West Midlands Combined Authority

Health of the Region 2020

Addressing health and wellbeing inequalities and the impacts of COVID-19 in the West Midlands

Contents

Foreword

Since the publication of the Marmot Review in 2010, life expectancy in England has stalled and health inequalities have continued to widen. Across the West Midlands Combined Authority, both life expectancy and healthy life expectancy remain lower the national average. This has been both exposed and exacerbated by the ongoing coronavirus pandemic, with our Black, Asian and Minority Ethnic (BAME) communities among those most affected.

To reduce widening and persistent health inequalities, a radical shift is needed to put communities at the heart of public health, to tackle systemic discrimination and disadvantage as a public health problem, and build healthy, resilient, connected and empowered communities.

While empowering individuals and communities to improve their own health is important, it is crucial to recognise that we all live within social and environmental contexts. Radical prevention is about tackling entrenched social disadvantage, working across the whole system to bring about a fundamental shift towards addressing the underlying causes of poor health.

The interdependence between health and wealth is the core theme that unites the work of the WMCA with that of health partners in the region. Health and wealth are two sides of the same coin; the impact of socioeconomic deprivation on health has long been recognised, but equally prosperity cannot be achieved without good health.

The key to building a healthier, fairer and greener West Midlands is to put health and wellbeing at the heart of our social, economic and environmental policies, and to ensure that every citizen is able to maximise their full potential at every stage of their lives. Despite the challenges faced in responding to and recovering from the coronavirus pandemic, the renewed focus on health inequalities gives us a once-in-a lifetime opportunity to re-evaluate, reset and redress the balance. And we must do this now.

In a recent interview, Sir Michael Marmot was asked about the urgency of tackling these issues and his response was very clear: "We address structural racism today, right now. We don't say, 'Oh, we'll put it off while we deal with the crisis.' No, we do it right now because it's causing the problems right now."

This report is a call to action for all of our partners and stakeholders to work together to address long-standing inequalities in the West Midlands, and to make a collective commitment to achieving positive change in our region.

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We are particularly grateful to the organisations and individuals who responded to the Call for Evidence for their invaluable insight into the activities across the West Midlands in response to COVID-19, and the impact this has had. We are also grateful to participants in two BAME roundtables hosted by the mayor who provided helpful insights at the beginning and the end of this work. Without the submissions to the Call for Evidence and the roundtables, this report would not have been possible. A summary of evidence is listed in Appendix 1.

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Executive Summary

The Health of the Region 2020 report presents a comprehensive analysis of the health of the West Midlands population. In particular, it highlights national and regional evidence of the impacts of the coronavirus (COVID-19) pandemic which shows that long-standing inequalities in physical and mental health have widened as a consequence of the pandemic, both through direct effects of the virus, and through indirect effects of the control measures taken – and particularly among our Black, Asian and Minority Ethnic (BAME) communities.

The report shows that:

- We must begin with the urgent task of improving outcomes for BAME communities. Targeted and immediate action to tackle structural racism is an urgent and immediate priority.
- But lasting change will only happen when we take a systemic approach to tackling the wider determinants of health and dealing with the structural inequalities we find in our economy, housing market, education, justice and transport systems.
- Similarly, we must tackle inequalities in the health and care system and widen access to health and care services. This requires a fundamental rebalancing of funding and focus on primary and preventative care.
- These challenges, in turn, will create the conditions in which people-powered health can flourish and healthy lifestyles can become the norm.

Health inequalities in the West Midlands:

- Even prior to the pandemic, there were entrenched and persisting health inequalities in our region. On average people in the WMCA have a shorter life expectancy than England overall, and spend more of their lives in poor health. Women in the WMCA live for 82.2 years on average (England 83.2) and spend 22 years in poor health; men live for 78.0 years on average (England 79.6) and spend 18 years in poor health.

- This is due largely to above national average rates of premature deaths from preventable causes (cardiovascular disease, cancer, liver disease and respiratory disease) as well as higher infant mortality rates. These correspond to higher rates of problem drinking, obesity (child and adult) and physical inactivity as well as lower cancer screening cover.

- Premature deaths from preventable causes in turn correspond to wider determinants of health, or the 'causes of the causes'. Most areas in the WMCA have a greater level of socioeconomic deprivation than the national average, with approximately a quarter of children living in low income households. Gross Disposal Household Income (GDHI) per person in 2017 was £16,479 compared with £19,514 in the UK as a whole.

- The lives of many people in the WMCA are hard, and unhealthy behaviours are often coping mechanisms for people who live in challenging circumstances, or reflect the limitations of the environments they live in. Often people want to make positive changes to improve their health, such as being more active or giving up smoking, but are not supported to do so and feel powerless to make positive change.

The impact of Covid-19 in the West Midlands

- In line with national findings, the pandemic has exposed and exacerbated existing health inequalities. The WMCA has a higher rate of cases overall than the region as a whole, with Birmingham and Sandwell most affected; rates are also high in Solihull, Walsall and Wolverhampton. The highest rates of COVID-19 related deaths are in more deprived areas, and areas with a greater proportion of residents from BAME communities.

- Lockdown and social distancing measures have had direct impacts on wellbeing and on health behaviours. Anxiety has increased significantly in the West Midlands region, with almost half of people surveyed (47.9%) reporting high levels of anxiety compared to a 2019 average of 21.9%. On average, people reporting feeling 'often lonely' ranged from 4.9% to 6.5% over this period; and was generally higher for younger people.

- Although the pathways are complex and multi-faceted, the fundamental link between health and wealth is still clear. Ultimately, where people are already marginalised and excluded, they are likely to be left further behind as we respond to and recover from COVID-19 unless we actively work to address this. Engagement with stakeholders has consistently highlighted the need to address structural racism and discrimination, which interacts with social and economic determinants of health across the whole system.

A ‘radical prevention’ approach

- In order to address the immediate and emerging health impacts of Covid-19 and take steps towards a happier and healthier population, more resilient to future pandemics, we need to adopt a ‘radical prevention’ approach.

- Radical prevention means taking action as a whole system to tackle the underlying causes of poor health and health inequalities (the ‘causes of the causes’) and shifting to more person and community-centred approaches to health and wellbeing. Early intervention and prevention in the early years can have lifelong impact, as well as yielding significant return on investment.

- Radical prevention also involves demanding more inclusive economic growth which can reduce health inequalities. This can be done through improving access to employment, raising income, increasing community safety, improving housing quality and affordability, raising aspirations and improving educational outcomes, providing a high quality local environment and green space, enhancing social relationships and connectedness, and increasing opportunities for participation.

Commitments to action and recommendations

We have identified 4 key challenges arising from this work and for each of these challenges, the WMCA and its partners have made over 50 commitments to action and set out a series of 12 recommendations to government. These are summarised in the tables on the following two pages.

- Challenge 1: Improving outcomes for BAME communities

- Challenge 2: Tackling the wider determinants of health

- Challenge 3: Widening access to health and care

- Challenge 4: People-powered health

Challenge 1: Improving outcomes for BAME communities

Selected Commitments to Action (full list in Section 3)

- PHE West Midlands will develop a BAME and Disparities workplan
- Birmingham and Solihull STP will routinely produce data with detailed analysis of factors including ethnicity and deprivation
- WMCA will develop a targeted Thrive mental health programme co-designed with BAME employers and employees

Recommendations to government

- Government should produce a clear and comprehensive action plan setting out how it will work with local and regional partners to take action on race disparities and associated risk factors.
- Government should commission further data, research and analytical work at the local and regional level to understand the geographical and place dimensions of race disparities in health.

Challenge 2: Tackling the wider determinants of health

Selected Commitments to Action (full list in Section 3)

- WMCA will work with partners to become a Marmot City-Region and develop a 3-year action plan for change.
- The new multi-agency Midlands System Transformation Recovery (STaR) Board, working with PHE WM, will establish a Health Inequalities Working Group which will:
  - support Integrated Care Systems to plan and be held accountable for addressing health inequalities within the populations they serve;
  - provide standards, guidance and tools to ensure health inequalities are considered in the design and evaluation of new NHS services.

Recommendations to government

- The NHS should make local action on tackling health inequalities the focus of the NHS 'Phase 4 Letter' on Covid19.
- Government should make health and wellbeing outcomes a key driver of economic development and levelling-up policies including industrial strategy and local industrial strategies; the UK Shared Prosperity Fund; Towns Fund; and future devolution deals.
- Government should double the proportion of health and social care spending focused on prevention and public health from 5 to 10 percent over time.

Challenge 3: Widening access to health and care

Selected Commitments to Action (full list in Section 3)

- Black Country and West Birmingham CCG will develop an Academy to provide population health management capacity to the system. It is developing a number of population health management projects that will widen access to health and care including early diagnosis of cancer in vulnerable groups.
- Birmingham and Solihull STP will develop population health management within Primary Care Networks (PCNs) and ensure its primary care estate is under one digital domain by March 2021 promoting digitally enabled care for staff to work together in virtual multi-disciplinary teams.
- University Hospitals Birmingham will use digital transformation to reduce health inequalities by enabling people to access healthcare and information in a more accessible way, including creating community diagnostic hubs in local neighbourhoods.

Recommendations to government

- Government should ensure that Local Authorities have sufficient powers to improve public health and reduce health inequalities, with Mayoral Combined Authorities providing support where they can add value.
- Government should support the WMCA's proposal to establish digital screening hubs in high footfall transport locations.
- Government must close the gap in primary care provision between the most and least deprived neighbourhoods in terms of funding per patient and serving GPs.
- Government must widen its plans and increase its investment to tackle digital poverty with a particular focus on those who do not access health and care services online.

Challenge 4: People-powered health

Selected Commitments to Action (full list in Section 3)

- WMCA is committed to increase cycling from 3% to 5% of mode share by 2023 through the delivery of the WM Cycling Charter and extending cycling and walking routes.
- WMCA will work with other Commonwealth Games Delivery Partners to develop a long lasting physical activity and wellbeing legacy for the region.
- Black Country & West Birmingham CCG PCNs will have recruited 63 social prescribing link workers, 38 care coordinators and 12 Health and Wellbeing Coaches by March 2021 and plan to recruit more than 200 posts by March 2024.
- The Walsall for All Board will raise public awareness about the support available to improve mental and physical wellbeing through the Walsall Together partnership.

Recommendations to government

- Government should invest in the WMCA's Radical Health Prevention Fund to drive forward innovation, social prescribing and other initiatives to tackle health inequalities in the region
- Government should pilot the Kruger report's Community Right to Serve provisions for health and social care in the West Midlands.

Introduction

Background

National and regional evidence on the impacts of coronavirus (COVID-19) shows that inequalities in physical and mental health have widened as a consequence of the pandemic. This is a result of both the direct effects of the virus, and the indirect effects through the control measures taken.[1]

Although this has led to an increased focus on health inequalities, particularly those affecting BAME communities,[2] the reality is that these disparities have persisted for a long time. The recent update to the Marmot Review[3] showed that even before the pandemic increases in life expectancy were slowing down, particularly in the most deprived areas of the country and especially for women. There is also a marked social gradient in healthy life expectancy, with people in the most deprived areas spending more of their lives in ill health.

It has long been recognised that the conditions in which we are born, grow, live, work and age have important implications for our physical and mental health, as individuals and across wider society – and that for many citizens in the West Midlands, these conditions are far from optimal. Broadly, greater socioeconomic deprivation is associated with poorer health outcomes. This is due to the impact of deprivation on the wider determinants of health – our social, physical and economic environments. Housing, employment and skills, and social connections– 'jobs, homes, friends' – are key, and can be interpreted in their broadest senses. Again some of these effects are direct, and others are indirect, or mediated by health behaviours; for example, a lack of green space and poor air quality can have a direct impact on respiratory health and mental wellbeing, and also an indirect impact through reducing participation in physical activity.

Health inequalities across the life course

Health problems in working age and older adults reflect the impact of cumulative disadvantage across the life course. Child poverty rates have increased nationally and will continue to have long-term negative impacts on the lives of children, families and communities. On average, 22% of children were living in poverty before housing costs in England in 2017/18 – 30% after taking into account housing costs, and higher in areas with high housing costs. This increased to 47% for children in lone parent families, and over 70% for those living in workless families.[4]

Taking a life course perspective to reduce health inequalities means acting as early as possible to reduce the cumulative disadvantage that begins in early childhood. However, it also means recognising that there are opportunities to improve health & wellbeing at any age.

Recognising the impacts of COVID-19

The Royal College of Physicians and Public Health England have worked with NHS Providers and the Provider Public Health Network to identify groups that may be disproportionately affected by COVID-19 (Figure 1).[5] These include people with protected characteristics; those who are socioeconomically disadvantaged or live in deprived areas; and inclusion health and marginalised groups.

Social distancing and isolation can also have a detrimental impact on mental health and wellbeing, including through harmful health behaviours and reducing access to services and support. People who misuse or are dependent on drugs and alcohol may be at increased risk of becoming infected with the virus, and infecting others. They may also be more vulnerable to the impact of infection due to underlying conditions. Rough sleepers are a particularly vulnerable group and are unable in the ordinary course of events to self-isolate.

Understanding population vulnerabilities, risk factors and inequalities is important to inform both the acute response phase and the recovery and repair phase over the longer term. As well as mitigating the impact of COVID-19 it is important to ensure existing physical and mental health and wellbeing needs are being met, and that we continue to address health inequalities through improving the social and economic conditions in which people live.

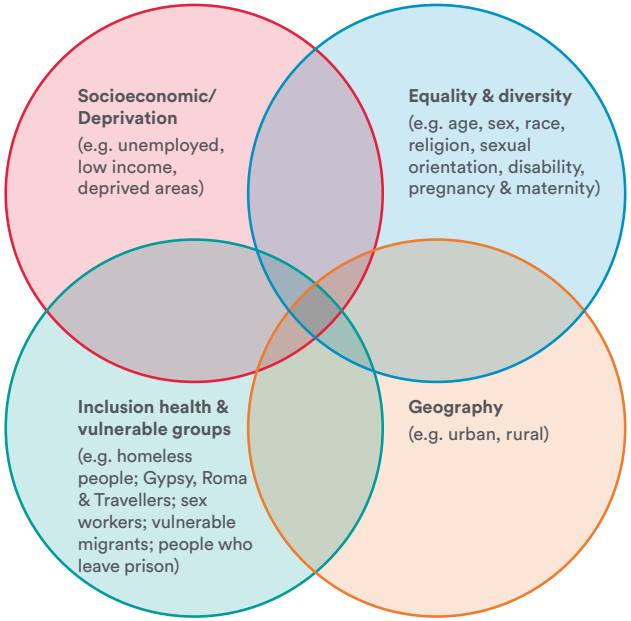


Figure 1: Groups that may be disproportionately affected by COVID-19 (adapted from PHE/RCP, 2020)

The Regional Health Impacts of COVID-19 Task & Finish Group

The Regional Health Impacts of COVID-19 (RHIC) Task & Finish Group was convened in June 2020 to focus on the relationship between the disparities in the health and economic impacts of the pandemic identified by the PHE review and wider health inequalities in the WMCA Region. The group includes representation from the WMCA, PHE, local authorities, the NHS, universities and the voluntary & community sector.

An interim report[6] was published by the WMCA and the PHE Population Intelligence Hub for the RHIC group in August 2020. This included analyses of population vulnerabilities, risk factors and inequalities, and occupational inequalities intersected with ethnicity which are discussed in the following section. The interim report also identified stakeholder concerns around the upcoming challenges facing the West Midlands over the coming months and the unique opportunities for action and partnership working presented by the pandemic.

The report was accompanied by a call for evidence[7] which sought to understand experiences and impacts of COVID-19 among individuals and communities; challenges and barriers for citizens, communities and organisations; examples of good practice in improving accessibility; and changes in approach and further support needs. A variety of reports, quantitative data and qualitative feedback was received in response to the call for evidence, which have informed subsequent sections of the report. A thematic analysis of qualitative submissions can be found in Appendix 2.

