Sunderland Covid-19
Health Inequalities Strategy

Annex one

Sunderland City Council

1. Overview

The coronavirus (COVID-19) pandemic, and the wider governmental and societal response, have brought health inequalities into sharp focus.

People facing the greatest deprivation are experiencing a higher risk of exposure to COVID-19 and existing poor health puts them at risk of more severe outcomes if they contract the virus. The government and wider societal measures to control the spread of the virus and save lives now (including the lockdown, social distancing and cancellations to routine care) are exacting a heavier social and economic price on those already experiencing inequality. The consequences of this action, and the economic recession that is likely to follow, risk exacerbating health inequalities now and in years to come[1].

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, 'Fair Society Healthy Lives', was published in February 2010, and concluded that reducing health inequalities would require action on key six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

The recent report entitled Health Equity in England: The Marmot Review 10 Years On[2], examines a decade of data to understand the worsening situation of health inequality in the UK and paints a terrifying picture of the health and well-being of the people of the North East of England.

As the Marmot review 10 years on showed, deprived communities in England have seen vital physical and community assets lost, resources and funding reduced, community and voluntary services eroded, and public services cut over the past decade. All of this has damaged health and widened inequalities. Looking ahead to the aftermath of the pandemic, lessons from the past decade of austerity must be learned. People can now expect to spend more of their lives in poor health:

Improvements to life expectancy have stalled for the first time in over 100 years, and actually declined for the poorest 10% of women;

- The health gap has grown between wealthy and deprived areas;
- That place matters – living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less.

Speaking at The Stadium of Light in March at the North East Annual Public Health conference, Professor Sir Michael Marmot made three very telling points with regard to the findings of the 10 years on report:

- The actual number of years spent in illness is rising in the whole population;

[1] https://www.health.org.uk/publications/long-reads/will-covid-19-be-a-watershed-moment-for-health-inequalities#lf-section-59576-anchor

[2] https://www.health.org.uk/funding-and-partnerships/our-partnerships/health-equity-in-england-the-marmot-review-10-years-on

- As pension age increase to 68 so is the proportion of the population that has a disability leading to a general decline in the quality of life;

When the 2010 report was produced there was an understanding of the causes of health inequality. In the next 10 years, austerity was clearly a cause of a significant increase of health inequality and this remains the case today.

Deprived communities may experience more direct and indirect impacts because they already have greater vulnerability and are likely to have a compromised ability to respond to the extra impact of COVID-19. ONS data indicates that people from the most deprived areas of England and Wales are more likely to die with coronavirus than those in more affluent places. The data shows there were 55 deaths for every 100,000 people in the poorest parts of England, compared with 25 in the wealthiest areas.

David Finch, Senior Fellow at the Health Foundation, said: 'The link to deprivation is complex given the virus has spread more in densely populated urban areas that tend to be more deprived. However, there are clearly ways in which existing inequalities mean the crisis is having a disproportionate impact on certain groups. Those facing greater socio-economic disadvantage tend to live in cramped housing conditions and many are now classified as essential workers who don't have the option of working from home, placing them at higher risk of exposure to COVID-19. People living in more deprived areas are also more likely to have one or more long-term health conditions, which means they are at greater risk of suffering severe symptoms from the virus if exposed[3].

The Office of National Statistics data released on the 1st May 2020 provides important and early insight into how the patterns of death from COVID-19 are corresponding with patterns of deprivation in local areas in the UK. It reveals a clear and worrying trend – that deaths in the most deprived areas are more than double those in the least deprived[4].

Public Health England 'Disparities in the risk and outcomes from COVID-19[5]' confirms the impact of COVID-19 on existing health inequalities and it concluded that it will be difficult to control the spread of Covid unless these inequalities can be addressed.

The largest disparity 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.
- The risk of dying among those diagnosed with COVID-19 was higher in males than females - however in the North East females had higher diagnosis rates than in London.
- By deprivation - higher in those living in the more deprived areas than those living in the least deprived.
- By ethnic group - higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups.

When compared to previous years, they found a particularly high increase in all cause deaths among those in a range of:

- Caring occupations including social care and nursing auxiliaries and assistants
- People who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs
- Those working as security guards and related occupations
- Those in care homes

[3] https://www.health.org.uk/news-and-comment/news/deaths-from-covid-19-in-the-most-deprived-areas

[4] https://www.ons.gov.uk/deaths/datasets/deathsinvolvingcovid19bylocalareaanddeprivation

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

Public Health England has published a further report 'Understanding the impact on BAME communities[6]' which gives recommendations 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.

Whilst public health can target those at greatest risk of health inequalities as a result of COVID through its commissioned services, a whole system and health in all policies approach that engages the wider council and partners is required to strengthen the recovery response with key at risk populations. At the time of writing there is clear evidence that Covid-19 is impacting on our most deprived communities. Key risk groups include residents of care homes, people with long term conditions, those on low incomes, at risk to domestic abuse, with mental illness, vulnerable children, older people, unemployed, with physical and learning disabilities and ethnic minorities and religious groups, however this may change as we gain more insight of the impact of Covid-19 on our communities.

This strategy sets out Sunderland's response to COVID-19 and its impact on health inequalities in Sunderland. It builds on previous strategies where health inequalities have been identified including the Sunderland Health and Wellbeing Strategy, Director of Public Health report 2019[7] and Draft Public Health Strategy[8] and City Plan[9].

This strategy will focus on all available evidence to date where key health inequalities have been recognised as a result of COVID-19, but it will also consider and respond timely to any emerging evidence as it evolves. This will include the literature review and health inequalities framework currently underway, led by Public Health England.

Therefore, the Health Inequalities Strategy will:

- Raise awareness of the importance of health inequalities in both the response and recovery to Covid-19
- Follow the key principles set out in the Healthy City Plan, and use data, intelligence and evidence to systematically understand the natural and unintended consequences that may have widened health inequalities
- Support local organisations and communities to consider how their work may impact on health inequalities, as described in the Sunderland Prevention and Health Inequalities Framework
- Consider the evidence to ensure that any recommendations will prevent or mitigate health inequalities widening as part of the Covid-19 pandemic

There is a danger that in our response to COVID-19 we abandon our community asset-based approach to reducing health inequalities as we have set out in the Health and Wellbeing Strategy, Healthy City Plan and draft Public Health Strategy. However, it is the opportunity to accelerate the approach by using and responding to local intelligence, build on relationships and resident experiences gathered as part of the City's immediate response from volunteers (existing and recruited as part of the response), shielded call themes, risk assessments on our vulnerable young people, any other sources of intelligence.

