

# COVID-19 and BAME Communities

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# Introduction to COVID-19

- Coronaviruses: large group of viruses-some causing less severe cold-like diseases-other causing more severe life threatening illness such as Middle Eastern respiratory syndrome (MERS)
- January 2020 - a novel coronavirus was first identified
- The virus is called SARS-CoV-2. The associated disease is COVID-19
- Main route of transmission is respiratory droplets (coughing and sneezing) and contact routes (person to person contact and environmental surfaces)
- Incubation period (time from exposure to developing symptoms) is 2-10 days. 50% of people will develop symptoms by day 5
- The main symptoms are a high temperature, cough and anosmia (loss or change to normal sense of taste or smell)

# Introduction to COVID-19

- COVID-19 is a new disease and there is limited information regarding risk factors for severe illness.
- National guidance has advised that older adults, pregnant women, and people who have underlying health conditions may be at higher risk for severe illness from COVID-19.
- There is emerging evidence around additional risks for vulnerability: smoking, high blood pressure, certain occupational groups and people from BAME backgrounds.
- The growing research and evidence base around the risks of COVID-19 and BAME communities is new, emerging and complex.

# Ethnicity in Bolton

Bolton is richly diverse - over one fifth of the population are from a Black, Asian or Minority ethnic (BAME) background. According to Census (2011) data, the proportion of the population from a BAME background doubled between 2001 and 2011.

The most common BAME groups are of Indian (7.8%) and Pakistani (4.3%) background.

Bolton has a larger Indian population than the national average of 2.5%.

The Black African population makes up 1.2% of Bolton's total population, a lower proportion than the national average.

In addition, 1.8% of the population is of a mixed ethnicity

Source: Bolton JSNA

<https://www.boltonjsna.org.uk/ethnicity>

	Bolton		Greater Manchester		England	
Ethnic group	Number	%	Number	%	Number	%
White British	219,794	79.41	2,141,687	79.84	42,279,236	79.75
Other White	6,851	2.48	106,436	3.97	3,001,906	5.66
Mixed/multiple ethnic group	4,892	1.77	60,710	2.26	1,192,879	2.25
Asian/Asian Indian	21,665	7.83	53,461	1.99	1,395,702	2.63
Asian/Asian Pakistani	12,026	4.34	130,012	4.85	1,112,282	2.10
Other Asian	5,058	1.83	88,700	3.31	1,635,419	3.08
Black/African/Caribbean/Black British	4,652	1.68	74,097	2.76	1,846,614	3.48
Other ethnic group	1,848	0.67	27,425	1.02	548,418	1.03
BAME	56,992	20.59	540,841	20.16	10,733,220	20.25