Aims and purpose of report

This report is divided into three sections to describe the extent of health inequalities in the WMCA region and opportunities for action, considering the relationship between health and wealth and the impacts of the COVID-19 pandemic. It should be viewed alongside the State of the Region report,[8] which focuses on the economy and growth.

Part 1 of the report describes the health of the people who live in the West Midlands. It shows where change was needed even before COVID-19, and how existing inequalities have been exposed and exacerbated by the pandemic.

Part 2 discusses how change can happen to build community resilience and embed prevention across all we do. It considers a new approach, taking full advantage of the many opportunities presented by a Combined Authority and its partners – and emerging opportunities following the COVID-19 pandemic.

Part 3 sets out priority areas for action and next steps, with a series of commitments for action from key partners.

Comment on Black Asian and Minority Ethnic (BAME) phrase and representation

In the aftermath of the PHE reports on adverse impact of Covid-19 on Black Asian and Minority Ethnic (BAME) communities, there has been an important debate around the appropriateness of the use of the phrase BAME as a collective for all ethnic minorities. The use of BAME has been debated for a few years[9,10,11] and the phrase is mainly used in the UK, while the US prefer to use "person of colour" to identify the collective.[12] While useful in relating to national policy documents, there are a number of reasons why the phrase is problematic.

First, if the only qualification for inclusion in BAME is being non-white, then we miss out on many ethnic minority groups that identify as White Other, such as Roma people, Traveller communities or some Turkish or Arab communities.[13] Black British Academics have also argued that using BAME 'reproduces unequal power relations where white is not a visible marker of identity and is therefore a privileged identity'.[14,15] Secondly, experiences of people within the BAME categorisation are quite different, owing to their group identities and journeys within the UK. The nuances between South Asian groups' experiences and also between Black African and Black Caribbean are important, and these are in danger of being masked with a collective phrase such as BAME[16]. There are also issues of intersectionality and multiple disadvantage within groups, based on gender, language, religion and/or sexual orientation.

Different phrases are used to describe people from ethnic minority backgrounds, but even the phrase 'ethnic minority' is contested. Some suggestions have included the use of 'racialised communities' as an alternative, to describe groups of people who have essentially been at the receiving end of structural racism or othering. While others have opted to spell out BAME to indicate a heterogenous group and then go even more granular and state Pakistani, Bangladeshi or Vietnamese instead of Asian or Nigerian or Jamaican instead of Black or Black African or Caribbean.

Given there is a lack of a clear alternative, it seems there is still usefulness in the use of BAME classification, as it ensures consistency with current wide usage amongst public bodies and many other institutions. It is important to acknowledge the discourse and sensitivities around the classification and continue to use BAME as a collective phrase until a widely used alternative is agreed upon.

Section 1

Health and health inequalities in the West Midlands region

This section describes the people who live in the WMCA's seven constituent local authority areas, how long they live, and the factors that contribute to inequalities in health, wellbeing and quality of life. It also considers who is most vulnerable to COVID-19, both in terms of health and economic impacts.

1.1 Who are our people?

The West Midlands Combined Authority (WMCA) membership consists of 18 local authorities (seven of which are constituent members) and three Local Enterprise Partnerships (LEPs) (Figure 2). For the purpose of this report, the main focus will be on the seven constituent authority areas: Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton. However, many of the issues and approaches identified will be applicable across the West Midlands region as a whole, particularly in relation to groups that may be disproportionately affected by the health and economic impacts of COVID-19.

The WMCA has a population of approximately 2.9 million people. Birmingham is the largest constituent authority with approximately 1.1 million residents; the remaining population is more or less evenly distributed between the other six constituent local authorities. The population of the WMCA is diverse, both between and within Local Authority areas.

Population density is the highest in Birmingham, with 42.6 people per hectare and lowest in Solihull with 12.2 people per hectare (2019 mid-year population estimates, ONS). The population has grown faster than previously anticipated and is projected to increase by 9.6% by 2038.

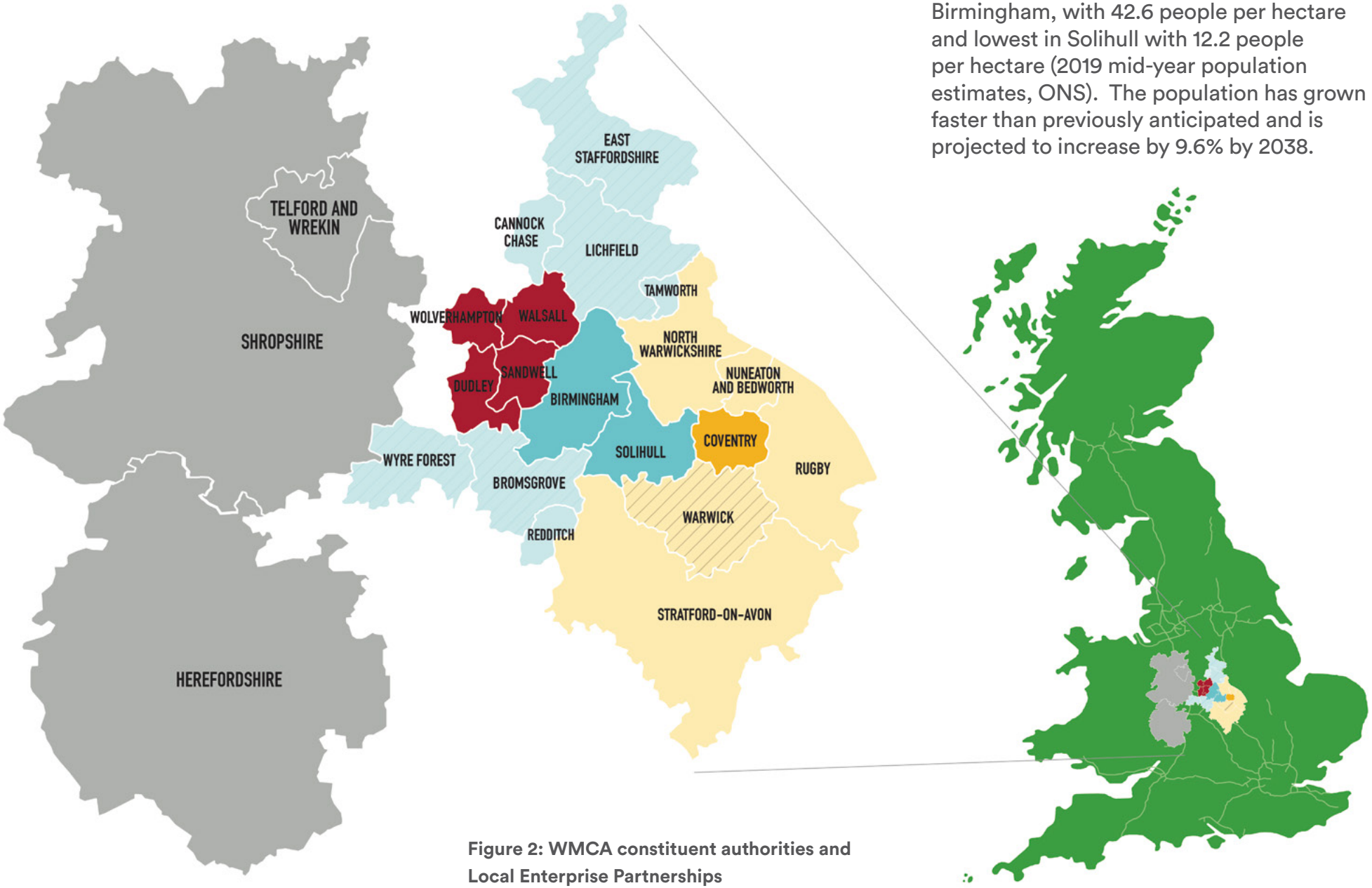


Figure 2: WMCA constituent authorities and Local Enterprise Partnerships

Age and sex

Figure 3 shows the distribution of female and male residents across 5-year age bands. On average, the population is slightly younger than the England average and has a slightly higher proportion of working age people. However, this varies considerably across the region, ranging from 32.1 years in Coventry to 43.1 years in Solihull.

Table 1: WMCA population estimates by age group

Total Population	Aged 0-15	Working age population	Aged 65+	Dependency ratio
2,916,415	626,190	1,839,350	450,875	0.59
49.5% male; 50.5% female	21.5% (England average = 19.2%)	63.1% (England average = 62.6%)	15.5% (England average = 18.2%)	England average = 0.60

Source: Mid-year estimates, ONS (2018)

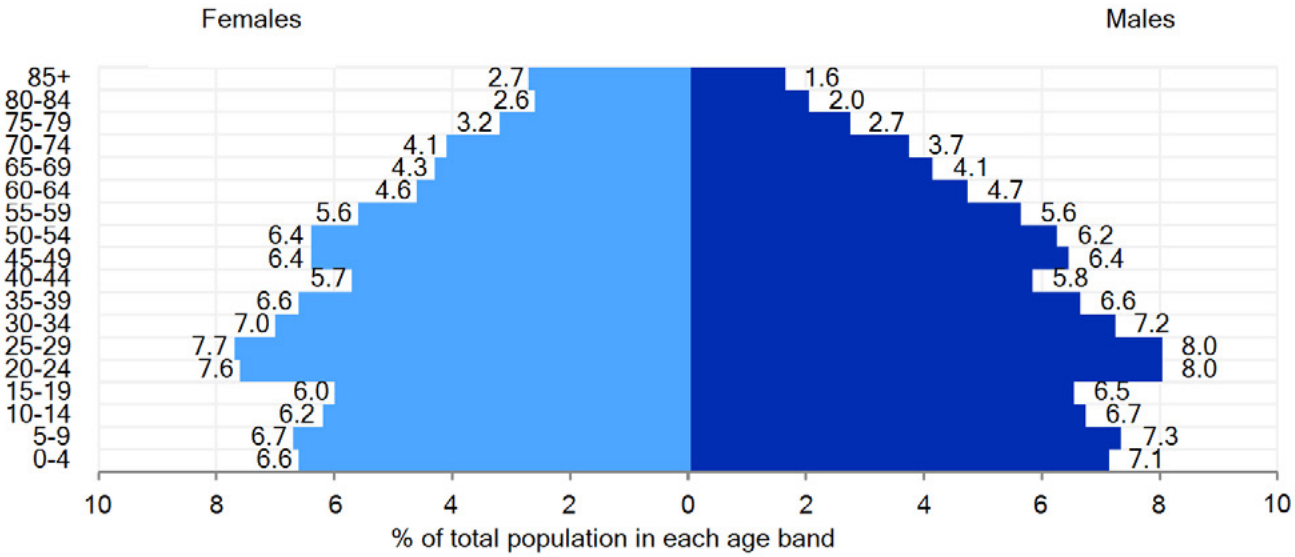


Figure 3: WMCA population Estimates by 5-year age band
Mid-year estimates, ONS (2018)

Ethnicity

The WMCA population is more ethnically diverse than that of both England and the West Midlands region overall, and a high rate of international net in-migration with variations in the origins of migrants means that this diversity is likely to increase with our growing population. In the WMCA an estimated 30.6% of our residents are from BAME groups compared with 14.0% in England and 17.4 across the whole of the West Midlands. This ranges from 9.0% in Dudley to 43.0% in Birmingham.

We also have slightly more residents who were born outside the UK or do not have English as their main language, though the gap is far smaller. In the WMCA 16.6% of the population were born outside the UK (England average 13.8%), and just 5.7% are in households where no members have English as a first language (England average 4.4%; ONS Census 2011). These figures will include people from White non-British backgrounds.

This reflects the nuanced relationship between ethnicity and nationality, and the fact that many families from diverse ethnic backgrounds have been settled in the UK for a number of generations. This is especially relevant when considering approaches to community engagement: although there may be characteristics and experiences that are common among specific groups, the categories are broad and it is important to understand the diversity of the populations – and their needs and experiences as individuals and families - within them. Rather than providing an in-depth analysis of the issues affecting specific demographic groups, these profiles serve as indicators of where further attention may be needed.

Sexual Orientation

In 2018, 94.4% of the England population aged 16 years and over identified as heterosexual or straight. This represents a continuation of the decrease seen since 2014, when 95.1% of the population identified themselves as heterosexual or straight. 2.3% of people identified as lesbian, gay or bisexual, with 0.6% identifying as 'other' and 2.8% stating that they did not know or did not want to say.[17] It is acknowledged that there is likely to be underreporting of LGB identities, and the actual figure is estimated to be around 5-7%.[18]

The East Midlands and West Midlands were the regions that saw the largest change in the proportion of people identifying as LGB over the last four years, with both increasing from 2014 to 2018 (from 1.2% to 2.2% and 1.3% to 2.3% respectively).

No robust data on the UK transgender population exists; however, the Government Equalities Office tentatively estimates that there are approximately 200,000-500,000 trans people in the UK.[19]

Faith or Belief

People in the West Midlands region have a greater level of religious affiliation than in England & Wales overall (ONS Census 2011). The majority of the population (60.2%) are Christian (E&W 59.0%), and 6.7% are Muslim (E&W 5.0%). 22.0% declared that they have no religion compared with 25% in England & Wales.[20]

Disability

Almost 1 in 5 people in the West Midlands Metropolitan area (19.2%) has a limiting or long-term illness or disability. This is higher than England overall (ONS Census 2011).

The Equality Act defines disability as any physical or mental impairment that has a substantial and long term effect on people's ability to carry out day to day activities. This covers a broad spectrum of conditions including mobility difficulties, sight loss, hearing loss, people with mental health impairments, dyslexia and other neurodiverse conditions, speech impairments and people with learning disabilities. Progressive conditions such as HIV, cancer, dementia and multiple sclerosis are also included.

1.2 Life expectancy and quality of life

How long are lives?

Life expectancy is the average number of years that an individual is expected to live based on current mortality rates. People in the WMCA have shorter lives than the average for the UK, with women living a little longer than men in line with national trends (Table 2). Life expectancy in the WMCA is 82.2 years for females and 78.0 years for males – this is 1.0 years lower than England for females and1.6 years lower for males respectively. This corresponds to a higher level of socioeconomic deprivation across the WMCA overall compared to the national average.

The length of life also varies significantly within the WMCA area. People live longest in Solihull and lives are shortest in Sandwell and Wolverhampton, again reflecting patterns of socioeconomic deprivation. There is also variation within these areas. Inequality in life expectancy at birth is a measure of disparity which shows how much life expectancy varies with deprivation within England as a whole and within local areas. Within the WMCA region, inequality in life expectancy at birth is greatest in Coventry and Solihull, indicating that the relative advantages these areas have are not distributed evenly across their populations (see Table 2).

Whilst most people live long lives, it is also sadly true that more babies die here before the age of one than they do on average in the rest of England. Our infant mortality rate is 6.7 per 1,000 live births compared with a national figure of 3.9. Again, there are differences across the region, from 4.4 per 1,000 live births in Dudley to 8.2 in Sandwell.

Table 2: Overview of health inequalities in the WMCA

Indicators	Period	England	WMCA	Birmingham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolverhampton
Deprivation score (IMD 2019)	2019	21.7	31.9	38.1	25.6	24.1	34.9	17.4	31.6	32.1
Life expectancy at birth (Female)	2016-18	83.2	82.2	82.2	82.1	82.8	81.1	84.1	82.0	81.4
Life expectancy at birth (Male)	2016-18	79.6	78.0	77.7	78.5	79.0	76.9	80.3	77.5	77.2
Inequality in life expectancy at birth (Female)	2016-18	7.5	-	5.6	8.3	7.6	8.0	9.8	8.8	6.3
Inequality in life expectancy at birth (Male)	2016-18	9.5	-	8.3	10.7	9.0	8.6	12.3	10.4	7.8
Infant mortality (persons <1 yr) – crude rate per 1000 live births (2016-18)	2016-18	3.9	6.7	7.4	5.0	4.4	8.2	5.4	7.1	6.0
Mortality from causes considered preventable - age-standardised rate per 100,000 population (2016-18)	2016-18	180.8	219.0	225.7	217.6	207.2	241.3	165.3	226.0	237.2

Compared with England: Better | Similar | Worse

Quintiles: Best | Worst | Not applicable

Source: PHE Public Health Profiles.

