

Health, Social and Economic Impact of COVID-19 on our Residents

September 2020
Public Health Intelligence

Executive Summary

Just as the national evidence has identified COVID-19 as a story of inequalities, the evidence we have drawn on in this report shows this is also the case for Greenwich residents and communities.

The evidence has identified inequalities in

- who is likely to contract the condition
- who knows how to seek help and where from
- who is more likely to have severe disease
- who is more likely to die and therefore who will suffer grief
- who has been impacted by the national response to reduce transmission through isolation and job loss

The national review of inequalities identified

Age and Gender

People aged 80 or over were seventy times more likely to die than those under 40. Men had a statistically significantly higher rate of death (9.9 deaths per 100,000) compared to women

Deprivation

COVID-19 has had a proportionally higher impact in the most deprived areas when compared to all deaths. Some groups are particularly at high risk; Migrants; people with Nil recourse to public funds; Homeless; Children and Young people (impact of school closures)

Ethnicity

The risk of dying is higher for those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. BAME groups present in hospital with more severe disease leading to poorer outcomes. Late access to support may have influenced poor outcomes

Occupation

The occupations identified as at high risk include; Caring occupations (social care and nursing auxiliaries and assistants). Those employed driving private and public vehicles including taxi and minicab drivers and chauffeurs; Security guards and related occupations.

Settings

There were 2.3 times more deaths in care homes than expected in the same period

Underlying health issues

Risk factors for poorer outcomes include High blood pressure, Cardiovascular diseases, Diabetes mellitus, Obesity, Smoking, COPD and chronic kidney disease

Executive Summary

In Greenwich we know

Age and Gender

Women in Greenwich live for fewer years in good health and this has increased the risk of poor outcomes from COVID-19 for women

Deprivation

We have significant areas of deprivation. 23% of our population live in more deprived areas, increasing the risk of poorer outcomes from COVID-19

Ethnicity

Our BAME communities are more likely to live in areas of deprivation, in overcrowded housing and be in front line occupations. There was higher use of Community Hub for essential support from BAME groups (Food, Medicines and Welfare support) during lockdown indicating more food and financial insecurity

Occupation

70% of the employment in Greenwich is linked to negative impact by COVID-19, either by staff working on the front line or due to furlough or job losses. A higher proportion of men in Greenwich are in front occupations which increases likelihood of being infected

Settings

16% of deaths from COVID-19 were to residents who normally live in care homes compared to 26% for London

Underlying health issues

50% of our population with Type 2 Diabetes are from BAME communities. Smoking and obesity contribute significantly to premature mortality and morbidity and are significant risk factors for poor outcomes from COVID-19. Greenwich has a higher proportion of smokers and higher levels of obesity than most areas in London

National research has identified significant impact of COVID-19 on Physical and Mental Health, social and environmental factors and the economy. The Public Health England report shone a direct light on the inequalities for Black, Asian and Minority Ethnic communities. There is no evidence that Greenwich residents and communities will suffer less than anywhere else in the country.

The recommendations that were included in the PHE research apply directly to our Greenwich residents and while there may be slight differences in the impact for some groups, as anchor institutions we need to implement the recommendations in the national report.

References.

1. PHE, 2020. Disparities in the risk and outcomes of COVID-19.

Executive Summary - Recommendations

Public Health England identified seven recommendations that if tackled will start to address the inequalities that have been identified during the pandemic. The seven recommendations:

- Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collections, including death certification
- Support community participatory research where researchers and community stakeholders engage as equal partners to better understand the determinants of COVID-19 in BAME communities
- Improve the access, experiences and outcomes of NHS, local governments and integrated care systems by BAME groups
- Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings
- Fund, develop and implement culturally competent Covid-19 education and prevention programmes, working in partnership with local BAME and faith communities
- Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non communicable disease, promoting elements like healthy weight and physical activity
- Ensure COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health

These need to be addressed as key actions in all of the plans that we develop both individually as anchor organisations and within partnership plans that so that they become part of our business as usual approach to delivering services

Introduction

Introduction

Coronavirus disease (COVID-19) was first identified in December 2019 in China. It is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus experience mild to moderate respiratory illness and recover without requiring special treatment. However it was quickly recognised that older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

This report considers the health, social and economic impact of COVID-19 on our residents providing an overview of the COVID-19 outbreak at a local level and considers the impact on different population groups where possible. The document is structured around three key sections:

- What is COVID-19 and what are its impacts
- Emerging evidence on who is most likely to be affected
- What happened in Greenwich

The intelligence and evidence regarding COVID-19 are evolving rapidly. This document presents our best understanding at time of writing. Further information will be added as it becomes available.

What is COVID-19 and what are the impacts?

What is COVID-19?

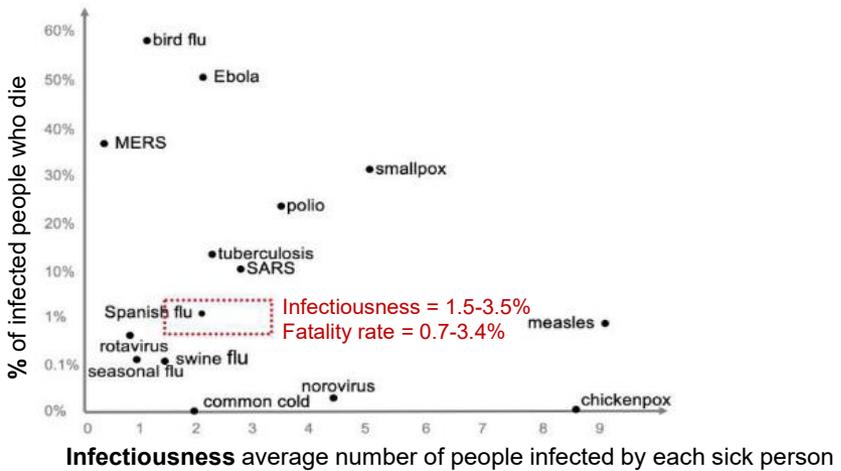
What is coronavirus?

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

COVID-19 is a new strain of coronavirus that was initially recognised as affecting principally lungs and airways but as the pandemic developed more symptoms have been identified. It was first identified in Wuhan City, China, but is now identified and spreading globally.

It can take up to 14 days for someone who has been infected to show symptoms and a further 17 days before the severity of the condition is known. This means the infection is virus is harder to manage because it is harder to identify where someone might have been when they contracted the condition.

How contagious is it? 1.5% to 3.5% of the population will be infected with a fatality rate of between 0.7% to 3.4% (close to Spanish flu).



Seriousness of symptoms

It is estimated that 80% of people infected have mild or no symptoms (asymptomatic). However 1 in 5 will have severe disease that will require hospitalisation and 1 in 3 of those having been hospitalised will be critical and require intensive care.

Possible symptoms of COVID-19

Main Common Less common

fever **dry cough**

diarrhoea chills headache
nausea fatigue muscle pain vomiting

loss or change of taste or smell

Shortness of breath Rash on skin conjunctivitis
Discolouration of fingers/toes Sore throat

Emergency symptoms – requiring medical attention

Loss of speech or movement

difficulty breathing

New confusion Bluish lips or face

chest pain or pressure

inability to wake or stay awake

In an epidemic, one of the most important numbers is R – the reproduction number.

The Reproduction number R is the number of people who are likely to be infected by a single case. (i.e. if R = 2, 1 person infects 2 people) If R is below one, then on average each infected person will infect fewer than one other person meaning the number of new infections will fall over time. Therefore the aim is to reduce R to below 1

However, R is difficult to calculate when the number of cases falls and R can vary by area. This means that although the England R number might be less than 1, London or Greenwich could have a higher rate indicating there is an outbreak.