# Evidence on COVID-19 and BAME Communities

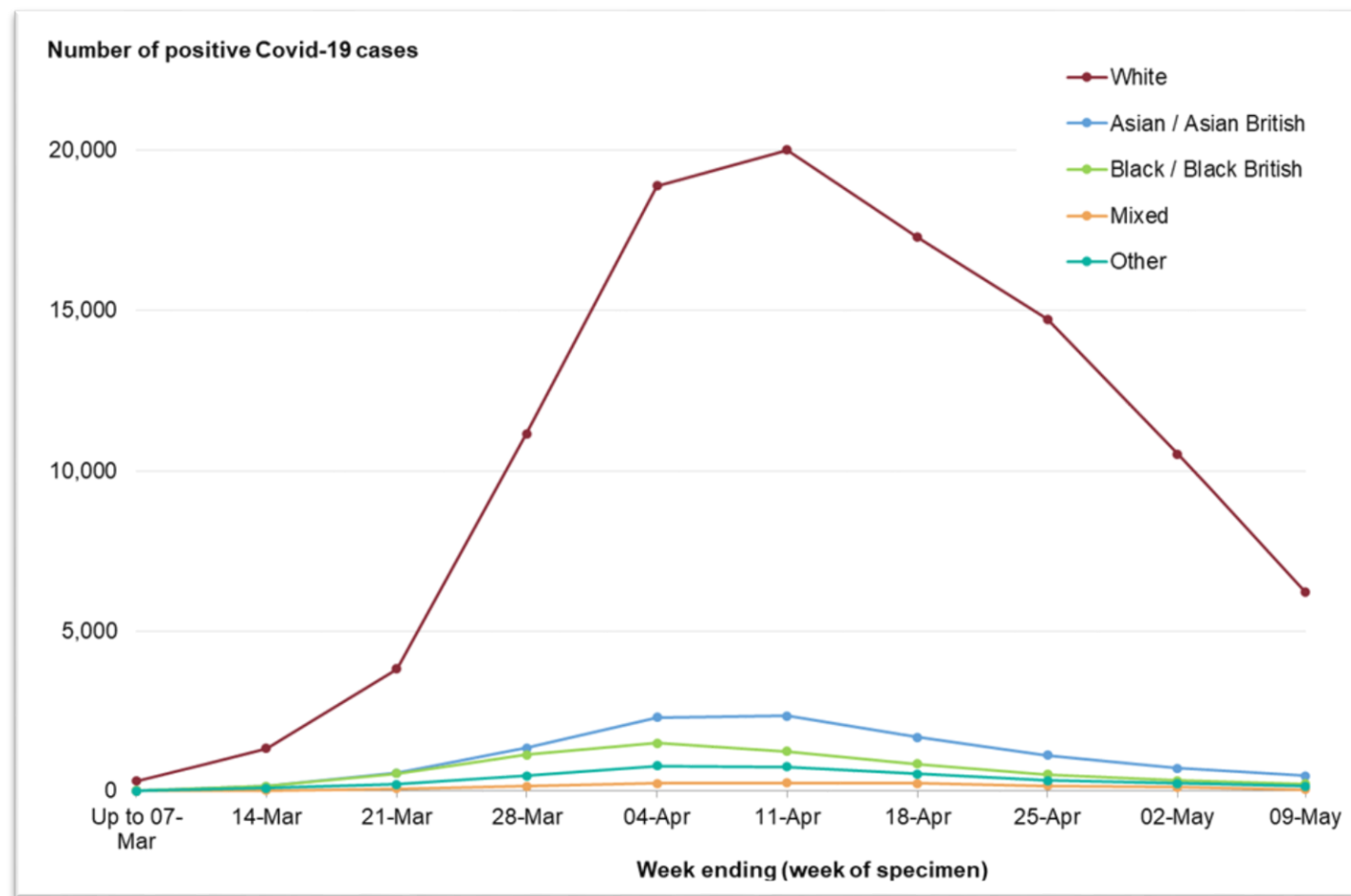
- There is emerging evidence and heightened media coverage suggesting that Black Asian and Minority Ethnic Groups (BAME) are at increased risks associated with COVID-19.
- Most of the evidence we have to date of the impact of COVID-19 on BAME communities is drawn from national surveillance monitoring and datasets on morbidity and mortality.
- Public Health England (June 2020) published the findings of a review into [disparities in the risk and outcomes of COVID-19](#). The review was announced following emerging evidence suggesting a disproportionate impact of COVID-19 on people from BAME backgrounds

# Laboratory confirmed positive tests by ethnicity

Weekly number of laboratory confirmed positive tests from the start of the pandemic up to May 9<sup>th</sup> 2020

NB the majority of testing during this period was for Pillar 1- those with a medical need and key workers rather than the general population-so tends to represent those with most severe disease than all those who get infected within the community.

Source: Public Health England Second Generation Surveillance System.



