Covid-19 Impact in Merton

Overview of initial data on infections & deaths and planned future work for Merton Joint Consultative Committee with Ethnic Minorities

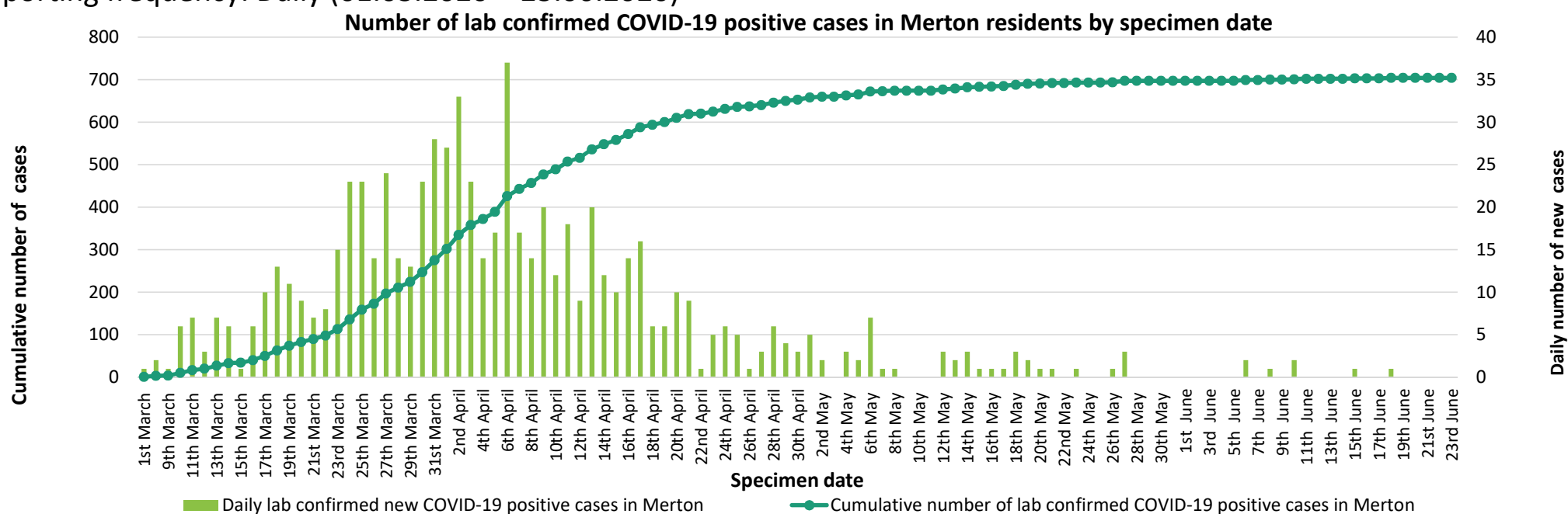Dr Dagmar Zeuner, Director of Public Health

Version 1.4 30 June 2020

Number of lab-confirmed COVID-19 positive cases among Merton residents by specimen date (Pillar 1 testing only)

Source: PHE
Reporting frequency: Daily (01.03.2020 – 23.06.2020)

Number of lab confirmed COVID-19 positive cases in Merton residents by specimen date

Cumulative number of lab-confirmed cases in Merton Date: 23rd June	Rate of cumulative lab confirmed COVID-19 positive cases in Merton (per 100,000 population) Date: 23rd June	Current Rank by rate (1 = lowest rate)	Cumulative number of lab-confirmed cases in London Date: 23rd June	Note: number of lab confirmed COVID-19 positive cases are residents in Merton determined by home postcode provided by person being tested.
704	**341.4 per 100,000 population**	**23rd out of 32 London boroughs**	**27,473**	

Number of deaths registered among Merton residents

Source: ONS
Reporting frequency: Weekly (04.01.2020 – 12.06.2020)

Number of deaths in Merton by week of registration

Legend:
- COVID-19 deaths
- Non COVID-19 deaths
- Total number of deaths registered per equivalent week in 2019

X-axis: Week of death registration
Y-axis: Number of deaths

Non COVID-19 death values by week:
37, 23, 26, 26, 24, 20, 18, 21, 19, 29, 18, 35, 66, 73, 107, 61, 47, 33, 20, 27, 11, 13, 21

COVID-19 death values by week:
0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 1, 6, 22, 35, 51, 31, 17, 10, 10, 8, 2, 3, 1

