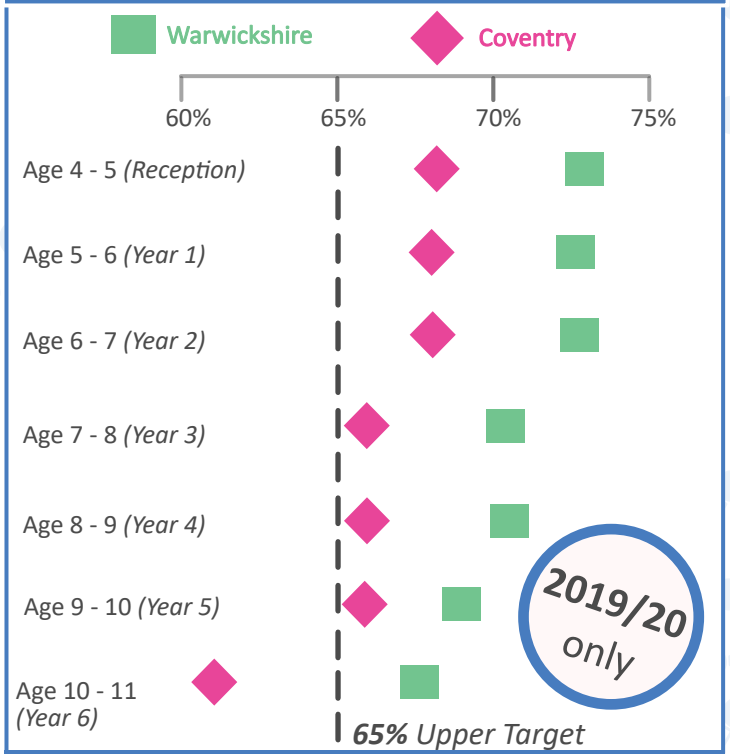
3 year olds:



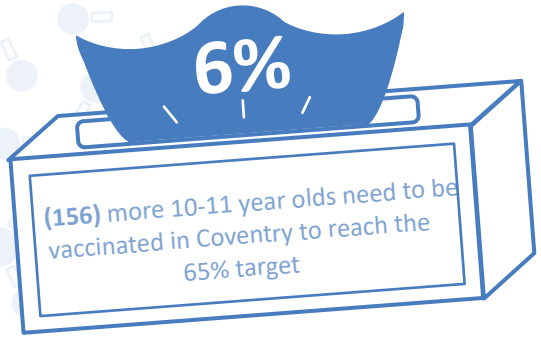
All CCGs have seen a fall in vaccination uptake rates between 2018/19 and 2019/20 for 3 year olds



4 - 11 year olds:



Other than age 10-11 year olds (in Coventry), all primary school uptakes in Coventry and Warwickshire are above the upper national target

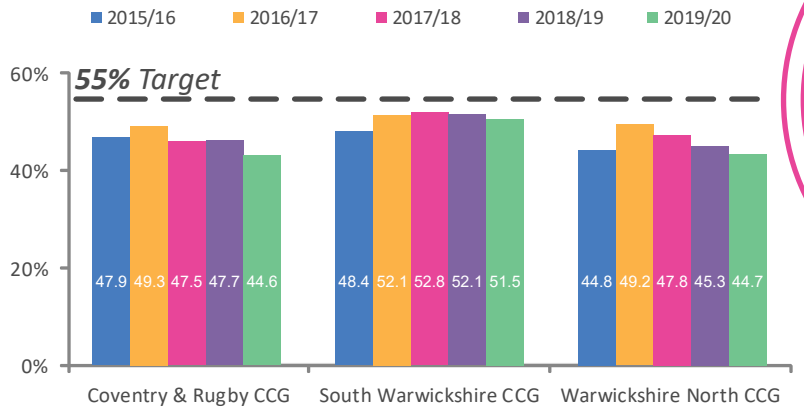


Data source: Public Health England (2020), https://www.gov.uk/government/collections/vaccine-uptake

Produced by Business Intelligence, Warwickshire County Council.
Icon(s) made by Freepik at www.flaticon.com

Seasonal Flu Vaccination Adult Risk Groups

Pregnant Women:

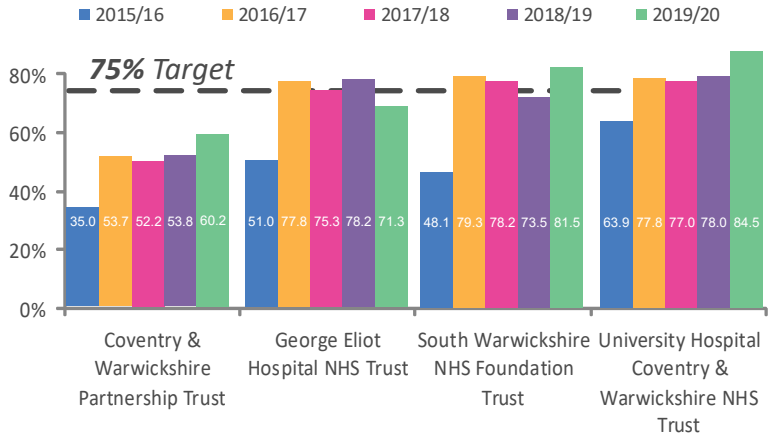


All 3 CCGs are yet to meet the national target (55%) for vaccinations in pregnant women

18%

(921) increase in vaccinations required across Coventry & Warwickshire to reach target for pregnant women

Healthcare Workers:



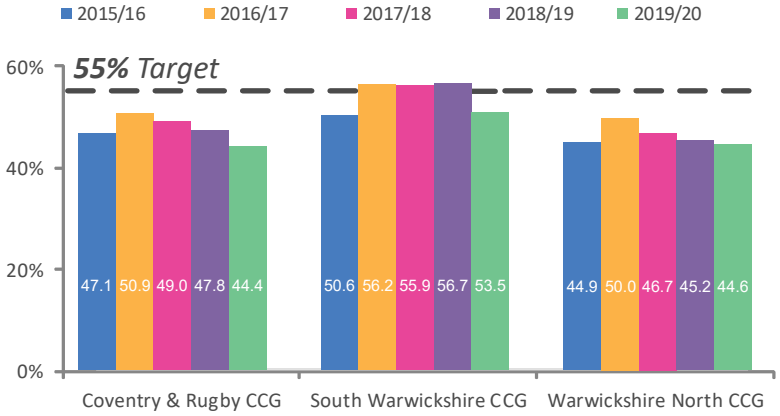
Two out of four Trusts in Coventry and Warwickshire exceed the target (75%) for healthcare worker vaccinations in 2019/20

17%

(8,846) increase in vaccinations required across Coventry & Warwickshire to reach target for up to 65 year olds

Don't wait, vaccinate

Up to 65 years (Clinical at risk):

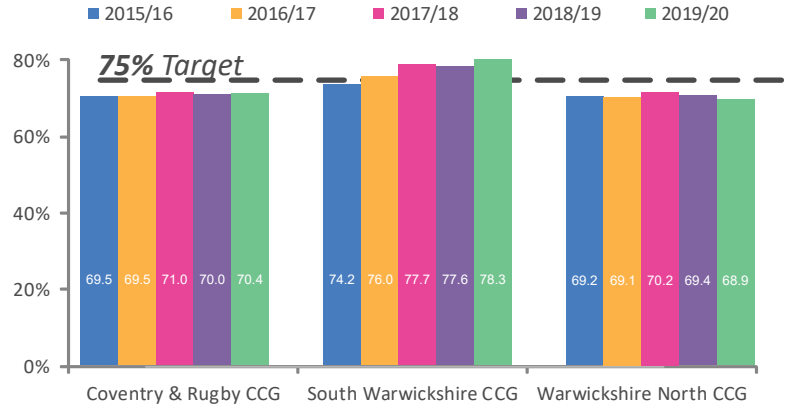


South Warwickshire CCG did not met the target for those aged up to 65 years who are clinically at risk in 2019/20 for the first time in 4 years

3,490 increase in vaccinations required across Coventry & Warwickshire required to reach target for 65+ year olds

3%

65+ years:



South Warwickshire CCG has been close to or over the 75% target for the last 5 years

Agenda Item 9

Health and Wellbeing Board

Coventry & Warwickshire Local Maternity System Smoking in Pregnancy (SiP) Review

15 September 2020

Recommendation(s)

It is recommended that the Health and Wellbeing Board:

1. Support the adoption of a Tobacco Control/Smokefree 2030 programme of work including smoking cessation in pregnancy and support the use of resource to address this priority

2. Support the adoption of a place-based, system-wide approach that addresses the inequalities and social norms that result in higher smoking in pregnancy rates in some areas (e.g. Nuneaton) of Warwickshire, compared to others

3. Support the co-production of a new model for Specialist Smoking in Pregnancy Services, embedded within maternity services, that provides rapid access to specialist advice and NRT

4. Identify potential funding sources for a strategic LMS Smokefree Pregnancy Lead / Programme Manager to plan and drive the implementation of a system-wide approach to tackling SIP across Coventry & Warkwickshire

1. Background and Key Issues

1.1 The Coventry & Warwickshire Smoking in Pregnancy (SiP) Review[1], which ran from October 2019 to April 2020**,** was commissioned by the Local Maternity & Neonatal System (LMNS) Board in order to provide a detailed picture of the women who smoke during pregnancy, the support they received and to identify any further measures that could be taken to enable them to stop smoking.

1.2 The sources of insights were:

1.2.1 three years of maternity booking data/antenatal records, a data set on birth outcomes, and stop smoking service data;

1.2.2 case note audits of 300 maternity records and 100 Health Visitors records;

1.2.3 exploration of compliance with NICE and other guidance;

[1] Full report and executive summary report: https://www.happyhealthylives.uk/our-priorities/maternity-and-paediatrics/pregnancy-smoking/

1.2.4 580 survey responses from key staff and additional feedback from 228 workers during discussion groups.

1.3 There are differences in the midwifery workforce at the three Trusts and differences in the level of investment that do not necessarily reflect population need. Whilst the NHS Long Term Plan should offer some opportunity to secure improvements, more substantial investment would be required across the LMNS system to secure meaningful and sustainable change.

1.4 The specialist Smoking in Pregnancy service is currently funded by Warwickshire County Council (Public Health grant fund). A future integrated stop smoking in pregnancy service model within maternity services will alter current commissioning arrangements and the way these public health funds are used to reduce smoking in pregnancy rates.

2. Key Issues and Findings

2.1 Scale of the problem**:** SiP is associated with significant morbidity, mortality and cost, with almost double the rate of stillbirth, preterm delivery and Low Birthweight babies in smokers vs non-smokers. Massively increased NHS and wider system costs – the SiP review reported that up to £1.6m each year for neonatal intensive care alone across C&W, with an estimate of £3.4m for an annual cohort of children born prematurely because of SiP, by the time they are 18 (to meet education, health and other needs).

2.2 Failure to meet targets: The national 6% SATOD target by 2022 will not be met across C&W unless there is significant change. Targets to reduce stillbirths and preterm deliveries are also likely to be missed.

2.3 Epidemiology: Approximately 1,550 women are Smoking At Booking (SAB) across C&W. They tend to be younger, less ethnically diverse and have more co-morbidities than non-smokers. There is a strong relationship with deprivation and geographical ‘hot-spots’ have been identified. SAB ranges from 9% for the South Warks CCG, 13% for Coventry & Rugby CCG and 17% for the Warwickshire North CCG populations. Approximately 365 women quit each year and there are about 1,000 women Smoking At the Time of Delivery (SATOD).

2.4 Access to specialist support: If not all, a high proportion of smokers are referred for specialist support but overall, only 50% accept the offer, and of those only 39% manage to quit (20% of those referred). Women face many barriers in quitting – in particular living in smoking households, particularly where partners smoke, and living in communities where smoking is the social norm. Together with other challenging life circumstances the barriers to quitting are often too great.