R provides an indication of the growth of the epidemic and not its overall size and it can take 2-3 weeks for increases in cases to show in the R number.

Reference
ONS, 2020. Coronavirus Infection Survey Pilot: England, 9 July 2020.
Latest R Number: <https://www.gov.uk/guidance/the-r-number-in-the-uk>



What are the Impacts of COVID-19? - Risks and Immediate Impacts

How vulnerable someone might be to COVID-19 and the severity of its impact can be looked at in the context of whether they are likely to be in contact with the virus (exposure), how the virus is passed from person to person (transmission) and if they are likely to suffer complications (severity)

Risk of Exposure

People are more exposed to COVID-19 if they are

- frontline health and care staff,
- transport workers such as bus and taxi drivers
- essential retail worker

Risk of Transmission

There is greater risk of transmitting the virus if people

- live close together (homes of multiple occupation)
- use public transport
- work in an environment that puts them in contact with lots of other people

Risk of severe illness or death

People are known to have poorer outcomes if they are

- older (over 65 years)
- men (particularly in front line jobs)
- Black Asian or ethnic minorities (BAME)*
- suffering from long term conditions

Evidence for the impact on ethnic minorities is still developing but they are more likely to live in overcrowded and multigenerational households; in the UK 30% of Bangladeshi households, 16% of Pakistani households and 15% of Black African households are overcrowded compared to just 2% of White British. They are also more likely to work in front line occupations and have underlying health conditions

References

1. ONS, 2020. Which occupations have the highest potential exposure to the coronavirus (COVID-19)?
2. ONS, 2020. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales
3. ONS, 2020. Deaths involving COVID-19. England and Wales deaths in March 2020.

What are the Impacts of COVID-19? – What are the mitigations?

Reducing the Risk of Exposure

- Effective use of Personal Protective Equipment for the workforce and in public places
- Social Distancing (more than 2 metres)
- Wearing face coverings on public transport
- Handwashing
- Covering coughs and sneezes

Reducing the Risk of Transmission

- Effective use of Personal Protective Equipment for the workforce and in public places
- Increased responsive testing
- Work with local communities to ensure messages for shielding vulnerable residents are clear
- Handwashing
- Covering coughs and sneezes

Reducing the Risk of severe illness or death

- Supporting the NHS in messaging to not delay presentation to acute services.
- Supporting primary care to ensure long term conditions are monitored and treated.
- Promote health improvement services including physical exercise, healthy eating and smoking cessation.

Emerging Evidence

Emerging Evidence

Who is most affected? – National Evidence Summary

A rapid review found evidence that:

- Ethnicity and income inequality are independently associated with COVID 19 mortality.
- BAME groups are more likely to be tested and to test positive
- Individuals from BAME groups are more likely to:
 - Live in overcrowded housing
 - Work in occupations which place them at increased exposure to COVID 19
 - Use public transport to travel to work
- Individuals from BAME groups may be less likely to:
 - Seek care when needed
 - Speak up when they have concerns about PPE or testing
- Nursing assistants, security guards and cab drivers have experienced bigger increase in deaths than other occupations
- Nursing auxiliaries and assistants, security guards and related occupations, and taxi and cab drivers and chauffeurs were found to have experienced a relative increase in deaths in 2020 significantly higher than the average among people of working age (20-64)

Evidence from the national study

Death rates are influenced by factors such as comorbidities but may also be influenced by variation in testing between areas. Risk of dying following a positive test for COVID 19

- 70 times higher in people 80 years or older compared to those under 40
- Twice as high for working aged men compared to women (in previous years 1.5 times higher in men)
- Twice as high for those living in the more deprived areas compared to those living in the least deprived areas
- Up to twice as high in many Black (10-44% higher), Asian (13-50% higher) and Minority Ethnic (BAME) groups compared to White British ethnic group

This investigation adjusted for age, sex, deprivation, region and ethnicity, but not the existence of comorbidities. Other evidence has shown that when comorbidities are included, the difference in risk of death by ethnic group among hospitalised patients is greatly reduced.

In terms of Ethnicity; the risk of dying among those diagnosed with COVID-19 is higher in those in BAME groups than in white ethnic groups.

After accounting for the effect of sex, age, deprivation and region, it found that people of Bangladeshi ethnicity were at most risk, with around twice the risk of death than people of white British ethnicity. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicity had between 10% and 50% higher risk of death when compared to white British.

In terms of comorbidities; diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This proportion was higher in all BAME groups when compared to White ethnic groups (43% in the Asian group and 45% in the Black group). The same disparities were seen for hypertensive disease. Diabetes was more likely to be mentioned on the death certificate in more deprived areas.

National Stakeholder engagement with BAME communities found common themes:

- Impact of long standing social and economic inequalities
- Increased exposure to COVID (occupation, transportation, and living conditions)
- Increased risk of complications (timely access and long-term conditions)
- Racism, stigma, fear, discrimination and trust (role of the media, poorer access to PPE, stigma and fear of disease, cultural understanding, late presentation)

References.

1. PHE, 2020. Disparities in the risk and outcomes of COVID-19.

Emerging Evidence

Medium and Long-Term Impacts of COVID-19

As the pandemic has gone on it has become evident that not only will there be longer term health impacts from the virus but also social and economic impacts on our communities from the response to trying to contain the virus. These impacts are often inter-related and affect a number of population groups disproportionately. The next few pages will highlight the emerging evidence and analysis on the consequences on COVID-19 of health social economic and environmental impacts

Health Impacts

Impact on Mental health and wellbeing

- Levels of poor mental wellbeing have increased due to the direct impact of having had condition and/or bereavement and indirect impact related to effects of the social distancing (isolation) and lockdown measures (financial insecurity)
- Stress from fear of the illness and the impact of the illness is leading to increase in anxiety and depression, and risks of PTSD in health and care workers. In extreme cases, increases in death by suicide are being seen

Impact on Physical health

- Those with underlying chronic health conditions e.g. cardiovascular disease, cancer, hypertension, respiratory conditions and diabetes, are at a higher risk of complications from COVID-19 and increased risk of death
- Those with long-term conditions are expected to have worsened conditions over lockdown in part due to reduced access to health services
- For some of those who have had COVID-19 (including with mild symptoms) increasingly there are long-term illnesses and relapses
- There have been both positive and negative changes in Individual health behaviours
 - smokers showing an increased motivation to quit
 - high risk drinkers have increased intake (low risk reduced intake)
 - Increased snacking and eating leading to weight gain
 - Reduced physical activity in those who were least active pre-COVID

Impact on access to health and social care

- There has been a significant reduction in number of people attending emergency care and those with long-term conditions accessing general health care
- BAME groups with COVID have been slower to access care for a variety of reasons including stigma and fear. Late presentation has led to poorer outcomes
- There are knock-on effects as NHS services tackle backlog of elective interventions with concerns about the impact of delayed diagnoses including on cancer
- Cancer screening has been paused so there will be a drop in early stage cancer detection and a possible increase in number of cancer deaths.
- School immunisations have paused. Childhood and essential immunisations in pregnancy (e.g. pertussis) are continuing although anecdotal evidence suggests uptake rates may have dropped locally. A drop in coverage could lead to increased vaccine preventable diseases

References

1. IPPR, Care fit for carers: Ensuring the safety and welfare of NHS and care workers during and after COVID-19, 2020
2. WHO, Alcohol and COVID-19, 2020
3. <https://www.ijmu.ac.uk/~media/phi-reports/2020-07-direct-and-indirect-impacts-of-covid19-on-health-and-wellbeing.pdf>

