DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		THE EMERGING PICTURE - COVID-19 AND HEALTH INEQUALITIES IN SOUTHAMPTON		
DATE OF DECISION:		3 SEPTEMBER 2020		
REPORT OF:		INTERIM DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
N/A

BRIEF SUMMARY

Southampton experienced significant health inequalities before Covid-19. There is evidence to show that Covid-19 is exacerbating health inequalities through a variety of mechanisms. Some groups are at much higher risk of either being infected by, or severe outcomes from the virus; there have been changes in the use of and access to health services over the course of the pandemic to date; there is emerging evidence to show the measures taken to control the spread of the virus have had unequal socioeconomic impacts, and it is anticipated this may continue.

This paper provides an initial analysis of the impact of Covid-19 on health inequalities in Southampton. Detailed analysis is limited to data of those who have had a positive test for coronavirus and deaths from Covid-19. Further analysis is required once data and capacity is available, to understand the full impact of Covid-19 on health inequalities in the city, and inform action planning to mitigate this impact.

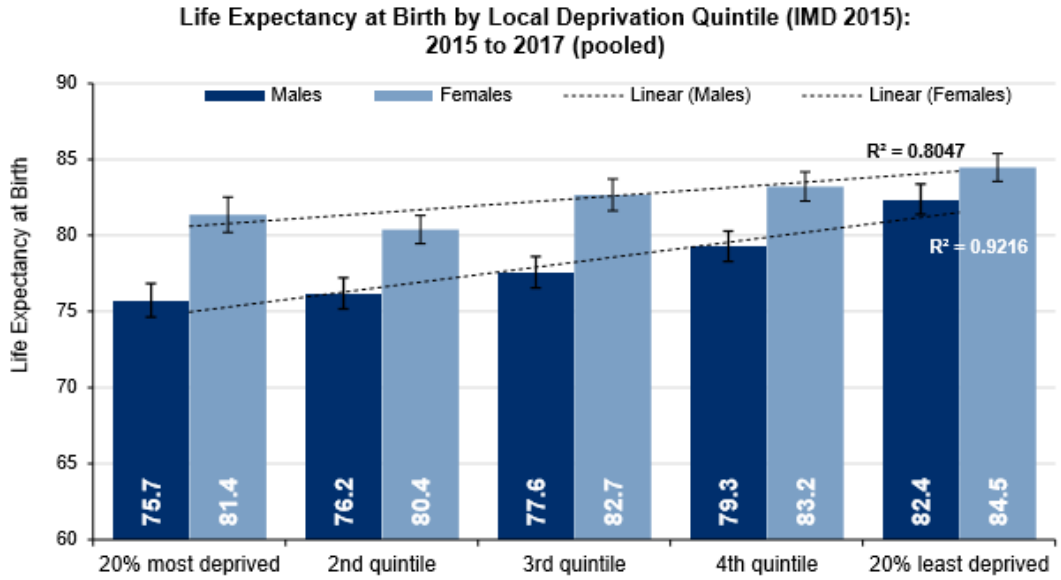
There are a range of evidence-based interventions for reducing health inequalities, which take a lifecourse and place-based approach. Evidence shows that a focus on the wider determinants of health will have the maximum population impact. These approaches require a 'whole-system' approach. The Health and Wellbeing Board has recognised they are well-placed to lead this approach to reduce health inequalities and improve health outcomes for the city.

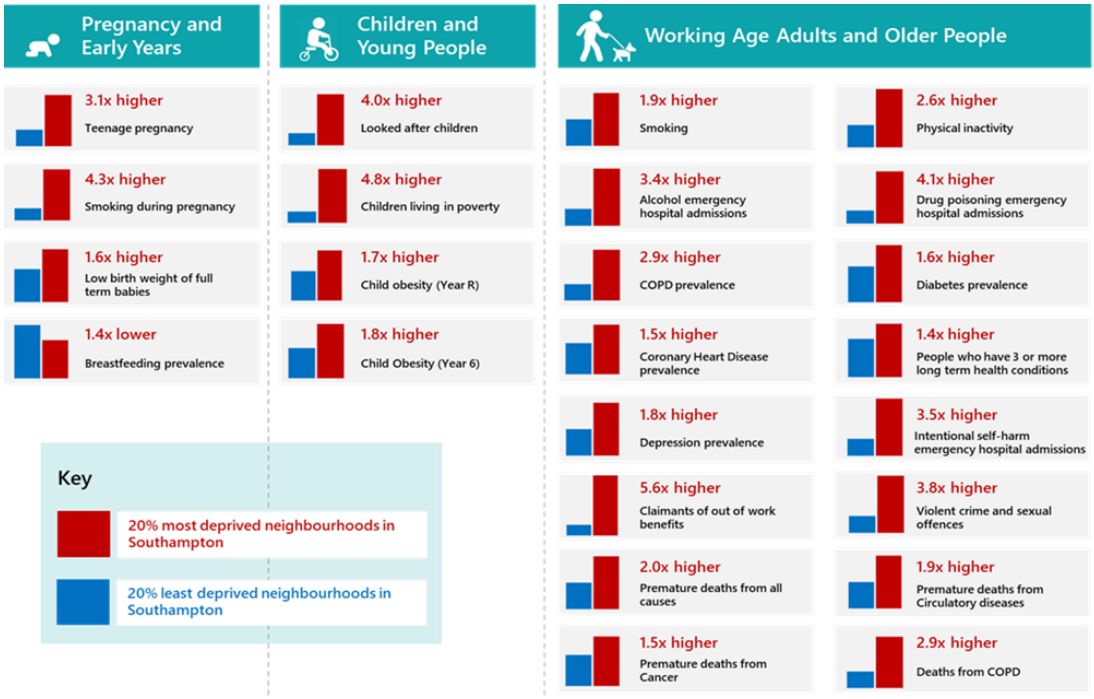
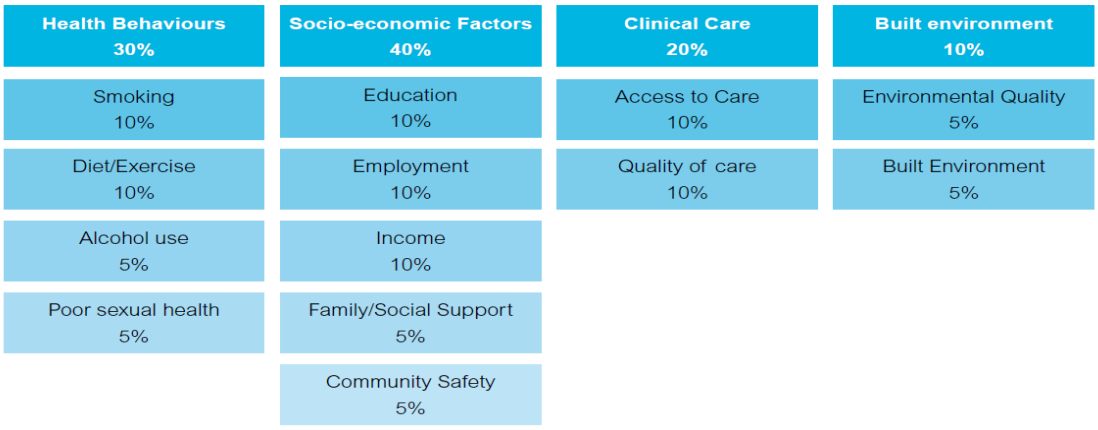
RECOMMENDATIONS:		
	(i)	That the Panel note, discuss and debate the content of this report.

