City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Director of Public Health to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 18th August 2020

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Subject: Impact of COVID 19 on Health Inequalities in Bradford District

Summary statement:

Health inequalities existed in Bradford District before COVID-19. The impact of COVID-19 has shone a light on inequalities in terms of poor outcomes relating to deprivation and ethnicity. This report describes health inequalities, provides national and local data on health inequalities in relation to COVID-19, discusses what actions have been taken to date and are planned.

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Portfolio:

Healthy People & Places

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

- Health inequalities existed in Bradford District before COVID-19. Connecting People and Places for Better Health and Wellbeing, the Joint Health and Wellbeing Strategy for Bradford and Airedale 2018 – 23 includes a guiding principle "We work to reduce health inequalities between different people and different parts of the district."
- The impact of COVID-19 has shone a light on inequalities in terms of poor outcomes relating to deprivation and ethnicity. This report describes health inequalities, provides national and local data on health inequalities in relation to COVID-19, discusses what actions have been taken to date and are planned.
- Members are being asked to note the contents of the report and share views on how to progress work to reduce health inequalities.

2. BACKGROUND

- In June Sarah Muckle, the Director of Public health presented to the committee giving an overview of the COVID-19 Outbreak Control Plan including updates on testing, NHS Test and Trace and outbreak management. Ms Muckle was invited by the committee to return to give a more detailed briefing on the impact COVID-19 has had on health inequalities.

3. REPORT ISSUES

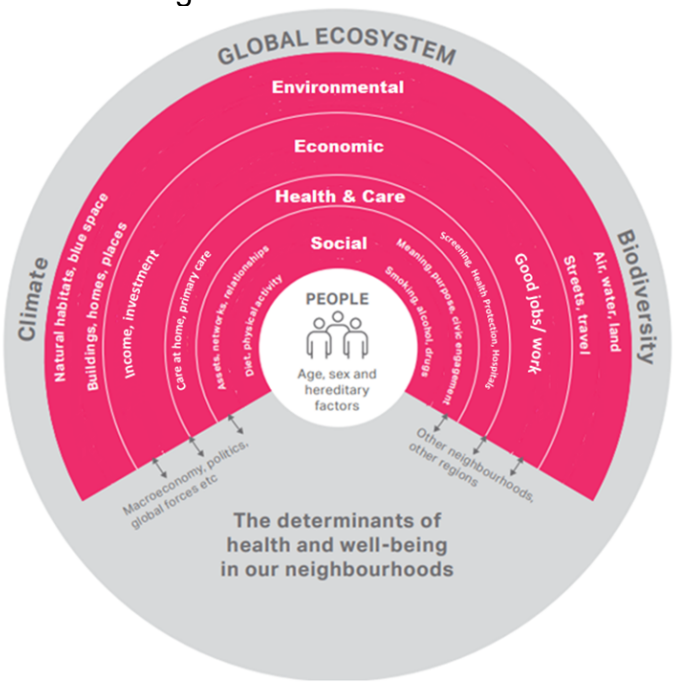
3.1 Health inequalities in Bradford District

In Bradford today there is a 10 year gap in Life Expectancy for both men and women between the most and least deprived areas of our District. A male who lives in the most deprived ward in Bradford (Manningham) can expect to live approximately 10.5 years less than a male who lives in the least deprived ward (Wharfedale) in Bradford (72.8 years compared to 83.2 years). Similarly, a female who lives in Manningham can expect to live approximately 10.3 years less than a female who lives in Wharfedale (78 years compared to 88.3 years). In areas of our District with higher unemployment, lower incomes, more social isolation and poorer housing quality, people are experiencing greater levels of poor mental wellbeing and more people are living with more ill health and dying earlier.