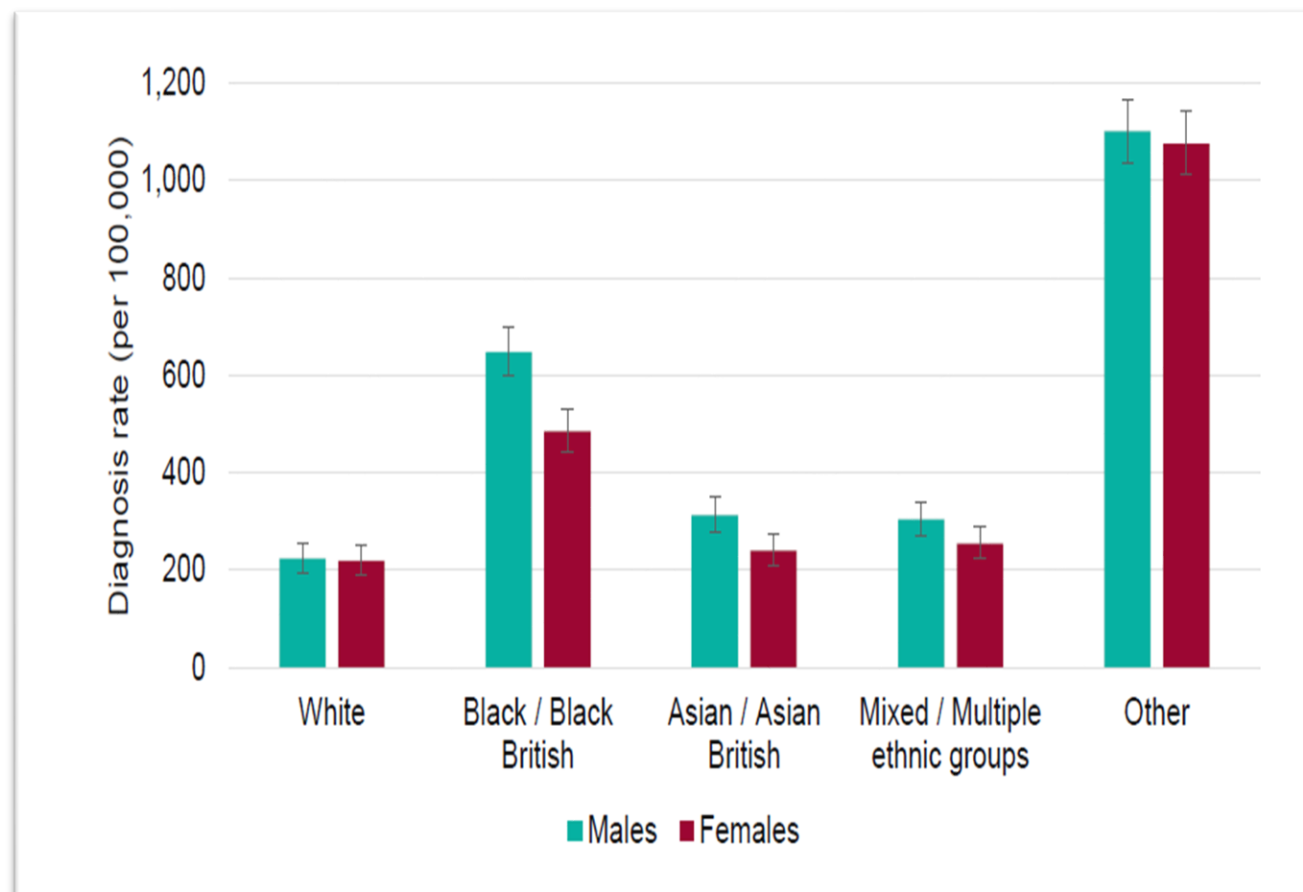
# Diagnosis rates by ethnicity and gender

Laboratory confirmed positive cases up to May 9<sup>th</sup> 2020 shows that once adjusted for age the highest COVID-19 diagnosis rates were amongst those groups recorded as 'other ethnic groups' followed by Black/Black British groups.

These results are not adjusted for some factors that may influence the likelihood of becoming infected, such as geographical location