2.5 Compliance with guidance: The review found that not all smokers are being identified at booking, but for those that are identified the guidance is broadly being followed; although there is scope for improvement. SWFT show greater

compliance, possibly due to enhanced baseline maternity investment relative to UHCW and GEH.

2.6 Staff engagement: **(i)** The vast majority of staff think SiP is important, but a much smaller proportion think it is their job to address it. Making Every Contact Count (MECC) is not happening in relation to SiP. **(ii)** Staff do not feel well trained – 27% of maternity staff say they haven't been trained, others lack knowledge and confidence. There is wide misunderstanding about the harm reduction potential of e-cigarettes **(iii)** and staff identified opportunities for change, including the following:

- More investment for socially deprived areas
- The need for a revised model of specialist provision with more rapid access
- More work with partners/families given the pivotal role of household smoking

2.7 Evidence: The evidence identified in the SiP review confirms that interventions to reduce SiP are cost effective and can be cost saving. Elsewhere (for example in Great Manchester) a system-wide approach has seen a doubling of quit rates.

3. Options and Proposal

3.1 The key areas to be addressed include the following:

- An increased system wide focus to reduce population smoking among higher risk communities and reshaping social norms around SiP
- A greater focus on pre-conception advice with a family/household focus.
- Increased ownership of SiP across all services and across all staff groups in all maternity service settings, making MECC a reality.
- Introduce mechanisms to 'cohort' smokers within maternity services so that specialist support can be provided to smokers efficiently.
- A 'levelling up' of resources and support such that the systems and processes adopted in SWFT can be emulated in UHCW and GEH.
- Improved training, in particular for midwives, enabling them to have challenging conversations, so their advice motivates women to quit.
- A revised model of specialist support is required whereby women have more rapid access to specialist advice and Nicotine Replacement Therapy (NRT) to enable their quit attempt

3.2 Key review recommendations are as follows:

- Develop a comprehensive C&W wide Tobacco Control Plan, that includes a focus on activity with 'higher risk' communities. The plan should seek to promote smoke-free homes and communities drawing on the contribution of a wide range of services and partner agencies. It should build on evidence of what works in reducing smoking especially among higher risk groups.
- Implementation of a systematic approach to smoking cessation within maternity services and across the local maternity system based on the

evidence based 'BabyClear' approach from Greater Manchester – including an LMNS-level smokefree pregnancy strategic lead, dedicated leadership within maternity services, enhanced staff training and revised pathways including delivery of the 'Risk Perception' intervention.

- Co-produce a new model for Specialist Smoking in Pregnancy Services, embedded within maternity services, that provides rapid access to specialist advice and NRT

  Note: The review report includes a series of additional specific recommendations for consideration

4. Financial Implications

4.1 There is a need to identify a resource to support a dedicated strategic lead/s for Smoking in Pregnancy and Tobacco Control/Smoke-free 2030 across Warwickshire and Coventry. LMNS 2020-21 Transformation Funds are expected to support the recruitment of a public health midwife at GEH and UHCW (SWFT already has a post). These specialist midwives will lead on Trust-level smoking in pregnancy. However, additional resource needs to be found to fund an LMNS strategic smokefree lead, for at least 2-3 years, if a Baby Clear-type model is to be successfully implemented across Trusts and systems.

4.2 LMNS 2020-21 Transformation Funds have been awarded by NHS England and the release of these funds has been paused due to the COVID-19 pandemic. They were originally planned to be released in the summer of 2020 but a new release date has not yet been set. This funding does not impact on WCC finances i.e. does not result in additional funding for WCC.

4.3 The specialist Smoking in Pregnancy service is currently funded by Warwickshire County Council (Public Health grant fund). However, there is no further funding within this grant to pay for a strategic lead(s). Therefore the board is asked to identify potential funding sources for this post to plan and drive the implementation of a system-wide approach to tackling SIP across Coventry & Warkwickshire.

4.4 Cost: Recruit a strategic LMS Smokefree Pregnancy Lead / Programme Manager to plan and drive the implementation of a system-wide approach to tackling SIP across Coventry & Warkwickshire. Cost: salary NHS band 8a, £45,753 to £51,668 per annum (excluding on costs).

5. Environmental Implications

5.1 The LMNS Smoking in Pregnancy Review does not raise any specific environmental concerns or implications

6. Timescales associated with the decision and next steps

6.1 Due to Covid19, the presentation of the review's findings and recommendations to the Cov & Warks LMNS has been delayed until the LMNS Board meeting on 14 September. The LMNS is expected to advise on the next steps to developing and implementing a new systems-wide stop smoking in pregnancy model that is fully embedded within maternity services.

6.2 Coventry and Warwickshire Public Health Departments are in discussions regarding the new Coventry & Warwickshire Tobacco Control strategy to be developed by winter 2020.

Background Papers

1. Smoking in Pregnancy Review - Full report and executive summary report: https://www.happyhealthylives.uk/our-priorities/maternity-and-paediatrics/pregnancy-smoking/

	Name	Contact Information
Report Author	Liann Brookes-Smith Sophy Forman-Lynch	liannbrookes-smith@warwickshire.gov.uk sophyforman-lynch@warwickshire.gov.uk, Tel: 01926 731443
Director of Public Health	Shade Agboola	ShadeAgboola@warwickshire.gov.uk
Strategic Director	Nigel Minns	Nigel.minns@warwickshire.gov.uk
Portfolio Holder	Cllr Les Caborn	Lescaborn@warwickshire.gov.uk

Review findings and recommendations were shared with the following members prior to publication:

The report was circulated to the following members prior to publication: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

Other members: Elected members who sit on the following strategic place-based forums:

- Rugby H&W Partnership (presented to forum on 3 June)
- North Warwickshire H&W Partnership (22 June)
- South Warwickshire Citizen's Forum (15 July).