There are obvious links to the Council's Social Recovery Group and its functions, which are to:

- Gain an understanding of the current and future impact of COVID-19 on Sunderland's households and communities;
- Identify what additional demand for service, if any, may present because of COVID-19 and if the ask will be different to what we are used to;

[6] https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

[7] Director of Public Health report 2019

[8] Draft Sunderland's Public Health Strategy

[9] Healthy City Plan

- Seek to integrate existing data sets to understand what interventions and prevention measures will be required and what responses will be required by council services more generally.

The Strategy will follow the key principles and messages set out in the Heathy City plan:

- Recognition of the stark health inequality across the city
- Acknowledgement that the social determinants of health (Marmot) are still relevant 10 years on
- Focus on prevention
- Focus on closing the disadvantage gap

It is important however to acknowledge the evidence the Strategy will change as we identify and respond to evolving need.

2. What do we know about Health Inequalities?

As highlighted by 'Health Equity in England: The Marmot review 10 years on' report, health is affected by the environment and community in which we live. The more deprived the area, the shorter the life expectancy and the poorer the state of health within these shorter lives.

Diagram one: What makes us Healthy?

Director of Public Health Report 2019

Sunderland's Director of Public Health Report 2019[10] shares how the health of the city's people continues to be heavily impacted by the economic and social inequalities that individuals and communities experience. We know that 38% of the population are amongst the most disadvantaged in England and one in five of our children live in poverty.

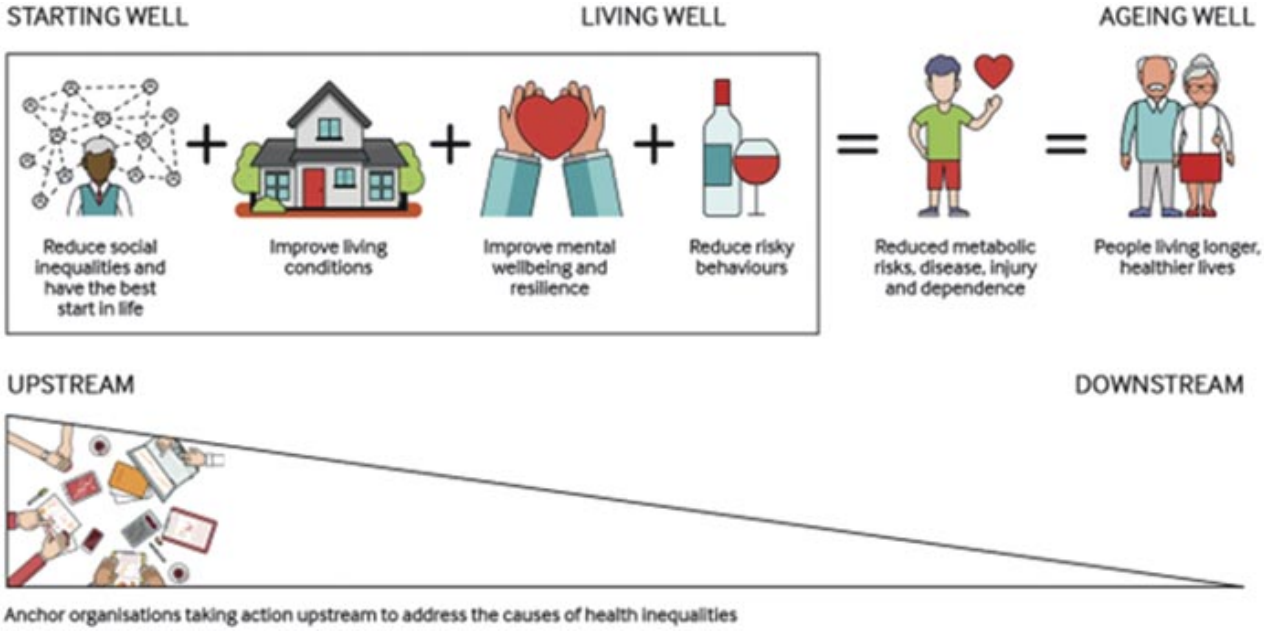
The report goes on to highlight the stark inequalities in health outcomes both between Sunderland and the rest of the country and within the city itself (diagram three). The causes vary in the way they impact on health and can be thought of as having either an "upstream" or "downstream" effect. Intervening "upstream" means that we are preventing poor health developing, whereas when we focus "downstream" we are less likely to impact on peoples' health in the long term.

Sunderland Health and Wellbeing Board

Sunderland's Health and Wellbeing Board Framework for reducing health inequalities and preventing poor health demonstrates how we will implement this effectively through an "upstream: downstream" approach. Intervening "upstream" means that we are putting measures in place to prevent poor health developing, whereas when we focus "downstream" we are treating poor health. Often multiple actions are needed to address any single issue. The framework in diagram two is embedded within Sunderland's Healthy City Plan:

[10] https://www.sunderland.gov.uk/article/13881/Director-of-Public-Health-Annual-Report