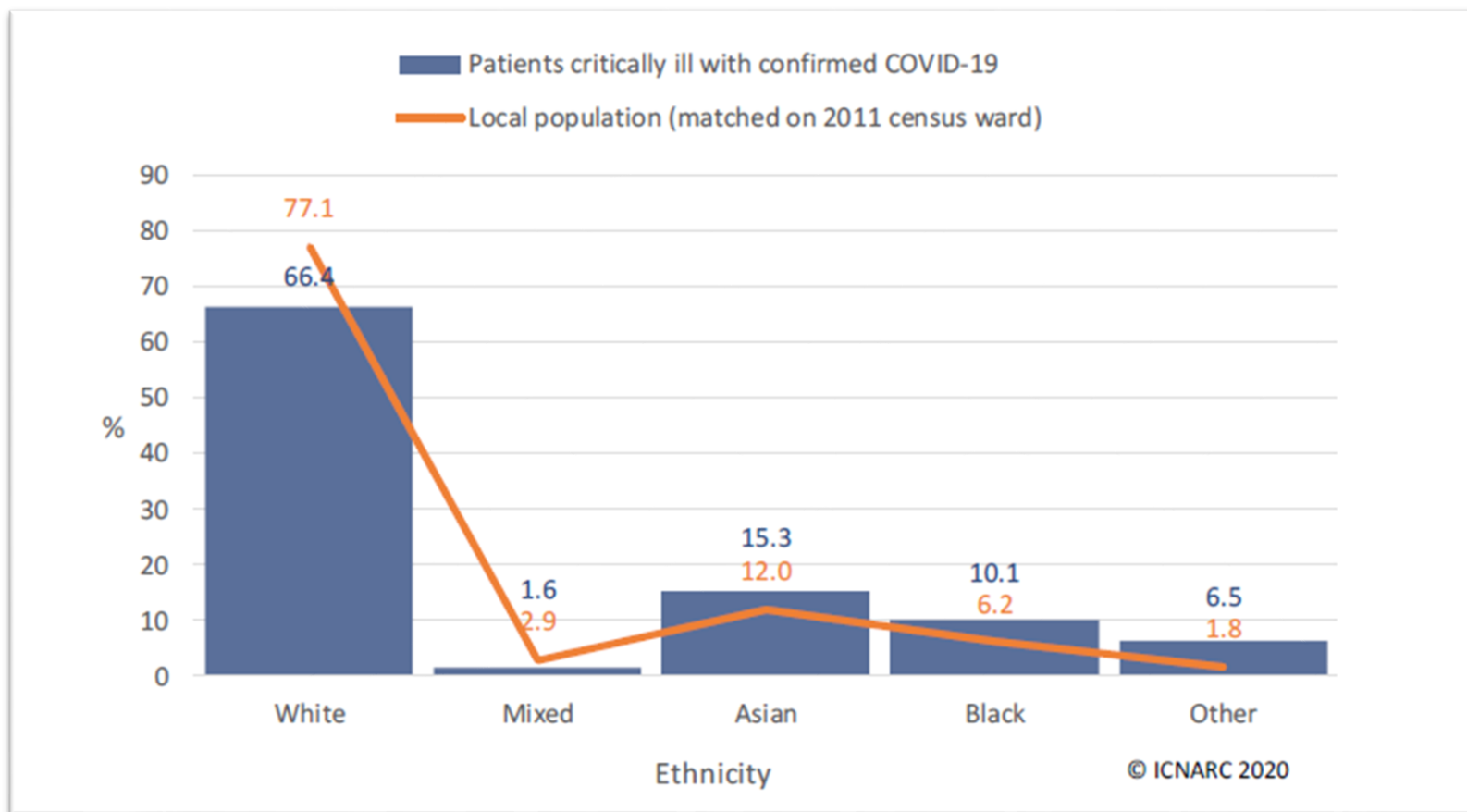
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# Ethnicity distribution of patients critically ill with confirmed COVID-19

Black and minority ethnic groups (BAME) over-represented in ICU admissions for COVID-19