This page is intentionally left blank

Health and Wellbeing Board

Joint Strategic Needs Assessment (JSNA) Update

15 September 2020

Recommendations

It is recommended that the Health and Wellbeing Board:

1. Note the progress made in delivering the JSNA to date;

2. Use the JSNA evidence base to ensure partners are working to a consistent understanding of local need, enabling joined up service provision targeted to the right areas and driving commissioning intentions;

3. Endorse the proposals for the future work programme and governance, noting the possible impact of the COVID-19 pandemic on timescales.

1. Executive Summary

1.1 This paper provides an update on the delivery of the JSNA programme from April 2018 to date, with reports via the link: https://www.warwickshire.gov.uk/jsna. Information is also available via the Warwickshire Insights Tool.

1.2 Engagement on the JSNA is complete. It included face to face stakeholder meetings, presentations to a wide range of partners and community groups, completion of over 2000 on-line surveys, and work with under-represented groups such as young people, BAME groups and armed forces veterans.

1.3 Reports have been signed off by steering groups and have been uploaded to the JSNA webpage. Aggregated plans are being produced for each of the three places of South Warwickshire, Rugby and Warwickshire North. Links will also be made to the emerging Integrated Care System to inform the production of 'Place Delivery Plans' for health and care services, and to the refresh of the HWB Strategy.

1.4 Warwickshire County Council (WCC) has commissioned Grapevine to mobilise and engage communities in action planning. A Community Organiser started in February 2020 to work in Lighthorne Heath, Shipston, Wolston and Camp Hill initially for 12 months. A Community Organiser was recruited by Grapevine to begin work in February 2020. Due to the COVID-19 pandemic the project has been put on hold and the officer placed on furlough. The officer will commence work again from 1st September and begin working with communities whilst observing social distancing.

1.5 A proposed core work programme for 2020/21 is outlined below in Table 1.

Evaluation of place-based JSNA approach	August 2020	November 2020
Dissemination plan including how to best use the overview of Warwickshire findings from place-based approach *(infographics and survey analysis)*	August 2020	November 2020
Thematic Needs Assessment Pilot: Mental Health	August 2020	January 2021
Thematic Needs Assessment prioritisation and workplan development	November 2020	January 2021
JSNA Place Dashboard (Power BI)	March 2021	March 2022
Pharmaceutical Needs Assessment (PNA)	April 2021	March 2022

Table 1: Proposed Work Programme for the JSNA for 2020/21

1.6 Due to the COVID-19 outbreak the timescales highlighted in Table 1 are revised and may be further impacted. If this is the case, they will be reprofiled as required.

1.7 The work programme includes evaluating the place-based approach and developing tools to analyse data for different audiences to encourage actions that address the health needs of communities. Following a prioritisation process a workplan will be developed containing a prioritised list of needs assessments that will be brought back to the Health and Wellbeing Board for endorsement. The needs assessments will be thematic and draw on and add to the data, with the aim of informing local commissioning decisions. The proposed membership of the evaluation group is shown in Appendix 1 and governance arrangements in Appendix 2.

1.8 An initial pilot for a thematic needs assessment is proposed on **mental health.** This would inform the commissioning of outcome-based contracts for mental health by the CCGs and WCC in 2021 – 2022. There are also opportunities to connect with the Year of Wellbeing legacy, and the draft HWB Strategy for 2020-25 in which mental health and wellbeing is a proposed priority.

1.9 Collaboration on the JSNA programme is key moving forward. With over 140 analysts working in health care and local government in Coventry and Warwickshire, there is an opportunity to work jointly on the JSNA to develop more capacity and complete a larger programme in the future.

2. Financial Implications

2.1 It is currently anticipated that any costs incurred as a result of taking the recommended actions will be managed within operational budgets. Opportunities to work collaboratively across organisations will also be

explored.

2.2 Additional funding has been secured from the Early Intervention Fund of £45,289 to commission Grapevine Coventry and Warwickshire to engage communities in action planning. This funding was secured in 2019/20 to be delivered in 2020/21. Moving forward partners may wish to consider great collaboration and sharing of resources to address priorities.

3. Environmental Implications

3.1 There are no environmental implications from this report.

4. Timescales associated with the decision and next steps

4.1 Timescales for the JSNA work programme are outlined in Table 1, however these are subject to potential delays due to the COVID-19 response. A further update will be provided at the next Board meeting on 6th January 2021.

Appendices

1. Appendix 1: Proposed membership of evaluation group
2. Appendix 2: Proposed governance of future JSNA programme

Background Papers

1. None

	Name	Contact Information
Report Author	Duncan Vernon, Catherine Shuttleworth	duncanvernon@warwickshire.gov.uk, catherineshuttleworth@warwickshire.gov.uk
Assistant Director	Dr Shade Agboola	ShadeAgboola@warwickshire.gov.uk
Lead Director	Strategic Director for People	nigelminns@warwickshire.gov.uk
Lead Member	Portfolio Holder for Adult Social Care & Health	cllrcaborn@warwickshire.gov.uk

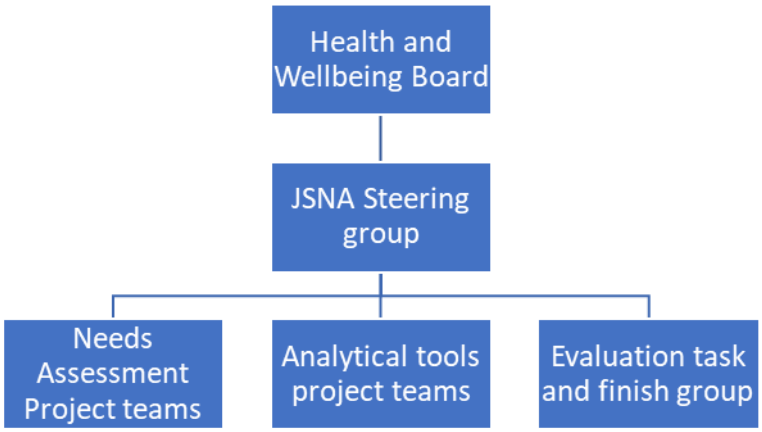
The report was circulated to the following members prior to publication: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