In addition to this inequality *within* our District, Bradford as a whole also often compares poorly to England as a whole too. A clear key headline measure of health inequality is Healthy Life Expectancy; this tells us the average number of years a person would expect to live in good health. In the most recent published data, 2016-2018, Healthy Life Expectancy has actually fallen for men in Bradford District to 60.1 years – the lowest figure on record- while Life Expectancy has risen. This means that a male born in Bradford District can now expect to live on average 17.7 years in poor health before their death; 3.4 years longer than the national average. The trend in the data for women for this same time frame is slightly more positive with an increase in Healthy Life Expectancy from 59.0 to 60.0 years however, the inequality when compared to the national data is much worse with a woman born in Bradford District still living 21.6 years in 'poor health'; 3.9 years longer than the national average. It is a stark symbol of social injustice that those living in the most deprived communities spend more years in ill health and die sooner.

Inequalities in Life Expectancy and Healthy Life Expectancy such as those we see in Bradford can often be attributed to unfair and avoidable differences across the population also and between different groups within society. Inequalities in health are evidenced to arise as a result of systematic variation for a range of social, environmental and economic and health and care service related factors intertwined with individual characteristics such as ethnicity and gender. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. The factors creating these variations are shown in Figure 1; they are complex, frequently intertwined and often mutually reinforcing.

Figure 1: Factors influencing health



3.2 The impact of COVID 19 on health inequalities

3.2.1 National data

Public Health England undertook a national review of the disparities in the risk and outcomes of COVID-19 which was published in June 2020. The review presents findings based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets.

It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them. The largest disparity found was by age. Among people already diagnosed with COVID19, people who were 80 or older were seventy times more likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher

in White ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity, but they do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.

When compared to previous years, PHE also found a particularly high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes. These analyses do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and could explain some of these differences.

3.2.2 Local data

The analysis below is based on the 305 deaths registered in Bradford District between 18th March and 18th July 2020 where covid-19 was listed as the *primary* cause of death.

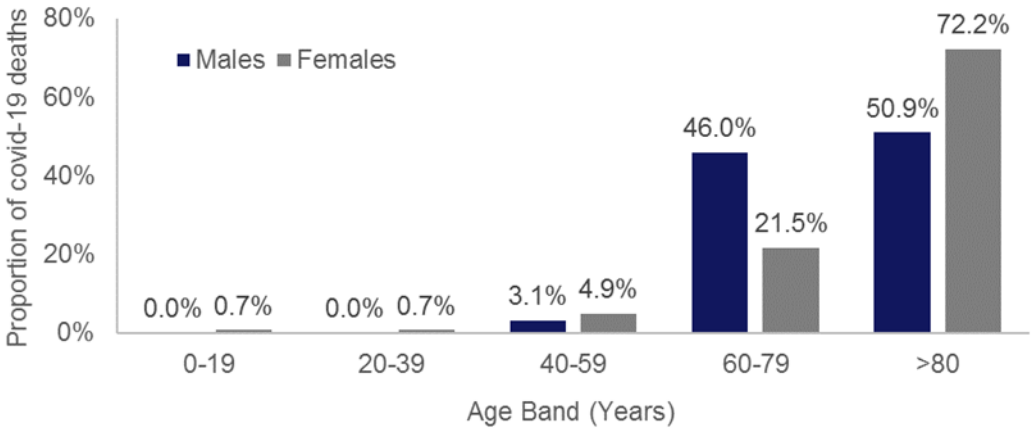
Age and gender

In Bradford District the largest disparity in terms of death from COVID 19 is also age. Figure 2 below shows the relationship between dying from COVID 19 and age and gender. In Bradford District, where COVID-19 was listed as the primary cause of death, 52.8% of people who died were male and 47.2% were female.

In terms of age, the majority of deaths were in people aged 60 years and above, this is true for both males and females (96.9% and 93.8%). For males 46% of deaths were aged 60 to 79 years and 50.9% were aged 80 years and above. For females 21.5% of deaths were aged 60 to 69 years and 72.2% were aged 80 years and above. The disparity between the proportion of male and female deaths aged 80 and above is likely due to differences in population structure.