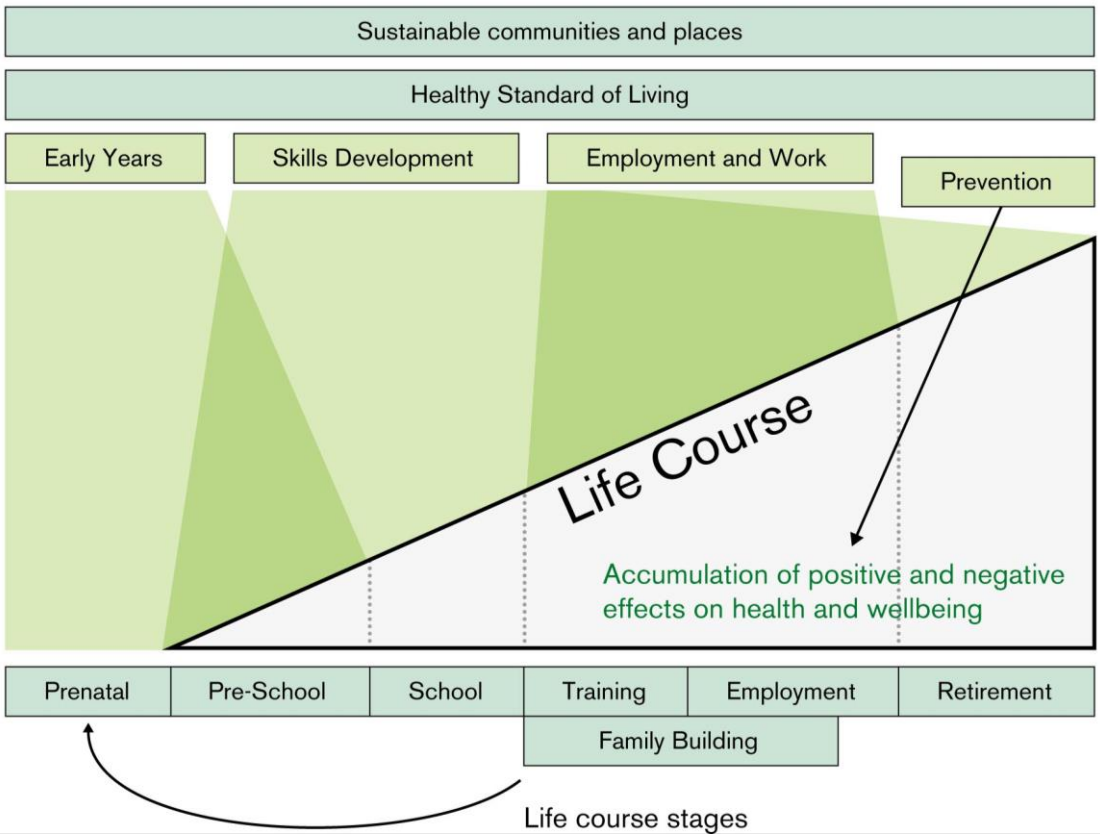
REASONS FOR REPORT RECOMMENDATIONS	
1.	To enable the Panel to discuss the emerging picture with regards to Covid-19 and health inequalities in Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None

DETAIL (Including consultation carried out)	
	Background

3.	Health inequalities are defined as “differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.” (NICE, 2012)
4.	A major incident was declared by Hampshire and the Isle of Wight Local Resilience Forum in March 2019, in response to Covid 19, the disease caused by a novel coronavirus spreading in the community. The virus and measures put in pace to control its’ spread have had large and far-reaching impacts across society.
5.	It has become increasingly apparent over the course of the Covid-19 pandemic that impact from Covid-19 has not been experienced equally across society. Some quantitative evidence of this differential impact comes from international, national and local sources, whilst some evidence is developing. An exacerbation of health inequalities are anticipated based on this evidence and expert opinion about likely future impact.
	Health Inequalities in Southampton pre Covid-19
6.	Men living in the most deprived quintile in Southampton live on average 6.6 years less than those in the most affluent quintile. For women this difference is 3.1 years. The graph below shows a clear relationship between life expectancy and deprivation.  Sources: NHS Digital Primary Care Mortality Database, ONS Mid-Year Population Estimates & IMD (2015) People living in the most deprived quintiles in Southampton are almost twice as likely to die prematurely (under 75 years old) than those in the most affluent.
7.	People living in the most deprived quintile in Southampton are more likely to have long term health conditions compared to those in the most affluent quintile. For example, they are almost three times as likely to have COPD, over one and a half times more likely to have diabetes. Those in the most deprived quintile are 1.78 times more likely to have depression and 2.77 times more likely to have schizophrenia.[1]
8.	People living in the most deprived quintile in Southampton are 1.93 times more likely to smoke and 2.6 times more likely to be inactive and children 1.7 times more likely to have excess weight compared to those in the most affluent quintiles.[1]

9.	Southampton had significant health inequalities before the major incident in response to Covid-19. This difference was seen across a range of different health outcomes, as summarised in the infographic below. Health inequalities exist both in mortality and morbidity and across physical and mental health outcomes.[1] 
	The determinants of health
10.	Our health is affected by a wide range of factors as shown in the figure below. The biggest determinant of health is socio-economic factors, followed by health behaviours, then clinical care and the built environment. The socio-economic and environmental are referred to as the wider determinants of health.  **Source**: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status
11.	The distribution of social, economic and environmental assets impacts differently on health outcomes across society and results in inequalities in health outcomes. This impact starts before birth and builds over the life-course, as the positive and negative impacts of the wider determinants of health accumulate over time.