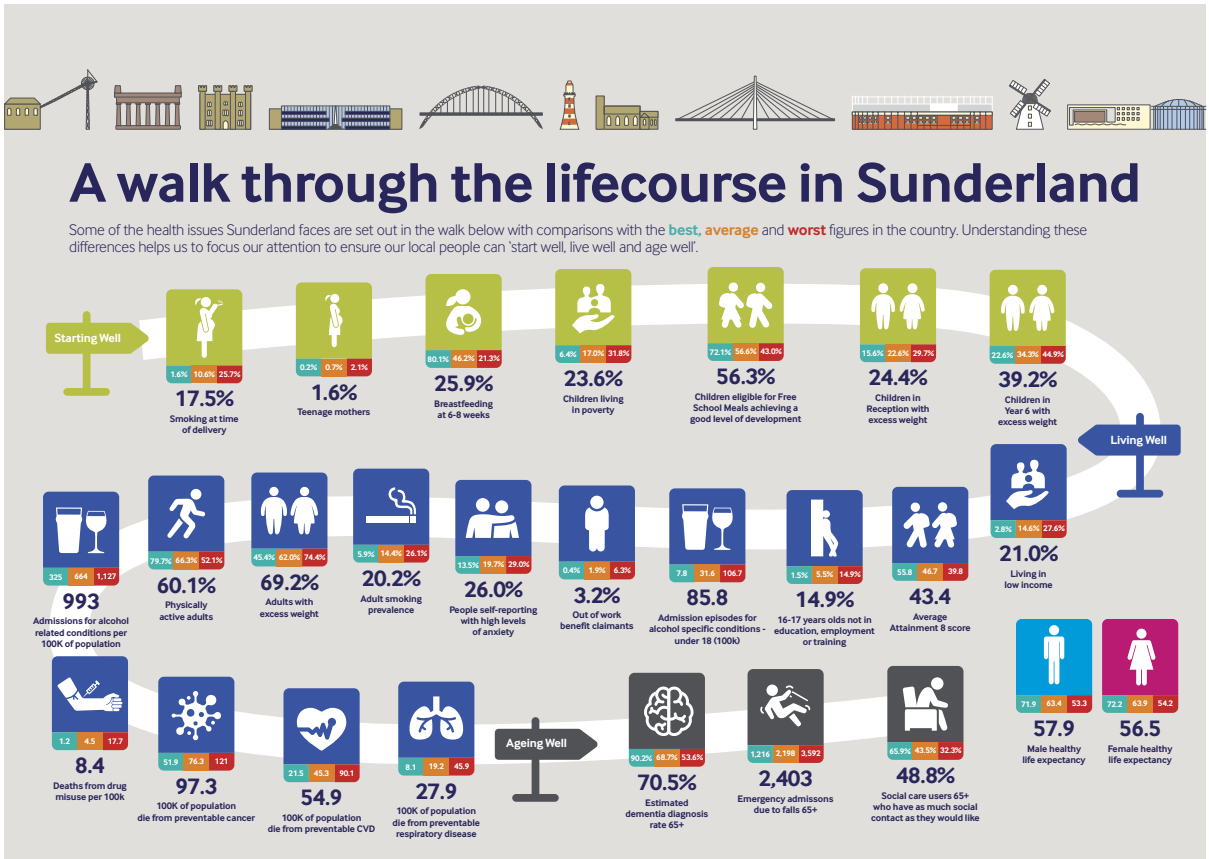
Diagram two:
Framework for reducing health inequalities and preventing poor health



Anchor organisations taking action upstream to address the causes of health inequalities

The Health and Wellbeing Board adopts a life course approach which identifies the key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age and into older age.

Diagram three:
Health through the lifecourse in Sunderland



Sunderland City Plan

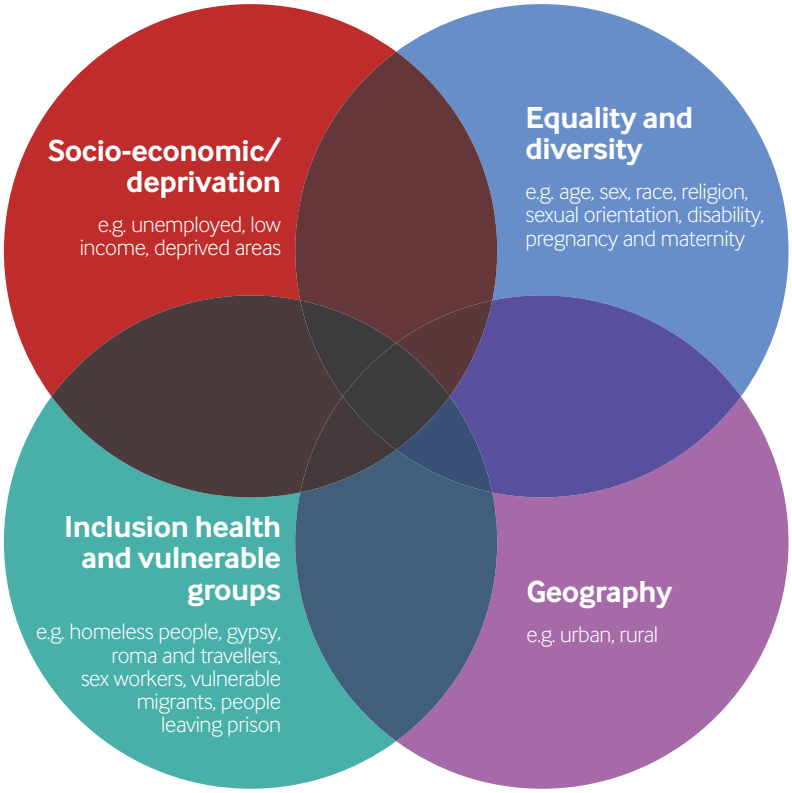
Our City Plan with its ambitions to create a Dynamic, Healthy and Vibrant City, will have the greatest impact on people's lives in relation to social determinants. Changes are already happening with modern homes and workplaces being built, access to the city is being improved and historic buildings are being restored and re-imagined for the future. The City Board will oversee these improvements.

3. An evidenced based approach

Recent work carried out by the Royal College of Physicians gathered evidence and examples of how to mitigate the impact of COVID-19 on inequalities[11]. Diagram four below illustrates how some groups within the population may be disproportionately affected by COVID-19. There are clear reasons for giving consideration and support to those groups that experience health inequalities.

The economic and social response to COVID-19 has the potential to exacerbate these health inequalities. Those in low paid or insecure work, or with existing health conditions or who were already socially isolated, may find it increasingly difficult to afford rent, bills and food and also struggle to access the services they need. This is likely to have a significant toll on both their physical and mental health.

Diagram four: Overlapping dimensions of health inequalities



According to the Joseph Roundtree Foundation people locked in poverty face challenges staying afloat in the face of rising costs and income loss that will come as a result of the Coronavirus outbreak. They are also more likely to be in poor health, disabled, and to be caring for others. In addition, people stuck in poverty are more likely to experience anxiety, depression and other mental health difficulties. The services on which people on low incomes rely on are also at risk of disruption, such as food banks and advice teams.