Weeks:
4th Jan - 10th Jan, 11th Jan - 17th Jan, 18th Jan - 24th Jan, 25th Jan - 31st Jan, 1st Feb - 7th Feb, 8th Feb - 14th Feb, 15th Feb - 21st Feb, 22nd Feb - 28th Feb, 29th Feb - 6th March, 7th March - 13th March, 14th March - 20th March, 21st March - 27th March, 28th March - 3rd April, 4th April - 10th April, 11th April - 17th April, 18th April - 24th April, 25th April - 1st May, 2nd May - 8th May, 9th May - 15th May, 16th May - 22nd May, 23rd May - 29th May, 30th May - 5th June, 6th June - 12th June

Covid-19 impact on Merton

Rate of COVID 19 related deaths among residents in Merton between 1st March and 31st May
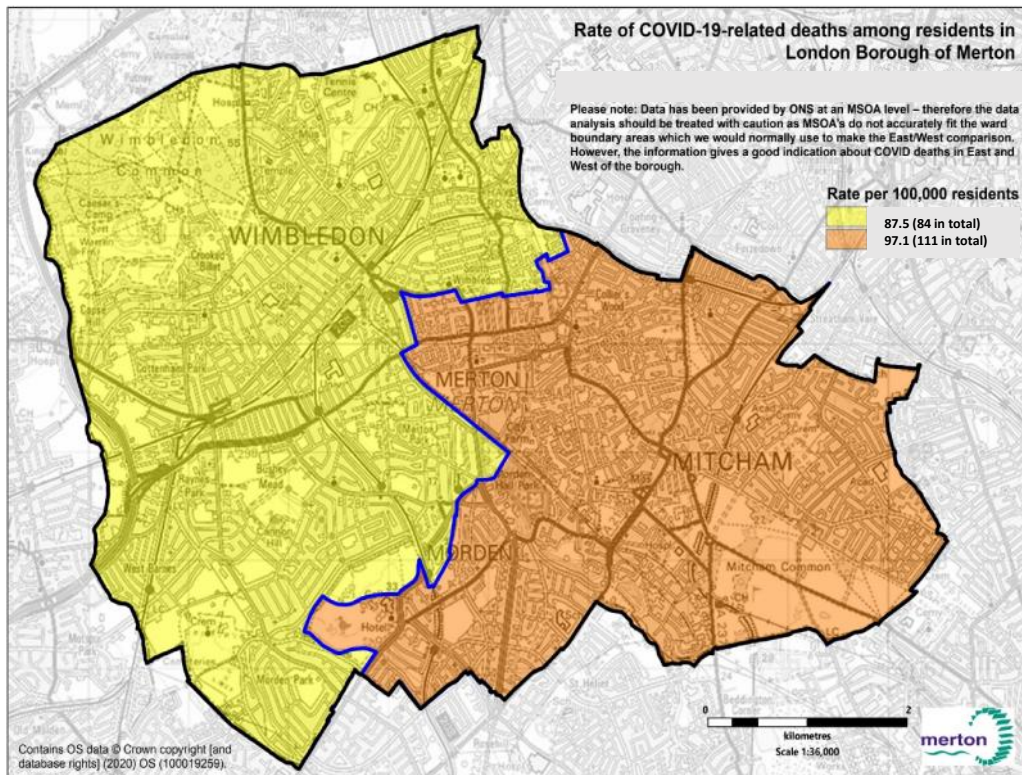
Previous data released by ONS calculated that between 1st March and 17th April, the difference in death rate per 100,000 residents between East and West Merton was 17.7 however the difference is now 9.6.
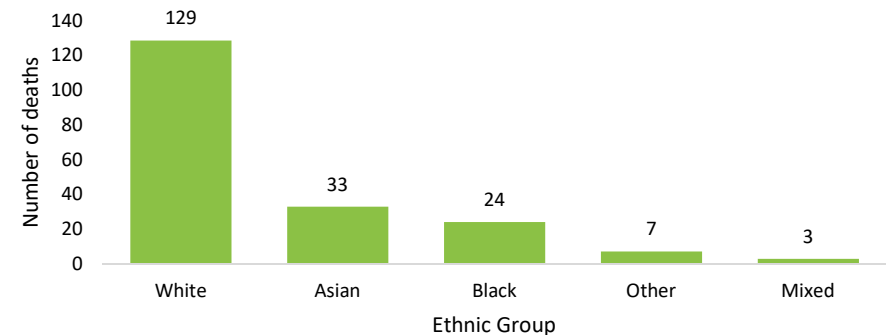
Modelled estimates of number of positive cases by ethnic group among Merton residents
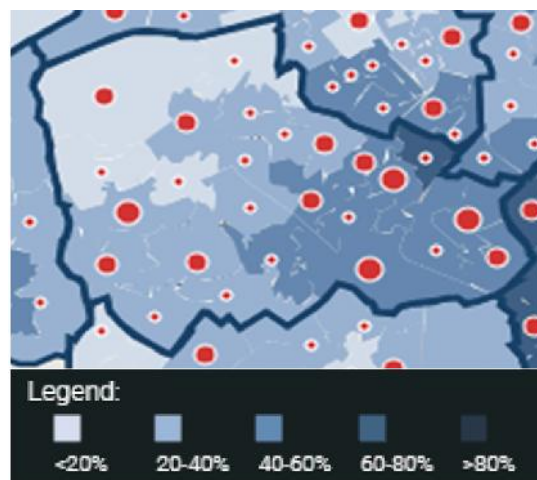*Source: PHE/GLA/ONS*
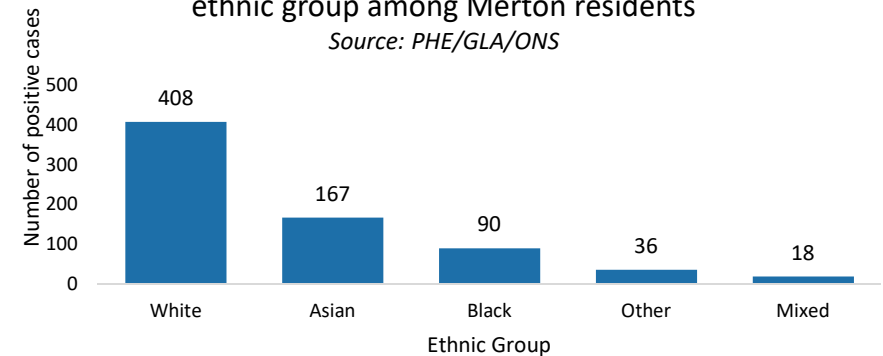
Modelled estimates of number of deaths by ethnic group among Merton residents
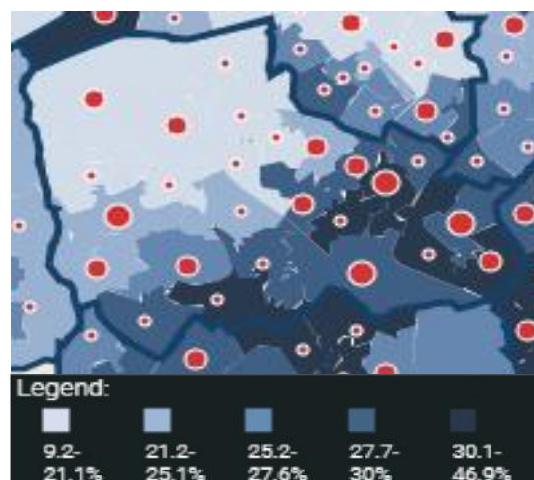*Source: PHE/GLA/ONS*