Emerging Evidence

Medium and Long-Term Impacts of COVID-19

Social Impacts

Impacts on family, friends and communities

Positive Impacts

- There have been increases in civic participation reported. For instance during the initial period of lockdown there was a rapid rise in people wanting to volunteer
- There have been positive impacts on social cohesion reported in some areas
- There were positive reports of wellbeing and kindness in the community

Negative Impacts

- There has been increased social isolation which in its own right can have a negative impact on health
- Social distancing has been identified as increasing loneliness, particularly for those who are shielding and vulnerable
- Lockdown has increased the risk of domestic abuse and safeguarding difficulties, with long-term negative psychological impacts on families and individuals, and increased risk of harm to mainly women and children
- Safeguarding issues have been hidden from view

Impact on education and skills

- There is emerging evidence suggesting that children and young people may be hit hardest by the social distancing and lockdown measures
- School closures have exacerbated existing inequalities in educational attainment with poorest households
 - less likely to ask for and therefore be offered active help from school
 - spending less hours a day on home learning
 - less likely to have access to technology

Impact on the way we live

- Some people have been less physically active and/or have had difficulty accessing healthy food. This is likely to widen inequalities
- People experiencing food insecurity are likely to have poor diets and stress which can adversely affect mental wellbeing and physical health
- Lockdown exacerbated food insecurity particularly among children with numbers experiencing food insecurity estimated to have quadrupled
- Food banks have reported an increase in demand from families and a decrease in supply coming in from shops
- Alcohol sales in the UK have increased since lockdown. The immediate impacts of this increase include an increase in risk-taking behaviours, mental health issues and violence, and long-term impacts include risk of liver disease and cancer
- People who are shielding or extremely vulnerable had issues accessing food and continue to be at risk with a second wave or local outbreaks

References

1. IPPR, Care fit for carers: Ensuring the safety and welfare of NHS and care workers during and after COVID-19, 2020
2. WHO, Alcohol and COVID-19, 2020
3. <https://www.ljmu.ac.uk/~media/phi-reports/2020-07-direct-and-indirect-impacts-of-covid19-on-health-and-wellbeing.pdf>

Emerging Evidence

Medium and Long-Term Impacts of COVID-19

Economic and Environmental Impacts

Impact of lockdown on money and resources

- The predicted/expected economic downturn will have significant health impacts in the short and longer term
- As a result of job losses household incomes have fallen particularly among the lowest earners
- A quarter of businesses temporarily closed, with a rise of almost 500% in Universal Credit claimants and in Jobseeker's Allowance benefits
- Low earners are 7 times more likely than high earners to have worked in a sector that is now shut down
- Young workers and low earners have been impacted the most from lockdown, with greatest impact on BAME groups

Impact of Housing and Living Conditions

- Those living in overcrowded or multi-generational homes are at higher risk of contracting and falling ill from COVID-19.
- The increased time spent at home is expected to exacerbate the health impacts of poor housing conditions.
- There is an increased risk of people becoming homeless or falling into debt due to an inability to pay rent

Impact on our surroundings and transport

- More time at home during lockdown has potentially exacerbated the health impacts of poor-quality housing
- Air was cleaner and healthier in early lockdown, but global emissions have since rebounded since restrictions were lifted to close to 2019 levels
- 12% of households have no access to a private or shared garden during lockdown
- Inequalities exist in access to good quality and safe public green spaces which has exacerbated the impact of lockdown on mental wellbeing
- There are concerns about the lasting damage that may be done to public transport systems, fewer people using it has meant less income for companies
- More positively, more people have been cycling, but whether the changes will be lasting is not clear

References

1. IPPR, Care fit for carers: Ensuring the safety and welfare of NHS and care workers during and after COVID-19, 2020
2. WHO, Alcohol and COVID-19, 2020
3. <https://www.ijmu.ac.uk/~media/phi-reports/2020-07-direct-and-indirect-impacts-of-covid19-on-health-and-wellbeing.pdf>

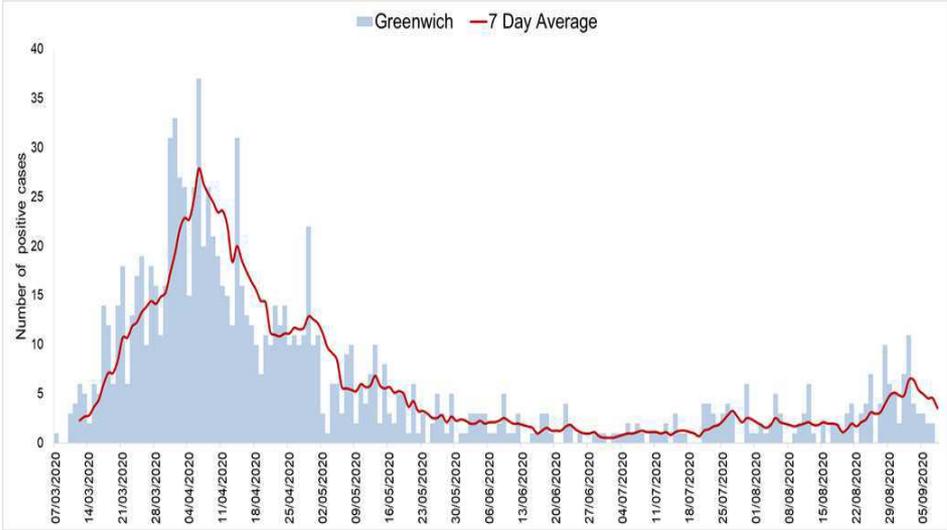
What is happening in Greenwich?

What happened in Greenwich?

Cases in Greenwich

Over the course of pandemic so far, Greenwich has mirrored the rest of London, There was a sharp increase between March and the beginning of April the highest daily rate was on 6th April. The rate slowly reduced between April and the end of May when the rate remained low. Towards the end of July, 3 weeks after the lifting of lockdown there has been a slight increase in the daily rate (increasing from 0 to 2 cases per day to 0 to 6 cases per day). While the increase was small it highlighted the importance of adhering to the measures to minimising contact and transmission of the virus. Since the start of September the numbers have increased at faster rate and are now similar to the levels seen at the end of May and beginning of June. In line with the rest of London, there is a worrying trend that could indicate the start of the second wave.

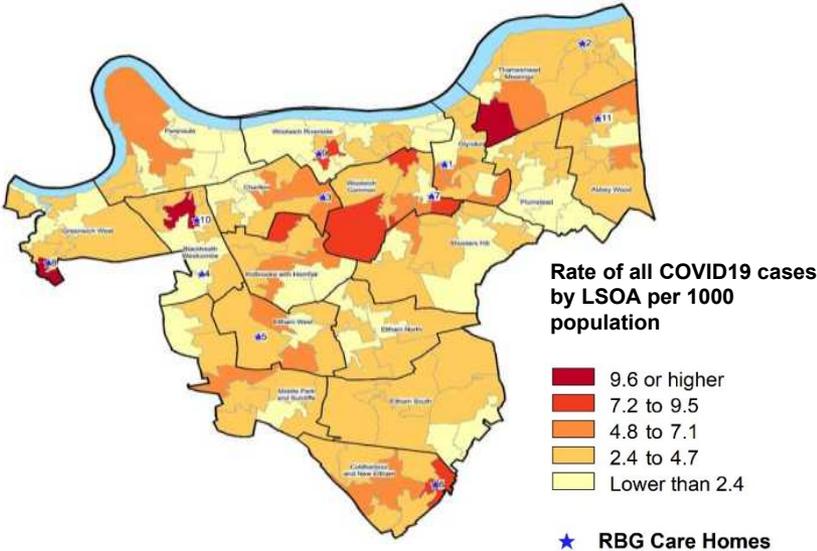
**Confirmed Cases daily in Greenwich
March to September**



The map identifies where there have been higher rates of positive cases and therefore identify areas likely to be at increased risk.