Workers trapped in poverty are more likely to have insecure jobs, with fewer rights and employee benefits, and they are less likely to have savings to help cover additional unplanned costs or gaps in income. People on low incomes face additional costs from rising prices in shops and higher bills from staying at home[12].

[11] https://www.rcplondon.ac.uk/news/covid-19-and-mitigating-impact-health-inequalities

[12] https://www.jrf.org.uk/report/talking-about-coronavirus-and-poverty-guide-framing-your-messages

Research by the Institute for Fiscal Studies (IFS) has concluded that Britons from black African backgrounds are dying from coronavirus at 3.5 times the rate of white people. Those with black Caribbean or Pakistani heritage are also at significantly greater risk of dying from COVID-19. The IFS study said given demographic and geographic profiles, most minority ethnic groups are dying in "excess" numbers.

The impact of COVID 19 is likely to further exacerbate health inequalities across Sunderland. Sadly, there are many groups in society who will be hit harder by the outbreak: not only older people, those with underlying health conditions and healthcare workers but those who are vulnerable simply because they do not have the same opportunities to stay healthy.

C-WorKS[13] has been set up to support the collation and sharing of knowledge and intelligence across the system about the impacts of COVID-19 (and the response to this) on non-COVID morbidity and mortality. Its primary aim is to bring people and organisations who will hold different pieces of knowledge and understanding together to enable more effective, equitable and efficient ways of working across the whole region. C-WorKS will facilitate sharing of information, reduce duplication, highlight gaps and maximise the value of non-COVID, system-wide work done in this region

[13] https://khub.net/web/guest/welcome?p_p_state=normal&p_p_mode=view&refererPlid=47706490&saveLastPath=false&_com_liferay_login_web_portlet_LoginPortlet_mvcRenderCommandName=%2Flogin%2Flogin&p_p_id=com_liferay_login_web_portlet_LoginPortlet&p_p_lifecycle=0&_com_liferay_login_web_portlet_LoginPortlet_redirect=%2Fgroup%2Fphine-network-north-east

4. Impact of Covid-19

Across the life Course

The Institute of Fiscal Studies in their report[14] "We may be in this together, but that doesn't mean we are in this equally" highlights a wide range of socioeconomic consequences of Covid-19 impacting across the life course (diagram five) including:

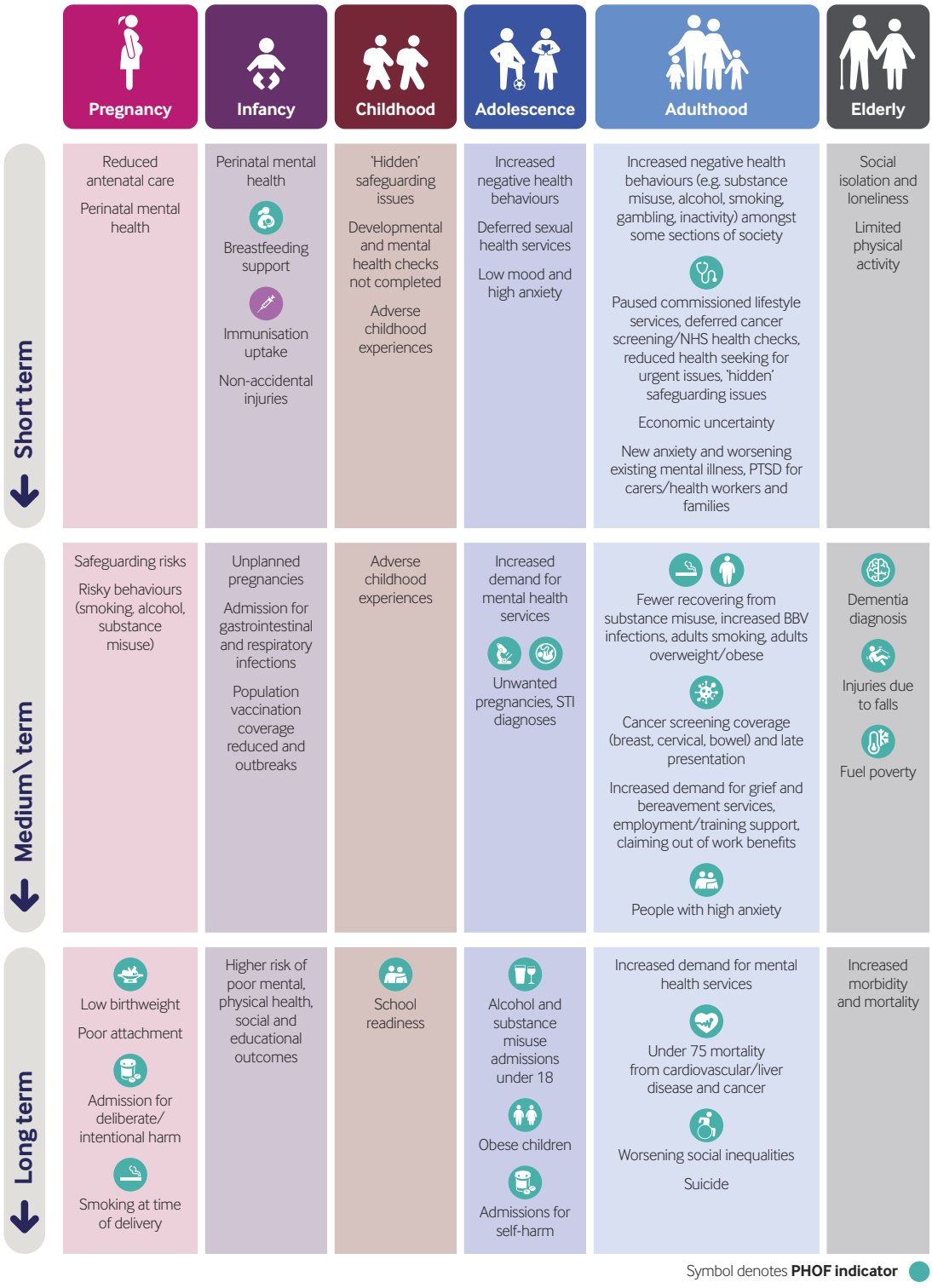
- Young People (workers under 25) – are two and a half times more likely than those over 25-year olds to work in sectors that have closed entirely, or experienced significant impact of Covid-19 such as hospitality and non-food retail;
- Young People (those leaving school or graduating from university this summer) - will be entering the labour market in the middle of a severe recession reducing their employment opportunities;
- Universal Credit claimants – the furlough scheme will protect many workers in the short term, however in the medium to long term many job losses may be experienced by this population group;
- Implications for older people staying healthy;
- Implications for the business and housing sector.