Quality of life

Health is not only measured in how long we live. It is also measured by the quality of our lives. Here too, the picture is generally not as good here as it is elsewhere in the UK. Healthy life expectancy is measured as the number of years we live in generally good health. Data show the same pattern of below average outcomes, and of variation across and within our region (Table 3 & Figure 4).

Table 3: Quality of life measures in the WMCA – local area comparisons.

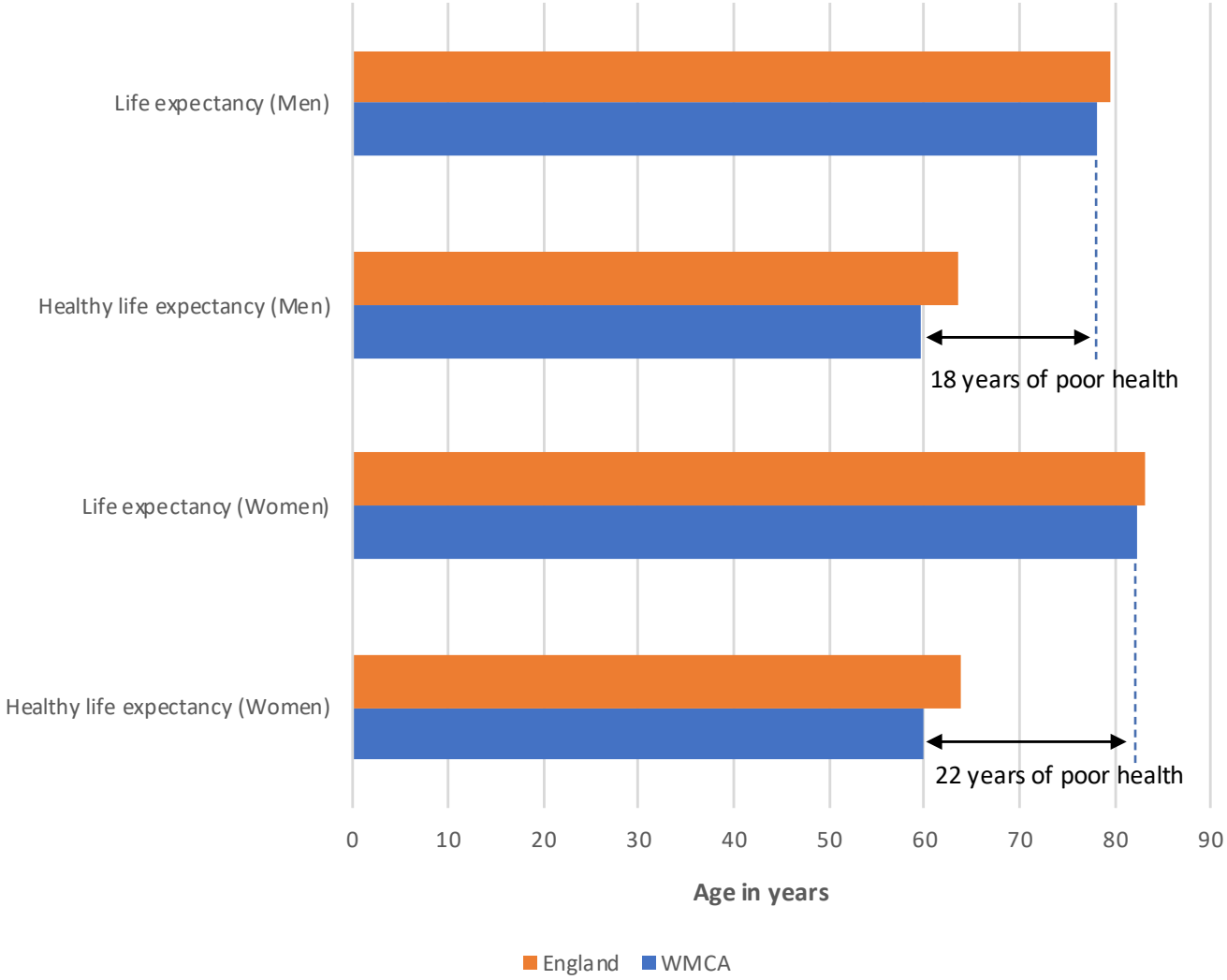
Indicators	Period	England	WMCA	Birmingham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolverhampton
Healthy life expectancy at birth (Female)	2016-18	63.9	59.8	59.6	62.5	60.3	57.9	64.3	55.7	58.0
Healthy life expectancy at birth (Male)	2016-18	63.4	59.6	59.2	61.9	59.4	57.1	65.3	56.4	58.7
School readiness: percentage of children achieving a good level of development at the end of Reception - %	2018/19	-	71.8	-	68.0	69.0	67.1	66.8	72.6	67.5
Health-related quality of life for older people	2016/17	0.735	0.696	0.696	0.703	0.713	0.660	0.744	0.683	0.697
Self-reported well-being - high satisfaction score: % of respondents	2018/19	7.8	-	7.4	9.8	8.1	8.9	6.7	10.5	7.8
Self-reported well-being - high happiness score: % of respondents	2018/19	19.7	-	17.2	21.7	17.8	17.2	19.4	23.8	14.4

Compared with England: Better | Similar | Worse

Source: PHE Public Health Profiles.

The foundations for good health begin in the earliest stages of life. School readiness is a key measure of early years development across a wide range of developmental areas, and is a useful indicator of whether children have had a good start in life. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early.[21] In the WMCA the percentage of children achieving a good level of development at the end of Reception year is lower than the England average in all areas except Solihull. However, even in Solihull almost a third of children are not school ready at this stage (Table 3).

Figure 4: Life expectancy and healthy life expectancy in the WMCA (2016-18)



Impacts of COVID-19 on length and quality of life

At present it is too early to say how life expectancy and healthy life expectancy may change over the longer term as a result of the pandemic. In addition to deaths resulting from COVID-19, it is also important to look at what is happening with trends in deaths from other causes.

Figure 5 shows rates of confirmed COVID-19 cases across the West Midlands region as of 29th October 2020. It is clear that the WMCA has a higher rate of cases overall than the region as a whole, with Birmingham and Sandwell most affected. Rates are also high in Solihull, Walsall and Wolverhampton.

Figure 6 shows that there was an increase in excess deaths from the week ending 27 March, peaking in the week ending 10 April before declining and returning to baseline levels in the week ending 22 May. While many of these were COVID-19 related, a marked proportion of excess deaths during this period did not have COVID-19 mentioned on the death certificate, suggesting an increase in deaths from other causes during this period. As of October 2020, the overall rate of deaths in the WMCA region is not significantly different to previous years, with 6.0% of those deaths known to be COVID-19 related.

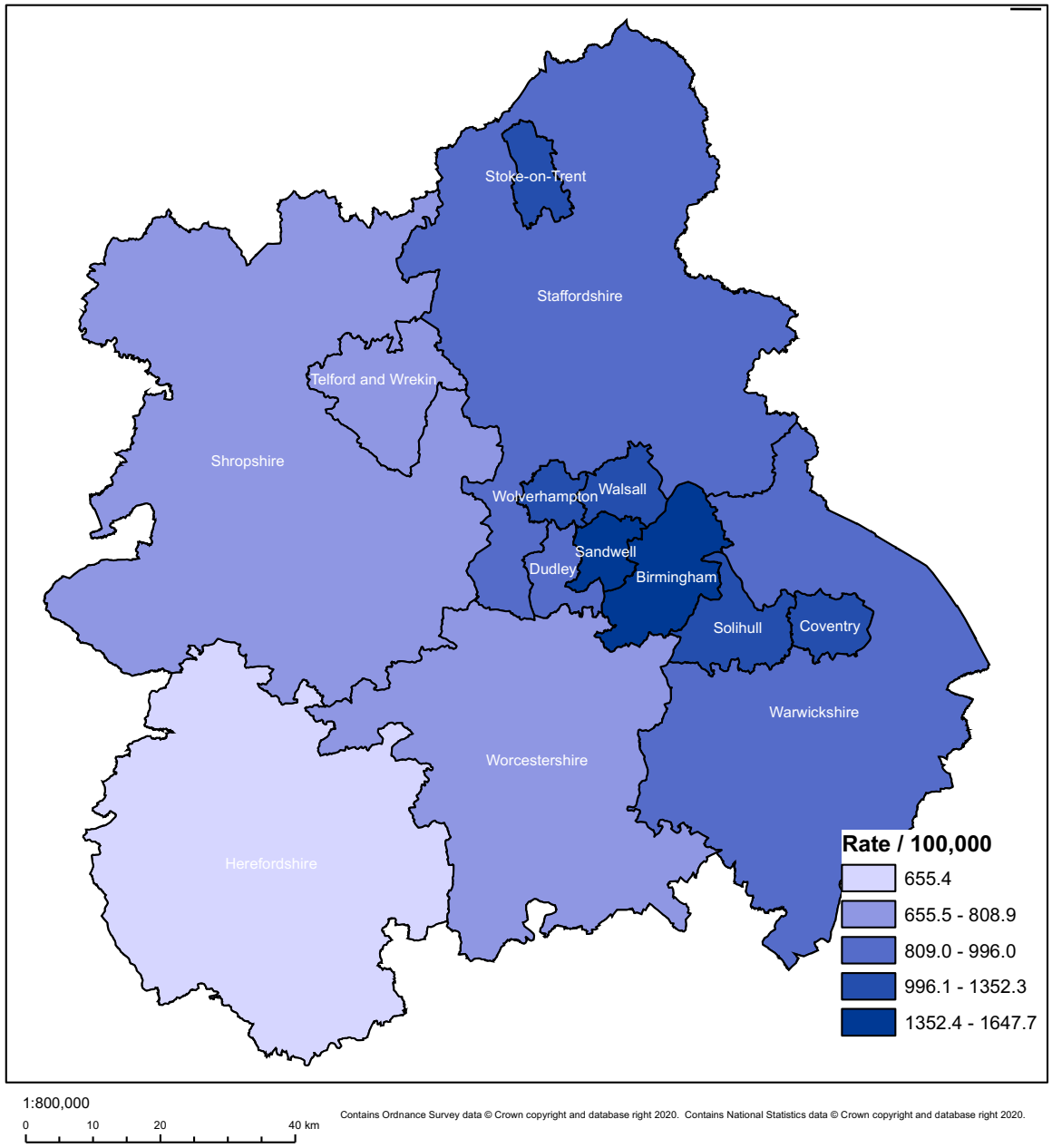
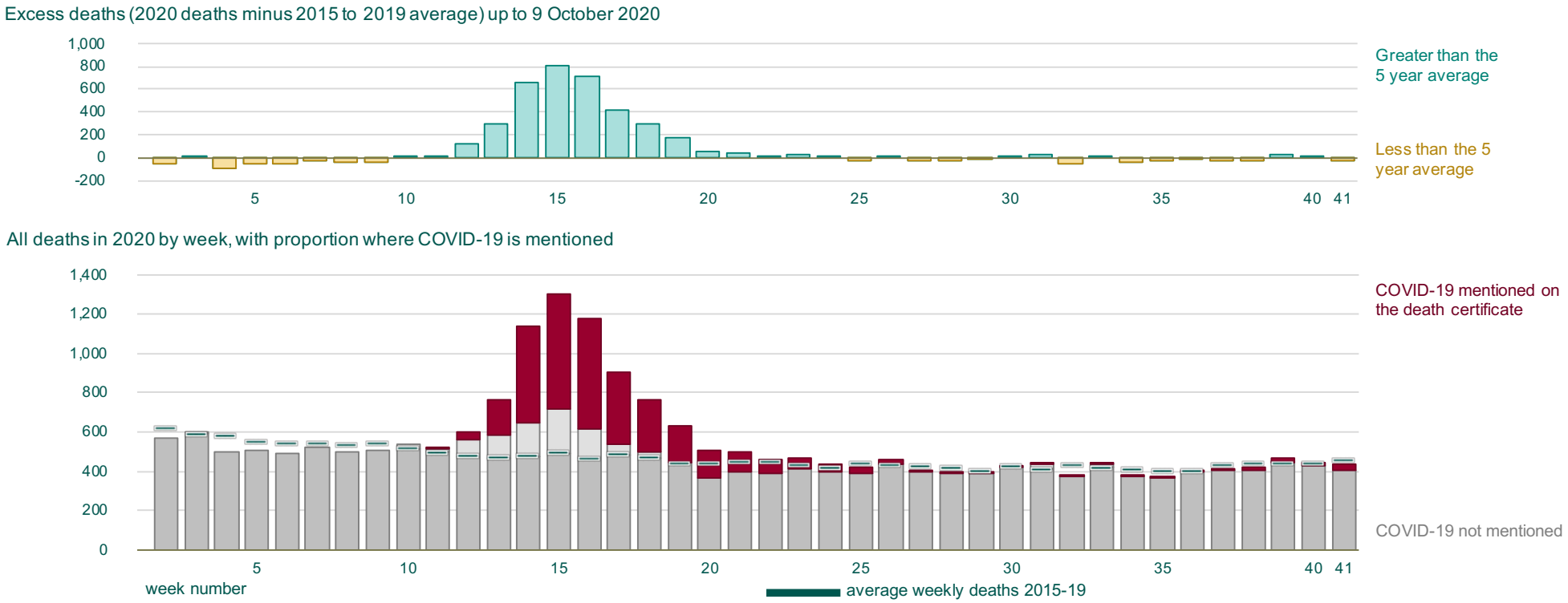


Figure 5: Confirmed COVID-19 cases in the West Midlands (up to 29 Oct 2020)

Weekly provisional figures on deaths occuring, minus the weekly average occurence 2015 to 2019, with proportion where coronavirus (COVID-19) was mentioned on the death certificate (week 41 - up to 9 October 2020)

Week 41: WEST MIDLANDS LRF, death occurrences



ONS - Deaths registered weekly in England and Wales, provisional

Death occurrences in week 41 =	435
Excess death occurrences in week 41 (using 2015-19 weekly averages) =	-22
Death occurrences mentioning COVID-19 in week 41 =	26
Death occurrences mentioning COVID-19 in weeks 1 to 41 =	3,302

(Note: Week 1 is currently not being displayed. Average counts were lower than expected and this is being investigated)
Historic average weekly deaths are presented here as the mean of the years 2015 to 2019

Figure 6: Death occurrences in the WMCA (to 9 October 2020)

Who is most at risk?

Our interim report details existing risk factors and inequalities in the WMCA that are associated with increased risk of infection and death or complications from COVID-19. The risk associated with age – of those 80 or older – is lower in the WMCA area than the national average; however, this appears to be countered by other risk factors and inequalities, most notably socioeconomic deprivation, ethnicity, occupation and prevalence of excess weight and diabetes.