Appendix 1: Proposed Core Membership of Evaluation Group:

- Public Health representative
- WCC Business Intelligence – to analyse and embed the data from the PHOF and Wave Based approach to the needs assessment and ensure relevance to the three Places.
- Analysts from other organisations – to ensure that service data is included and analysed and aggregated in a way to compare against health needs.
- WCC Community Engagement officers to find ways to consult the public on the proposals and support engagement activities
- Healthwatch to represent patient lived experience on the group
- Clinicians from either NHS trusts or PCNs.
- Commissioners from the CCG
- Communications professional
- Public Health Principal to set timescales and oversee the project

Appendix 2: Proposed Governance Arrangements

It is proposed that the governance is restructured underneath the JSNA Strategic Group to create a series of direct reports from the JSNA project teams in the two work streams, as well as encompassing an evaluation of the Place Based Profiles.



This page is intentionally left blank

Agenda Item 11

Health and Wellbeing Board

Pharmaceutical Needs Assessment

15 September 2020

Recommendations

1. The Board is asked to note the update on the Pharmaceutical Needs Assessment (PNA) for Warwickshire;

2. To agree the process for Warwickshire to conduct its revised PNA in partnership with Coventry City Council; noting the potential impact of the COVID-19 response on timescales.

1. Executive Summary

1.1 This report provides an update on the PNA in Warwickshire. The Health and Wellbeing Board has a legal responsibility to keep an up to date statement around the needs for services from community pharmacies. The purpose of the PNA is to assess local needs for pharmacy provision, to identify any gaps in service or unmet needs and to highlight any services that community pharmacies could provide to address these needs.

1.2 The last PNA was published in March 2018 and is due for refresh by March 2021. The last PNA concluded that the number and distribution of the current pharmaceutical service provision in Warwickshire was sufficient, but highlighted an estimated 13,600 houses were due to be built in Warwickshire in 2018-2021. In areas of significant development and population growth, additional future pharmacy provision will need to be considered.

1.3 In light of the COVID-19 pandemic and subsequent pressure on resources NHS England has extended the deadline for publication of the PNA by one year to March 2022.

1.4 To maximise the resources available and align with local planning footprints, it is proposed to work with Coventry City Council on the PNA, as previously. This aligns with the Coventry and Warwickshire Concordat where both Health and Wellbeing Boards have agreed to work together on areas that will improve outcomes for the public. The key milestones for the proposed consultation and production of the new PNA are outlined below (Table 1):

Drafting surveys/initial consultation	April to May 2021
Initial public survey	May to July 2021
Pharmacy survey	May to June 2021
Mapping of needs	July to August 2021
Write PNA document	August to September 2021
Formal consultation	16th October to 18th December 2021
Drafting final document and recommendations	December 2021 to January 2022
Final draft to delegated Cabinet member for sign off	January 2022
Final document submitted to delegated Cabinet member	February 2022
Document live	1st April 2022

Table 1: Proposed Process for Production of the Warwickshire PNA

1.5 the timescales highlighted in Table 1 may be subject to change if the are further impacts of a second wave of COVID-19.

1.6 The process will be led by the Directors of Public Health and their teams from both Warwickshire and Coventry, with a small steering group in place.

2. Financial Implications

2.1 It is currently anticipated that any costs incurred as a result of taking the recommended actions will be managed within operational budgets, working together with Coventry City Council to maximise the resources available.

3. Environmental Implications

3.1 There are no environmental implications from this update.

4. Timescales associated with the decision and next steps

4.1 The timescales for the proposed process are outlined in Table 1. An update will be brought to a future Health and Wellbeing Board meeting with a final draft for approval in January 2022.

Appendices

1. None

Background Papers

1. None

	Name	Contact Information
Report Author	Duncan Vernon	duncanvernon@warwickshire.gov.uk
Assistant Director	Dr Shade Agboola	shadeagboola@warwickshire.gov.uk
Lead Director	Strategic Director for People	nigelminns@warwickshire.gov.uk
Lead Member	Portfolio Holder for Adult Social Care & Health	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication: WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

This page is intentionally left blank

Agenda Item 12

Health and Wellbeing Board
Warwickshire Better Together Programme

15th September 2020

1. Recommendation(s)

1.1 To note the update on the Better Care Fund Policy Framework and Guidance for 2020/21.

1.2 To note the Better Together Programme schemes that are directly contributing to the local response to the national COVID-19 Hospital Discharge Requirements.

1.3 To note the progress of the Better Together Programme in 2020/21 to improve performance against the four national Better Care Fund areas of focus.

2. Executive Summary

Better Care Fund Policy Framework and Guidance for 2020/21

2.1 Areas have been advised that the 2020/21 Better Care Fund (BCF) Policy Framework will be published at the end of August or early September. These dates are dependent on and subject to change, to enable systems to focus effort in dealing with COVID-19.

2.2 As 2020/21 is a roll-over year, it is expected that the guidance will be mainly consistent with previous years. One likely change is the replacement of the Delayed Transfers of Care target. This has been suspended during COVID-19, with an increased focus on reducing Length of Stay in acute beds and managing timely discharges against the new 'right to reside (in an acute bed)' criteria.

2.3 Although the Policy Framework is still awaited, as previously reported, the schemes and priorities to be delivered this year, have already been agreed locally through the Better Together Programme and have continued to be commissioned and delivered, where possible to do so, during the COVID-19 emergency period.

Schemes directly supporting the local COVID-19 response

2.4 The NHS 'COVID-19 Hospital Discharge Service Requirements' published on the 19th March 2020 set out the discharge requirements for all NHS trusts, community interest companies, private care providers of acute, community beds and community health services and social care staff in England, and

requirements around discharge for health and social care commissioners (including Clinical Commissioning Groups and local authorities). Unless required to be in hospital, patients must not remain in an NHS bed and based on the COVID-19 criteria, acute and community hospitals must discharge all patients as soon as they are clinically safe to do so.