Most areas with higher rates of cases are in areas of higher deprivation. Some of these rates have been influenced by the presence of outbreaks in care homes and higher proportion of houses of multiple occupation.

**Rates of cases in Greenwich by small area (LSOA)
March to September**



LSOA is a Lower Super Output Area which has been developed to facilitate the reporting of small area statistics

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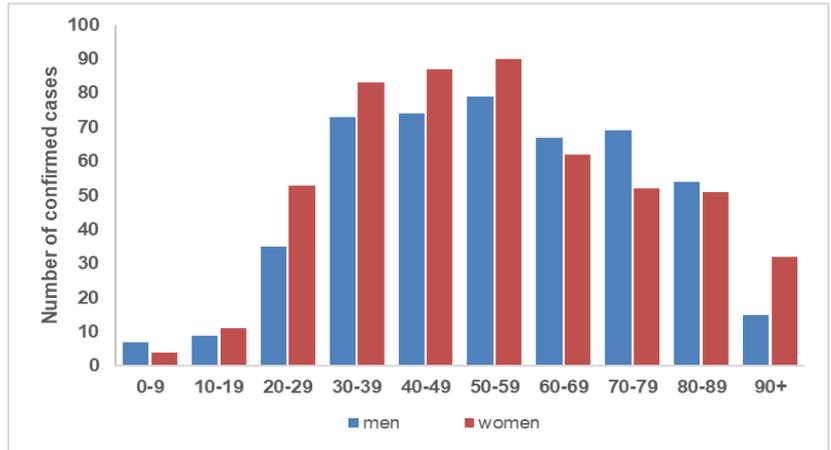
What happened in Greenwich?

Differences in the impact of COVID-19 in Greenwich

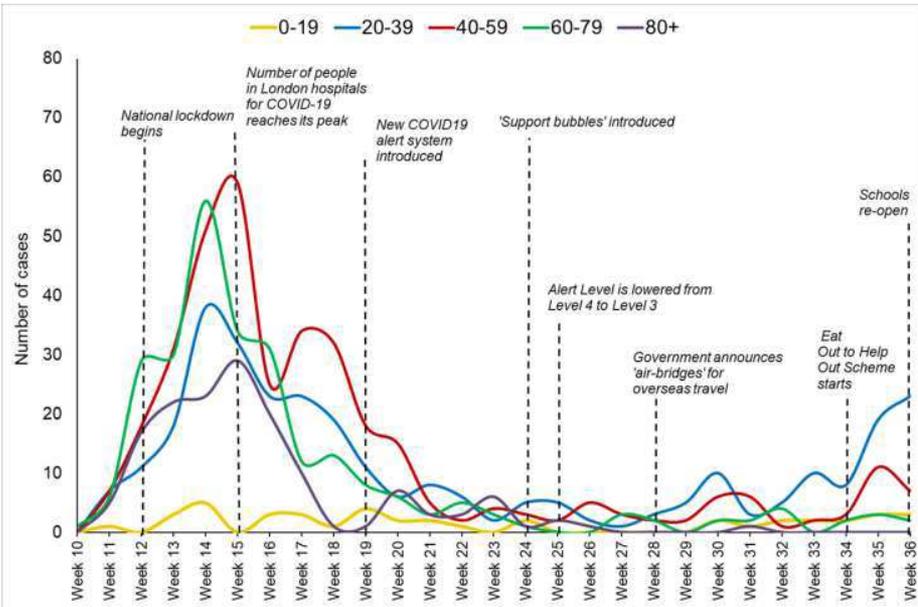
Age
Nationally there have been differences in the case profile of different age groups.

This has been seen in Greenwich. Initially the impact was seen predominantly in the 40-59 and 60-79 age bands with very few cases amongst the 0-19 age band. The increase in the last few weeks have predominantly been in the younger adults (20-39) which may reflect the lifting of lockdown measure particularly an increase in going out for meals or to pubs and also for holiday travel.

Confirmed Cases in Greenwich by age and sex March to September



Confirmed Cases in Greenwich by 20 year age bands March to September



Age and Gender

In Greenwich diagnosis rates were higher in men than women in the older age group and this mirrored the pattern of all London boroughs.

Regionally and nationally, among people under 60, diagnosis rates were higher in females than males, and among people aged 60 years and older, diagnosis rates were higher in males. This is also seen in Greenwich

In Greenwich, 2 in 3 cases have been in those under 65 years. Nationally the numbers are slightly less than 2 in 3 reflecting a young population in Greenwich.

What happened in Greenwich?

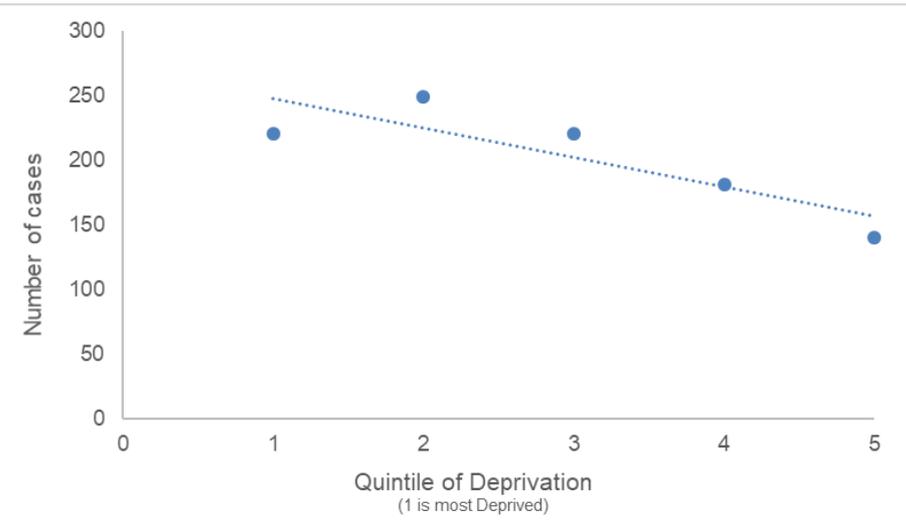
Differences in the impact of COVID-19 in Greenwich

Deprivation

Nationally the evidence has shown that people living in more deprived areas have been disproportionately affected. People who live in more deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. This could be driven by increased risk of acquiring the infection through occupational differences, behavioural factors and accessing care. Higher diagnosis rates in London compared to England can be attributed to geographic proximity to infections and housing density/housing type. Boroughs with higher diagnosis rates have a greater proportion of social housing and densely populated areas than those with the lowest rates.

This pattern has also been seen in Greenwich, with 2 in 3 cases at postcodes in the more deprived areas (IMD Quintiles 1-3) and 1 in 3 cases from the least deprived areas (IMD Quintiles 4-5).

**Confirmed Cases by Quintile of Deprivation (IMD 2019)
March to September**



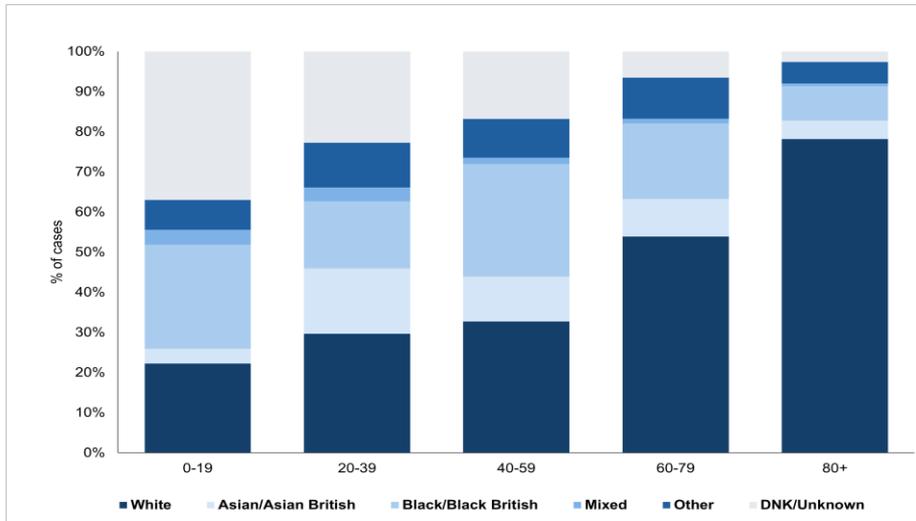
Ethnicity

Nationally the highest age standardised diagnosis rates of COVID-19 were in people in the Other and Black ethnic groups, and the lowest rates were in the White ethnic groups.