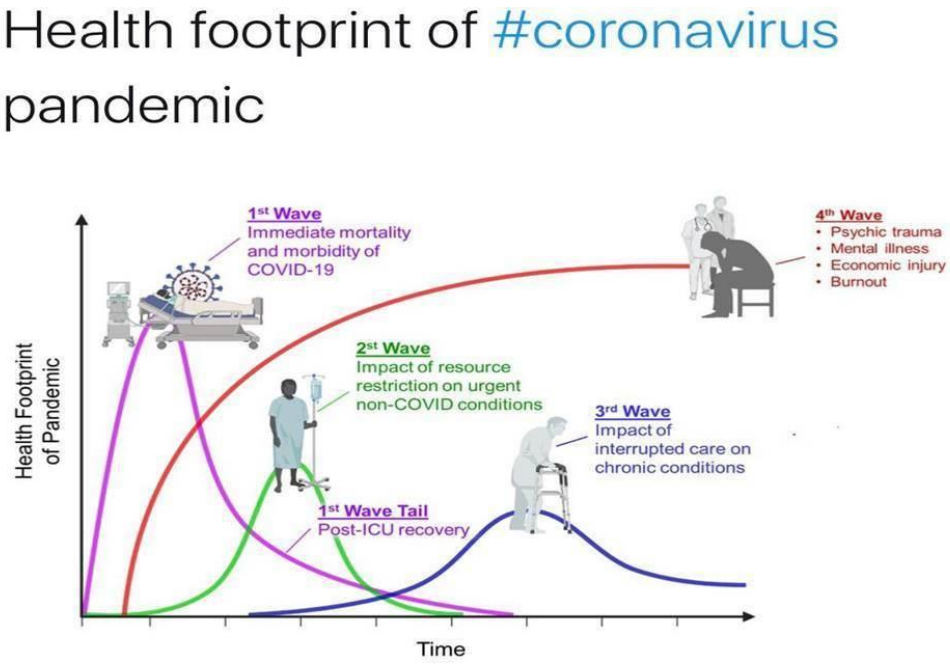
Marmot 'Fair Society, Healthy Lives' 2010.

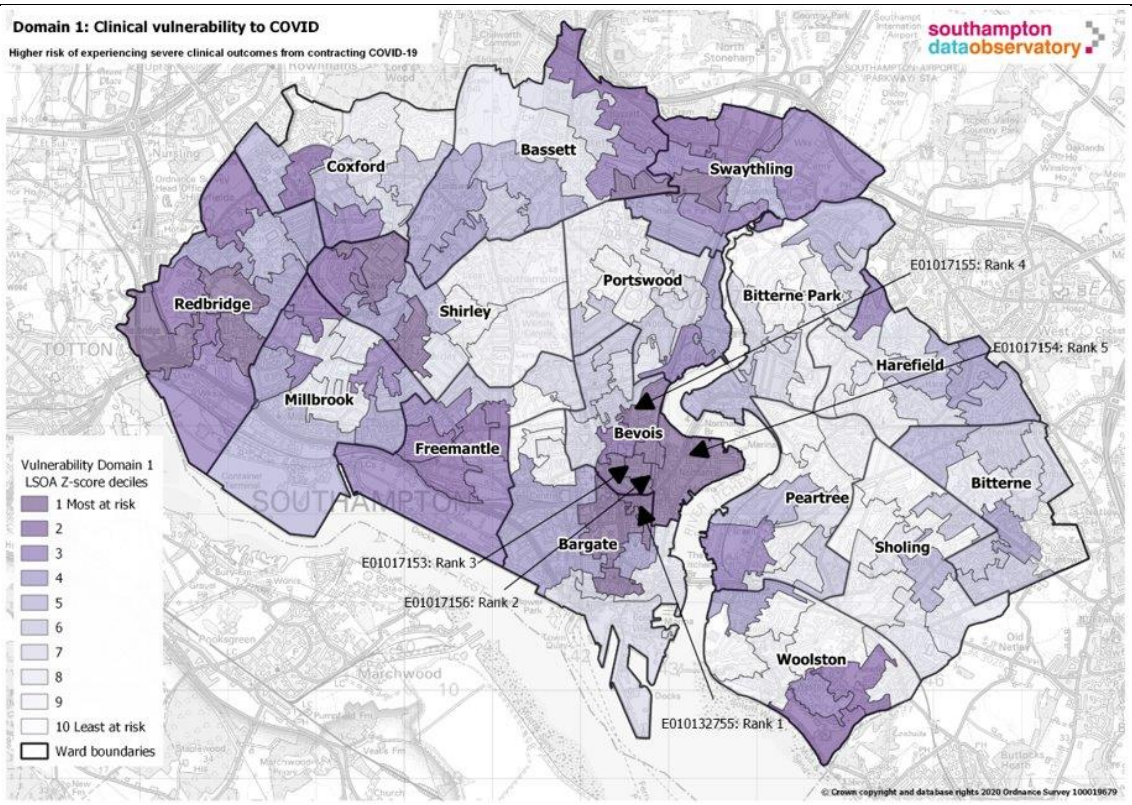
12. This evidence has informed the life-course approach to reducing health inequalities, which recognises that no one agency can implement any of these objectives on its own. Reducing health inequalities requires collaboration, partnership and collective action in many different spheres of activity.

13. The chart below shows the impact of actions taken across the life-course on health outcomes, health inequalities and both the speed of this impact and the strength of evidence for its effectiveness. Action on the best start in life, healthy schools and pupils, jobs and work, access to green space and leisure opportunities and health and spatial planning have the highest impact on health inequalities.