The measures taken to manage the spread of COVID-19 will have extensive implications for income, job security and social contact and safety. The Health Foundation (2020) describes how these factors will have a powerful influence on people's ability to live healthy lives stating "Without consideration of the long-term health implications of the lockdown and likely economic shock, which stem from necessary measures to protect lives in the short term, the toll on the nation's health risks going well beyond the number of people who will die with COVID-19".

As we move into the Covid-19 recovery and response phase sustaining a steady low-level of transmission of the virus is important if we are to effectively manage the avoidance of further outbreaks. This can be achieved by the continuation of effective health protection measures including social distancing which run in parallel with a range of evidence-based interventions during the short- and medium-term recovery and response process.

[14] https://www.ifs.org.uk/publications/14821

Diagram five:
Impacts of Covid-19 pandemic through the lifecourse



5. Groups identified as vulnerable as a result of Covid-19

Public Health England suggests several groups have been identified as vulnerable as a result of COVID -19 and the measures put in place to manage the pandemic.

Low income families

Workers in poverty are more likely to have insecure jobs with fewer rights, and less savings to help them bridge any gaps in income. Currently 21% of the city's population have low income.

People may experience loss of income from social distancing in several ways. For example, those in public facing roles or workplace closures or those who cannot go back to work due to school closures. There are large numbers of the population who are vulnerable to the economic effects as they do not get sick pay, are on zero hours contracts, or are self-employed.

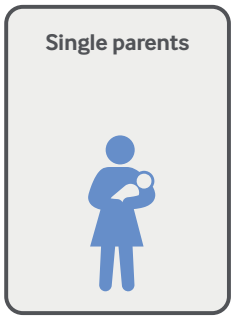
People on low incomes face additional costs from rising prices in shops and higher bills from staying at home.

They are more likely to be in poor health, disabled, and/or caring for others, and services they rely on, such as food banks and advice teams, are also at risk of disruption.

Domestic abuse victims

The emergency response to the COVID-19 pandemic may exacerbate and escalate domestic abuse. The isolation of families could exacerbate domestic abuse, as perpetrators will be more likely to be at home with the victim, and the traditional routes to help and support such as schools, GPs and workplaces may be closed. There will also be new domestic abuse cases during this period. Isolation will also mean there are less opportunities to identify the early warning signs of abuse as new domestic abuse cases emerge. (ref: https://www.local.gov.uk/tackling-domestic-abuse-during-covid-19-pandemic)

The UK's Domestic Abuse line reported a 25% increase in online requests and phone calls since lockdown began. In mid-April, the Victims' commissioner for England and Wales indicated that there had been 16 domestic homicides, including those of children, in the first three weeks of lockdown, the highest it's been for 11 years.



Single Parents

The Covid-19 virus offers a particular challenge for single parents and their children as they rely on one income and are without the support of another adult in the household to balance childcare arrangements. Nationwide measures to limit the spread of the virus will put huge pressures on single parents when faced with the practicalities of self-isolation and school and childcare closure.

The lone parent charity Gingerbread has seen a huge increase in the number of calls and online forum calls for support. The CEO of the charity stated that "Single parents will be affected by the financial, practical and emotional implications of the coronavirus pandemic... Single parents are on their own and it is easy to feel isolated, overwhelmed and unsupported if they don't have anyone to talk to or take over the load." (Ref: https://www.gingerbread.org.uk/policy-campaigns/covid-19-briefing/

People in prisons and secure settings, prison leavers

People facing greater socio-economic disadvantage risk greater exposure to COVID-19, for example, key workers working often in large institutions such as secure settings or prisons.

Ethnic and religious minorities

Ethnic inequalities can develop in two main ways, through exposure to infection and health risks and though low paid employment and exposure to loss of income. The impacts of the COVID-19 crisis are unlikely to be equal across ethnic groups and aggregating all sub groups together will miss important differences. Understanding why these differences exist will be crucial for thinking about the role policy can play in addressing ethnic inequalities. (Ref: www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/)

Occupation may partially explain disproportionate deaths for some ethnic groups, health and social care key workers are at higher risk of infection. More than two in ten black African women of working age are employed in the health and social care sector. Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors. (Ref: www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/)

Kinship carers

Grandparents Plus carried out a survey with kinship carers at the beginning of May 2020. The results of this survey show how kinship carers are coping with continued restrictions, their exhaustion, their concerns over the well-being of the children in their care and their practical difficulties of home-schooling.

Summary of key concerns (169 responses):

Kinship carers are exhausted and not receiving the help and support they need

Many children in kinship care are now feeling the impact of the lockdown restrictions and this is affecting their mental health and well being

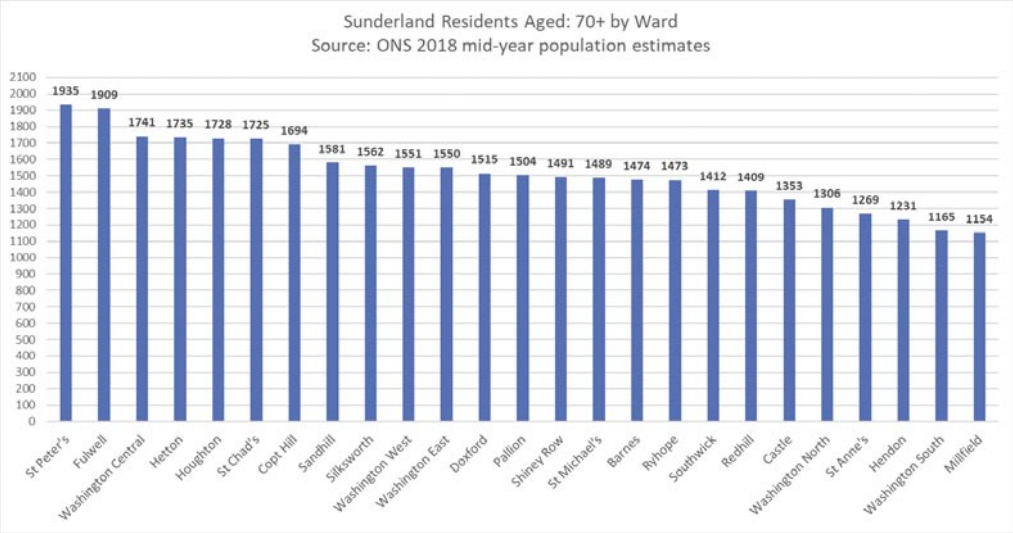
(Ref: https://www.grandparentsplus.org.uk/news/impact-covid-19-kinship-families-may-update/)