2.5 In response commissioners and delivery leads from Strategy and Commissioning and the Adult Social Care Team in the People Directorate at Warwickshire County Council, have worked with commissioners in the Clinical Commissioning Groups and delivery leads at South Warwickshire NHS Foundation Trust Out of Hospital Collaborative, to support the acute hospitals to discharge patients requiring care and support safely.

2.6 Health and Social Care services currently commissioned or delivered through the Better Together Programme, which are funded in full or in part through the Better Care Fund, have and continue to be critical to our local COVID-19 response as they directly support discharge (step-down) and/or admission avoidance (step-up). Examples include:

- Domiciliary care
- Reablement
- CERT – The Community Emergency and Response Team
- Discharge to Assess pathways 2 (bedded residential) and pathway 3 (nursing)
- Moving on Beds
- The Hospital to Home Service
- The Hospital Social Care Team and the Trusted Assessors for Care Homes
- ICE – The Integrated Equipment Service
- The Learning and Development Partnership which is leading on the bespoke training for Infection Prevention Control for domiciliary care providers

Performance update

2.7 Locally our plan for 2020/21 focusses our activities to improve our performance in the four key areas which are measured against the National Performance Metrics. These being:

a. Reducing Delayed Transfers of Care (DToC) – currently suspended due to COVID-19
b. Reducing Non-Elective Admissions (General and Acute)
c. Reducing admissions to residential and care homes; and
d. Increasing effectiveness of reablement

2.8 A summary of performance against the four national areas of focus using the most recent data available:

Metric	Q1 20/21 performance where available	Target	Status
Delayed Transfers of Care (DToC)	Quarter 4 Actual: Data not available as not published by NHS England	44	n/a
Non-Elective Admissions	Quarter 1 Actual: 11,481	14,912	-23% (below / better than target)
Admissions to residential and care homes	Quarter 1 Actual: 144	182	-20.8% (below / better than target)
Effectiveness of reablement	2019/20 Actual: 94.5%	89%	5.8% (above / better than target)

3. Financial Implications

3.1 The programme and initiatives for its success are in part funded through national grants: Better Care Fund, Improved Better Care Fund and Winter Pressures Grant (2020/21: £57.6m). The former comes from the Department of Health and Social Care through Clinical Commissioning Groups, while the latter two are received by the local authority from the Ministry for Housing, Communities and Local Government. All three are dependent on meeting conditions that they contribute towards the programme and the targets, and that plans to this effect are jointly agreed between Clinical Commissioning Groups and the Local Authority under a pooled budget arrangement.

4. Environmental Implications

4.1 None.

5. Supporting Information

5.1 Performance against the four national areas of focus using the latest confirmed data available.

a. <u>Reducing Non-Elective Admissions (General and Acute)</u>

i) In quarter 1, Warwickshire non-elective admissions were 21.4% lower than the same period last year and 23% below target.

Non-Elective Admissions performance:

Quarter	Actual	Target (lower is better)	% over/below target
Q2 2019/20	14,581	14,175	2.9%
Q3 2019/20	14,520	14,031	3.5%
Q4 2019/20	13,717	14,120	-2.9%
Q1 2020/21	11,481	14,912	-23.0%

NHS	65+ NEAs	All Age NEAs
SWCCG	-27.1%	-29.7%
WNCCG	-11.8%	-17.0%
Rugby	-9.6%	-5.8%
Total	**-19.3%**	**-21.4%**

ii) All Age Non-elective admissions from South Warwickshire Clinical Commissioning Group have seen the greatest decrease in quarter 1 compared with the same quarter last year (-29.7%), compared to Warwickshire North Clinical Commissioning Group at -17.0%. Coventry and Rugby Clinical Commissioning Group saw a 5.8% decrease in all age non-elective admissions. All three sites also reported decreases of 65+ admissions. South Warwickshire Clinical Commissioning Group with the biggest decrease of 27.1% compared to the same quarter last year, Warwickshire North Clinical Commissioning being 11.8% lower than last year for the 65+ age group. Rugby saw a decrease of 9.6% against the same period last year. The variances when comparing to the same periods last year are due to the decrease in activity at hospitals during the Covid pandemic.

b. <u>Reducing long term admissions to residential and nursing care 65+</u>

i) Permanent admissions were 26.53% lower than quarter 1 19/20 and 20.8% below target in quarter 1 2020/21.

ii) The target for 2020/21 is 732 admissions per 100k population, which equates to a quarterly target of 182.

Quarter	Actual	Target (lower is better)	% over/below target
Q2 19/20	200	182	9.9%
Q3 19/20	172	182	-5.5%
Q4 19/20	204	182	12.1%
Q1 20/21	144	182	-20.8%

c. <u>Increasing the effectiveness of reablement</u>

i) This target measures the percentage of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement or rehabilitative services. This target is an annual measure and performance for 2019/20 was 94.5%.

Year	Actual	Target (higher is better)	% over/below target
2017/18	93.0%	89%	4%
2018/19	96.8%	89%	8%
2019/20	94.5%	89%	5.8%

6. Timescales associated with the decision and next steps

6.1 Members are requested to note the latest update on implementing the Better Care Fund in Warwickshire.

Appendices

None

Background Papers

None

	Name	Contact Information
Report Author	Rachel Briden	rachelbriden@warwickshire.gov.uk
Assistant Director	Becky Hale	beckyhale@warwickshire.gov.uk
Lead Director	Strategic Director for People, Nigel Minns	nigelminns@warwickshire.gov.uk
Lead Member	Portfolio Holder for Adult Social Care & Health, Councillor Les Caborn	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication: WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

This page is intentionally left blank

Agenda Item 13

Health and Wellbeing Board

Feedback from the Place Forum

15 September 2020

Recommendations

The Health and Wellbeing Board is asked to:

1. Note and comment upon the outcomes of the joint meeting of the Coventry and Warwickshire Place Forum and Health and Care Partnership Board meeting on 15th July.