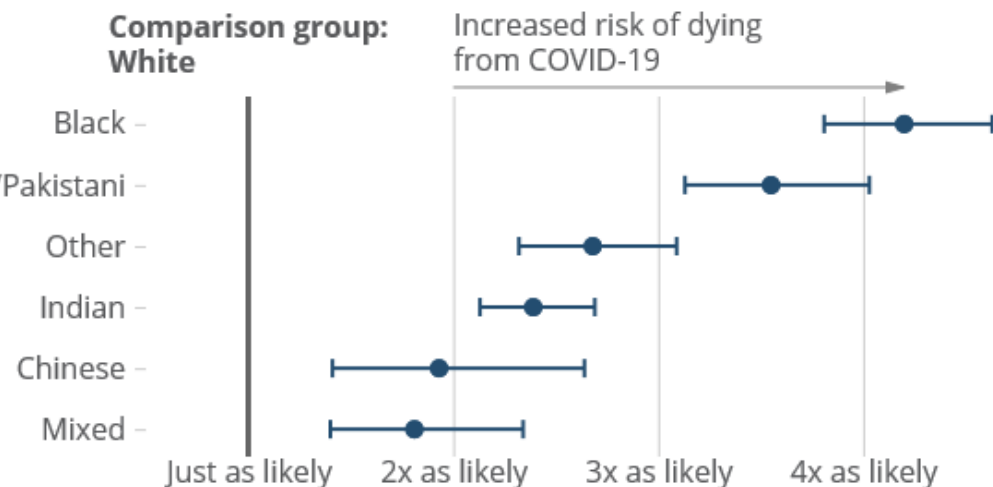


# Risk of COVID-19-related death by ethnic group and sex, England and Wales, 2 March to 10 April 2020

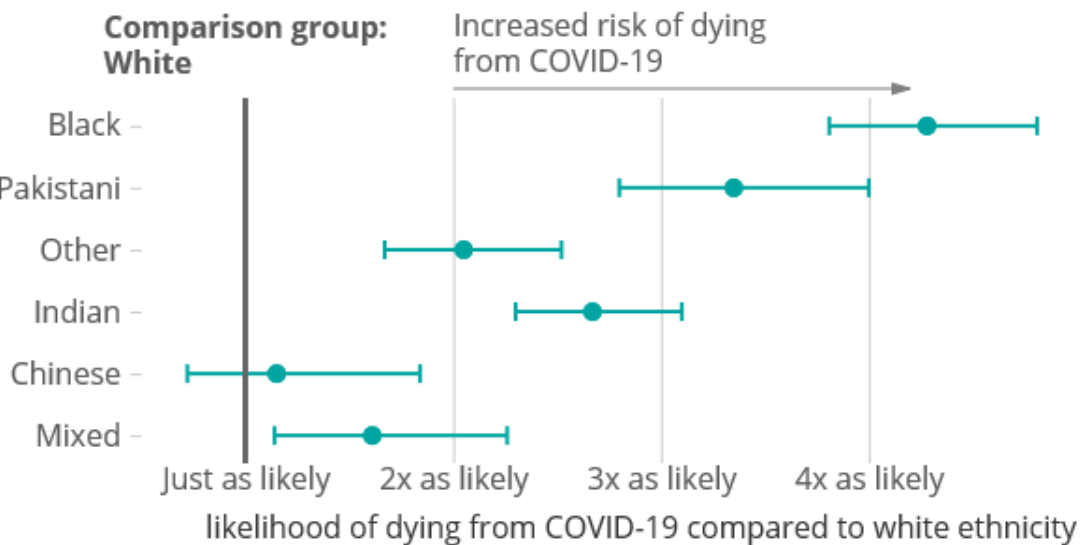
## Age-adjusted model

- When taking into account age in the analysis, Black males are 4.2 times more likely to die from a COVID-19 related death and Black females are 4.3 times more likely than White ethnicity males and females.
- People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also had significant raised risk of death involving COVID-19 compared with those of White ethnicity.