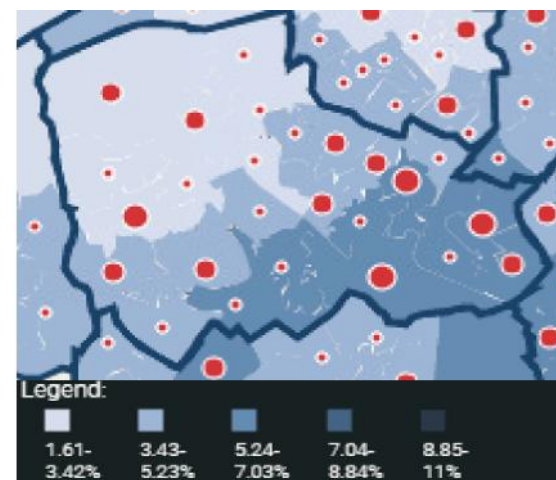# Relationship between Covid 19 deaths and selected population characteristics
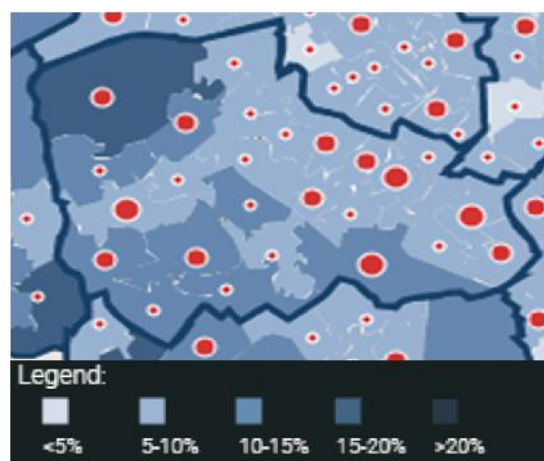
% BAME (all ethnic minorities)