A further 3.1% of male deaths and 4.9% of female deaths were aged 40 to 59 years. There were zero male deaths aged between 0 to 39 years registered with COVID-19 as the primary cause of death in Bradford District. However, for females 0.7% of deaths were aged 0 to 19 years and 0.7% were aged between 20 to 39 years.

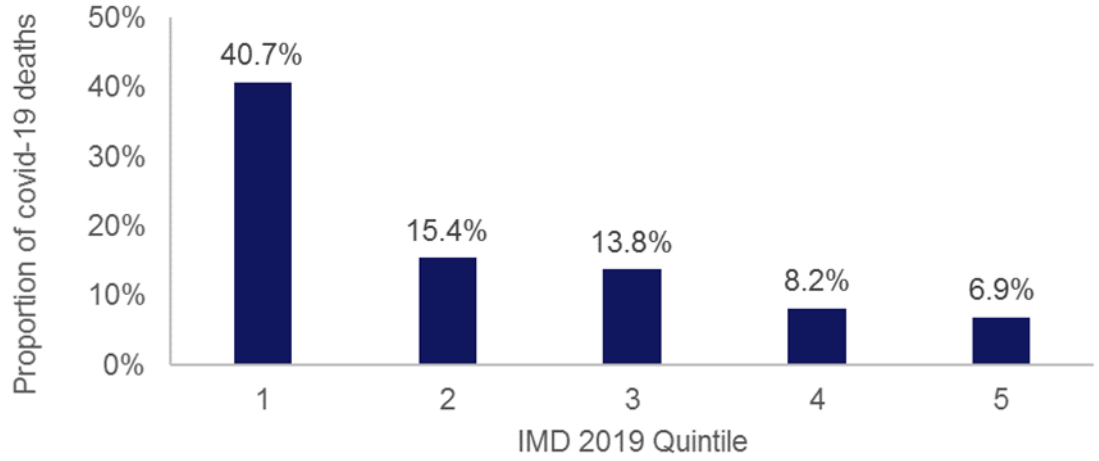
Figure 2: The proportion of covid-19 deaths in Bradford District by age and gender



Deprivation

The correlation between dying from COVID-19 and deprivation is strong. 40% of people who died were residents who lived in the most deprived areas of Bradford District (quintile 1) compared to 7% in the least deprived areas (quintile 5). A further 15.4% of deaths were residents in quintile 2; 13.8% in quintile 4 and 8.2% in quintile 4. The quintiles describe the proportion of people in Bradford District who are amongst the 20% most deprived nationally. 47% of our population live in Lower Super Output Areas which are categorised in the most deprived quintile and 9% of LOSOAs are categorised as quintile 5.

Figure 3: The proportion of covid-19 deaths in Bradford District by IMD 2019 quintile



Ethnicity

Ethnicity is not currently recorded on death certificates so it is not possible to produce a graph of death by ethnicity. Public health did plot postcodes of deaths against the percentage of population identifying as Black Asian and Minority Ethnic in the 2011 census and found no correlation between ethnicity and death. These data are identifiable so have not been included. However, ethnicity is recorded in hospital data. BIHR have analysed hospital data for COVID 19 patients. The risk of dying is very slightly lower in Pakistani patients in Bradford compared to White British patients. The risk of catching COVID 19 it is more difficult to measure as not everyone reports symptoms, has contact with health services, and is tested - and there could be differences in each of these between different groups. At the

moment there is an assumption that more South Asian people are exposed to the virus and have a higher risk of catching it because of high numbers in households, inter-generational living and jobs where they are more exposed.

People who are socially vulnerable to COVID-19

COVID-19 can impact directly (illness and death) or indirectly. In addition to illness and death, research has been undertaken in Bradford District to consider which groups of people may be more socially vulnerable to the impacts of COVID 19. This work was led by Pippa Bird, working with partners in the Covid Scientific Advisory Group. Whilst everyone is affected by measures to control COVID-19, some groups in Bradford are experiencing disproportionate health, social and economic impacts. COVID-19 has both amplified the existing inequalities in society, and created new risks and impacts for people who may not previously have considered themselves to be vulnerable. The following groups have been identified as particularly vulnerable to wider health, social and economic impacts. These categories overlap (some people face multiple vulnerabilities) and are likely to change throughout the COVID-19 response. The following groups have been identified as particularly vulnerable to the wider impacts of COVID-19. This list has been developed through theory and evidence, including from groups included in PHE work on a COVID-19 health inequalities impact assessment and discussion with members of the CSAG work stream on vulnerable groups.

