Cabinet

Black and Minority Ethnic Communities and Covd-19

9 July 2020

Recommendations

1. To note the main findings from the Public Health England Review of the Impact of COVID19 on Black, Asian and Minority Ethnic (BAME) communities

2. To consider the recommendations included in the report and support their adoption, where the Director of Public Health considers relevant, for Warwickshire and Warwickshire County Council

3. To endorse, using place based JSNA approaches, a review into the relationship between ethnicity and COVID19 in North Warwickshire and Nuneaton and Bedworth.

1. Executive Summary

1.1 Evidence from the early stages of the COVID19 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 COVID19 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 recognizes 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 and its relationship with ethnicity, there is ongoing work within WCC to include BAME status in organisational risk assessments.

1.8 Mangers 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 None

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 is beyond the scope of one organisation to influence, WCC needs to consider which of these are relevant, doable and achievable as an organisation with employees from BAME backgrounds.

4.2 There is also a need to explore the possible relationship between ethnicity and COVID19 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

Appendix

Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities - 10 Recommendations

Background Papers

Beyond the data: Understanding the impact of COVID-19 on BAME groups. A Public Health England Report. June 2020.

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The report was shared with Councillor Les Caborn prior to publication

Appendix

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 11

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