In Greenwich proportionally Black and Asians and Other Groups are over represented in confirmed cases, particularly in young adult populations.

However there is significant cases where ethnicity is unknown especially in the younger ages and therefore caution needs to be applied when interpreting the results

**Ethnic breakdown of Confirmed Cases
March to September**



What happened in Greenwich?

Differences in the impact of COVID-19 in Greenwich

Underlying Health Conditions

Evidence has shown that people with underlying health conditions are at higher risk of poor COVID-19 outcomes than those without.

Underlying health conditions have been observed in 90% of all COVID-19 related deaths, with the average case having more than two pre-existing conditions

COVID-19 deaths are more likely to include reference to conditions such as cardiovascular diseases, diabetes and chronic respiratory conditions (COPD)

Having multiple long terms conditions does not mean people will die from COVID-19, but they are a risk for more severe disease. The conditions that have been identified as being associated with more severe disease are

- Heart Disease (such as heart failure),
- Respiratory Disease (such as Chronic Obstructive Pulmonary Disease or asthma),
- Diabetes,
- Risk factors such as Hypertension Smoking and Obesity,
- Chronic liver disease,
- Chronic renal failure
- Conditions affecting the brain such as Parkinson's or Dementia,

In addition people who have a reduced immune system either due to a disease such as active cancer or are taking medicines that affect the immune system are also at risk

Disparities in Greenwich

Admissions to Hospital

Admission to hospital is a measure of the severity of the disease. Currently we only have data until the end of May. We have reviewed this data to look for any disparities between different groups in terms of severity of disease, but the numbers are too small to draw definite conclusions.

Men and Women

A greater number of men were admitted to hospital than women overall, and particularly in age group 45-64.

The rate (DSR) of deaths in hospital where there is any diagnosis of COVID-19 is indicated to be significantly greater in Greenwich men compared to Greenwich women. This is in line with national findings

Ethnicity

The recording of ethnicity for those who have been admitted to hospital is not complete (1 in 5 cases missing), which means that it is difficult to draw firm conclusions. However, the rate of admissions where there is any diagnosis of COVID-19 for people of Black Asian and Minority Ethnic background was higher than those of a white background.

Deprivation

The rate of admissions where there is any diagnosis of COVID-19 was greatest in the areas where there is more deprivation (IMD quintiles 1 and 2). This rate was significantly greater than the rate for patients in the least deprived neighbourhoods (IMD 4 and 5).

The rate of deaths in hospital where there is any diagnosis of COVID-19 is indicated to be significantly greater for those living in the more deprived areas (IMD Quintiles 1 and 2) compared to the least deprived area (IMD Quintile 5).

Overall the findings of this analysis in Greenwich reflect the national evidence

What happened in Greenwich?

Differences in the impact of COVID-19 in Greenwich

Specific Risks - Obesity

Overweight and obesity poses a major challenge to the current and future health of the Greenwich population. Higher BMI is associated with an increased risk of morbidity and mortality from a range of conditions including hypertension, heart disease, stroke, type 2 diabetes and several cancers. Obesity reduces life expectancy by an average of three years. Severe obesity reduces life expectancy by eight to ten years. Obesity also has economic and social impacts, it contributes to reduced employment, discrimination and stigmatisation, and increased social care costs.

Excess weight and Diabetes are associated with an increased risk of the following for COVID-19 outcomes; positive test, hospitalisation, advanced levels of treatment (including mechanical ventilation or admission to intensive or critical care) and death. The risk increases with increasing BMI above the healthy weight range. There is also evidence to suggest that disparities in excess weight may explain some of the observed differences in outcomes linked to COVID-19 for older adults and some BAME groups.

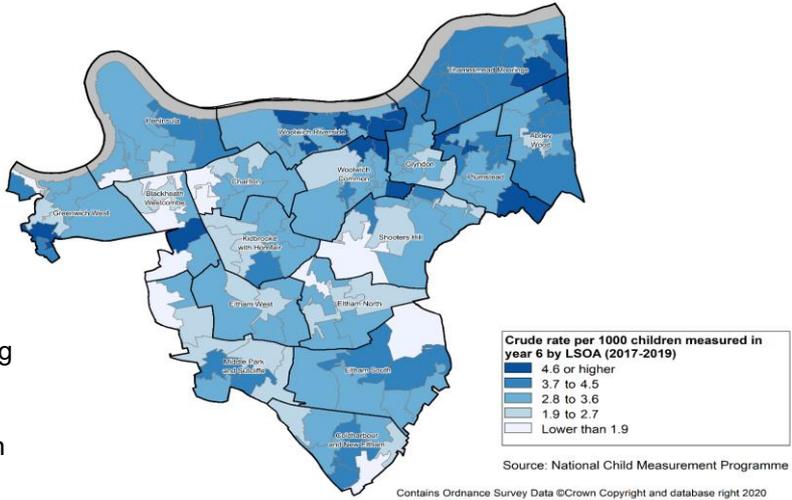
The top map shows where we have higher levels of obesity in children aged 11 (from the National Child Measurement programme (NCMP)). From NCMP we also know we have higher levels of obesity in our Asian and Black communities. Higher prevalence of Type 2 Diabetes is also linked to higher prevalence of obesity; in Greenwich **50% of those with type 2 diabetes are from BAME backgrounds** which is in line the higher prevalence of obesity in these community. This also links to the disparities in outcomes identified in national research.

Specific Risks – Smoking

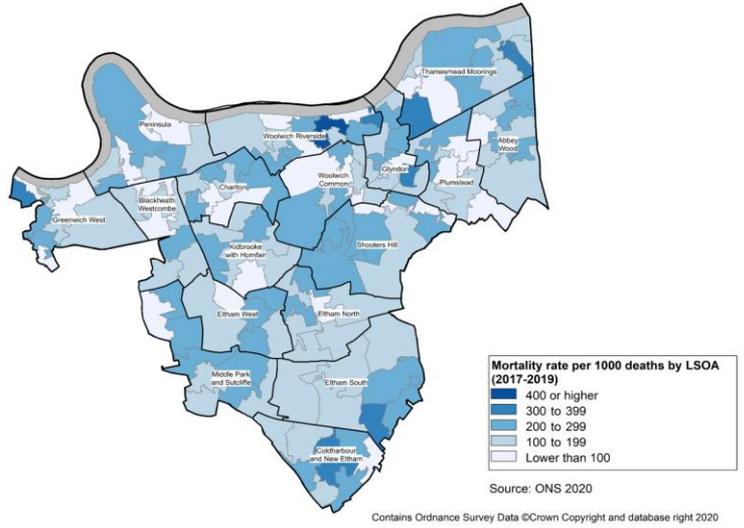
The harms of smoking are well-established. Tobacco causes significant deaths every year from cardiovascular diseases, lung disorders, cancers, diabetes, and hypertension. Smoking tobacco is also a known risk factor for severe disease and death from many respiratory infections. The evidence on smoking and coronavirus (COVID-19) is mixed and developing.