1. Executive Summary

1.1 Coventry and Warwickshire's Health and Wellbeing Boards met as the Place Forum in a joint meeting with the Health and Care Partnership Board on 15th July 2020. The meeting was held online via Microsoft Teams and attended by over 70 people.

1.2 The meeting reflected on the response by health and care system agencies to the Covid-19 pandemic and allowed the opportunity to have wider conversations about the implications of COVID19 and the opportunities for working together as a health and wellbeing system and to enable consideration of the most effective route forward.

1.3 The aims of the session were to:

1.3.1 Reflect on the experience and learning from the Covid-19 pandemic
1.3.2 Understand how the pandemic has affected our local communities
1.3.3 Share plans for ongoing virus management and restoration and recovery
1.3.4 Provide key business updates

1.4 The agenda and presentations are available at: https://www.happyhealthylives.uk/about-us/our-partnership-board/

2. Outcomes of the Joint Place Forum and Health and Care Partnership Board

2.1 Learning from our Covid-19 response: Two case study examples of learning from the COVID19 response were shared:

- an emerging proactive approach to staff wellbeing which is being led by Coventry and Warwickshire Partnership Trust, to address the psychological impact of COVID19 on staff across the system; and

- collaborative action between NHS, local authorities and community and voluntary sector partners to implement the national discharge requirements locally – emphasising the strength of existing relationships which enabled a rapid and effective response.

It was noted that the first case study importantly emphasised the inequalities that have been highlighted by the impact of Covid-19 and the need to work across sectors and partners to address these. Related work recently completed by the NHS Assembly was referenced.

2.2 Understanding our communities – the impact of Covid-19 (Duncan Vernon): Findings about the impact of Covid-19 on our communities from a rapid Covid-19 health impact assessment undertaken collaboratively by local authority and CCG insight and intelligence teams were shared. The presentation and discussion reinforced the wide-ranging and long-term consequences of the pandemic and the importance of working together beyond the health and care system, in wider partnership-based approaches, to address these. It was noted that the pandemic has exacerbated and entrenched existing inequalities, and an ongoing collective response will be critical.

2.3 Covid-19 Local Outbreak Control Plans – local implementation as a beacon site (Monica Fogarty, Valerie de Souza): The meeting received a presentation on the COVID19 Local Outbreak Control Plans and the role of Warwickshire, Coventry and Solihull as one of 11 national beacon sites for implementation of the Test and Trace programme. Work in each of the 9 priority workstreams was described, with additional capacity being commissioned in key areas of testing and infection control and prevention (IPC). Discussion focused on the importance of establishing trust with local communities and working with community partners to reinforce key messages to prevent and contain the virus. There was concern about mixed and confusing messages and the importance of "culturally competent" communication, with recognition that compliance would be achieved through community support rather than enforcement.

2.4 Looking forward: Resetting health and wellbeing in Coventry and Warwickshire (Pete Fahy, Shade Agboola): Plans to reset health and wellbeing priorities in Coventry and Warwickshire were shared, emphasising the need to take a population health approach to recovery. Key discussion points included "cultural competency" i.e. understanding values within different cultures and how what we do responds to what they need. This means working with communities and not assuming we know the answer. Discussion also included the need to reduce health inequalities and priority setting for this. The Health and Wellbeing Boards have a key role to play in priority setting, and in ensuring that data and evidence about how to address inequalities is used to inform priorities. There is a need for partners to take responsibility for addressing inequalities both within organisations and collectively as a system. The importance of place-based approaches was also emphasised – data must be combined with local intelligence to inform action in communities.

2.5 Looking forward: NHS Covid-19 restoration and recovery (Adrian Stokes, Andy Hardy): Details of the NHS Covid-19 Restoration and Recovery programme were presented, including examples from Primary Care and Cancer Care of how services have adapted in the context of the lockdown. Primary Care had seen a significant shift to telephone first, and digital consultations where possible, and similarly with 48% of cancer consultations happening through telephone or video. Work is now underway to reopen elective care, with challenges around productivity and prioritisation due to the complexity of different phases of pandemic management and recovery happening concurrently. The acute response to the pandemic was mobilised at impressive speed and this was dependent on collaborative work with system partners

2.6 CCG merger update (Sarah Raistrick, Sharon Beamish, David Spraggett): An update was given on the planned merger of the three CCGs, which remains on track for national approval in autumn 2020, to be effective from April 2021. The merger is an important step in the move to an Integrated Care System and will simplify commissioning, allowing a focus on population health and providing a vehicle to delivery at place. Recruitment to a single accountable officer post across all 3 CCGs is now in progress and it is expected that the appointment will be announced in September. Once the merger is approved, a new chair will also be recruited.

3. Financial Implications

3.1 There are no financial implications from this update.

4. Environmental Implications

4.1 There are no environmental implications from this update.

5. Timescales associated with the decision and next steps

5.1 The following next steps were agreed:

- Ensure that the achievements, challenges and lessons learnt from the system-wide response to the pandemic are captured and harnessed to inform future activity
- Use the Coventry and Warwickshire COVID-19 Health Assessment to inform recovery, restoration and reset plans as a system, in our places and in our organisations
- Work collectively as a system to ensure that priority is given to addressing inequalities in outbreak management and recovery plans
- Re-emphasise our system commitment to health and wellbeing in its widest sense by ensuring our population health model is the framework for

all outbreak management, prevention and recovery activity
- Support development of place recovery plans, working together with local communities to tackle inequalities and improve population health.

5.2 The next meetings of the Place Forum and the Health and Care Partnership Board are scheduled to take place on 3 November 2020

5.3 At the Place Forum meeting on 3 March, there was support for a proposal to hold a summit event, involving wider colleagues from the voluntary and community sector, primary care and community services, focused around the five year plan. An event in this form was not feasible in the current context but it is possible that this proposal could be revisited and, if appropriate at the time, the opportunity could be taken in November to connect with a wider audience.