National data show that disabled people (those limited a little or limited a lot in their day-to-day activities) made up almost 6 in 10 (59%) of all deaths involving COVID-19 during the period from 2 March to 14 July 2020. After adjusting for region, population density, socio-demographic and household characteristics, the relative difference in mortality rates between those disabled and limited a lot and those non-disabled was 2.4 times higher for females and 2.0 times higher for males.[22]

Table 4: COVID-19 cases and deaths by Local Authority, WMCA. [23]

Upper Tier Local Authority District name (2019)	IMD (2019) Average Rank per 1,000	Number of confirmed COVID-19 cases	Rate of confirmed COVID-19 cases per 100,000	Number of COVID-19 related deaths	Rate of COVID-19 related deaths per 100,000	% Est. Population BAME groups 2019
Birmingham	25.32	17,896	1,567.3	1,036	90.7	43.0
Coventry	19.43	4,054	1,091.2	218	58.7	29.1
Dudley	18.19	2,924	909.2	256	79.6	9.0
Sandwell	25.28	4,721	1,437.4	337	102.6	35.4
Solihull	12.51	2,703	1,249.2	208	96.1	12.5
Walsall	22.15	3,765	1,287.3	307	107.5	17.4
Wolverhampton	23.27	3,288	1,248.5	258	92.0	31.0
WMCA	**20.88**	**39,351**	**1,343.68**	**2,620**	**89.4**	**30.6**
West Midlands	14.26	65,597	1,105.4	4,778	80.5	17.4
England	16.36	647,025	1,149.5	38,996	69.3	14.0

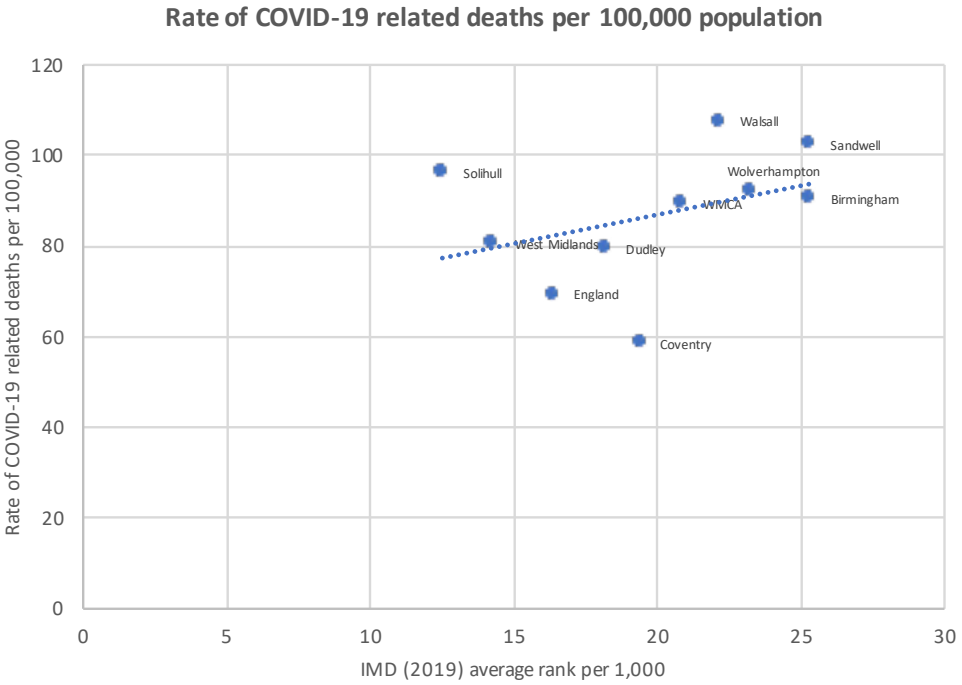


Figure 7a: Rate of COVID-19 related deaths and area deprivation (WMCA, 21 October 2020)

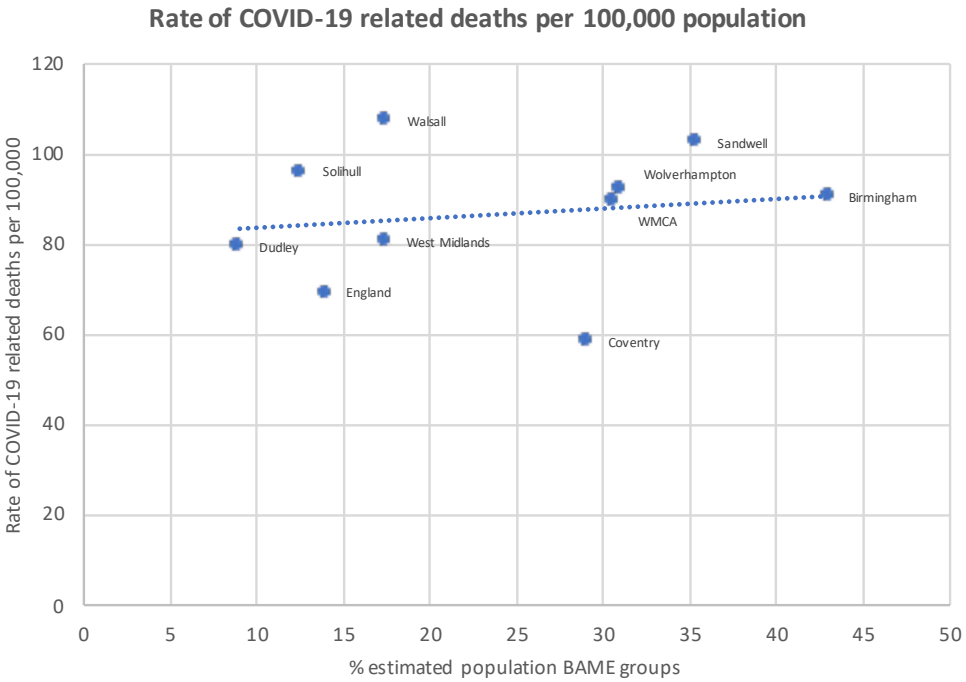


Figure 7b: Rate of COVID-19 related deaths and % estimated BAME population (WMCA, 21 October 2020)

In line with national findings, aggregate data for the region shows that higher rates of COVID-19 deaths were broadly associated with greater levels of deprivation and a higher proportion of residents from BAME communities (Table 4 and Figures 7a and 7b). National analyses showed that as of April 2020, men and women in the black community were over four times (4.2 and 4.3 times respectively) as likely to die from COVID-19 than the white population once age had been accounted for. Men of Bangladeshi and Pakistani origin were 3.6 times more likely to have a COVID-19 related death, while the figure for women was 3.4 times more likely.[24]

Once geography (region, area deprivation and whether rural/urban), household composition, socio-economic status and health had been adjusted for, the risk reduced considerably: Black men and women were both 1.9 times more likely to die from COVID-19 than the white population, while the figures for men and women of Bangladeshi and Pakistani origin were 2.1 and 1.6 respectively.

The SAVI is an empirically informed measure of COVID19 vulnerability for each Middle Super Output Area (MSOA) in England. The SAVI index investigates the association between each predictor (proportion of the population from Black, Asian and Minority Ethnic (BAME) backgrounds, income deprived, over 80 years old, living in care homes, living in overcrowded housing and having been admitted in the past 5 years for a chronic health condition) and COVID19 mortality using a multivariable Poisson regression, whilst accounting for the regional spread and duration of the epidemic.

The SAVI provides a score for each MSOA in England that indicates the relative increase in COVID mortality risk that results from the level of each of the six vulnerability measures for each area.

Nationally, high levels of vulnerability to COVID-19 have been found to cluster in the North West, West Midlands and North East regions. Out of the 513 MSOAs covering the WMCA 3 LEP area there were 49 MSOAs (10%) that had a score under 1 whilst 15 MSOAs had a score of 2 plus (3%). The most vulnerable MSOA within the WMCA 3 LEP area was Tettenhall South in Wolverhampton with a score of 2.89 for increase in risk (the 16th highest score in England). Within the West Midlands region, there were high scoring clusters in Wolverhampton, Birmingham, Bromsgrove, Wyre Forest, Stratford-on-Avon and Rugby.

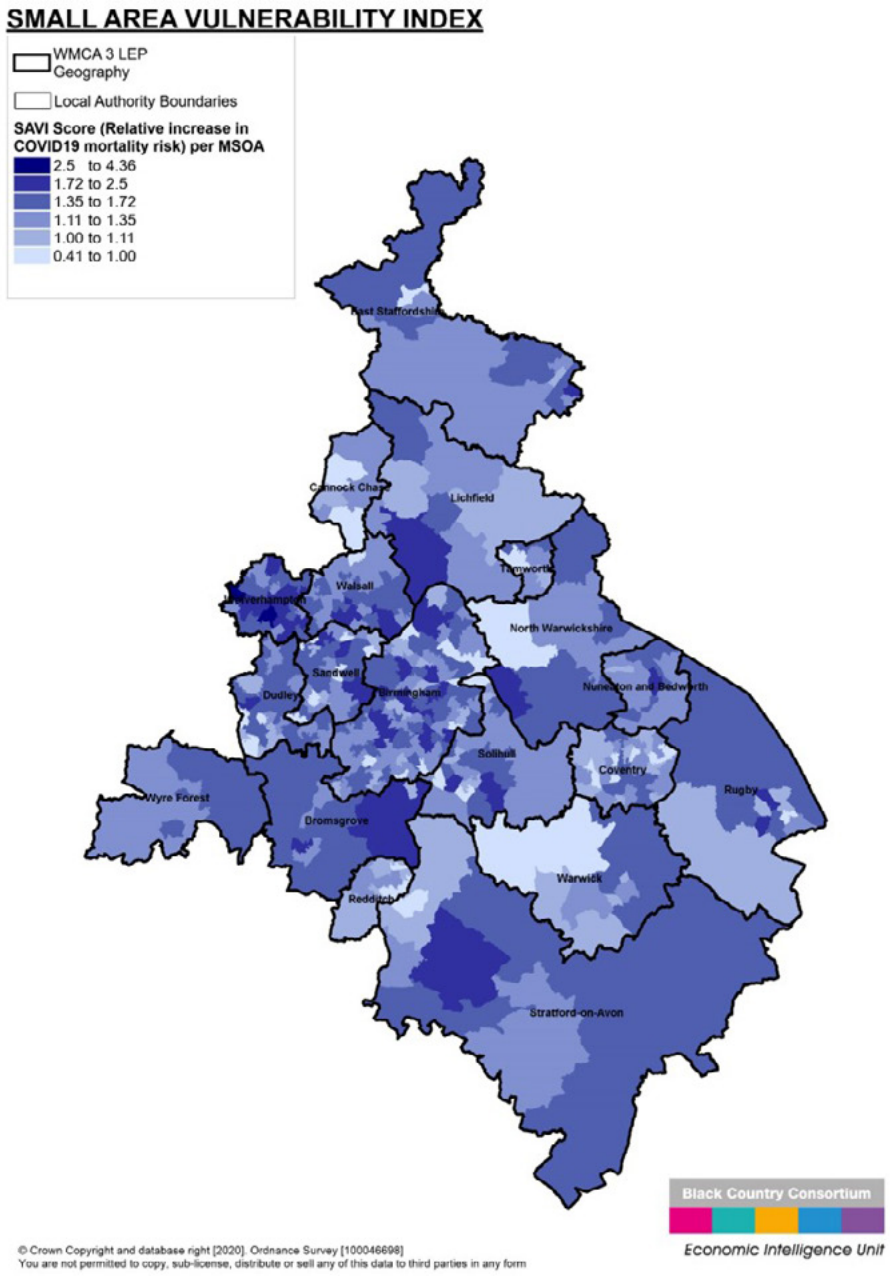


Figure 8: Small area vulnerability index (SAVI) score by MSOA, West Midlands (12 Jun 2020)

PHE's more recent analysis,[25] which included age, sex, deprivation, region and ethnicity, showed that the risk of dying following a positive test for COVID-19 (pillar 1) was:

- 70 times higher in people 80 years or older than those under 40
- Higher in males than females (2x in working ages)
- Higher in those living in the more deprived areas vs those living in the least deprived areas (2x)
- Higher in many Black, Asian and Minority Ethnic (BAME) groups than the White British ethnic group (up to 2x)

Compared with the White British group, the risk of dying following a positive pillar 1 test was:

- 2.0 times higher for the Bangladeshi group
- 1.4 times higher for the Pakistani group
- 1.3 times higher for the Chinese group
- 1.2 times higher for the Indian group
- 1.1 times higher for the Other Asian group
- 1.1 times higher for the Black Caribbean group
- 1.4 times higher for the Other Black group
- Not significantly different for those in the Other ethnic group

The analysis did not include comorbidities, and it was noted that other evidence had shown a marked reduction in risk of death by ethnic group among hospitalised patients when comorbidities had been taken into account. More recently, the Race Disparity Unit's first quarterly report on progress to address COVID-19 health inequalities confirmed that the evidence showed an increased risk for Black and South Asian ethnic groups, with a reduced relative risk of mortality when taking into account socioeconomic and geographical factors associated with different ethnic groups such as occupational exposure, population density, household composition and pre-existing health conditions. It was noted that deprivation is a good marker of many of these factors. However, despite most of the increased risk for ethnic minorities being readily explained by these factors, it was not fully explained for some groups such as Black men.[26]

What this tells us is not that the risks presented by COVID-19 are any less severe for people from ethnic minority groups than we had first thought. It tells us what is driving those risks - namely occupation, housing, income - and is a powerful illustration of how structural disadvantage is entrenched in the social, economic and environmental determinants of health.

This is emphasised in the findings and recommendations of the Doreen Lawrence Review (2020) on the 'avoidable crisis' that is the disproportionate impact of COVID-19 on people from BAME communities. The review demonstrates how people from BAME communities have been overexposed, under protected, stigmatised and overlooked during the pandemic, and calls for urgent action to reduce health inequalities and tackle systemic racism.[27]

Box 1: Why have our Black & Minority Ethnic (BAME) communities been most affected by COVID-19?

National and regional evidence suggests that increased risk among BAME communities is due to a number of intersecting factors, including:

- Increased prevalence of chronic disease
- Reduced likelihood of using primary care services
- Being more likely to work in sectors associated with increased risk, particularly in the health and care, hospitality and transport sectors
- Failure to protect key workers and a lack of PPE in the early stages of the pandemic
- Income inequality and deprivation, including household overcrowding
- A system that is inadequately equipped to address the issue, including a lack of complete and high-quality ethnicity data and a lack of funding where it is most needed

These factors are not independent of one another, but instead interact to increase not just the direct risks associated with COVID-19, but its socioeconomic and psychosocial impacts.

Systemic racism and discrimination operates across the health and wider system to influence all of these factors.

Regionally, this was explored in greater depth through the West Midlands Inquiry Into COVID-19 fatalities in the West Midlands published in August 2020.[28] The Inquiry reported evidence given to Birmingham Health and Wellbeing Board that in March 2020, 64% of COVID-19 deaths in Birmingham City Hospital where from 'the Black African and Asian communities' and in April, the figure was 50%. It concluded that a 'perfect storm' of factors meant the BAME community was hit the hardest: increased prevalence of chronic disease, reduced likelihood of using primary care services and failure to protect key workers, particularly in the health and care, hospitality and transport sectors, placed individuals from BAME communities at disproportionate levels of risk. Income inequality was identified as a key factor in exacerbating the risk further.

These findings have been supported by regional analyses and additional evidence submitted by stakeholders. An analysis of occupation and its intersection with ethnicity revealed that the WMCA area has a higher proportion of jobs within sectors associated with a higher increase in excess all cause deaths and increased exposure to infection – and that jobs in these sectors are disproportionately held by ethnic groups associated with poorer COVID-19 health outcomes.[29] Exacerbation of existing

inequalities, disproportionate impacts on people from BAME communities and access to healthcare were prominent themes in the evidence provided by local stakeholders regarding the impacts of COVID-19 in their communities (see Appendix 2).

The inquiry also highlighted system issues that make us inadequately equipped to tackle entrenched systemic discrimination, including a lack of complete and high-quality data on ethnicity, and a lack of funding where it is most needed. It was revealed that the most diverse areas in the West Midlands – Birmingham, Wolverhampton and Sandwell – have suffered the greatest cuts in public health funding over the last 5 years, with cuts of 9%, 8% and 15% respectively (England average 5%).

A recent report from University Hospitals Birmingham NHS Foundation Trust, which found that there were more admissions from South Asian patients than would be expected based on the local population. Those patients were admitted with a worse severity of COVID-19 respiratory compromise without a significant delay in presentation and experience a higher level of mortality even when differences in age, sex, deprivation and key comorbidities were taken into account.[30]

Overall, the factors driving the association between ethnicity and COVID-19 risks and outcomes are multi-faceted and interact with one another. Later in this paper in Section 1.5, we also consider the role of structural racism.