People aged 70+ and those clinically vulnerable groups who are being 'shielded'

People aged 70+ and clinically vulnerable groups

30.6% of Sunderland's overall population are at increased risk of COVID-19, this includes 37,956 over the age of 70 years of age [see below graph one for the ward breakdown] and 44,651 of all age deemed in a clinical at risk group.

The older adult population are at increased risk of COVID- 19 and severe disease or death following infection, resulting in significant implications for the health and social care sector. Older people are not just struggling with greater health risks but are also likely to be less capable of supporting themselves in isolation



People living in care homes

People living in care homes

Care home residents and staff are particularly vulnerable to COVID-19 as a consequence of the setting and client's complex health conditions.

It is projected that approximately 400,000 older people in the UK live in care homes this is a bed base three times that of the acute hospital sector in England.

Sunderland like other areas has experienced the devastating consequences of outbreaks in care homes.

People experiencing mental illness

People experiencing mental illness

Evidence shows that having someone to rely on in times of trouble is the top driver of a high-wellbeing nation. Already evidence showing that 5% of the UK population feel chronically lonely, and the overlap between loneliness and those at risk of low wellbeing. (Ref: Emotional wellbeing issues - Paul Litchfield, Chair, What Works Centre for Wellbeing) COVID-19 lockdown measures have been found to create or increase existing feelings of anxiety, isolation and low mood. The ONS personal wellbeing indicators indicate 32.3% people had high levels of anxiety.

Advising or compelling people to self-isolate at home risks serious social and psychological harm. The effects are exacerbated by prolonged isolation, fear of the infection, frustration, boredom, inadequate supplies and information, financial loss, and stigma.

People who are socioeconomically disadvantaged or in poor physical or mental health are at higher risk. Online and telephone support needs to be provided for vulnerable groups, especially those living alone.

Staff on the front line of health and social care services will experience varying levels of stress and distress due to Covid-19. It is essential that organisations take every effort to support the physical and mental wellbeing of the workforce, to enable staff to stay healthy and protect themselves, colleagues, patients and families as we continue to deliver services through this challenging period.

Vulnerable Children

The North East Child Poverty Commission (2020) highlights the impact of the Covid-19 on children and young people already being raised by North East MPs, including in relation to financial support for families and additional resources for schools to support the most disadvantaged pupils.

In terms of the impact of Covid-19 on childhood development and risk to widening health inequalities, the Sutton Trust highlights that differences in parental engagement and the home learning environment are key for children from all socio-economic backgrounds, suggesting "the home learning environment and parental engagement is more important than ever."

Unemployed

There is likely to be an increase in the number of people claiming welfare benefits, as people become out of work either on a temporary or permanent basis. Between Jan 2019 – Dec 2019, 6.5% (8,600) of the Economically Active residents of Sunderland 74.5% (133,100) were unemployed pre COVID-19.

According to NOMIS April 2020, Universal Credit claimant counts (requirement to seek work), shows a significant rise in number (more than the NE and England).

Claimants as a proportion of residents aged 16-64 years increased from March 20 to April 20

Sunderland increased from 5.1% to 7.6%

North East increased from 4.6% to 6.9%

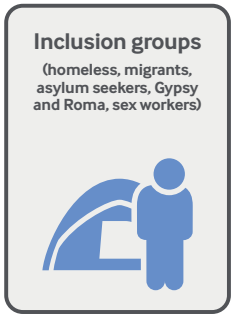
England increased from 3.0 to 5.0%

People with disabilities or LTC

The Institute of Fiscal Studies (2020) suggests a 50% drop in accident and emergency attendances highlighting that normally Accident & Emergency admission rates are 80 per cent higher among residents of the most-deprived areas than among those living in the most-affluent neighbourhoods further exacerbating existing health inequalities

People missing vital appointments or not attending emergency departments, with both the service and public so focused on covid-19. Bigger effect on heart disease and stroke patients heart disease related conditions patients, for example. Attendances relating to myocardial infarction at emergency departments have dropped right down, whereas ambulance calls in relation to chest pain have increased.

Individuals and their carer's who live with autism spectrum disorder and learning difficulties are being identified as a group at higher risk for complications from COVID-19. This group also experience additional behavioural challenges which can impact on their ability to cope with disruptions to their daily lives and thus require additional consideration in relation to measures put in place to manage COVID-19 such as social distancing and test and trace plans.



Inclusion groups

The British Medical Journal (BMJ, 2020) highlights the health benefits of social distancing measures in terms of slowing the spread of infection, however it also highlights some groups are more susceptible to the effects social distancing measures have on their health such as homeless, rough sleepers those with a physical or learning disability and those experiencing mental health issues.

Specific at-risk population groups will need to be considered through our recovery and response including test and trace roll out.

5. Risk factors for mortality

In Sunderland around 59% of the life expectancy gap (calculated by looking at the causes of excess deaths) between Sunderland and England is due to higher rates of death from cardiovascular diseases (mainly coronary heart disease), cancers (mainly lung cancer) and respiratory diseases (particularly chronic obstructive airways disease, COPD); making some of the Sunderland population at higher risk to COVID 19[15].

A paper published by the Local Government Association[16] set out the estimated percentage of the population at increased risk of severe illness from Covid-19 (table one).