However, in Greenwich there are a higher proportion of smokers compared to London or England particularly for routine and manual workers which could reflect the increase of poor outcomes from COVID-19 in those from more disadvantaged backgrounds.

Children in year 6 who were recorded as overweight or obese by LSOA in Greenwich (2017-2019)



Deaths related to smoking by LSOA in Greenwich (2017-2019)



What happened in Greenwich?

Differences in the impact of COVID-19 in Greenwich

Occupation

There is increasing evidence that a range of public facing occupations may have higher death rates relating to COVID-19.

ONS identified roles such as transport workers, security guards and some care worker roles as having significantly higher levels of mortality from COVID-19.

PHE have expanded this analysis and identified nursing auxiliaries and assistants as also having higher mortality levels. It is worth noting that analysis by occupational group is complex and should be interpreted with caution and staff within broad occupational groups may have differing levels of exposure due to the nature of their specific roles, particularly during a pandemic.

In Greenwich, ONS figures from April 2019 to March 2020 suggest that only 1 in 3 of the people occupying managerial professional and highly skilled jobs are of BAME background but 1 in 2 are in front line roles such as carers, frontline staff in retail and manual workers.

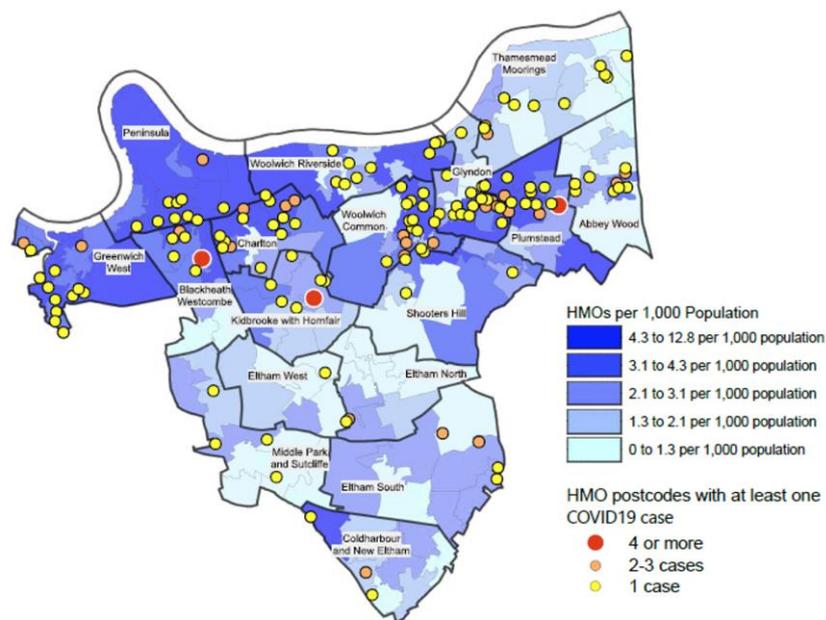
This suggests that many of our BAME have public facing roles and therefore will have greater exposure to the virus.

Occupation	All Cause Deaths 2014-2018 average	All Cause Deaths 2020	Relative Increase
Nursing auxiliaries & assistants	52	128	2.5
Security guards & related roles	80	209	2.6
Taxi drivers & chauffeurs	87	217	2.5
All people 20-64	9,440	14,409	1.5

Housing

There is evidence that living conditions such as overcrowding or multigenerational living increases the risk of contracting and falling ill from COVID-19.

In Greenwich there are significant numbers of houses of multiple occupation (HMO). Although there has not so far been a clear association with high numbers of cases, the risk for those living in HMOs remains high.



References

1. ONS, 2020. Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020.
2. PHE, 2020. Disparities in the risk and outcomes of COVID-19.
3. Nomis (ONS data) 2020.

The impact of COVID-19 on Mortality

What happened in Greenwich? – Impact of COVID-19 on Mortality

Differences in the outcomes of COVID-19 in Greenwich

The WHO estimates that COVID-19 is fatal in about 3.4% of cases.

Research by PHE has identified certain people are disproportionately affected. That is, there are inequalities in who catches the virus, who has more severe disease and who dies from it.

Weekly data from ONS allow us to monitor all COVID-19 registered deaths among Greenwich residents. By 31st July there had been 227 COVID-19 related deaths in Greenwich, representing 1 in 5 deaths since the beginning of the year.

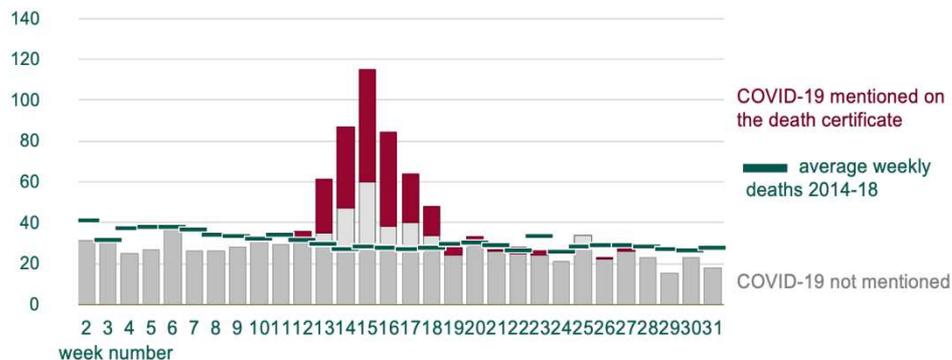
The majority of COVID-19 deaths among Greenwich residents have occurred within hospital (85%), which is higher the national (63%) and regional pattern (74%).

Cumulative COVID-19 related deaths registered between 1 Jan 2020 to 31 July 2020

Area	Hospital	Care Home	Home	Elsewhere	Total
Greenwich	188 (83%)	22 (10%)	10 (4%)	67 (3%)	227
South East London	1,249 (76%)	247 (15%)	107 (7%)	42 (3%)	1,645
London	18,807 (74%)	4,161 (16%)	2,040 (8%)	576 (2%)	25,584
England	31,111 (63%)	14,647 (30%)	2,304 (5%)	1,121 (2%)	49,183

Weekly excess deaths in Greenwich

All deaths in 2020 by week, with proportion where COVID-19 is mentioned



Excess deaths measure the additional deaths within the population compared to what we would normally expect. It is generally considered the best indication of the pandemic impact on mortality.

The number of deaths among Greenwich residents has exceeded what we would normally expect since week 12 (week ending 20 March). This is mainly associated with the increase in COVID-19 related deaths over the period.

The number of deaths among Greenwich residents has exceeded what we would normally expect from week 12 (week ending 20 March) to week 20 (week ending 15th May)

Week 15 saw the highest number of deaths in Greenwich at 115.

- 55 deaths were recorded as COVID related.
- 60 deaths were recorded as other reasons.
- As there were an average of 28 deaths in the same week in the previous years, in week 15 there were 32 excess deaths which were not recorded as COVID related.