The role of underlying inequalities and structural disadvantage is nevertheless key, and it is clear that change is needed over the longer term to address these inequalities. In the short to medium term, it is important to identify where action can be more readily taken to improve outcomes. A review paper by the Scientific Advisory Group for Emergencies (SAGE) of the drivers of increased COVID-19 incidence, mortality and morbidity among minority ethnic groups concluded that although the relative importance of different pathways causing ethnic inequalities in outcomes is not well understood, we should focus on understanding those that are immediately modifiable – for example occupation and healthcare access.[31] The review also emphasised the importance of data quality, noting that limited information on the clinical presentation of the disease and the social determinants of health limits insights that can be gained from detailed quantitative analysis.

Impacts on wellbeing

Effects on wellbeing are more readily measurable at this point, although the issue of whether population wellbeing has declined as a result of the pandemic is less straightforward. Data on self-reported wellbeing measures from the first week post-lockdown (week ending 22 March) to the most recent data available (w/e 02 August) show that in England, percentages of people aged 16+ reporting high anxiety and low life satisfaction, self-worth and happiness were generally higher throughout 2020 than in 2019.[32]

Nationally, while low self-worth and low life satisfaction have fluctuated over this period, anxiety and low happiness have generally declined since the start of lockdown. In the West Midlands region:

- The percentage of people reporting a **high anxiety** score was **47.9%** during the week ending 22 March compared with 41.2% during the week ending 02 August - baseline **21.9%** (England averages 50.6 and 35.2 respectively – baseline 22.6). In the West Midlands, anxiety was the only measure which showed a statistically significant increase from baseline to the most recent measure.

- The percentage of people reporting a **low life satisfaction** score was **3.8%** during the week ending 22 March compared with **9.4%** during the week ending 02 August – baseline **9.7%** (England averages 7.7 and 8.1 respectively – baseline 5.7).

- The percentage of people reporting a **low self-worth** score was **5.6%** during the week ending 22 March compared with **6.9%** during the week ending 02 August - baseline **4.9%** (England averages 7.0 and 7.7 respectively – baseline 2.9).

- The percentage of people reporting a **low happiness** score was **14.5%** during the week ending 22 March compared with **10.7%** during the week ending 02 August - baseline **8.4%** (England averages 20.9 and 10.0 respectively – baseline 8.2).

Loneliness is a key contributor to poor mental wellbeing. Figures 9a and 9b show the percentages of people in England who reported feeling 'often lonely' or 'never lonely' since the start of April 2020. On average, people reporting feeling 'often lonely' ranged from 4.9% to 6.5% over this period; when disaggregated by age group, this was generally higher for younger people (16-34) and lower for older people (65+), although this fluctuated over the lockdown period (Figure 9a). Conversely, the percentages of people who reported feeling 'never lonely' was consistently highest for older people (65+) and lowest for younger people (16-35), with those in the middle age group (36-64) consistently in between (see Figure 9b; England average range 17.9% to 21.7%).

This may reflect those in education or employment experiencing greater changes to their usual levels of social contact as a result of lockdown. However, people who had an underlying health condition were consistently more likely to report often feeling lonely, which is consistent with data showing that a large proportion of adult social care users experience social isolation (see 1.5 below).

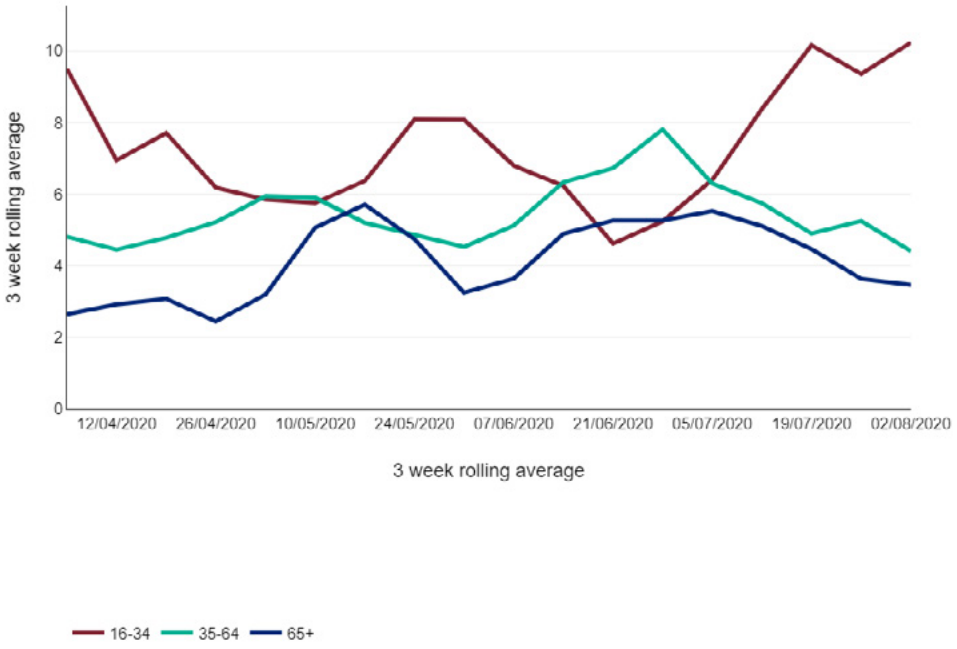


Figure 9a: Trend in percentage of respondents who are often lonely in England, by age group

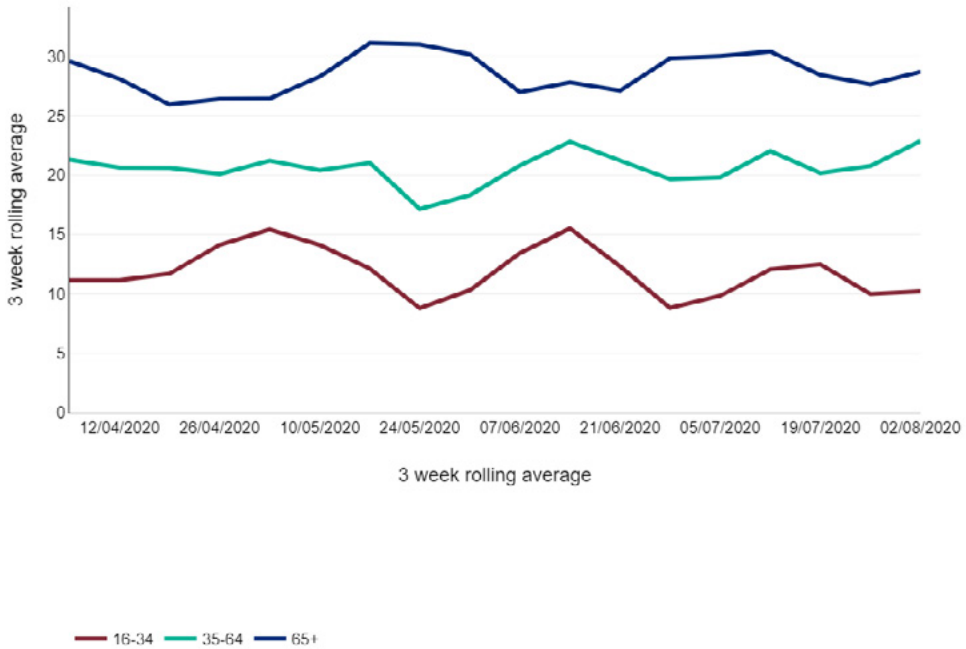


Figure 9b: Trend in percentage of respondents who are never lonely in England, by age group

Data from the online mental health support services Kooth and Quell[33,34] released in May 2020 demonstrated an increase in requests for support nationally compared to the same period in 2019, for both children and young people (33% increase) and adults (53% increase). In areas that were most affected by COVID-19, there was a sharp increase in children and young people seeking support for bereavement and loss of families. Among adults, the health of others was a key concern, as well as the pressures of changing work cultures and environments, and increases in loneliness, sadness and depression. In the Midlands region overall, presentations to the service by children and young people decreased for sadness, sleep issues, family relationships and loneliness, but increased for eating issues, school/college worries and suicidal thoughts. Among both age groups there was a national increase in presentations relating to abuse; this is discussed further in section 1.5. It is important to note that these data only include those with access to online support, and may not reflect additional challenges faced by those who are digitally excluded (Box 4).

1.3 Causes of ill health, early death and preventable disease

There are many different ways to answer the question of what causes early death and ill-health. We need to know more about the different conditions which have led to the death, and we need to know more about what increases the risk of developing these conditions.

It is important to note that averages across local authorities may mask inequalities at smaller area levels, or between demographic groups. Nationally, there is a marked social gradient in the causes of premature death considered preventable, with significantly higher rates in more deprived areas. In addition, degree of caution is needed when interpreting data on service use and benefit claims. Higher values may reflect higher population prevalence of a condition, but alternatively they may indicate increased likelihood of diagnosis and access to support.

Conditions

Any death under the age of 75 years is considered to be a premature death, and many of the diseases that cause these deaths are preventable. The gap in life expectancy between the WMCA and England overall is due to increased premature death from a number of preventable conditions. Under 75 mortality from preventable cancers and from cardiovascular, liver and respiratory diseases are all higher in the WMCA than the national average. This is broadly consistent among all constituent authorities, with the exception of Solihull where rates are generally lower. Alcohol-specific mortality follows a similar pattern. Excess winter deaths, and deaths from drug misuse and suicide across the region generally reflect the national average, but this does not diminish their importance and impact.

Table 5: Health outcomes in the WMCA – local area comparisons.

	Indicators	Period	WMCA number	England	WMCA	Birmingham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolverhampton
Premature death	Under 75 mortality from cancer considered preventable - directly standardised rate per 100,000 population	2016-18	5,512	76.3	87.0	88.8	85.7	90.1	87.7	69.0	89.3	93.9
	Under 75 mortality from cardiovascular diseases considered preventable - directly standardised rate per 100,000 population	2016-18	3,706	45.3	58.5	61.9	56.2	48.6	68.5	39.7	61.6	68.1
	Under 75 mortality from liver diseases considered preventable - directly standardised rate per 100,000 population	2016-18	1,451	16.3	22.0	21.4	20.1	21.9	26.2	16.9	22.1	26.3
	Under 75 mortality from respiratory diseases considered preventable - directly standardised rate per 100,000 population	2016-18	1,402	19.2	22.6	23.2	24.5	20.1	27.7	15.5	22.6	23.4
	Excess winter deaths index (Aug 2017-Jul 2018)	Aug17-Jul18	2,263	30.1	29.0	27.9	28.2	28.2	27.8	30.7	31.6	31.1
	Alcohol-specific mortality - directly standardised rate per 100,000	2016-18	1,155	10.8	15.6	15.0	13.5	16.0	20.7	9.6	16.1	18.9
	Deaths from drug misuse - age-standardised rate per 100,000 population	2016-18	-	4.5	4.6	6.3	3.3	4.2	1.2	4.8	4.6	4.0
	Suicide (persons, 10+ yrs) – age-standardised rate per 100,000 population	2016-18	-	9.6	-	8.1	8.6	9.7	10.6	12.2	8.2	9.0
Long-term conditions	Diabetes: QOF prevalence (18+)	2018/19	210,154	6.9	8.4	8.7	6.7	8.0	9.5	7.3	9.2	8.4
	CHD: QOF prevalence (18+)	2018/19	98,372	3.1	3.1	2.7	2.3	4.1	3.6	3.2	3.9	3.1
	People reporting a long term musculoskeletal (MSK) problem - %	2018/19	-	16.9	17.5	17.9	18.5	15.4	16.5	21.5	20.3	16.9
Mental health problems	Depression: Recorded prevalence (aged 18)	2017/18	-	9.9	9.6	9.2	9.3	11.7	8.6	9.0	10.5	10.0
	Estimated prevalence of common mental disorders: % of population aged 16 & over (modelled)	2017	-	16.9	-	21.1	19.1	17.4	21.5	14.7	19.4	20.5
	ESA claimants for mental and behavioural disorders: crude rate per 1,000 working age population	2018	59,470	27.3	33.3	36.0	31.4	24.9	37.0	22.0	36.5	35.2

Compared with England: Better | Similar | Worse | Lower | Similar | Higher

Source: PHE Public Health Profiles

Mental health problems and inequalities

Physical and mental health are inextricably linked. Poor mental health is both a cause and consequence of poor health in general across the life course, with most mental health problems developing before the age of 25. People with severe mental illness (SMI) die 15-10 years earlier on average compared with the general population and two thirds of these deaths are from preventable physical illnesses, including cancer and heart disease. The determinants of physical and mental health problems often overlap; mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination.[35] Poor mental health also has a detrimental effect on health behaviours; for example, 40.5% of adults with SMI in England are smokers compared with 13.9% of the general population. In the WMCA these figures are 40.3% and 14.6% respectively (PHE Tobacco Control Profiles).

The health data show that mental health and well-being in the WMCA is of concern as well as physical health. As might be expected from an understanding of the causes of the causes of poor physical health, it also shows the pattern of variation between the different parts of the WMCA area. Here, the comparison with the UK average is not so stark; however, this should again be understood in the context that wellbeing across the UK is also of concern.

Walsall and Wolverhampton have a higher recorded prevalence of depression, and a higher proportion of people claiming ESA for mental and behavioural problems. This is in in line with lower levels of self-reported wellbeing in these areas. For Solihull these are generally lower. Among other areas, however, there appears to be little consistency between these indicators (Table 5). Figure 10 shows the excess under 75 mortality rate in adults with serious mental illness in the WMCA; rates are highest in Birmingham and Wolverhampton and lowest in Sandwell and Solihull.

Excess under 75 mortality rate in adults with serious mental illness 2014/15

Indirectly standardised ratio - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	370.0	365.5	374.5
CA-West Midlands	–	-	437.6	415.9	460.1
Birmingham	–	-	487.0	451.0	525.1
Wolverhampton	–	-	478.8	405.5	561.5
Dudley	–	-	430.1	359.0	511.0
Coventry	–	-	406.3	348.6	470.7
Walsall	–	-	387.9	325.0	459.4
Sandwell	–	-	374.8	319.8	436.5
Solihull	–	-	359.5	291.5	438.6

Figure 10: Excess under 65 mortality rate in adults with serious mental illness

People from BAME communities are significantly more likely to suffer poorer mental health outcomes due to facing more barriers to accessing treatment and poorer experiences of services. Ethnic minorities are at an increased risk of involuntary detention under the Mental Health Act, but less likely to access earlier intervention and treatment. High levels of inequality in access to, and experience of, mental health care are also evident for children and young people; lesbian, gay, bisexual, transgender and/or queer/ questioning 'plus' (LGBTQ+); homeless people; and people living with physical or learning disabilities. There is often intersection across these groups and with other determinants of health.[36]

Causes of preventable disease

At its simplest, unhealthy lifestyles increase our chances of ill-health. There are four major, relatively straightforward, behaviours which will increase the risks of ill-health and death from these preventable diseases. These are smoking; taking too little exercise; eating too much of foods that are high in fat, salt and sugar; and drinking too much alcohol. Figures 11a and 11b show the main causes of preventable deaths in the WMCA, and the key health behaviours associated with those risks.