Area	Scale of problem in relation to public health	Strengths of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Longer	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

9 http://www.kingsfund.org.uk/publications/improving-publics-health

	Impact of Covid-19 on health inequalities
14.	The health impacts of Covid-19 include the immediate impact of mortality and morbidity from Covid-19, followed by later impacts due to restricted care on both urgent and long-term conditions, and then longer-term impacts on mental health and poor health due to the economic impact of measures to control its spread. At this stage in the pandemic, we have some information about the immediate impact of Covid-19 related mortality and morbidity. However, information about the later impact of Covid-19 on the later stages outlined below is not yet available. 
15.	Covid-19 and the measures put in place to control its spread have been experienced differently across different parts of the community and differentially across the lifecourse[2]. This is expected to increase health inequalities. Differences in vulnerability to Covid-19 are presented below, followed by an analysis of cases and deaths by age, gender, ethnicity and deprivation quintile; then emerging evidence of the impact of the pandemic on the wider socioeconomic determinants of health.
16.	**Vulnerability to Covid-19** Vulnerability to Covid-19 varies with age, gender, comorbidities, excess weight, housing overcrowding, geography, occupation, ethnicity and deprivation. This vulnerability comprises of the risk of being infected with the virus, and a range of factors that increase the risk of severe outcomes from the disease once infected. Southampton's intelligence team have created vulnerability indices, considering; 1. clinical vulnerability to Covid-19 2. risks of contracting Covid-19 through work / living conditions and vulnerability to 3. negative impacts from Covid-19 related policies The maps of these vulnerability indices show that vulnerability to Covid-19 is distributed unevenly across the city. Some parts of Bevois, Bargate and Millbrook, followed by Woolston and Bitterne have high vulnerability to all 3 indices.