5.4 Proposals for the November meeting will be developed and brought to a future meeting of the Board.

Appendices
None

Background Papers
None

	Name	Contact Information
Report Author	Gemma Mckinnon, Catherine Shuttleworth	gemmamckinnon@warwickshire.gov.uk, catherineshuttleworth@warwickshire.gov.uk
Director of Public Health	Dr Shade Agboola	shadeagboola@warwickshire.gov.uk
Lead Director	Nigel Minns	nigelminns@warwickshire.gov.uk
Lead Member	Cllr Caborn	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication: WCC members: Councillors Caborn, Redford, Bell, Adkins, Kondakor and Roodhouse

Agenda Item 14

HWB Board *08/01/20*	**Discussion items**	
	New Health and Wellbeing Strategy 2020-25. *Development of a new strategy for discussion.*	Rachel Barnes
	Health Protection Strategy 2017-21. *Progress update.*	Nadia Inglis
	Promoting Health and Wellbeing through Spatial Planning. *Draft guidance document for endorsement.*	Gemma McKinnon
	RISE Update: *Local Transformation Plan Year Four refresh.*	Louise Birta
	Updates to the Board	
	Warwickshire Better Together programme. *Progress update.*	Becky Hale
	Coventry and Warwickshire Health and Care Partnership. *Update report, and position statement from the 3 place partnerships.*	Sir Chris Ham
	Children 0-14 unintentional injuries. *Update from multi-agency steering group on progress.*	Shade Agboola
	JSNA Update. *Implementation of the place-based approach.*	Duncan Vernon
	Drugs and Alcohol Update. *Position statement.*	Rachel Jackson
	Feedback from the Place Forum. *Summary of November meeting and Year of Wellbeing update.*	Rachel Barnes
Place Forum *03/03/20*	**Joint meeting of HWBBs and Executive Team.** *Meeting in Coventry.*	-
HWB Board *06/05/20*	**Discussion items**	
	Draft Health and Wellbeing Strategy 2020-25. *For endorsement.*	Rachel Barnes
	HWBB Governance Review. *Proposed refresh of Membership for endorsement.*	Rachel Barnes
	Place Forum Legacy Report	Rachel Barnes
	Health and Wellbeing Partnerships. *Presentation of Partnership Plans from Rugby, Warwickshire North and South Warwickshire.*	Partnership Leads
	Homelessness Prevention Strategy. *Update on progress.*	Emily Fernandez
	Virtual updates to the Board/Circulation	
	Warwickshire Better Together programme. *Progress update.*	Becky Hale
	Coventry and Warwickshire Health and Care Partnership. *Update report.*	Sir Chris Ham
	Children 0-14 unintentional injuries. *Report from multi-agency steering group on progress.*	Shade Agboola
	Mental Health and Wellbeing update. *Including suicide prevention.*	Emily van de Venter
	Feedback from the Place Forum. *Summary of March meeting.*	Rachel Barnes
	JSNA Update. *Report on the place-based approach.*	Duncan Vernon
	Pharmaceutical Needs Assessment. Progress update.	Duncan Vernon
Place Forum *15/07/20*	**Joint meeting of HWBBs and Executive Team.** *Meeting in Warwick.*	-
HWB Board *15/09/20*	**Discussion items**	
	Commissioning Intentions. *Reports from the CCGs, for endorsement.*	CCGs
	Annual Reports from the Safeguarding Boards. *From Adults and Children's Safeguarding Boards.*	Amrita Sharma
	Health and Wellbeing Partnerships. *Progress reports from the partnerships in South Warwickshire, Warwickshire North and Rugby.*	Partnership Leads
	Smoking in Pregnancy Review. *Presentation*	Liann Brookes-Smith
	Healthwatch Annual Review. *Report for approval*	Chris Bain
	HWBB Governance. *Report for approval*	Gemma McKinnon

	Covid-19 and BAME Report	Shade Agboola
	Immunisation update *Progress report*	Nadia Inglis
	Health Impact Assessment *Report for approval*	Duncan Vernon
	Health and Wellbeing Strategy *Report for approval*	Gemma McKinnon
	Updates to the Board/Updates to the Board/Circulation	
	Warwickshire Better Together programme. *Progress update.*	Rachel Briden
	Coventry and Warwickshire Health and Care Partnership. *Update report.*	Sir Chris Ham
	Feedback from the Place Forum. *Summary of July meeting.*	Catherine Shuttleworth / Gemma McKinnon
	JSNA Update. *Progress report*	Duncan Vernon
	Pharmaceutical needs assessment *Progress report*	Duncan Vernon
	Joint meeting of HWBBs and Executive Team. *Meeting in Coventry*	-
Place Forum *03/11/20*	**Discussion items**	
HWB Board *06/01/21*	**Commissioning Intentions.** *Reports from the CCGs, Public Health and Adult Services for endorsement.*	CCGs and WCC
	New Health and Wellbeing Strategy.	Gemma McKinnon
	Health and Wellbeing Partnerships. *Progress reports from the partnerships in South Warwickshire, Warwickshire North and Rugby.*	Partnership Leads
	Health Protection Strategy 2017-2. *Progress update*	Nadia Inglis
	Homelessness strategy	Emily Fernandez
	Director of Public Health's Annual Report. *Presentation*	Shade Agboola
	Health and Wellbeing Board Governance	Gemma McKinnon
	Updates to the Board/Circulation	
	Warwickshire Better Together programme. *Progress update.*	Becky Hale
	Coventry and Warwickshire Health and Care Partnership. *Update report.*	Sir Chris Ham
	Children 0-14 unintentional injuries. *Update from multi-agency steering group on progress.*	Shade Agboola
	Pharmaceutical Needs Assessment. *Update report.*	Shade Agboola
	JSNA Update.	Duncan Vernon
	RISE Update. *Update on the Local Transformation Plan Year*	Rob Sabin
	Feedback from the Place Forum. *Summary of November meeting.*	Rachel Barnes
	Joint meeting of HWBBs and Executive Team. *Meeting in Warwick*	-
Place Forum *02/03/21*		