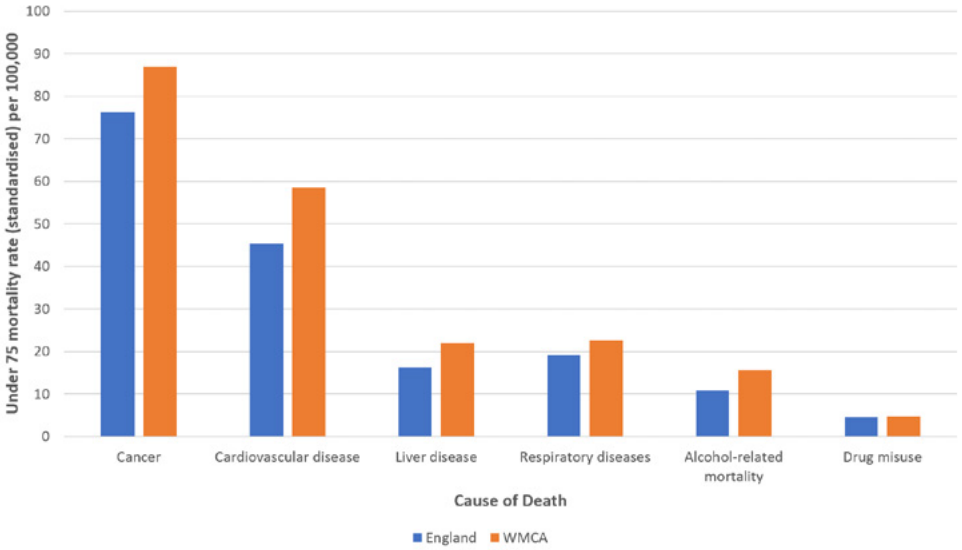


Figure 11a: Main causes of preventable mortality, WMCA 2016-18

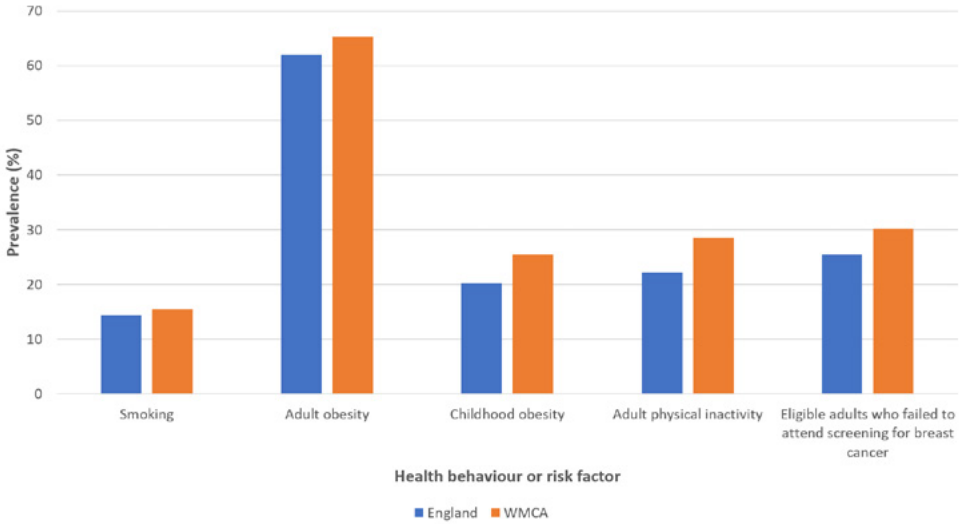


Figure 11b: Prevalence of key health risks and behaviours, WMCA

People in the WMCA are more likely than the England average population to smoke, drink too much alcohol, be overweight or obese, and be physically inactive (Figure 11b and Table 6). In some cases, it can be seen that the figures are high nationally too. It is important that this does not dilute the need to pay attention to reducing these figures in the West Midlands. These are worrying signs that unhealthy lifestyles across the UK are very common and that improvements are not yet being made across the wider system to support people to live healthier lives.

Unhealthy lifestyles are not only evident amongst adults. A younger generation of residents are now likely to grow up into being unhealthy adults, whose quality of life is not as good as it could be. Here, as nationally, this may be the first generation of children who do not live as long as their parents.

Table 6: Health behaviours and risks in the WMCA – local area comparisons.

	Indicators	Period	WMCA number	England	WMCA	Birmingham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolverhampton
Smoking	Smoking prevalence in adults (18+): current smokers - % (APS)	2019	-	13.9	14.6	14.8	15.1	13.5	15.3	12.6	15.0	15.1
	Smoking status at time of delivery - %	2018/19	3,514	10.6	10.5	8.6	10.6	12.8	10.1	8.3	11.5	16.7
	Smoking prevalence in adults with anxiety or depression (18+): current smokers (GPPS) - %	2016/17	-	25.8	25.6	26.6	24.9	22.9	27.2	17.4	28.1	25.5
	Smoking prevalence in adults with a long term mental health condition (18+): current smokers (GPPS) - %	2017/18	-	25.6	26.6	24.9	22.9	27.2	17.4	28.1	25.5	34.5
Alcohol and drug use	Admission episodes for alcohol-specific conditions – DSR per 100,000	2018/19	18,422	626	718	762	925	561	741	527	650	756
	Percentage of adults who abstain from drinking alcohol	2011-2014	-	15.5	-	30.9	16.9	14.6	28.4	13.5	22.7	36.0
	Percentage of adults drinking over 14 units of alcohol a week	2011-14	-	25.7	-	18.9	25.8	24.7	25.4	25.2	22.0	15.0
	Percentage of dependent drinkers	2014/15	35,660	1.39	1.67	1.66	1.81	1.56	1.95	1.09	1.61	1.84
	Admission episodes for alcohol-specific conditions (under 18s) – crude rate per 100,000	2016/17 – 18/19	440	31.6	21.3	16.2	30.0	29.1	24.7	28.6	14.9	22.2
	Estimated prevalence of opiate and/or crack cocaine use - crude rate per 1,000	2016/17	21,945	8.9	11.9	14.2	7.5	10.5	11.7	7.8	11.0	13.6
Nutrition and obesity	Baby's first feed breastmilk - % (2018/19)	2018/19	-	67.4	-	68.2	62.6	61.3	63.5	63.0	52.2	59.9
	Adults meeting the recommended '5-a-day' on a 'usual day'- % (2017/18)	2018/19	-	54.6	46.7	47.8	43.6	49.4	35.7	57.0	42.4	51.0
	Adults (aged 18+) classified as overweight or obese - %	2018/19	-	62.3	65.5	61.7	62.9	71.5	70.9	62.8	73.2	67.3
	Reception: Prevalence of obesity (including severe obesity) - %	2018/19	4,254	9.7	11.4	11.4	10.2	10.3	13.0	8.1	12.4	13.5
	Year 6: Prevalence of obesity (including severe obesity) - %	2018/19	9,529	20.2	25.5	25.7	22.6	24.2	28.3	18.3	26.2	29.3
Physical activity	Physically active children and young people - %	2018/19	-	46.8	-	44.2	50.8	41.6	43.4	48.6	38.8	46.5
	Physically active adults - %	2018/19	-	67.2	60.9	63.3	61.1	59.5	54.7	68.1	55.9	58.0
	Physically inactive adults - %	2018/19	-	21.4	27.2	24.8	27.4	26.1	32.6	23.2	32.1	29.8
	Adults walking for travel at least three days per week - %	2017/18	-	23.1	-	22.5	24.0	18.6	21.9	19.2	20.5	21.6
	Adults cycling for travel at least three days per week - %	2017/18	-	3.2	-	2.9	2.4	1.0	2.1	1.6	0.3	0.8

Compared with England: Better | Similar | Worse

Source: PHE Public Health Profiles

Smoking

Smoking prevalence among adults in general and those with anxiety, depression or a long-term mental health condition are broadly similar in the WMCA to the England average. However, national data show a marked social gradient, highlighting smoking as a key cause of health inequalities. Over a quarter of adults with mental health problems are smokers compared with approximately 15% of the general population. Smoking status at delivery shows marked inequalities across the region; while overall WMCA prevalence is similar to the national average, it is significantly higher in Dudley and Wolverhampton.

Alcohol and drug use

The WMCA has a higher than national average prevalence of dependent drinkers. Above average rates of hospital admissions for alcohol-specific conditions are driven by high rates in Birmingham, Coventry, Sandwell and Wolverhampton. However, most of these areas also have a higher than average percentage of adults who abstain from drinking altogether, which may reflect the cultural diversity of localities. The rate of alcohol-specific admissions for under 18s is also lower than average overall. The percentage of adults drinking above the recommended 14 units per week is similar to or lower than the England average across WMCA areas; however, it should be noted that this still nearly 1 in 5 adults in the WMCA. The rate of opiate or crack cocaine use is similar in the WMCA to the national average, but masks significant inequalities across the region with high rates in a number of areas.

Nutrition and obesity

Nationally, just over two thirds of babies have breastmilk as their first feed. With the exception of Birmingham, this is significantly lower across constituent local authorities. Among adults, less than half in the WMCA report having the recommended '5 a day' portions of fruit and vegetables – significantly lower than the England average.

Physical activity

For adults across the WMCA, rates of physical activity are lower and rates of physical inactivity are higher compared with England overall. 27.2% of adults in the WMCA are doing less than 30 minutes of physical activity per week. Only 61% of adults and less than half of children and young people are meeting recommended weekly levels of physical activity. Both regionally and nationally, less than a quarter of adults walk at least three times per week for travel; only a small minority (<3%) cycle for this purpose.

Supporting people to live healthier lives would have substantial health and economic benefits for the region. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually. Reducing alcohol-related harm is one of Public Health England's seven priorities for the next five years (from the Evidence into action report 2014). Low physical activity is one of the top 10 causes of disease and disability in England, and regular physical activity can help to prevent and manage over 20 chronic conditions and diseases; persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent 1 in 10 cases of stroke and heart disease in the UK and 1 in 6 deaths from any cause.[37] There are also significant inequalities in physical activity, with people

from BAME groups, women, people from lower socio-economic groups and disabled people less likely to be active. In the West Midlands, 52% of disabled adults are inactive.[38]

Diet and physical activity habits often begin in childhood, and are influenced from pre-conception and beyond, so it is important to act as early as possible to embed positive behaviours at the earliest opportunity. However, it is never too late to support people to live healthier and more active lives, and taking action across the life course can help to reduce the health inequalities associated with obesity and physical inactivity.

Screening and early intervention

Unhealthy lifestyles increase the risk of developing preventable disease. However, many of these diseases are identifiable and treatable in their early stage. There are significant differences across the region, and between different groups of people, in terms of whether or not people receive this early help.

Screening is carried out on healthy populations, or those without symptoms of a disease, to identify those who may have an increased risk of a particular condition. Cancer screening is one of the most effective ways to reduce the risk of premature mortality. Breast screening is offered to women aged 50 to 70 to detect early signs of breast cancer, and is estimated to save 1,400 lives in England each year. Cervical screening enables detection of cell abnormalities that may become cancer and is estimated to save 4,500 lives in England each year. Bowel cancer screening targets older adults aged 60 to 74 to support early detection of cancer and polyps that may develop into cancers over time.

Screening is also important to identify early signs of poor health leading to opportunities for early interventions. The NHS Health Check programme targets adults aged 40 to 74 to help prevent heart disease, stroke, diabetes and kidney disease. Eligible people who have not already been diagnosed with one of these conditions are invited for a health check every five years to assess their risk, raise awareness and support them to manage their risk of cardiovascular disease.

Table 7: Screening and early intervention in the WMCA – local area comparisons.

Indicators	Period	WMCA number	England	WMCA	Birmingham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolverhampton
Cancer screening coverage - breast cancer	2019	193,280	74.5	69.8	68.2	69.8	75.4	70.7	73.4	73.5	60.1
Cancer screening coverage - cervical cancer (25-49 years old)	2019	354,810	69.8	65.8	61.9	65.7	72.1	66.0	72.5	71.2	66.7
Cancer screening coverage - cervical cancer (50-64 years old)	2019	173,834	76.2	74.2	73.4	76.1	73.2	72.7	77.4	76.0	72.7
Cancer screening coverage – bowel cancer	2019	195,329	60.1	53.4	48.9	55.5	58.5	50.7	61.4	56.5	52.1
Chlamydia proportion aged 15 to 24 screened	2019	62,669	20.4	15.3	17.1	15.6	12.4	13.6	17.6	9.8	13.6
Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2015/16-19/20	386,098	41.3	52.8	54.5	51.3	69.1	53.6	48.8	54.3	28.5

Compared with England: Better | Similar | Worse

**Please note that there may be data quality issues with these figures*

Source: PHE Public Health Profiles

In 2019, the percentage of eligible WMCA residents who attended screening for breast, cervical and bowel cancer was significantly lower than the England average, with approximately a third to a quarter of the target populations not being screened (Table 7). Chlamydia screening was significantly lower than the national average for all WMCA areas. For NHS Health Checks, the WMCA generally performed better than the national average, with over half the eligible population receiving their health checks during the 4-year period from 2015/16 to 2019/20. Screening coverage in the WMCA has declined in recent years for breast and cervical cancer.

If the WMCA reached the national average benchmark for the year:

- **12,196** more women would be screened for **breast cancer**
- **20,331** more women aged 25-49 and **4,554** more aged 50-64 would be screened for **cervical cancer**
- **21,779** more people would be screened for **bowel cancer**
- **15,667** more young people would be screened for **chlamydia**

The COVID-19 pandemic has had an impact on cancer services. Referrals on the urgent two week wait cancer pathway showed a significant reduction as the pandemic hit the Midlands. By September referral rates had increased to over 90% of previous activity levels and continue to grow. Restrictions in out-patients, diagnostics and treatment capacity, due to social distancing and infection control measures, have significantly reduced patient throughput, against increasing demand. Systems across the West Midlands have worked hard to return cancer services as quickly as possible, adopting alterative models of care and digital technologies such as telephone and video consultations, community tele-dermatology clinics and alternatives to endoscopy, such as FIT testing.

There are plans in place to protect cancer services with the cancer treatments and other clinically urgent patients being prioritised. There are some patients who are reluctant to attend, as they are concerned about the risk of infection, and work is ongoing to provide reassurance and encouragement to these patients to attend their appointments.

Breast screening

The four breast screening providers that cover the WMCA area have all restored screening. They are working through the backlog, and commissioners (NHSE/I) are supporting services to get to a capacity that is greater than 100% that will be needed to catch up to the required screening intervals. All services have implemented national changes to the programme to aid the return to the three-year screening intervals, including the open first appointments. There has been some excellent innovation in the WMCA screening providers in an attempt to return to the three year round length, such as novel invitation models, and services are putting in addition actions to improve uptake, such as additional phone calls to some women.

Bowel screening

All four screening centres in the WMCA area have restored the assessment element of the screening pathway, and have cleared the backlog of screen positive patient left during the first peak of the Covid pandemic. All centres have also switched on the new screening invites (and home test kits). This currently ranges from 91 to 138 percent of the pre-Covid invite rates. Commissioners have set providers a deadline of 31st August 2021 to return to the two-yearly screening rounds.

Cervical screening

The national call-recall system in the cervical screening programme has begun an invite schedule that will mean that the programme has caught up – with women returning to the correct screening intervals – by May 2021.The HPV laboratories will have increased numbers of samples to process compared to pre-Covid

through winter 2020/21, with primary care taking more samples.

Through the early stages of the Covid pandemic (~March-April 2021), colposcopy units deferred the appointments of some low-grade patients. They have now caught up, and are appointing women in line with the pre-Covid programme guidance.

Impacts of COVID-19 on health behaviours and risks

The pandemic has the potential to exert indirect effects on health in two ways: firstly, by altering health behaviours, and secondly by reducing access to services and routine care. Changes to health behaviours may include negative coping strategies to manage anxiety, for example drinking or smoking more, or lockdown measures providing more (or fewer) opportunities to take part in physical activity. Reduced access to services may present additional risk if existing or emerging health conditions are not adequately managed.

Health behaviours

In the West Midlands region overall:[39]

- From 3rd April to 3rd August 2020, nearly a fifth of adults (18%) reported doing at least 30 minutes of physical activity on 0 days while just under a third (31%) reported doing it on 5 or more days (compared with 19% and 31% respectively in England). Nationally, men were significantly less likely than women to be physically inactive (21% vs. 18%) and significantly more likely to be active (34% vs. 29%).
- Compared with a typical week before introduction of COVID-19 restrictions, 34% of adults reported doing less, 34% reported doing more while 30% reported doing the same amount of physical activity. Nationally, women were significantly more likely to report doing less exercise (40% vs. 36%).
- 18% of parents reported their children doing the recommended 60 minutes or more of physical activity per day in the period 3 April to 25 May 2020, 33% reported doing 30-60 minutes, 38% reported doing less than 30 minutes, and more than a tenth (11%) reporting doing nothing – the highest regional level in the country.
- In the West Midlands, the prevalence of smoking during lockdown (the 4-week period ending 19 April 2020) was lower that reported in 2018 at (14% and 16% respectively).