Legend:
<20% | 20-40% | 40-60% | 60-80% | >80%

% in high-risk occupations

Legend:
9.2-21.1% | 21.2-25.1% | 25.2-27.6% | 27.7-30% | 30.1-46.9%

% with diabetes

Legend:
1.61-3.42% | 3.43-5.23% | 5.24-7.03% | 7.04-8.84% | 8.85-11%

% residents age 70 and over

Legend:
<5% | 5-10% | 10-15% | 15-20% | >20%

COVID-19 deaths per 1,000 residents:
<0.5 | 0.5-1 | 1-1.5 | 1.5-2 | >2

Source: GLA. Covid-19 deaths mapping tool. https://data.london.gov.uk/dataset/covid-19-deaths-mapping-tool (accessed 12.6.2020)

Disparities in COVID mortality

Risk Factor	Increased risk of death
Age	People > 80 years with positive tests have x70 risk of death compared to those < 40years. The majority of excess deaths observed in the period 20 March- 7 May compared to the same dates in previous years (75%) occurred in those aged 75 and over.
Sex	Working age males diagnosed with COVID-19 are twice as likely to die than females.
Black and Minority Ethnic (BAME)	People from BAME backgrounds are disproportionately affected by Covid-19. Not only deaths, but also rates of infection and hospital admission are increased compared to white people. The main underlying determinants are deprivation, high risk occupations, overcrowded housing, and increased prevalence of co-morbidities such as diabetes. Black males have x4.2 risk, and Bangladeshi/Pakistani males x3.5 risk of COVID-19-related death compared to White males. South Asian people are 20% more likely to die once admitted to hospital in the UK than white people. Other minority ethnic groups did not have a higher death rate in this study.
Deprivation	Age standardised death rates in the most deprived fifth of the England and Wales population were 2.3 times the rate in the least deprived fifth amongst males, and 2.4 times in females.
Co-morbidity	Diabetes, hypertensive diseases, chronic kidney disease, COPD and dementia are more associated with COVID deaths than deaths from all causes. Diabetes was mentioned on 21% of death certificates where COVID was also listed. This proportion was higher in BAME groups being 43% in the Asian group and 45% in the Black group.
Occupation	Men working as security guards, transport workers, chefs, sales assistants, lower skilled workers in construction, and men and women working in social care all have significantly higher rates of death from COVID than the general population. Individuals from BAME groups are more likely to be working in many of these occupations. In London, nearly 50% of NHS and CCG staff come from a BAME group.
Housing density	Every 5% increase in the rate of overcrowding by LA (2011 census) is associated with 30 additional COVID deaths/100,000 population , after adjusting for age and sex but not other factors. 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.
Care homes	May contribute >50% deaths caused directly or indirectly by the COVID-19 crisis.

References
PHE. Disparities in the risk and outcomes of COVID-19. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891116/disparities_review.pdf [accessed 11 June 202]
ONS. Coronavirus (COVID-19) related deaths by ethnic group www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirus
Harrison EM. Ethnicity and Outcomes from COVID-19: The ISARIC CCP-UK Prospective Observational Cohort Study of Hospitalised Patients. http://dx.doi.org/10.2139/ssrn.3618215
PHE. Beyond the data: Understanding the impact of COVID-19 on BAME groups. https://bit.ly/beyond-the-data
Inside Housing. https://www.insidehousing.co.uk/insight/insight/the-housing-pandemic-four-graphs-showing-the-link-between-covid-19-deaths-and-the-housing-crisis-66562
William Laing. www.laingbuissonnews.com/care-markets-content/news/care-home-deaths-from-covid-19-could-reach-26000-in-england-by-end-of-may-says-laing/

Recommendations from PHE review "Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities"

Topic	Summary of Recommendation
Data collection	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.
Further research	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.
Service user experience	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 BAME communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users
Occupational risk assessment	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.
Prevention campaigns	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.
Health promotion programmes	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
Wider determinants of health	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.

Reference
PHE. Beyond the data: Understanding the impact of COVID-19 on BAME groups. https://bit.ly/beyond-the-data

Future Work

Development of Local Outbreak Control Plan
- Actions for preparedness e.g. engagement with VCS and response e.g. plan for potential outbreaks in high risk settings e.g. care homes, schools, hostels etc

Continuing data analysis (led by HWB)
- Including indirect COVID-19 health impact (with focus on health inequalities)

Lived experience (led by HWB)
- Qualitative action research & engagement with local voluntary sector & community
- Focus on BAME, older people and learning disabilities, other (tbd)

Action planning
- Immediate - to protect from COVID-19 in case of further outbreaks e.g. targeted diabetes work
- Short-medium term - to mitigate main adverse health impacts from COVID response
- Medium-longer-term actions - to shape safe, fair and green recovery for Merton people and as a place in line with our Health and Wellbeing Strategy and Local Health and Care Plan