Reference

1. ONS, 2020. Deaths registered weekly in England and Wales, provisional:.

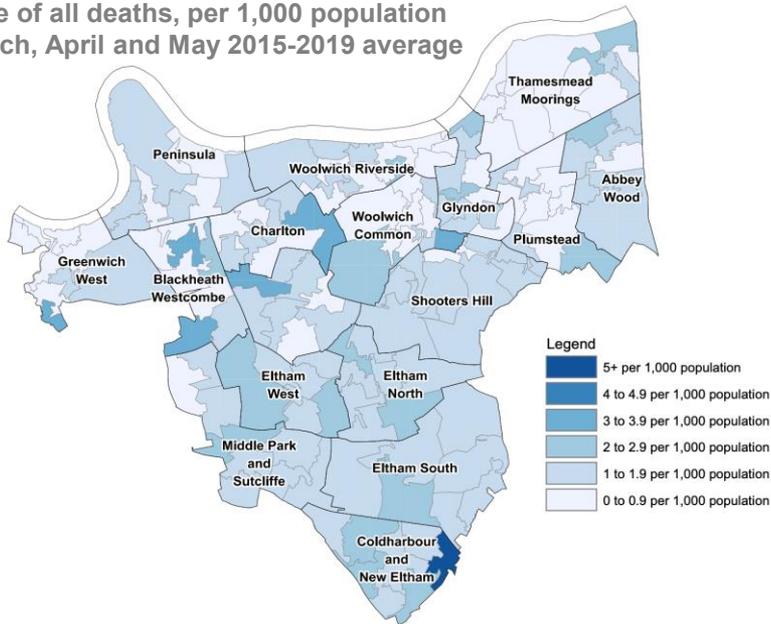
What happened in Greenwich? – Impact of COVID-19 on Mortality

Differences in the outcomes of COVID-19 in Greenwich

The maps demonstrate where some of the excess deaths have occurred in Greenwich. Most areas have had a similar proportional increase in deaths, where the rates of death (per 1,000 people) have increased in all wards with the exception of Peninsula and Woolwich Riverside where the population overall is younger (based on GLA estimates).

The average mortality in the previous 5 years (2015-2019) for March to May had only 1 ward with rates higher than 2/1,000 (Coldharbour and New Eltham). In 2020, there were only 6 wards with a rate lower than 2/1,000, Peninsula, Woolwich Riverside, Thamesmead Moorings, Glyndon, Plumstead and Shooters Hill. However the average increase on the previous 5 years was 180% with the highest increase seen in Woolwich Common of 228%

Rate of all deaths, per 1,000 population
March, April and May 2015-2019 average

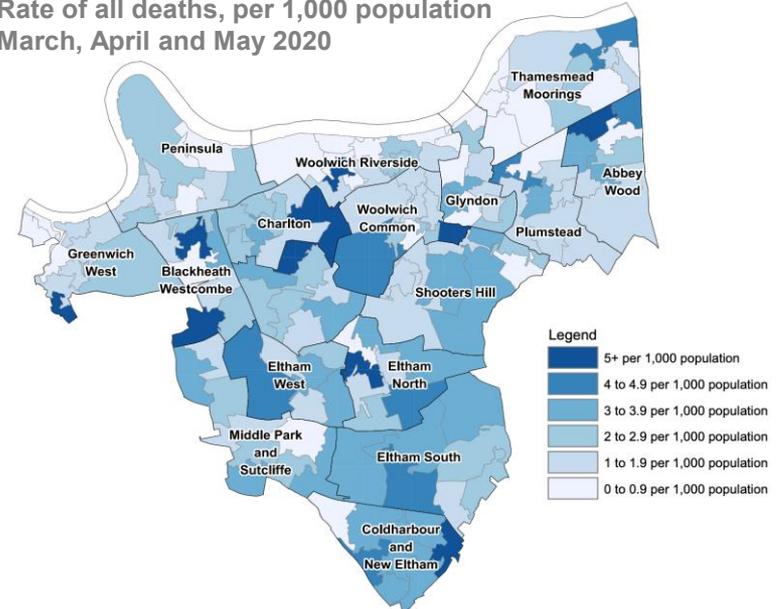


Deprivation

Where deaths were identified due to COVID-19, there was a gradient between the most deprived areas and least deprived areas. This was particularly stark for women with a rate of 160 deaths per 100,000 in the most deprived Quintile and of 53 per 100,000 in the least deprived Quintile.

For men the picture was less clear with the highest rate for those living in the second least deprived area. However this might reflect the impact of care homes and sheltered housing. There was also a larger number of excess deaths especially for men in the most deprived Quintile which were not identified as COVID related.

Rate of all deaths, per 1,000 population
March, April and May 2020



Note some of the increases in ward based deaths may be driven by care home deaths

Reference

1. ONS, 2020.

What happened in Greenwich? – Impact of COVID-19 on Mortality

Differences in the outcomes of COVID-19 in Greenwich

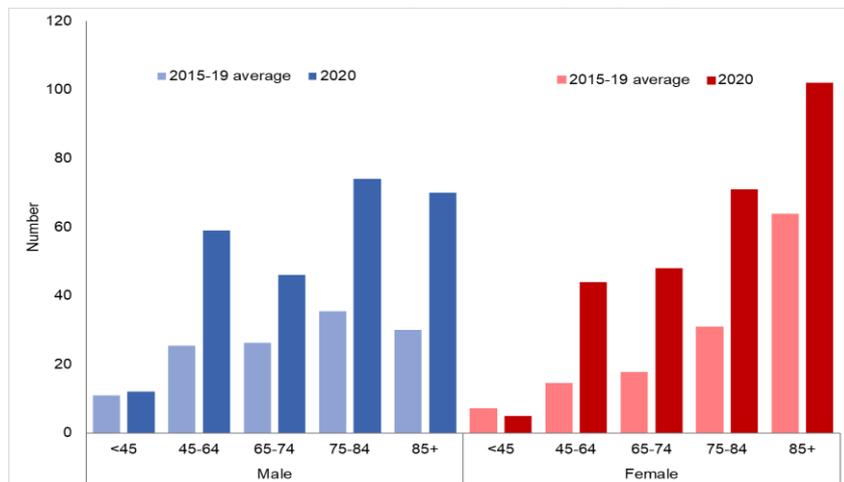
Age and Sex

National Research found over two-thirds of all COVID-19 related deaths have been in those aged 80+. Survival analysis for those with confirmed COVID-19 indicates those aged 80 and over are seventy times more likely to die than those aged under 40.

In Greenwich the number of deaths in men increased from 128 on average in 2015-19 to 261 in Mar-Apr 2020: around 133 excess deaths. For women the increase was from 134 to 270: around 136 excess deaths.

There were an increased number of deaths of men and women in all age groups over the age of 45. The largest increase in women is age group 45-64 (up 201%) from 15 deaths on average to 44. In men the biggest increase was seen in those aged over 85 (up 133% from 30 deaths on average to 70), but only slightly ahead of men aged 45-64 (up 132% from 25 deaths on average to 59).

Number of Deaths Registered in March and April 2020 compared to the 2015-19 5 year Average by Age and Sex



Mortality rates among working age men are more than double their female counterparts. It is not clear what is driving the difference between sexes, whether this is related to exposure, access to care or underlying biological differences.

Mortality rates were similar for both men and women in Greenwich which differs from national trend. The drivers for mortality differences are complex.

Boroughs with greater levels of socio-economic disadvantage and intergenerational poverty are ranked high for death rates in men and women yet other more affluent areas may have higher rates due to an older population.

Nationally, COVID deaths have an older age distribution, which may lead to a higher risk of critical care; people aged 80 or older were seventy times more likely to die than those under 40 if tested positive.

Underlying Health Conditions

Deaths from conditions that are known to impact on the severity of COVID-19 have also shown increases compared to the same period in previous years. Deaths from circulatory and respiratory illnesses have increased by 25% and 19% in men and women respectively.

There was a small increase in deaths due to cancer amongst women but no change for men.

Occupation

Death certificates do record occupation. Although the data isn't always clearly captured it does give some insights into the impact of occupation. For the deaths in Greenwich recorded in March and April; 46 were identified as having a paid occupation or job; 12 appeared to work in health or social care (Doctors, health care or care assistants) this was double previous years. 11 worked in roles that would have been front line such as catering, teaching and retail.

Reference

ONS, 2020. Coronavirus Infection Survey Pilot: England, 9 July 2020.