Nationally, over half of respondents (pooled data up to 10 Aug 2020) (52%) said that the amount of alcohol they were consuming had not changed during lockdown. 24% said they were drinking more and 24% said they were drinking less.

Healthcare access and screening

Between 13th May and 10th August 2020, 13.1% of people surveyed in England reported having a worsening health condition during the last week. This generally increased with age, from 12.5% in 18-24 year olds and 17.6% in over 75s. Approximately half (50.4%) reported not seeking advice during this period; this varied by age group but was lowest in those aged 65+. Of these respondents, over half stated that this was to avoid putting pressure on the NHS, with approximately a third raising concerns

about catching coronavirus or leaving the house, and another third citing another reason. While significantly more women than men reported a worsening health condition (14.9% vs. 11.2%), were no significant sex differences in not seeking help.

The NHS are dealing with a significant backlog of non-COVID related morbidity and it is likely that the effect of this will widen existing health inequalities and lead to avoidable cancer death as a result of diagnostic delays.[40] Across the UK it is estimated that 2.1 million people have missed out on screening, while 290,000 people with suspected symptoms have not been referred for hospital tests. This means that more than 23,000 cancers could have gone undiagnosed during lockdown.[41] Given that screening coverage is already lower in the WMCA than the national average, it is likely that these effects are also being felt in the region.

In the WMCA, barriers to healthcare access identified by voluntary, community and faith organisations were largely practical. These included reduced availability and capacity of services; challenges with online or telephone services; and lack of access to linguistically and culturally accessible public health information. Stigma, misinformation or lack of clarity, and mistrust in government were also cited. There were intersections with themes relating to disproportionate impacts on BAME communities and marginalised groups, including refugees and migrants, and the widening of existing inequalities (see Appendix 2). This links to the issue of digital inclusion, which is picked up in Box 4.

1.4 Causes of unhealthy lifestyles: understanding the 'causes of the causes'

The conditions in which we are born, grow, live, work and age have important implications for our physical and mental health, as individuals and across wider society. We understand much more now about why so many people live in ways that affect their health so badly. The 2010 Marmot review on health inequalities[42] first articulated the importance of understanding the 'causes of the causes' of ill-health. Often, unhealthy behaviours are coping mechanisms for people who live in challenging circumstances, or reflect the limitations of the environments they live in. Many times, people want to make positive changes to improve their health, such as being more active or giving up smoking, but are not supported to do so. The conditions of many people's lives within the WMCA are hard. There is clear evidence that too many people live in challenging circumstances which may well result in their needing unhealthy coping strategies, and in their feeling powerless to make positive change.

This is not to say that those living in challenging circumstances are destined to have poor health. Rather, the focus should be on creating the conditions to enable people to live healthier lives, and to make healthier options the default. This means considering individual health-related behaviours in their social, cultural, economic and environmental contexts, and working to overcome the barriers these present (e.g. food poverty, limited time or skills, or lack of access to green space) rather than only targeting the behaviours themselves.

Table 8: Wider determinants of health in the WMCA – local area comparisons

	Indicators	Period	WMCA number	England	WMCA	Birming-ham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolver-hampton
Housing	Statutory homelessness: Eligible homeless people not in priority need - crude rate per 1,000	2017/18	-	-	-	0.9	0.6	3.6	0.5	1.4	0.1	2.2
	Statutory homelessness: Households in temporary accommodation - crude rate per 1,000	2017/18	2,668	-	2.3	4.7	2.0	0.1	0.3	1.1	1.0	0.7
	Adults in contact with a learning disability who live in stable and appropriate accommodation - %	2018/19	4,286	77.4	69.5	77.2	49.3	79.0	63.0	86.7	64.3	85.4
	Adults in contact with secondary mental health services who live in stable and appropriate accommodation - %	2018/19	-	58.0	41.0	57.0	16.0	63.0	53.0	5.0	3.0	15.0
Income	Children in low income families (under 16s) - %	2016	-	-	-	27.6	21.8	20.7	25.5	15.9	25.8	26.3
	Fuel poverty - % of households	2018	142,685	10.3	12.4	14.2	12.1	10.6	12.0	8.2	11.8	12.7
	Average weekly earnings - £	2018	-	-	-	417.6	454.2	425.9	398.5	474.2	399.9	402.4
Education & employment	16-17 year olds not in education, employment or training (NEET) or whose activity is not known -%	2018	4,400	5.5	6.6	8.5	5.4	6.8	4.3	5.1	5.3	4.5
	People aged 16-64 in employment	2019/20	1,268,200	76.2	69.0	64.6	72.1	73.8	69.9	77.1	71.5	68.2
	Gap in the employment rate between those with a long-term health condition and the overall employment rate - % points (2018/19)	2018/19	-	11.5	11.6	7.1	14.9	11.8	17.6	11.3	15.3	15.2
	Gap in the employment rate between those with a learning disability and the overall employment rate - % points (2018/19)	2018/19	-	69.7	66.2	64.2	68.7	66.7	70.2	74.5	69.6	57.8
	Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate - % points (2018/19)	2018/19	-	67.6	64.0	61.5	61.7	64.6	66.0	66.0	63.8	64.8
Built & natural environment	Density of fast food outlets - crude rate per 100,000	2014	2,573	88.2	91.6	96.1	83.6	81.7	114.3	54.3	93.7	95.7
	Access to Healthy Assets & Hazards Index: Population living in 20% poorest performing LSOAs - %	2017	550,682	21.1	9.5	8.0	8.7	6.9	20.3	11.0	9.6	5.2
	Air pollution: Fine particulate matter - mean: µg/m3	2017	-	8.9	-	9.8	9.7	8.7	10.1	9.4	9.8	8.6
	Utilisation of outdoor space for exercise/health reasons - %	Mar2015-Feb2016	-	17.9	-	18.4	15.1	20.5	18.2	24.7	18.0	27.6

Compared with England: Better | Similar | Worse

Quintiles: Best | Worst

Source: PHE Public Health Profiles

Housing

Adults in the WMCA with a learning disability and those in contact with secondary mental health services are significantly less likely to be in stable and appropriate accommodation, in line with national figures.

Income

Significantly more children in the WMCA are in low income families compared to England overall. In several areas this corresponds to increased rates of fuel poverty and a household income lower than the national average. National evidence demonstrates that childhood poverty leads to premature mortality and poor health outcomes for adults.[43] Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

Education and employment

Employment rates are also low among adults with a learning disability and those in contact with secondary mental health services. In most WMCA areas the percentage of young people not in education, employment or training (NEET) is lower than the England average, but higher in Birmingham. Overall employment rates across the WMCA are lower than the national average, which may reflect poorer health among adults in the older working age groups.

Built and natural environment

Overall the WMCA has a similar density of fast food outlets to England overall, but this varies across the region, with Birmingham and Sandwell having a higher rate of outlets per 100,000 population compared with the national average. Air quality and access to healthy assets and hazards vary across the region; however there is likely to be substantial variation within localities depending on proximity to town and city centres. Utilisation of outdoor space for exercise or health reasons is similar to the England average for most areas in the WMCA but significantly higher in Wolverhampton; nevertheless this is still less than a third of residents.

Health and Wealth

Global evidence shows that population health is a good measure of social and economic progress. Inequalities in health are not inevitable but reflect avoidable inequalities in society and can be reduced by putting wellbeing at the centre of economic policy. Health and wealth are two sides of the same coin: improving health and reducing inequalities is fundamental to wealth creation and brings a range of social and economic benefits through improving productivity, reducing demand on services, and increasing social cohesion.

An analysis by Liverpool City Region (LCR) found that closing their health and life expectancy gap would increase employment by 5.6 percentage points which equates to an increase in Gross Value Added (GVA) of £3,353 per head. It is estimated that 54% of the productivity gap between LCR and the rest of England is due to ill-health and reducing this health gap would generate an additional £5.2bn in GVA.[44] It can be safely assumed that there would be similar, if not greater, economic benefits for the West Midlands. In addition, increasing healthy life expectancy is likely to have wider implications for wellbeing and quality of life.

- The productivity gap between the WMCA and England is £14.8bn[45], approximately £5bn of which is accounted for by the gap in employment rate (based on 2018/19 estimates).
- In the WMCA, 31% of the working age population age 16-64 is unemployed and it is estimated that 22% (125,000 people approx.) is due to poor health - predominantly musculoskeletal problems and mental health problems, many of which are preventable and/or manageable. This therefore accounts for approximately £1.1bn of the gap in GVA - although the wider health impacts on our economy are likely to be much larger.
- There is a percentage point gap of 9.5 between people in the WMCA with a long -term health condition and the general population (England 10.5).
- For people in contact with secondary mental health services, the percentage point gap is 64.0 (England 67.6).

The economic and environmental impact of COVID-19

Economic shock has been a major consequence of the pandemic, with the measures needed to control the spread of the disease having a significant impact on the national and regional economy. There is substantial evidence on the detrimental impact of economic shock on physical and mental health and wellbeing, for example in times of recession.[46] However, the COVID-19 pandemic has an additional dimension of direct health impacts, which in turn has an effect on anxiety and wellbeing alongside that relating to economic factors. This has contributed to the exacerbation of existing inequalities, both with increasing unemployment in more precarious sectors, and increased risk among those who have needed to attend their workplaces rather than working at home. Some of the people working in the lowest paid and/or least secure jobs have also been those most likely to come into contact with the virus, meaning that they have faced the dual impact of increased infection risk and economic consequences.

There have nevertheless been some positive impacts through changes to ways of working in a number of sectors. With more people working remotely, human benefits have included improved work-life balance and more time to participate in activities to improve health and wellbeing. The increased availability of activities online and rapid adoption of online platforms for face-to-face communication have increased opportunities for social connection and participation in the arts for many who were previously limited by their ability to travel. However, these benefits have not been realised equally across the population. In addition to those unable to carry out their roles remotely, people who are digitally excluded or face additional challenges may be left behind if their needs are not considered. The disruption in

routine human activity ('anthropause') has also shown emerging benefits for the environment and climate, with lockdown measures (most notably the reduction in planned travel) having immediate impact on air quality worldwide.[47] While the longer term benefits remain to be seen depending on the direction of recovery approaches taken, it is clear that there is an opportunity to learn from the pandemic about what it is possible to achieve.

Employment and sector impacts

The State of the Region 2020 report[48] provides a detailed analysis of the economic impact of COVID-19 in the WMCA, considering both the short-term consequences of the pandemic and the implications for economic recovery over the longer term. The report presents a mixed picture for the region, highlighting the following key issues in relation to employment and the economy:

- The West Midlands may face the largest economic decline of all regions at 9.2% (fall in GDP), however it may see the largest growth in 2021 at 8.1%, based on having the largest number of temporary closures and an expectation of most reopening.

- Youth unemployment has almost doubled, with the youth claimant count rising to 41,225 by May 2020 - 8.3% of the young population. It now sits 5th amongst combined authority areas but the rate of increase was much higher than elsewhere.

- Overall claimants stand at 208k, which is 6.3% of the working age population a rise from 115,000 and 3.5% in February, however overall increase in claims has been slower than other areas despite extensive furloughing.

- The number of people furloughed currently stands at 496k in the WMCA area, which equates to 26.9% of jobs. Headline analysis suggests that the public sector (including higher education) and the visitor economy sector will be the sectors most impacted from the Covid-19, followed by construction, manufacturing and retail. Analysis suggests that the life science and healthcare may be the only sector that will be relatively unscathed, but notably it is also one of main sectors that has took the brunt of the human impact from Covid-19.

- The WMCA has the highest level of apprenticeship vacancies compared to other regions (1,643), which is a positive for the region. However this has declined recently, and recent business surveys show a decline in training and apprenticeship opportunities.

- Purchasing Managers Index (PMI) show business activity has dropped from 51.2 (over 50 signals growth, under 50 signals contraction) to 10.9, the lowest levels ever and back to 27.9. However the PMI future business activity is holding up, rising from 55.9 to 62.1 (down from 72.3% signalling businesses are positive about the future once lockdown ends).

While the furlough scheme was generally seen as a positive policy approach by businesses, there is also concern that it may simply be delaying redundancies further down the line if the reduction in consumer spending and business activity continues over the longer term. Regionally, businesses are already concerned about the impacts of lockdown and social distancing measures on trade, and are reluctant to take on debt having already utilised spare funds and resources. There is considerable uncertainty around recovery of the worst hit sectors given the emergence of a second wave and continued lockdowns, including local restrictions in high-incidence areas which are already likely to be more deprived.

As described in our interim report, younger people are likely to be disproportionately impacted by closures due to being more likely to be employed in vulnerable sectors. This presents particular challenges in the WMCA due to the region having high numbers of young people, who also face additional difficulties through disruption to the education system and the weakening of transition points between school, further and higher education and employment.

The pandemic has also brought about changes in culture and behaviour that may persist beyond the crisis period. A reduction in travel, changes to ways of working and changing attitudes to what consumers need and value could have significant implications for economic recovery, particularly post-Brexit. Although there are a number of positive impacts of these changes which are described in the sections below, it is important that businesses are supported to adapt to ensure that existing socioeconomic inequalities are not exacerbated further.

Use of outdoor space for physical activity

Access to outdoor space, particular green space and 'blue' space (i.e. proximity to water) has direct benefits for mental wellbeing,[49],[50] as well as increasing opportunities to participate in physical activity. Access to natural outdoor spaces varies considerably across the region; areas bordering on Green Belt land in Shropshire, Staffordshire, Warwickshire and Worcestershire are very different to the more urban areas in the centre of the region. Yet this is not to say that residents in more urban areas do not have access to outdoor spaces that enable them to connect with nature. Birmingham has 35 miles of canals, which is said to be more than Venice, and they are enjoyed by walkers, runners, cyclists and narrowboaters. Across the West Midlands as a whole, there are 20,534.78 hectares of green space (34.53m2 per person) – 1,032.66 hectares of which are legally protected – and approximately 95% of the population live within a 10m walk of green space.[51] West Midlands residents have a similar distance to travel to a park or public garden at 968m (average distance from an address in the region) compared with an average of 987m for England, and around 90% of addresses in the West Midlands had access to private outdoor space in April 2020 compared with an average of 88% in England.[52]

Research by Fields in Trust (2018)[53] indicated that lower socio-economic groups assign a higher relative value to parks and green spaces than higher socio-economic groups, and urban residents value parks and green spaces higher than the UK average. BAME groups value parks and green spaces more highly than white groups, particularly once income is accounted for, and also tend to use them more for social purposes (e.g. meeting friends, children's activities and sports). Given that the WMCA area is more urban and more ethnically diverse than the region as a whole, our parks and green spaces are a valuable asset in reducing health inequalities in the region.

The WMCA has launched a number of initiatives with national and regional partners to encourage more outdoor activity in local areas. These include *Love Exploring* Black Country developed with Active Black Country and local authorities, which uses a walking app for people to capture their walks and find out about local history and nature; and a Public Space Trial, which has invested WMCA and Sport England funding into co-designing and repurposing sites in some of the most deprived areas of Sandwell, Walsall and Coventry to encourage more people to walk and be active in their local areas.