Figure 4: Groups who are vulnerable to the wider health, social and economic impacts of COVID-19 in Bradford District

Group/characteristic	Number of people	Data source & notes
a) POVERTY AND EMPLOYMENT		
Households living poverty or the most deprived areas	266,500 in most deprived areas	IMD. Definition: people living in the bottom two deciles
Children living in poverty	17,656 claim free school meals	DFE. However, many eligible children are not claiming FSM
Households with food poverty/insecurity	Current number unknown	Data can be compiled from community hubs, food banks BiB research
Households with insecure or poor quality housing or in HMOs	Tenants of 556 HMOs with shared entrance and hallways and 662 HMOs with shared kitchens/ bathrooms.	Bradford council – public health Insecure housing – awaiting estimate
Homeless people	52 street homeless people rehoused. Housing needs: 2,684	Bradford council – housing. Note – housing needs are annual figures

	people with prevention, relief/main duty in 2019/20. 3,420 people with statutory or urgent need.	
Self-employed people and their households	29,000 self employed 1,500 not covered by existing scheme	ONS data (1,500 estimate is based on a national estimate that 5% are not covered).
People with precarious employment	5,500 with flexible temporary contracts. 25,000 in informal/gig economy	ONS, Estimate based on a European Study
People who have become unemployed / been furloghed	Current number unknown	DWP universal credit new claimants
B) HEALTH AND DISABILITY		
People with long term health conditions (including shielding and clinically vulnerable groups)	16,000 people on the shielded list >200,000 are eligible for the flu jab	CCG. Note: flu jab data includes eligibility for other characteristics, including age and pregnancy
People with physical disabilities or communication difficulties	2,947 people with physical disabilities	CCG
People with autism or learning disabilities	4,724 people with autism; 1,128 children with autism known to schools 4,282 people with LD; 5,644 children with LD known to schools; 1,510 adults receiving long term social care support	CCG, Fingertips
People with mental illness, including severe mental illness	6,582 people with severe mental illness	CCG – SMI QOF register
People with alcohol or drug use problems	Alcohol: Estimated 6,275 dependent drinkers	Fingertips (LAPE) – estimated from APMS. Treatment numbers from

	and 765 people in treatment Drugs: 2,940 people in treatment for drug use	NDTMS. Number at risk of problem alcohol consumption unknown.
People with an unpaid caring responsibility	15,110 carers 251 registered young carers	CCG. However, many carers are not registered
c) PROTECTED CHARACTERISTICS		
People from Black, Asian and Minority Ethnic backgrounds	190,000	Council website
Recent migrants/ asylum seekers and refugees	Unknown	
Central and Eastern European people	12,000 CEE	Estimate (2014 Health Needs Assessment)
Roma and traveller people	Unknown. Estimates range from 6,000 up to 15-25,000 Slovak Roma people	Estimates from 2014 Health Needs Assessment and insights from services
Pregnant women and new parents	7,300 pregnant women	CCG
LGBT people	unknown	
d) OTHER VULNERABILITIES		
Single person households (especially single over 70)	59,000	Council website
Lone parent families	17,800	Annual population survey for Bradford
Digitally excluded people	33,230 no basic digital skills; 64,461 internet non-users. Over 75s: 62% women, 49% men internet non-users. Young people: 36% of 16- 24 year olds in mobile-only households	All figures are estimates. Application of Lloyds Bank Consumer Index figures to Bradford. ONS
People at risk of domestic violence or abuse	Victims of domestic violence - 21,300 (male=7,100, female= 14,310)	Estimate – application of British Crime and Victim Survey to population data.
Children at risk of safeguarding concerns	1,047 Children In Need	Social services. Current number of