PHE, 2020. Disparities in the risk and outcomes of COVID-19.

What happened in Greenwich? – Impact of COVID-19 on Mortality

Differences in the outcomes of COVID-19 in Greenwich

Ethnicity

Currently death certificates do not record the ethnicity of people who have died so it is not possible to definitively identify the disproportionate impact on different ethnic groups. The Office of National Statistics undertook an analysis of COVID-19 deaths across England and Wales by broad ethnic group using the 2011 Census to draw their conclusions.

The results show differences in risk between ethnic groups that are not currently explained by age, deprivation, housing composition, education, region, rural/urban setting, or self disclosed health status at the time of the 2011 Census.

When taking account of these factors, the risk of COVID-19 related death among Black ethnic groups is almost twice than among those of white ethnicity.

The subsequent investigation by PHE after accounting for the effect of sex, age, deprivation and region, found that people of Bangladeshi ethnicity were at most risk, with around twice the risk of death than people of white British ethnicity. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicity had between 10% and 50% higher risk of death when compared to white British.

While death certificates don't include the ethnicity of the person who has died, the information does include country of birth which can be used as a proxy although caution is needed when interpreting these figures as the numbers are low, and country of birth is not always a good proxy of ethnicity.

Local analysis of ONS mortality data indicates that ethnicity is a risk factor in excess and COVID related deaths in Greenwich. However caution needs to be applied with interpretation as numbers are very small.

Comparison of average numbers of deaths in March and April 2015-2019 compared to March and April 2020 shows:

- Residents born South-east Asia have the largest % increase in in deaths in the 2 month period. This was driven by the relatively high increase in deaths of people born in Vietnam
- The largest number of deaths of people born in Asia were born in India and Nepal
- Residents born in Africa had an increase of 273% deaths. The highest increase was seen in people from Sierra Leone and 2 in every 3 excess deaths in people born in Africa were COVID-19 related
- Numbers of deaths in residents born in Western Europe tripled; with people born in Cyprus seeing a marked increase (400%)
- The total number of deaths in March and April 2020 was more than double the average for previous five years with 1 in 3 deaths being COVID-19 related

Deaths in Greenwich residents March and April 2015-2019 compared to 2020

Region of Birth	2015-19 average	2020	% increase
Africa	14	53	273%
Asia	10	33	224%
Caribbean	8	19	132%
Eastern Europe	3	8	186%
South East Asia	3	13	400%
UK and Eire	214	376	76%
Western Europe	6	18	210%
Other regions/unknown	5	11	120%
Grand Total	263	531	102%

Reference

1. ONS, 2020. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020
2. PHE Disparities report



What Next?

What Next?

The pandemic has shone a light on entrenched health inequalities and provided a necessary wake-up call. The situation found nationally is no different in Greenwich. The learning from this has enhanced our plans for recovery and controlling future outbreaks.

The Council has developed an Outbreak Control Plan designed to control and manage the spread of COVID-19 infections in the community and in care homes and other supported accommodation in the borough. .

The Outbreak Control Plan (OCP) aims to:

- Effectively prevent and manage outbreaks of COVID-19 to mitigate the impact of the virus on Greenwich's population and communities
- Support a safe return to a normal way of life for residents, businesses and visitors to the borough

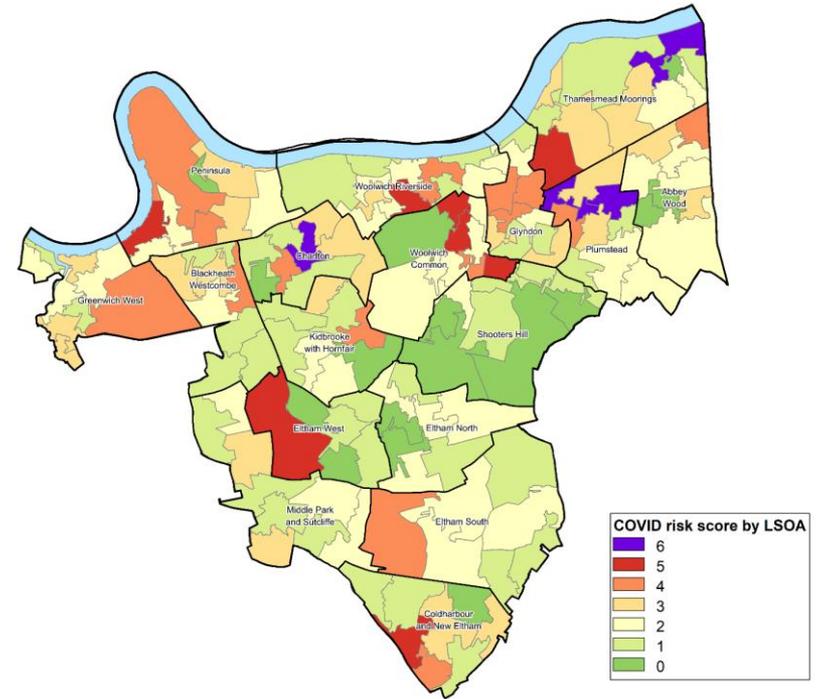
Key principles set out in the OCP are that:

- Test and Trace must be accessible for everyone to use; including people facing deprivation and digital exclusion.
- Deep engagement across our communities to ensure that no-one is left behind or overlooked and that are most vulnerable communities are protected.
- Support for residents continues to be a priority. Our Community Hub, which has been providing support to people needing to shield and self-isolate throughout the epidemic, will continue to provide a response to those needing help with food, medicines and other essentials whilst asked to self-isolate.

Workstreams are being developed around four key pillars of our approach to prevention and outbreak control:

- Mass generic communication across the borough
- Protecting people with underlying health conditions
- Deep engagement with identified highest risk communities
- Working with key settings and workplaces to support COVID safe practice

The map shows the risk stratification identified for neighbourhoods. While this doesn't preclude outbreaks occurring in other areas, initially our work will start with those areas that have the highest risk.



In order to support our residents and identify who is likely to be at increased risk, the key criteria that lead to poorer outcomes have been mapped at a small area level. This risk stratification includes:

- Levels of Deprivation (IMD 2019)
- Where BAME communities live (Census 2011)
- Historical and current infection rates
- Long-term condition prevalence (the people who were shielded)
- Obesity levels (as measured by Year 6 results from the Child Measurement Programme number of overweight and obese)
- Older population (over 70 years) (GLA population projections)
- Houses of Multiple occupation

What Next?

The NHS and Council (Health and Care) have developed a joint recovery plan (Borough-based Plan) that focuses on 3 key areas

- Tackling inequalities in health outcomes across physical and mental health, improving health outcomes for children and young people and for older people, and improving services that prevent future ill-health
- Delivering services focused on local communities, building on the success of the Community Hub over the first wave of the pandemic and the lessons learned, the plan looks at the way health and care services can develop new ways of working that better connect us all, including people, communities, organisations, local businesses, charities and community groups to improve support within local neighbourhoods
- Looking at new ways of delivering services, building on what has been learnt about digital service delivery and get the balance right between accessing services remotely and face to face care

The Borough-based plan also looks at implementing the PHE seven recommendations.

Healthwatch Greenwich ran a digital listening event involving local community leaders, the Council, NHS and other partner organisations. The findings and subsequent commitment from Health and Care organisations focus on addressing the concerns raised at the event, in line with the seven recommendations from the PHE equalities report.

The Council is developing an Equality and Equity Charter which sets out pledges to promote the values of equality, diversity and inclusion and welcome views to help shape the Charter and collectively agree on a set of commitments that we can all adopt in our organisations and groups. The work will inform an broader action plan due October 2020. This will set out wider plans to address issues raised from the national evidence and as part of the digital listening event.