Domain 1: Clinical vulnerability to COVID
Higher risk of experiencing severe clinical outcomes from contracting COVID-19
southampton dataobservatory
Coxford
Bassett
Swaythling
Portswood
Redbridge
Shirley
Bitterne Park
Harefield
Millbrook
Freemantle
Bevois
Peartree
Bitterne
Bargate
Sholing
Woolston
E01017155: Rank 4
E01017154: Rank 5
E01017153: Rank 3
E01017156: Rank 2
E010132755: Rank 1
Vulnerability Domain 1
LSOA Z-score deciles
1 Most at risk
2
3
4
5
6
7
8
9
10 Least at risk
Ward boundaries
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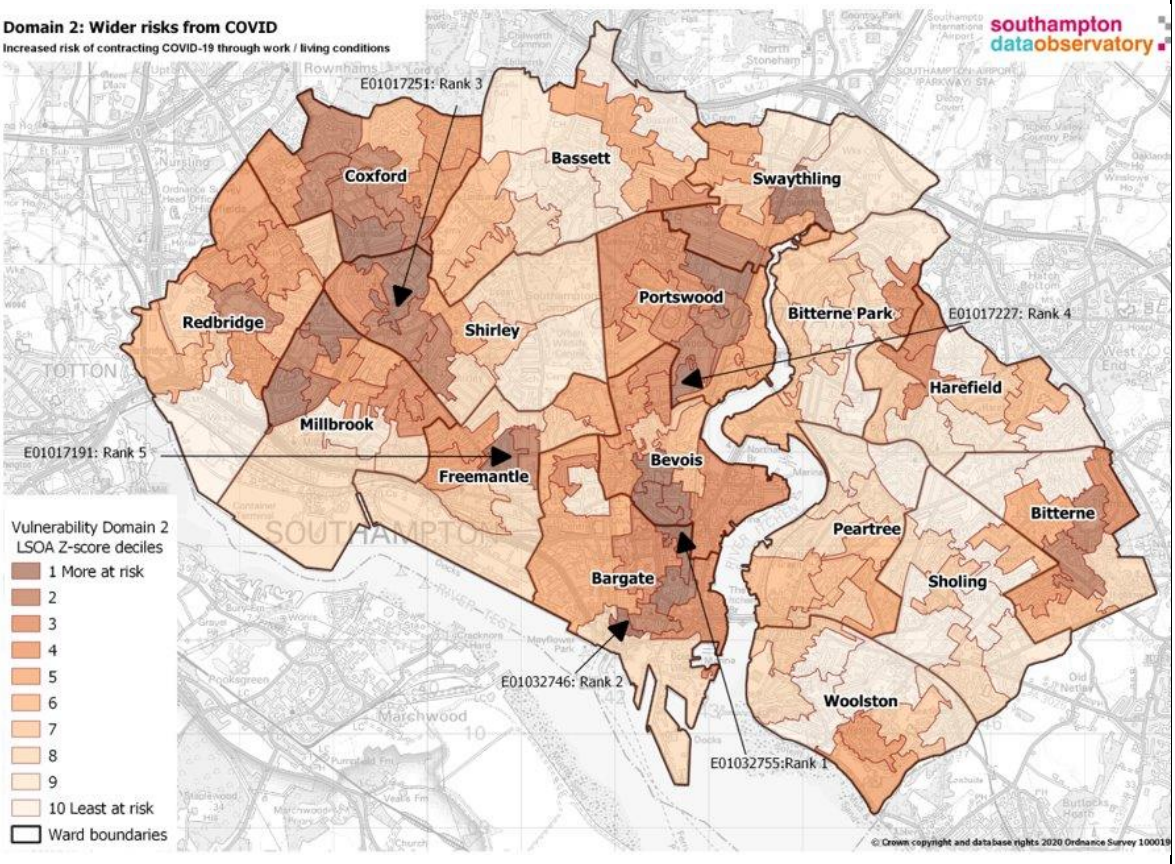
Domain 2: Wider risks from COVID
Increased risk of contracting COVID-19 through work / living conditions
southampton dataobservatory
E01017251: Rank 3
Coxford
Bassett
Swaythling
Portswood
Redbridge
Shirley
Bitterne Park
E01017227: Rank 4
Harefield
Millbrook
E01017191: Rank 5
Freemantle
Bevois
Bitterne
Peartree
Bargate
Sholing
E01032746: Rank 2
Woolston
E01032755:Rank 1
Vulnerability Domain 2
LSOA Z-score deciles
1 More at risk
2
3
4
5
6
7
8
9
10 Least at risk
Ward boundaries
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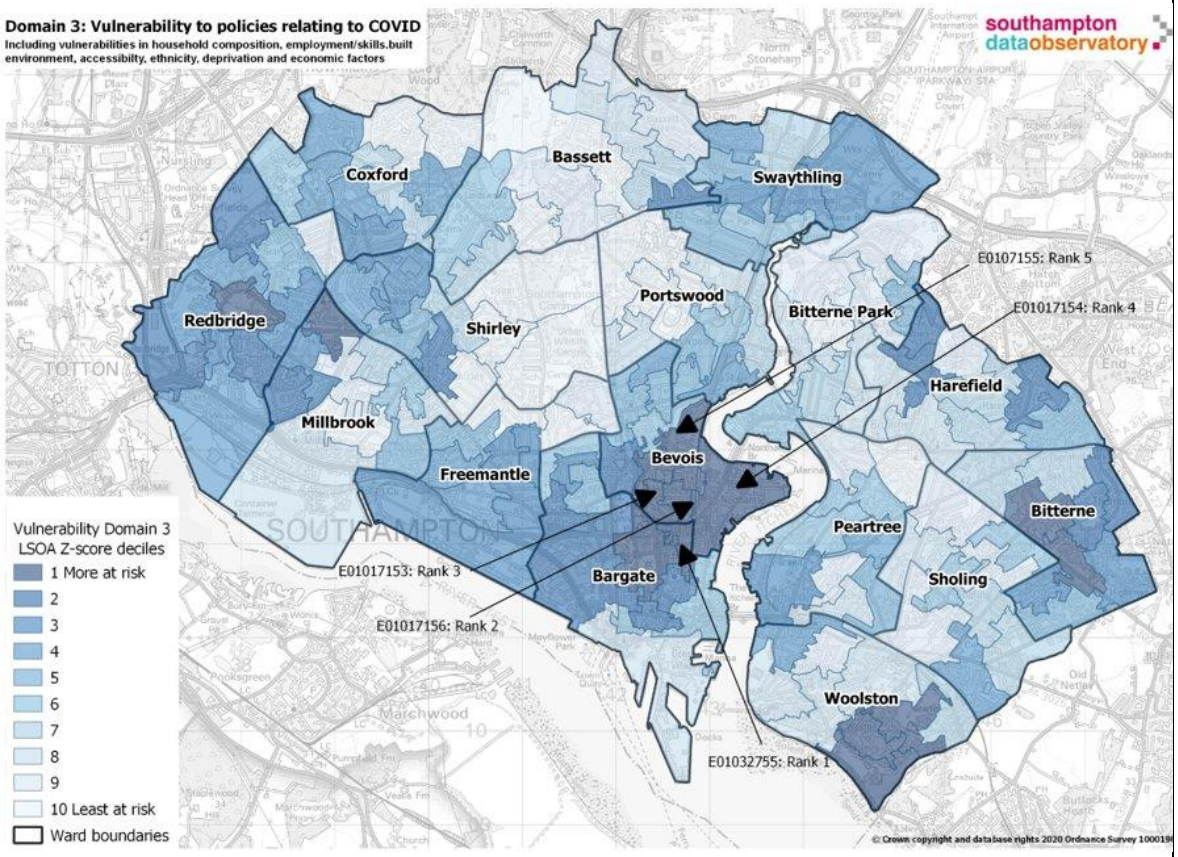
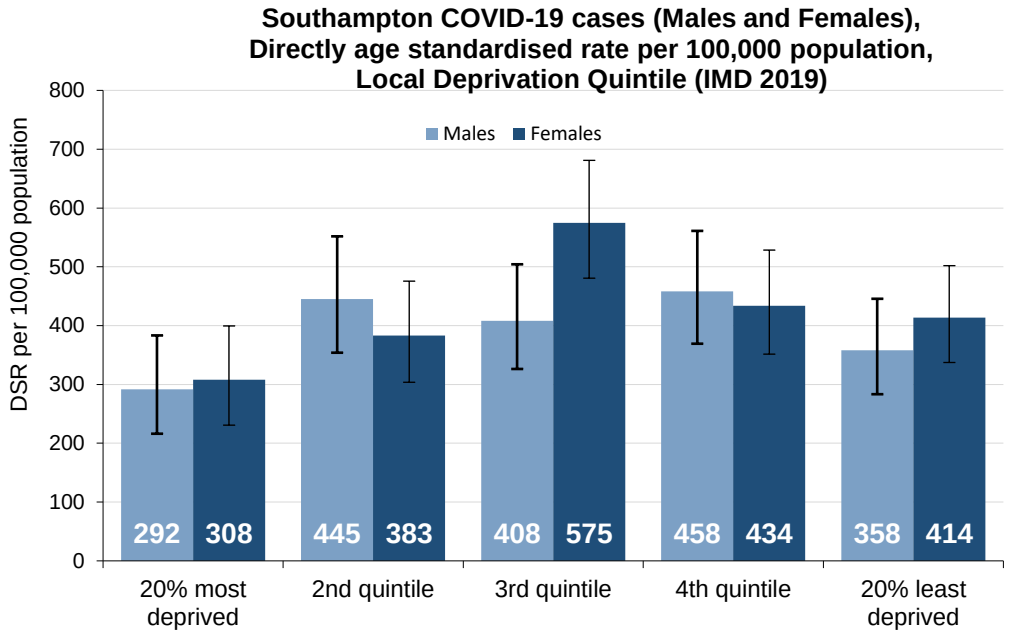
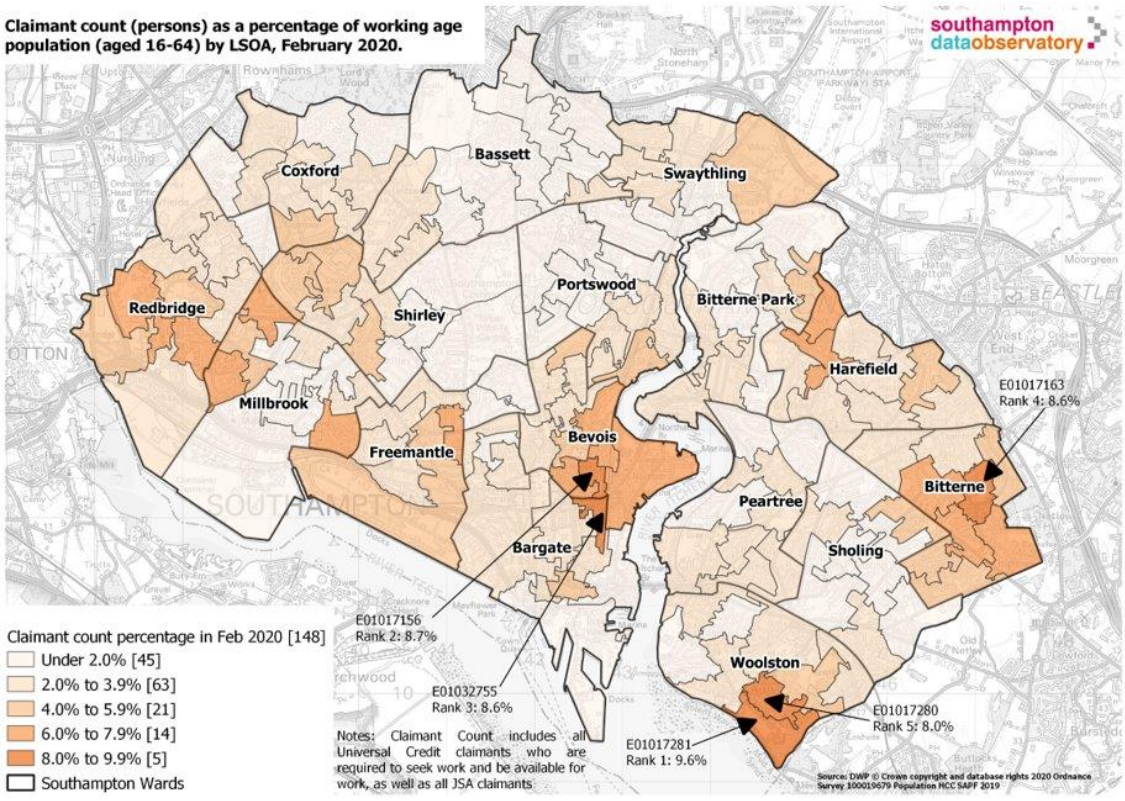
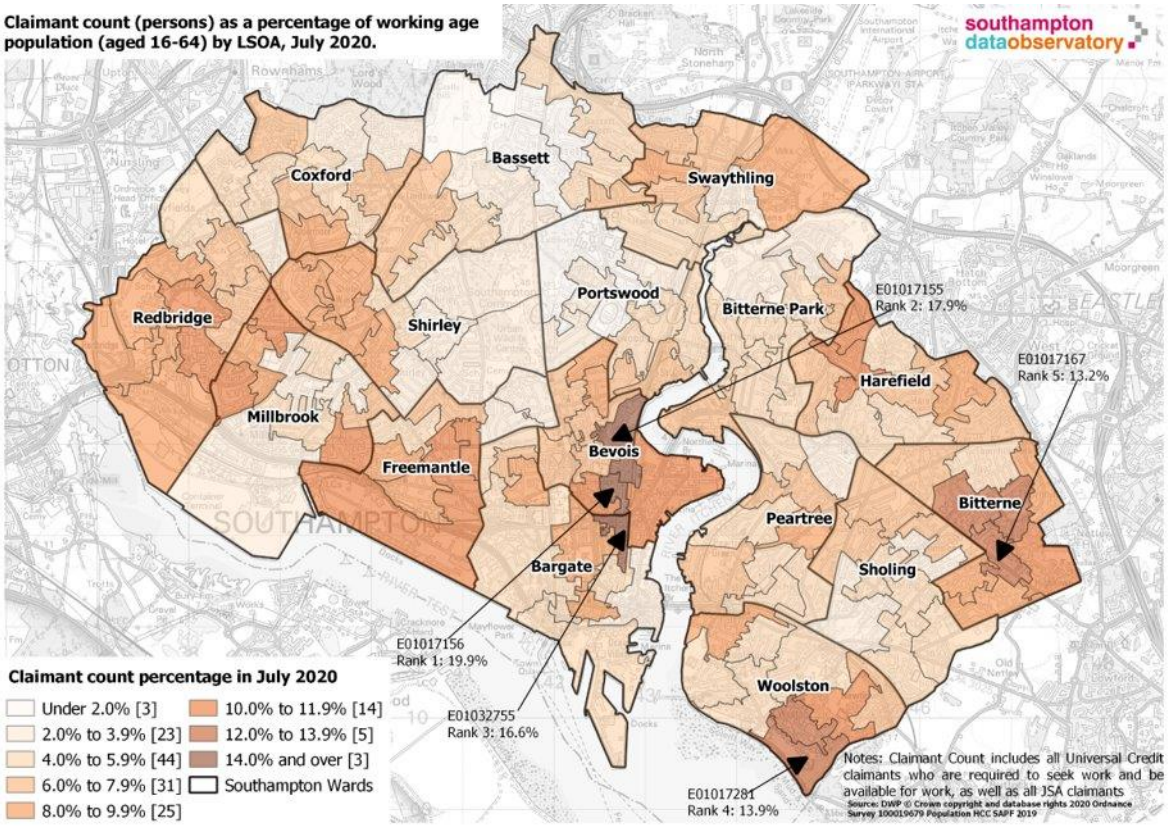
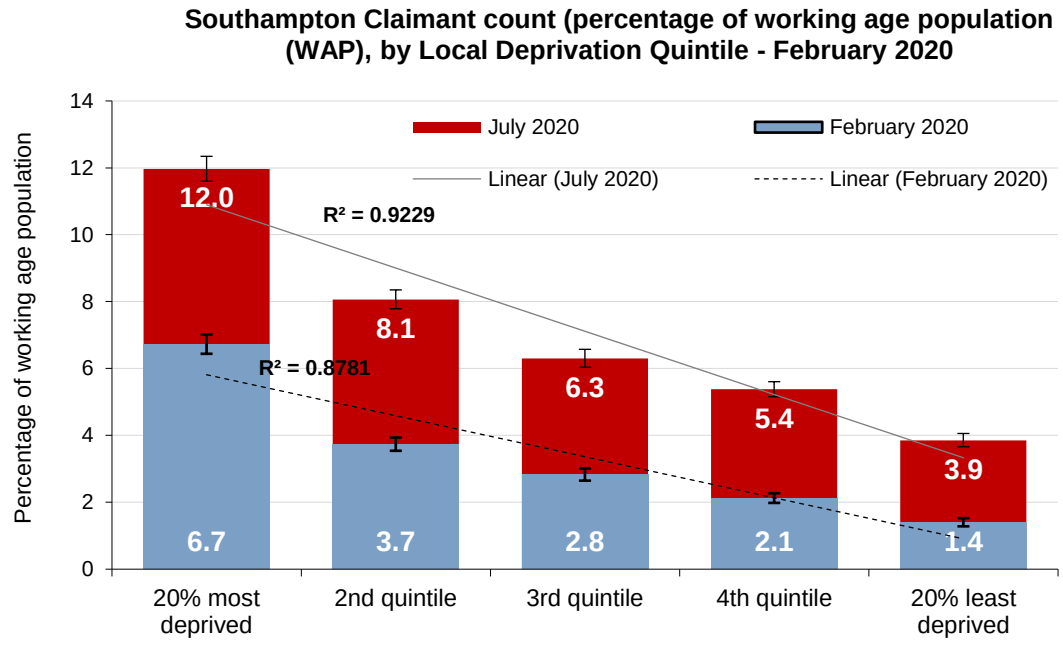
	