	958 Child Protection Plans	children at risk unknown.
People who have recently been released from prison	unknown	
People experiencing gambling harms	unknown	
People who are engaged in or at risk of sex working	80-100 people actively engaged	Service insight

The numbers of people in the groups identified, and the groups with greatest vulnerability are likely to change over time due to the large and rapid health, social and economic changes. It is difficult to predict who will suddenly lose income and require support for basic needs. Many of the groups identified are very large (e.g. over 200,000 fall into the government defined 'vulnerable' category who are advised to conduct strict social distancing). However, the groups overlap and many people are coping with multiple, overlapping vulnerabilities. These people are likely to be most at risk of wider health, social and economic impacts.

Social distancing and the COVID control measures have a particularly disproportionate health, social and economic impact on people living with low income for 2 reasons. Firstly COVID-19 and the control measures have created new risks and impacts, e.g. loss of employment, closing of schools and impact on the attainment gap. People living with a low income are more likely to be in work that exposes them to infection, e.g. working in retail, and are less likely to be able to work from home. Secondly COVID-19 and the control measures have also amplified the everyday experience of living in poverty – e.g. the impact of living in overcrowded housing is greater during lockdown due to increased family stress, lack of space for children to play or do school work when it is it not possible to go to the playground or to school.

These risks continue as we move into the COVID-19 recovery phase. For example community fears regarding vaccinations, digital exclusion of vulnerable people, hospitals might start clearing clinic and surgery lists from people living in affluent areas leaving deprived area people in worst circumstances.

3.3 Responding to COVID1-19 through an health inequalities lens

There have been three main ways Bradford Council has led the response to COVID-19; with the aim of reducing exacerbation of health inequalities. Firstly through working with communities, secondly through targeting prevention and control activities and finally through targeted research with partners.

Working alongside communities has been a priority. Community engagement underpins our whole strategy. We work with diverse communities and have ensured accessibility in different languages and formats. We have undertaken street level engagement in vulnerable communities. We have produced advice and guidance for multi-generational households - in community languages. We have produced one minute videos featuring clinicians and are working with Council for Mosques and engaging with the business community. We have a comprehensive and engagement plan in place.

We target infection prevention and control equitable to ensure needs are met. This

is set out on our multiagency Outbreak Control Plan which is published online. We continue to build relationships, capacity, systems, training and development to respond as needed. We are focused on communities and partners who work with our most marginalised communities to reduce inequalities. We have put in place a comprehensive testing strategy aiming to ensure testing is accessible to all e.g. new walk up city centre testing site, and work to explore and indoor / outdoor testing facility in Keighley. We want to secure test kits to distribute via community anchors and are involved in a national pilot offering tests to people who are asymptomatic but work in occupations that place them at higher risk of contracting COVID-19. We have strong partnership working relationships and share good practice with nearby councils, PHE, communities and research institutions.

We are a key member of the Covid-Scientific Advisory group, which is a collaborative multi-agency partnership coordinate evidence to produce intelligence, tailored to the District. C-SAS has focused on understanding risks and impact on communities facing a disproportionate impact from COVID-19, specifically people living in deprived communities and BAME communities. C-SAG evidence was reported directly into Bradford District Gold Command and informed the pandemic response.

3.4 Longer term response to reducing health inequalities in Bradford District

Tackling health inequalities is not new. It has been the focus of public health for decades. A huge amount of work is underway being delivered by public health, the council, PHE, the West Yorkshire Integrated Care System and broader partners. One example is a multiagency programme work, known as Reducing Inequalities in the City (RIC) programme led by the Bradford District & Craven CCG, focusing on about 150K population living in the most deprived areas served by the old Bradford City CCG. There are multiple work streams for example those focusing on improving health of homeless people, social prescribing for young people, mental health support in schools and communities, community connectors, community development workers, welfare benefits advice, enhanced primary care support for people who are shielding, carers and frail, improving chronic disease management, smoking cessation in pregnant women, tackling childhood obesity and improving early cancer screening.