### Males



### Females

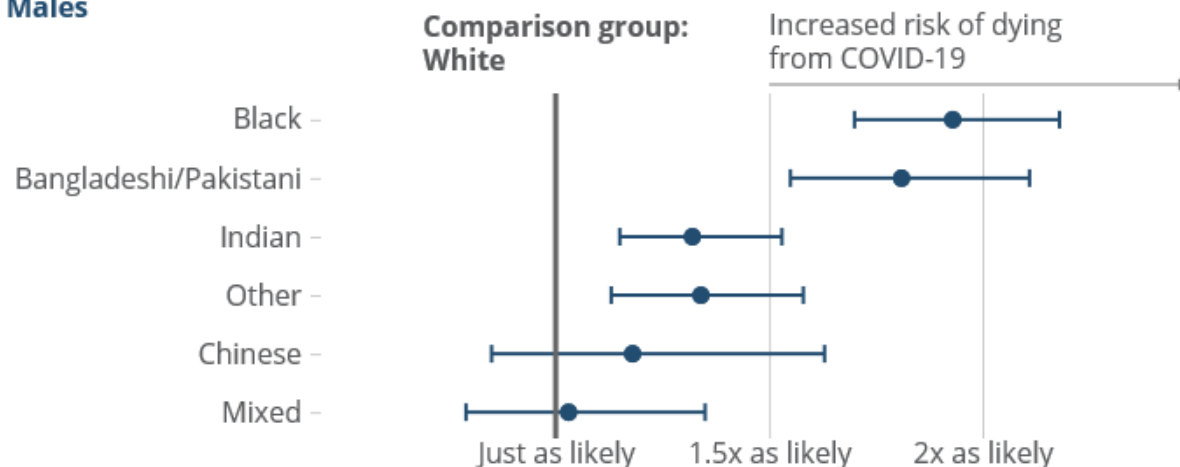


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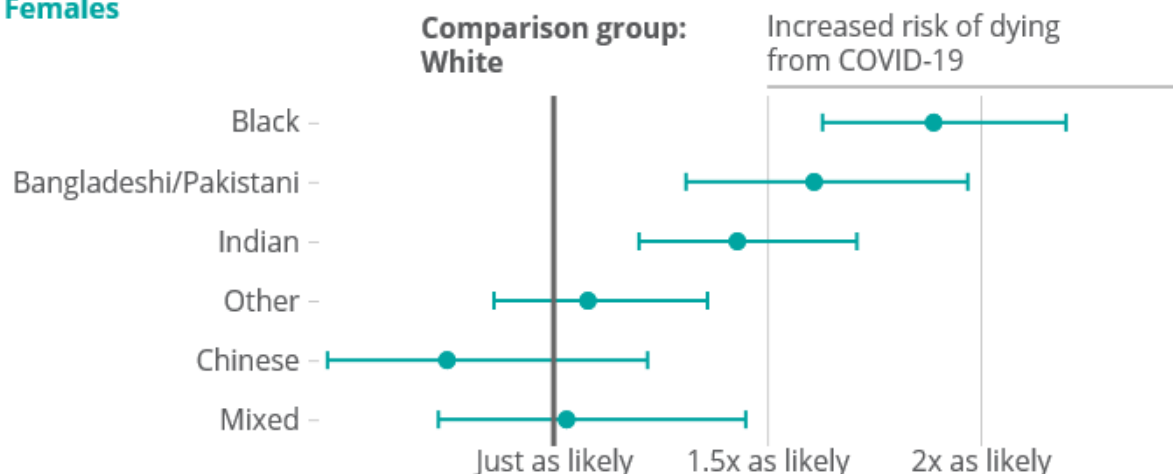
## Fully adjusted model

- Taking account of age and other socio-demographic characteristics and measures of self-reported health and disability at the 2011 Census, the risk of a COVID-19-related death for males and females of Black ethnicity reduced to 1.9 times more likely than those of White ethnicity
- Similarly, males in the Bangladeshi and Pakistani ethnic group were 1.8 times more likely to have a COVID-19-related death than White males when age and other socio-demographic characteristics and measures of self-reported health and disability were taken into account; for females, the figure was 1.6 times more likely.

### Males



### Females



likelihood of dying from COVID-19 compared to white ethnicity

# Key findings of ONS analyses

- Risk of death involving COVID-19 amongst some ethnic groups is significantly higher than those of white ethnicity
- Higher risk of death is partly explained by socio-economic disadvantage (ethnic minority groups tend to be more disadvantaged than their white counterparts) and 'other circumstances'
- Whilst a substantial part of the difference appears to be explained by socio-economic circumstances, the remaining part of the difference is not yet explained
- ONS note that some ethnic groups may be over-represented in public-facing occupations and may therefore be more likely to be infected by COVID-19. This is an aspect they are looking to explore in future analyses

# Public Health England review- Disparities in the risk and outcomes of COVID-19

- The review published June 2019 is a descriptive look at surveillance data on the impact of COVID-19 on risk and outcomes.
- The impact of COVID-19 has replicated existing health inequalities and, in some cases, exacerbated them further, particularly for black, Asian and minority ethnic (BAME) groups.
- The largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were 70 times more likely to die than those under 40.
- Risk of dying among those diagnosed with COVID-19 was also higher amongst:
  - males than females
  - those living in the more deprived areas than those living in the least deprived
  - those in BAME groups than in white ethnic groups.
- These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in white ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity.
- The review also found a high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations, including social care and nursing auxiliaries and assistants; public transport drivers; security guards and related occupations.
- However, the analyses do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and could explain some of these differences.