17.	**Cases of Covid-19 by age and gender** Southampton has had 958 confirmed cases of Covid-19 (as of 26th July 2020). Of the 950 people for which age and gender data are available, 44% are male and 56% female, with a median age of 50. Males aged 80+ years had the most confirmed cases, followed by the 30-34 age group and those aged 45-49 years. Females aged 80+ years also had the highest number of confirmed cases, with those aged 25-29 years the second highest, followed by those aged 30-34 years. Males and females aged under 20 years had the lowest number of confirmed cases. The percentage of confirmed cases in each age group were compared against the age structure of the resident population. This showed the percentage share of confirmed cases for males and females aged 80+ are higher compared to the resident population structure. Females aged 25-29 also have a higher percentage of confirmed cases compared to the resident population structure. Males and females aged under 25 years have a lower percentage share of confirmed cases compared to the resident population structure.
18.	**Cases of Covid-19 by ethnicity** Of the 783 cases of Covi-19 in Southampton for which ethnicity was recorded, 621 (79%) were recorded as White and 162 (21%) as Black, Asian and Minority Ethnic (BAME). This is in line with national findings, with BAME groups accounting for 22% of confirmed cases nationally (Public Health England Surveillance reports). Analysis of the percentage breakdown of confirmed cases by ethnic group shows that Asian/Asian British residents have the highest percentage share (11% of cases) of confirmed cases among BAME groups. When comparing the percentage share of cases against the resident population, BAME groups have a higher