Following the spotlight COVID-19 has shone on entrenched health inequalities; to refocus a multiagency response to target efforts to reduce health inequality in Bradford District. A plan to reduce inequalities has been drafted and focuses on four approaches to reducing inequalities: civic interventions, community centred interventions, service based interventions and place based planning.

3.4.1 Civic interventions

Civic interventions focus on healthy public policy, which drives the social determinants of health and wellbeing. For example, transport, planning, education, employment and the built environment and welfare. It can be used to provide community infrastructures and to work effectively with services to inform, support and enforce. Tools to inform and drive change in this sphere include Health Equity Assessments and a Health in All Policies Approach which together can help to inform change and drive and embed action on health inequality.

3.4.2 Community centred interventions

Communities include neighbourhoods, workplaces, schools and other groups of common interest, culture or religion. They can use their assets within civic infrastructure, resources and support, working with services that listen, engage, adapt and empower people to become involved in some aspects of their health and wellbeing. The quality of community life, social support and social networks are major influences on individual and population health, both physical and mental. There are excellent resources from both NICE, PHE and NHS England on using community assets health and wellbeing covered in the next section. Both these resources can be used to support local action on inequalities with much potential to self-assess our existing Community Partnerships. Community Partnerships are our way of delivering integrated community health, care and wellbeing services, through locally led partnerships, covering communities of approximately 30-60,000 people.

3.4.3 Service based interventions

If high quality services producing good outcomes at an individual level are delivered with sufficient system, scale and sustainability, those successes can add up to population level change. Services for considerations extend much beyond health services and efforts should explore and be assured of equitable quality service provision in areas such as adult education and employment services, sport and leisure services and flexible affordable childcare services where inequality in provision and or outcomes in time can go on to create inequality in health.

Equity and equality should be considered at all stages of the commissioning/ procurement process with elements of community centred co-design at the outset and again throughout the cycle. Effective service based interventions work better with the combined input of civic and community interventions, for example a tobacco control strategy will include civic regulation on smoking in public spaces, and contraband sales; support to community campaigns and smoking policies in workplaces; as well as smoking cessation services.

3.4.4 Place based planning

Place-based planning which is built on quality characteristics such as strong leadership, effective partnership, joint vision and credible strategies, can drive measurable change bringing the impact of the individual segments together and can also enhance impact by focusing on the 3 interfaces or ‘seams’ between the segments. With creative working across, the whole can become greater than just the sum of the parts. This is the system leadership where multiple partners come together for the purpose of improving the ‘place’ of Bradford and though health care presence is paramount it does not need to be health centric.

4. RECOMMENDATIONS

Recommended -

The Committee note the contents of the report.

5. BACKGROUND DOCUMENTS

- Bradford District Outbreak Control Plan (June 2020) https://www.bradford.gov.uk/media/5921/bradforddistrictcovid-19outbreakplan.pdf
- Connecting People and Place for Better Health and Wellbeing. Joint Health and

Wellbeing Strategy for Bradford and Airedale 2018 – 23 Source: https://bdp.bradford.gov.uk/media/1331/connecting-people-and-place-for-better-health-and-wellbeing-a-joint-health-and-wellbeing-strategy-for-bradford-and-airedale-2018-23.pdf

- C-SAG (June 2020) Groups who are vulnerable to the wider health, social and economic impacts of COVID-19 in Bradford. Source: https://www.bradfordresearch.nhs.uk/wp-content/uploads/2020/07/CSAG-Socially-vulnerable-groups-Briefing-Paper-v5-22-06-20.pdf
- Public Health England (June 2020) Disparities in the risk and outcomes of COVID-19. Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf
- J West, G Santorelli and B Kelly. (2020) Ethnicity and COVID-19 cases and Deaths in Bradford District. Source: BIHR COVID-19 Scientific Advisory Group Briefing Paper: Ethnicity and COVID-19 cases and deaths in Bradford District 13th April 2020