Table one: Estimated percentage of the population at increased risk of severe illness from Covid-19

	Estimated number of people aged 70+ years (with or without clinical risk factors)	Estimated number of people in clinical risk group (based on flu vaccine risk group data) age ,70 years	Estimated number of women currently pregnant (and not incl. In clinical risk factor group)	Total number of people at increased risk of severe illness from Covid-19	% of total population at increased risk of severe illness from Covid-19	Total area all-age population (ONS mid-2018)
England	7,356,660	7,510,182	611,185	15,478,027	27.7%	55,977,178
North East	372,002	386,236	24,692	782,930	29.5%	2,657,909
Sunderland	37,956	44,651	2,277	84,884	30.6%	277,417

A more recent study undertaken by NHS England (2020)[17] identified further risk factors for Covid-19 mortality including:

- male
- older age
- deprivation
- diabetes
- asthma
- black or Asian ethnicity

[15] https://fingertips.phe.org.uk/indicator-list/view/7DVXEB34E2

[16] https://lginform.local.gov.uk/reports/view/lga-research/covid-19-case-tracker-area

[17] https://doi.org/10.1101/2020.05.06.20092999

This followed an earlier study[18] which reviewed data for 16,749 UK hospitalised patients with Covid-19 which found that there was a higher risk of death for patients with:

- Cardiovascular disease
- Pulmonary
- kidney disease
- malignancy
- dementia
- obesity

Data from NHS England[19] shows that 95% of patients who have died in hospitals in England and had tested positive for Covid-19 at time of death had an underlying condition, including:

- 26% with diabetes
- 18% with dementia
- 15% with COPD
- 14% with chronic kidney disease
- 10% with ischaemic heart disease
- 7% with asthma

Taking this evidence into account, the life expectancy gap for Sunderland and the findings from recent studies in relation to underlying health conditions and risk factors for mortality it would suggest the potential for increased susceptibility to COVID -19 within the Sunderland's population.

Cardiovascular disease

Cardiovascular disease is the second commonest cause of premature death in Sunderland with a death rate of 84.7 per 100,000 persons aged under 75 in 2016-2018. The rate of premature mortality from cardiovascular disease considered preventable is 54.9 per 100,000 persons aged under 75 for the same period. Both rates are significantly higher than the England average, but not significantly different from the regional average.

For coronary heart disease, recorded prevalence in Sunderland is 4.7% in 2018/19 (around 13,281 persons) compared to a prevalence of 3.1% in England.

Immunosuppressed

When people are immunocompromised they have a reduced ability to fight infection this may include a range of auto immune conditions and those on treatment or medication to manage their illness which has the effect of suppressing the immune system such as certain cancer treatments.

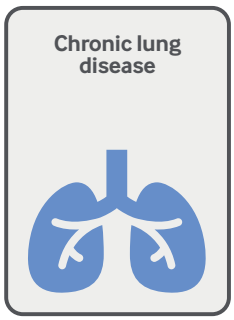
Within Sunderland, cancer remains a significant cause of premature death and health inequalities. Cancer is the commonest cause of premature death in Sunderland with a death rate of 162.9 per 100,000 persons aged under 75 in 2016-2018.

[18] https://www.medrxiv.org/

[19] https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/

A study carried out by University College London (UCL) and DATA-CAN, the Health Data Research Hub for Cancer has suggested that around 18,000 people could die from cancer over the next year in England due to the impact of Covid-19.

This is due to delays in diagnosing new cancers and getting treatment for those already diagnosed with cancer could adversely impact survival. Analysis of real-time weekly hospital data for urgent cancer referrals and chemotherapy attendances during the pandemic showed that the majority of patients with cancer or suspected cancer are not accessing health services. (Ref:https://britishlivertrust.org.uk/almost-18000-more-people-could-die-from-cancer-due-to-covid-19-impact/)



Chronic lung disease

Respiratory disease makes a disproportionate contribution to the health inequalities gap in Sunderland. "The incidence and death rates for people with lung diseases in England are higher in poorer groups and areas of social deprivation, where there are often higher levels of cigarette smoking and exposure to air pollution, as well as poorer housing conditions and exposure to occupational pollutants." Primary symptoms of COVID-19 are respiratory.

(Ref: https://www.england.nhs.uk/blog/tackling-lung-disease-can-help-reduce-health-inequality/)

NHS, QOF data from Fingertips shows that Sunderland already has a high prevalence of respiratory disease:

For COPD, recorded prevalence in Sunderland is 3.5% compared to a prevalence of 1.9% in 2018/19 in England;

For asthma (all ages), recorded prevalence in Sunderland is 6.2% compared to a prevalence of 6% in 2018/19 in England;

Sunderland is in the worst 99.8% for:

Rates of hospital admissions for asthma (under 19 years) (crude rate of 334 per 100,00 per data from 2018-19) and;

Mortality from COPD (83.6 per 100,000 population). (2015-17)

Chronic kidney and liver disease

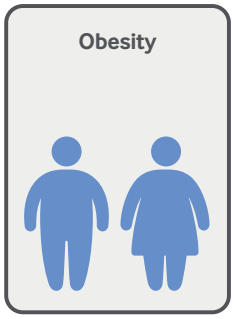
Chronic kidney and liver disease have been identified as a risk factor in COVID-19. In terms of Chronic Kidney Disease (QOF) prevalence (18+) (2018/19) shows Sunderland at 4.8% compared to 4.1% in England.

The Liver disease profile for Sunderland is significantly worse than England. This is often linked a wide range of factors often associated with increased deprivation such as drug and alcohol use and associated cardiovascular disease risks.

Diabetes

Diabetes (Types 1&2) has been identified as a risk factor in COVID-19 however its relationship at this time is unclear. In Sunderland the estimated prevalence of diabetes- diagnosed and undiagnosed (2017) was 8.7% for Sunderland compared to 8.5% for England.

The percentage of people with type2 diabetes aged 65-79 is 39.3% for Sunderland these individuals are amenable to modifiable risk factors such as physical activity and obesity interventions.



Obesity

Recent reports have suggested that obesity is one of the underlying health conditions that can cause a more severe reaction to COVID-19. This is significant given that for most Local Authorities the majority of adults are either overweight or obese. The prevalence of overweight and obesity in adults appears to be linked to higher levels of deprivation and is a contributing factor to a range of underlying health conditions such as diabetes and cardiovascular disease.