	percentage share of cases (21%) compared to the resident population structure (14% residents BAME).
19.	**Cases of Covid-19 by deprivation** The graph below shows there is no clear relationship between deprivation measured by Southampton deprivation quintile and Covid-19 cases recorded for Southampton residents.  Sources: PHE's Second Generation Surveillance System (SGSS), HCC SAPF 2019 and IMD (2019)
20.	**Covid-19 related deaths** Sadly, there were 163 Covid-19 related deaths in Southampton (as of 30th June 2020). Analysis shows that males account for 53% of these deaths and females 47%. The majority of Covid-19 related deaths occurred among those aged 70 and over, with deaths in this age group accounting for 83% of male and 90% female Covid-19 related deaths. There were very few deaths occurring among younger age groups, with no deaths occurring among those aged under 20 years. These findings are not surprising, and align with national evidence showing the risk of dying from Covid-19 strongly increases with age among other factors. Numbers are too small to draw any conclusions about Covid-19 related deaths by ethnicity in the city. The risk of death involving Covid-19 varies significantly with ethnicity. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to 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[2]. There is no clear relationship between deprivation and Covid-19 related deaths in Southampton.
21.	**Impact on the wider determinants of health** As outlined previously, the factors that affect our health most are the wider determinants of health, including socio-economic and environmental factors. The measures taken to prevent the spread of Covid-19, have had far-reaching impacts into many aspects of our lives. Some of this evidence is still emerging, however this report presents the quantitative data that is currently available on income;

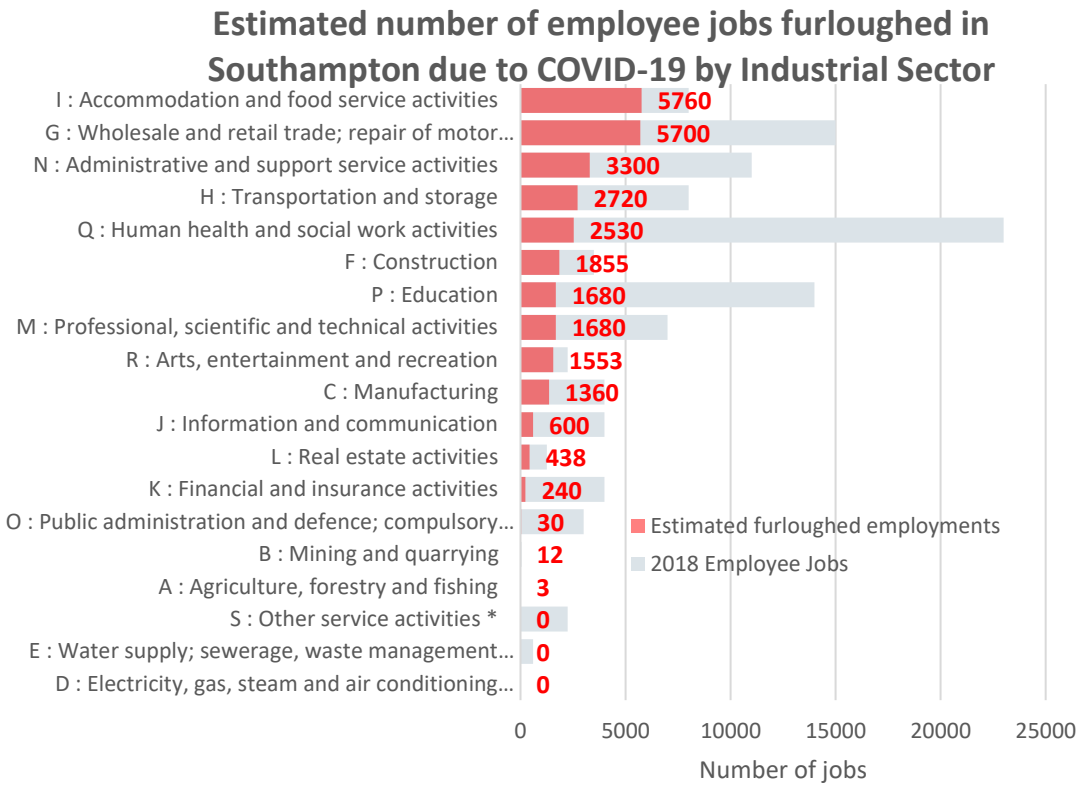
	employment and some anecdotal evidence on social impacts for vulnerable communities.
22.	**Income - benefit claimants and debt** The figures below show the percentage of people eligible for work (aged 16 to 64) claiming universal Credit by ward before lockdown in February, compared to the most recent figures for July. This shows that the proportion of people eligible for work who are claiming benefits has increased substantially over this time. Area with the highest proportion of claimants were in Bargate, Bevois, Bitterne and Woolston before lockdown, and these wards continue to be the wards with the highest proportion, despite increasing claimants overall. Voluntary services across the city have reported increased concerns from their service users about debt.[5] 



23. The figure below shows claimant count by local deprivation quintile in February compared to July. The increase for claimant counts over time was greatest for the 20% most deprived areas, and there is a relationship between deprivation and increase in claimant count. This suggests inequalities in income are widening across the city.