# Implications for BAME communities

The PHE Review found that the relationship between ethnicity and health is complex and increased risk is associated with multiple individual, biological, societal and economic factors

People of BAME communities:

**Are at increased risk of acquiring infection:**

- More likely to live in urban and/or deprived neighbourhoods
- In overcrowded/multi-generational households
- Have difficulties accessing services-language and cultural differences

**At increased risk of poorer outcomes after acquiring infection:**

- Due to co-morbidities that are more prevalent amongst certain BAME groups after acquiring infection e.g. Bangladeshi and Pakistani groups have higher rates of cardiovascular disease than white British ethnicity

# COVID-19: Children and young people

- Evidence on the impact of COVID-19 on children and young people from BAME communities is limited.
- COVID-19 has been reported in children and young people of all ages. However there are fewer confirmed cases compared with adults: <2% of total confirmed cases
- COVID-19 does not appear to be as severe in children than in adults: children are often asymptomatic or have a mild course of illness
- Serious COVID-19-related illness and death is extremely rare: mortality seems to be consistent at around 0.01% - in a similar region to seasonal influenza.
- It is uncertain how many children in the community have COVID-19 in the absence of widespread, high quality 'sero' or antibody surveillance studies, but increasingly likely that there are comparatively few children with COVID-19 disease in the community, particularly younger children.
- The role of children in transmission is unclear but at this time do not appear to be 'super spreaders' of COVID-19 infection. Children are less likely than adults to spread COVID-19, both at home and school

(Source: Royal College of Paediatrics and Child Health, 2020)

- If effective infection prevention control and social distancing measures are in place schools are safer settings in terms of exposure to coronavirus than other health and social care settings where contact with symptomatic people is more prevalent.

# Arrangements in school settings

Schools are starting to make arrangements around wider re-opening based upon:

- Ensuring social distancing and infection prevention control measures including PPE are in place. Webinars and resources have been issued to support
- Ensuring the whole school community knows about routes to be tested and arrangements for the developing contact tracing model
- Using the knowledge and intelligence about the whole school community
- Undertaking staff wellbeing conversations and conducting *holistic* risk assessments where needed:
  - The school setting
  - Workforce
  - Individual staff members



# A settings approach to assessing risk

Whole school setting-based approach to staff wellbeing that is fair and equitable.

Where risks are identified individual assessments and conversations can be offered to provide further understanding and supportive measures

Source: NHS Employers

## HOW TO USE THE RISK ASSESSMENT TOOL

Employers have a duty of care requiring them, as far as reasonably practicable, to secure the health safety and welfare of their employees. This includes an equitable approach to effective risk management and risk reduction of potential workplace hazards, for all staff which requires:





## **Further engagement with BAME communities**

There is a programme of engagement work being developed with the VCSE sector and partners to further understand the impact of COVID-19 and BAME communities.

This will help us understand and connect with diverse communities across Bolton to co-produce culturally fair and equitable public health messages and solutions.

# Questions

## **Further information available to the Government about risks to the BAME Community**

There is a second report on Covid-19 risks and BAME communities due to be published imminently by Public Health England. The report can be circulated to partners when it becomes available.

## **Access to the antibody test for school staff**

There is currently no national guidance on the arrangements for antibody testing. We will issue guidance to schools and other stakeholders when this information becomes available. People should be aware and warned against scams and rogue companies offering antibody testing.

## **Do we need individual risk assessments for members of staff who are from the BAME community?**

The risk assessment template sent to support schools is a holistic tool that schools may use to screen their school and workforce. We are advising that schools should undertake wellbeing conversations with all staff and where there are concerns about increased risk an individual risk assessment can be undertaken with a supportive action plan to mitigate risk as far as possible.

## **Support for bereavement**

Information has been added to the Extranet this week.

## **Central point for recording school closures**

Whilst the LA is linking with schools to keep a track of which year groups are currently in school, this information is subject to such frequent change that full accuracy can not be guaranteed, and may become misleading, so there are no plans to publish this externally