Obesity is clearly a complex issue influenced by environmental factors including access to healthy food options, for some people COVID 19 will have impacted on access to healthy food particularly for those with existing long-term conditions who are identified. as 'shielded' and for those experiencing food poverty and may be reliant of food bank and other provision.

There are a range of other risk taking and lifestyle behaviours identified below which further contribute to 'risk factors for mortality' including:

Physical inactivity

Reduction in levels of physical activity, and potential for changes in dietary behaviour impacts on health and wellbeing. This includes immediate impacts such as weight gain, stress, mental health and social isolation; plus, medium and longer-term impacts such as the management of a health condition, maintaining physical capacity and risk of frailty and falling. This is a particular risk for people who have limited access to their usual opportunities. (Ref: https://www.sportengland.org/news/new-exercise-habits-forming-during-coronavirus-crisis)

Smoking

According to the World Health Organisation (WHO), smokers and tobacco users are at higher risk of COVID-19 infection. Emerging evidence based on 1.5 million people from all over the UK from the COVID Symptom trackers suggests smoking significantly increases the risk of self-diagnosed Covid-19based on the classical symptoms (fever and persistent cough) by about 26%. (Ref: https://covid.joinzoe.com/post/smoking-and-covid-19)

Other studies indicate the risk of severe disease is probably higher and suggests smokers in hospital who have Covid-19are at a higher risk than non-smokers of severe illness impacting further on recovery.(Ref: http://www.tobaccoinduceddiseases.org/COVID-19-and-smoking)

In 2018/19 the Sunderland prevalence of smoking among adults over 18 years was 20.2%, compared to a North East average of 16.0% and a national average of 14.4%. (Ref: https://fingertips.phe.org.uk/profile/tobacco-control/)

Alcohol

The potential public health effects of long-term isolation on alcohol use and misuse are unknown.

Retail sales across the UK have fallen at a record pace under the lockdown, but demand for alcohol has soared. New ONS data has shown alcohol sales increasing by 31.4% against a record fall in overall monthly sales of 5.1% in March 2020.

New research from Alcohol Change UK (Ref: https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings) suggests that drinking habits of people in the North East and nationally have changed during the lockdown, with over 450,000 adults in the North East and 8.6 million adults in the UK drinking more frequently since lockdown.

However, over 650,000 NE adults and 14 million nationally are drinking less often or have stopped drinking entirely. More than four out of ten drinkers (or people who drank before the lockdown) appear to be taking active steps to try to manage drinking, suggesting that people are conscious that lockdown might lead us to drink more frequently or heavily.

Change to coping behaviours – increase in alcohol consumption, drug misuse and smoking prevalence:

- Increasing demand, and reduced provision of services for alcohol misuse and smoking cessation in the community.
- Increase demand for Tier 3 secondary care services for alcoholism.
- Increase in longer-term consequences of smoking and alcohol misuse leading to longer-term impact on services

6. How will we address health inequalities?

The document COVID-19 suggestions for mitigating the impact on health inequalities at a local level[20] details a range of actions the local authority and partners could take to help to mitigate the differential impact of COVID-19 on local communities. The consequences of disruption in relation to Covid-19 is likely to impact more on some groups, communities and places than others and result in further increases in health inequalities and focused targeted action needs to take place at a local level.

Health inequalities should be considered in all recovery plans. Some changes to services may have unintended consequences, therefore when developing any recovery plan, we will consider if any health inequalities are widened and how we will address these in the short-term (acute current phase) we will identify what services have been stopped or adapted, capture potential risks and mitigations and identify who are the high risk/ vulnerable populations who will have been impacted by COVID19. In the medium-term (adapting with COVID 19, some restrictions lifted) we will identify which services can resume and when, what are the risks and mitigations and the potential impacts on identified vulnerable populations.

Building on a Health in All Policies (HiAP) approach to policies we systematically and explicitly consider the health implications of the decisions we make, target key social determinants of health and the work we do with partners and tries to avoid causing harm with the aim of improving the health of the population and reducing inequity.

As part of recovery we will ensure that use available tools to ensure that health inequalities are considered for every policy and service. A local tool kit will be developed that will be continuously updated to take in to account any emerging evidence of the impact of Covid-19 on health inequalities which will include evidence-based actions that can be used to address these.

[20] Ref: https://www.local.gov.uk/sites/default/files/documents/COVID-19%20Suggestions%20for%20mitigating%20the%20impact%20on%20health%20inequalities%20at%20a%20local%20level%20%282%29.pdf


BHS

7. Strategic objectives

Continue to improve health outcomes for our most disadvantaged communities who are at greater risk of Covid-19 by adopting a lifecourse approach which identifies the key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age and into older age.

Take every opportunity to mitigate the impact that Covid-19 has had on our communities by building on a Health in All Policies (HiAP) approach to policies we systematically and explicitly consider the health implications of the decisions we make with the aim of improving the health of the population.

Ensure that as we move into recovery we take the opportunity to address health inequalities as part of our plans by using available tools to ensure that health inequalities are considered for every policy and service.

8. Key actions

Following on from our strategic objectives, our key actions are as follows.

- Embed the Health Inequalities Strategy as part of any response or recovery work in relation to Covid-19
- Develop and implement a local tool kit which will take in to account any emerging evidence of the impact of Covid-19 on health inequalities. This will include evidence-based actions that can be used to address these for use by the council, partners and voluntary and community sector
- Review and update the strategy and supporting resources which highlight the impact of Covid-19 on health inequalities, alongside local intelligence. This strategy will therefore be a "living" document
- Build on previous local intelligence, relationships and resident experiences as well as information gathered as part of the City's immediate response from volunteers, people who are shielded, our vulnerable young people and any other sources of community intelligence to inform our approach
- Consider how the recent enhanced interest in community and mutual aid approaches can be sustained to benefit priority communities and reduce demand on services
- Review social value secured through existing contracts and explore the potential to divert the social value offer where required for most vulnerable communities
- Progress the Marmot City principles which have been adopted by Sunderland Council
- Engage with key agencies and partners to develop an action plan with agreed key performance indicators. The action plan will be monitored through the Health and Wellbeing Board

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