Source: DWP and ONS

24.	**Employment** An analysis of jobs at risk in Southampton, based on data on furloughed workers shows that up to 23,000 jobs in the city may be at risk. The largest industrial sectors affected were accommodation and food services and wholesale and retail industries. Many workers in these industries are young and earnings lower than average, suggesting that these groups may be disproportionally affected by potential job losses.  *These figures have been estimated based on HMRC Coronavirus Job Retention Scheme registrations for the South East up to 30th June. These figures have been applied to the local industrial profile to estimate the number of jobs at risk due to COVID-19.* ** Data not available*
25.	**Social impacts** Nationally and locally there were reports of an increase in the severity and amount of reported domestic abuse over the course of lockdown; an increase in child on parent abuse; a reduction in reports to child safeguarding indicating potential 'stored up' neglect and abuse and an increase in demand for mental and emotional support.[5]
26.	**Children and young people** Child poverty is already an issue in the city, and this is expected to be exacerbated by job losses. Those now newly eligible for free school meals may mean more children and families will face food insecurity and digital exclusion is a concern where children and young people are unable to access the equipment and don't have Wi-Fi. There is emerging anecdotal evidence of the negative impact of Covid-19 on the mental health of young people.[5]
27.	**BAME communities** Nationally BAME groups are over-represented in those occupations more likely to be exposed to those with Covid-19 whilst doing their job, and over a third of these occupations had a median pay lower than the median UK hourly pay.[3] Locally,

	BAME communities in the city have expressed concerns with temporary and poorly paid jobs, including zero-hour contracts; children's education and home-schooling; and digital exclusion affecting a range of issues including education, access to welfare and other health and support services.[5]
	Work to reduce health inequalities in the light of Covid-19
28.	In recognition of their statutory responsibilities to reduce health inequalities, Southampton Health and Wellbeing Board reviewed the evidence to date of the impact of Covid-19 on health inequalities at their meeting in June 2020. The Board: • agreed their leadership is essential for the whole system approach required to reduce health inequalities • committed to put health inequalities at the heart of plans to rebalance following Covid-19.
29.	Members of the Health and Wellbeing Board also recognised their individual organisational statutory responsibilities to reduce health inequalities. This includes: • Southampton City Council's statutory responsibility to improve the health and wellbeing of residents and to reduce health inequalities. • The NHS's commitment to strengthening its' contribution to reducing health inequalities through the NHS Long Term Plan. This has subsequently been strengthened through NHSE call to action on the third phase of NHS recovery from Covid-19.
30.	The Health and Wellbeing Strategy prioritises reducing inequalities in health outcomes. This is supported by the Health and Care Strategic Plan's goal to target health inequalities and confront deprivation which is being reviewed in the light of Covid-19.
31.	Southampton Covid-19 Outbreak Control Plan sets out how partners across the system will protect the health of the population through: • Preventing the spread of Covid-19 infection • Early identification and proactive management of local outbreaks • Co-ordination of capabilities across agencies and stakeholders • Maintaining the support of residents to follow public health advice, and supporting those that need additional help to enable them to do so • Assurance to the public and stakeholders that this Plan is being effectively delivered The Plan includes a focus on vulnerable people. An Equality and Safety Impact Assessment (ESIA) is currently underway to evaluate the Southampton Outbreak Control Plan in terms of reducing inequalities and will make recommendations for change.
	Provisional conclusions about the impact of Covid-19 on health inequalities
32.	Evidence suggests that Covid-19 and the measures put in place to reduce its spread have had a disproportionate impact on those already experiencing health inequalities in the city, therefore without mitigation health inequalities in the city are likely to be exacerbated.
33.	The measures put in place to reduce the spread of Covid-19 have already had an impact on the wider determinants of health. It is likely that the number of people in the city experiencing social and economic hardship will increase, with the risk of an associated negative impact on health outcomes.

RESOURCE IMPLICATIONS	
Capital/Revenue	
34.	None
Property/Other	
35.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
36.	The Health and Wellbeing Board is a statutory board that aims to reduce health inequalities.
Other Legal Implications:	
37.	None
RISK MANAGEMENT IMPLICATIONS	
38.	None
POLICY FRAMEWORK IMPLICATIONS	
39.	None

KEY DECISION?	**Yes/No**
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION

Appendices	
1.	N/A

Documents In Members' Rooms

1.	N/A
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes/No***
** - ESIAs and DPIAs will be undertaken for any decision arising from actions proposed in the COVID-19 recovery plan as required.*	
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**Yes/No***
** - ESIAs and DPIAs will be undertaken for any decision arising from actions proposed in the COVID-19 recovery plan as required.*	
Other Background Documents **Other Background documents available for inspection at:** N/A	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	N/A	

Data Sources

1. Southampton data observatory. Health Inequalities https://data.southampton.gov.uk/health/health-inequalities/health-inequalities/health-inequalities.aspx
2. Public Health England. Disparities in the risk and outcomes from Covid-19. 2nd June 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889195/disparities_review.pdf
3. ONS. Coronavirus deaths by ethnic group. 7th May 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020
4. ONS. Deaths involving Covid-19, England and Wales; deaths occurring in April 2020. 15th May 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020
5. HIOW LRF, Protecting our Vulnerable Residents Group. Provisional Intelligence gathering to inform Community Impact Assessment.
6. Department for Work and Pensions (DWP). People on Universal Credit - Southampton, South East and England monthly trend: April 2019 to April 2020.