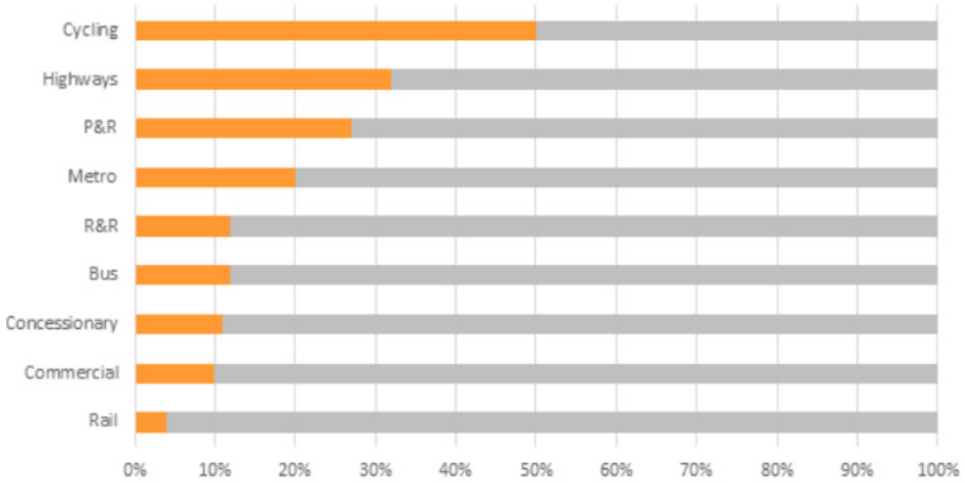


Figure 12a: Demand for different transport modes at Covid-19 peak against usual demand

Source: Phase 1 Public Opinion Survey

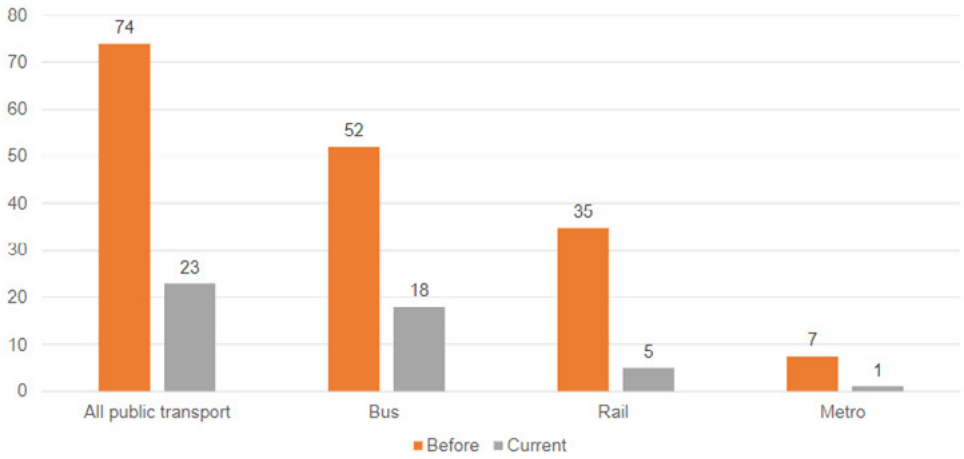


Figure 12b: Current levels of public transport usage before and after lockdown

Source: Phase 1 Public Opinion Survey

Transport and travel

Public opinion survey data from Transport for West Midlands (TfWM) show that the pandemic has seen unprecedented changes in travel demands and behaviours (see Figures 12a and 12b). The immediate impact has been a general reduction in all modes of transport (including car usage) as a result of lockdown. This in turn has had many positive aspects such as improved physical activity, air quality, reduced carbon emissions and safer roads, as more people have chosen to walk and cycle.

TfWM's Health and Transport Strategy (2019)[54] demonstrates how encouraging physical activity by making it easier to walk, cycle and use public transport has significant impacts on everyone's health, such as by reducing air pollution, increasing feelings of safety and creating environments in which people choose to participate and take up active travel. The region's transport network has operated at around 50% to 75% coverage and frequency throughout the pandemic, thus ensuring that our most vulnerable communities and those without access to a car could continue to access vital services (retail/health) and key workers could continue to access work – which was vital during lockdown.

Our transport system often shapes what is possible and impacts on the people and places around it. COVID-19 has given us a new perspective on what our economic, social and environmental priorities are, and what changes may be possible. Therefore, there is an opportunity to reshape our transport network for the better. In surveys of public attitudes during the crisis (covering over 6,000 responses), the majority of respondents wanted to see changes in areas such as cleaner air (81%), reduced traffic on roads/ reduced car use (75%) and improved work/life balance (67%), demonstrating a need for a more inclusive transport system.

Improving the interface between active travel and public transport is key to encouraging uptake. Grants of between £10,000 and £180,000 from the Better Streets Community Fund (BSCF) have been awarded to pay for a range of projects across the West Midlands including better paths, improved street lighting, secure bike storage and safe crossings, with around 40 projects supported across the region. Investment into active travel through the DfT's Active Travel Fund (see section 2.4.5) includes the Living Streets Walk to School initiative, whereby TfWM have local activators to encourage more young people to walk to school with their parents.

1.5 Living with challenges

There are a number of specific groups of people that not only have an increased risk of poor physical and mental health, but social, economic and digital exclusion. These groups are also more likely to face additional difficulties as a result of the pandemic. In this section we address a number of these key groups.

Structural racism and ethnic disparities as determinants of health

Structural racism has been consistently cited both regionally and nationally as a key factor in poorer health and wellbeing outcomes for people from BAME communities, including COVID-19 deaths and complications.[55,56,57] Prof Sir Michael Marmot has emphasised the need to act now on systemic racism and the structural determinants of health, rather than putting it off until the immediate crisis has been dealt with.[58] This is because these are causal factors in the crisis, and addressing them is key to prevention and resilience over the longer term.

A national survey of over 14,000 adults by the mental health charity Mind revealed that existing inequalities in housing, employment, finances and other issues have had a greater impact on people from BAME groups than on white people.

The reduction in access to health and wider services due to control measures is also likely to have a disproportionate impact on BAME groups and people with severe mental illness.[59] Experiences of discrimination and structural racism as barriers to accessing services are well documented,[60] and was a key theme identified through community engagement activities in the region.[61,62,63]

Key observations from the West Midlands Inquiry into COVID-19 Fatalities in BAME communities are summarised in Box 2. Many of these observations were echoed in the submissions received to the call for evidence, particularly around access to care and funding, disruption to ways of life, communication and lack of confidence for change (see Appendix 1).

Box 2: COVID-19 BAME Evidence Gathering Taskforce – Labour party Key observations from testimony

1. Fear of inequitable treatment that might be received in the NHS was a deterrent for many in the BAME asking for help quickly enough
2. Our BAME community experienced an NHS and care system that was overwhelmed
3. Public health messages about symptoms or what to do when in need were poorly communicated by Government to our BAME communities
4. The voice of the BAME community has simply not been heard in the way our health services are designed and delivered
5. The disruption to the traditions and process for grieving has created significant mental health risks
6. Many of the groups that worked with people with long-term health conditions have been underfunded
7. Many BAME frontline workers had direct experience of inadequate provision of PPE
8. Data we need to track the impact of the pandemic is not available, such as ethnicity recording on death certificates
9. A clear strategy for understanding the scientific evidence for the disproportionate impact of COVID-19 on the BAME community has not been communicated effectively
10. Confidence that lessons will be learned and change will come about is low to non-existent

While it is essential to address the role of systemic discrimination and racism in the system, care must be taken to avoid stereotyping and assuming that people from BAME communities all face the same challenges (even within specific ethnic groups) and therefore require the same approaches to engagement. Research has highlighted the importance of language in our communication (even around the term 'BAME' itself, as discussed previously), and the importance of developing 'race fluency' and confidence to enable meaningful and inclusive communication around issues affecting particular ethnic groups.[64]

Vulnerable children and young people

As outlined in section 1.2, facing challenges earlier in life can limit opportunities later on and lead to poorer health outcomes. PHE West Midlands established a task and finish group to focus on vulnerable children and young people, considering the impacts of COVID-19 and identifying ways to strengthen multi-agency working in understanding vulnerability and supporting recovery.[65] Children in care (i.e. those looked after by the local authority); those subjected to trauma, violence and exploitation; youth offenders; and children with special educational needs & disabilities (SEND) were identified as being at potentially increased risk as a consequence of the pandemic.

Children with experience of care have significantly poorer educational outcomes than their peers, which has implications for their future employment and life chances, and there is evidence that the gap persists even when additional needs are taken into account.[66] Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children, including an increased risk of suicide.[67] Providing unpaid care can have a significant impact on carers throughout the life course, affecting their education, employment, relationships, household finances, health and wellbeing. These effects tend to worsen with the more care provided.[68]

Childhood trauma is both a cause and consequence of social disadvantage and inequalities in physical and mental health.[69] In addition to ensuring that disadvantaged children and young people are able to access the opportunities and support they need, it is also essential to adopt trauma-informed approaches in providing this support.

Table 9: Living with challenges in the WMCA – local area comparisons

	Indicators	Period	WMCA number	England	WMCA	Birmingham	Coventry	Dudley	Sandwell	Solihull	Walsall	Wolverhampton
Care and carers	Children in care - crude rate per 10,000 (2019)	2019	-	65	-	67	89	95	109	90	90	102
	Children providing unpaid care (aged 0-15) - % (2011)	2011	6,636	1.11	1.15	1.10	1.37	1.03	1.21	1.03	1.18	1.20
	Children providing 20+ hours/week of unpaid care (aged 0-15) - % (2011)	2011	1,442	0.21	0.25	0.25	0.30	0.21	0.29	0.18	0.23	0.24
	Young people providing unpaid care (aged 16-24) - % (2011)	2011	20,600	4.8	5.6	5.8	4.7	5.8	6.3	5.1	5.6	5.7
	Young people providing 20+ hours/week of unpaid care (aged 16-24) - % (2011)	2011	6,271	1.3	1.7	1.8	1.2	1.7	2.1	1.3	1.9	1.8
	Unpaid carers - % (2011)	2011	77,216	2.37	2.82	2.66	2.50	3.03	3.23	2.48	3.26	2.97
	Teenage mothers - % (2019)	2019	305	0.6	0.8	0.7	0.9	0.8	0.8	0.5	1.4	1.3
	Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs) - % (2018/19)	2018/19	14,140	45.9	46.6	44.0	47.3	47.5	52.2	45.1	43.1	51.6
	Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2018/19	830	32.5	32.4	25.1	38.2	43.4	27.7	28.6	25.5	36.1
Absenteeism & exclusions	Pupil absence - % of half days	2017/18	7,306,605	4.8	5.0	5.13	4.86	5.02	4.75	4.88	4.99	4.62
	Primary school fixed period exclusions: rate per 100 pupils	2016/17	4,735	1.4	1.6	1.95	1.88	1.52	1.27	1.29	1.67	0.75
	Secondary school fixed period exclusions: rate per 100 pupils	2016/17	16,291	9.4	8.5	7.5	11.0	10.0	9.6	8.3	7.6	8.3
	Sickness absence: Employees who had at least one day off in the previous week - %	2016-18	-	2.1	2.1	2.8	1.8	2.6	1.1	1.8	2.4	1.3
	Sickness absence: Working days lost - %	2016-18	-	1.1	1.3	1.6	0.9	1.7	0.9	1.0	1.3	0.7
Injury and crime inc. violent crime	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) - crude rate per 10,000	2018/19	6,715	96.1	113.5	115.6	184.9	85.5	105.6	103.8	93.3	82.7
	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years) - crude rate per 10,000	2018/19	4,940	136.9	120.5	113.9	129.0	105.6	119.9	155.5	110.6	144.3
	Children in the youth justice system (10-18 yrs) - crude rate per 1,000	2017/18	1,686	4.5	5.2	5.2	5.2	4.5	6.4	2.5	3.9	8.4
	First time entrants to the youth justice system (10-17 yrs) - crude rate per 100,000	2018	88	238.5	308.0	377.7	244.8	260.1	239.9	120.3	248.7	423.6
	First time offenders - crude rate per 100,000	2018	5,926	211	238	266	228	174	244	127	206	328
	Reoffending levels - % of offenders who reoffend	2017/18	-	29.1	29.9	31.3	30.0	26.4	29.3	21.1	29.7	30.0
	Violent crime: Violence offences per 1,000 population - crude rate	2018/19	76,186	27.8	26.3	28.8	23.0	22.4	27.2	17.6	25.8	31.2
	Violent crime: Sexual offences per 1,000 population - crude rate	2018/19	7,175	2.5	2.5	2.8	2.4	2.2	2.3	1.8	2.2	2.7

Compared with England: Better | Similar | Worse

Quintiles: Low | Lower | Similar | Higher | High

Source: PHE Public Health Profiles

Care and carers

The rate of children looked after by the local authority is higher than the England average in all areas except Birmingham. The WMCA has significantly more people providing unpaid care than the national average, including children and young people providing substantial levels of care. The population proportion of teenage mothers, who are at increased risk of poverty and poor health if they are not adequately supported, reflects the national average across most areas but is significantly higher in Birmingham, Walsall and Wolverhampton. Social isolation is a key issue for both providers and recipients of care. While more adult social care users in the WMCA reported having as much social contact as they would like, this is still less than half. Only a third of adult carers, both regionally and nationally, have as much social contact as they would like, with substantial variation across areas.

Absenteeism and exclusions

Rates of school absences and primary school exclusions are significantly higher for the WMCA than for England overall, but lower for secondary school exclusions. Among working age adults, sickness absence rates are broadly similar to the national average but the number of days lost to sickness is higher, which may be due to higher rates of longer-term absence.

Injury and crime

Hospital admissions for intentional or unintentional injuries in children and young people are significantly higher for the WMCA than for England overall, and appear to be driven by high rates in a few areas. First time entrants to the youth justice system and first time offences are significantly higher in the WMCA than the national average. Rates of children and first time entrants to the youth justice system, first time and repeat offences, and violent and sexual crimes are consistently lower in Solihull and Dudley, and consistently higher in Birmingham and Wolverhampton.

Disability and long-term health conditions

Disability intersects across a wide range of health, wellbeing and social factors, including physical activity, education, employment and social participation. In addition to increased risk of death from COVID-19, people with disabilities or long-term health conditions are more likely to experience additional health impacts relating to access to services and essentials, and disproportionate social and economic impacts due to existing inequalities.

The ONS Opinions and Lifestyle Survey on the social impact of the COVID-19 pandemic in Great Britain included indicators relating to the impact on disabled people. For the purpose of the analysis this included anyone with a self-reported long-standing illness, condition or impairment that reduced their ability to carry out day-to-day activities. More than 8 in 10 (83%) disabled people compared with around 7 in 10 (71%) non-disabled people said they were “very worried” or “somewhat worried” about the effect that the pandemic was having on their life in September 2020; for disabled people, but not for non-disabled people, this was a similar level to that reported earlier in the pandemic (86% and 84% respectively in April 2020). In September 2020 disabled people reported lower ratings for all wellbeing measures than non-disabled people, and were more worried than non-disabled people about the effect of COVID-19 on their well-being, health, relationships, access to healthcare for non-coronavirus related issues and access to groceries, medication and essentials. People with mental health, social or behavioural or learning impairments tended to be most concerned about the impact of the coronavirus on their wellbeing, whereas people with dexterity, mobility, stamina, vision or other impairments were more worried about access to healthcare and treatment for non-coronavirus related issues. Disabled people were also more likely than non-disabled people to report their treatment was cancelled or never started before lockdown.[70]

Inclusion health and vulnerable groups

People in excluded or marginalised groups are at a higher risk of being exposed to the virus, as well as being more likely to suffer adverse impacts on physical and mental health and wellbeing through social and psychosocial impacts; impact on employment and finance; and reduced access to housing and services.[71]

A people with no recourse to public funds (NRPF)

In the West Midlands region in 2019, there were 5,236 asylum seekers in receipt of Section 95 support - 4,304 (82%) of which were in the West Midlands Metropolitan area, with the vast majority receiving both accommodation and subsistence support.[72] During the pandemic the Home Office made the decision to suspend evictions from asylum accommodation, move some processes online, and extend payments for those granted refugee status until they received their first welfare benefits payment.

However, many asylum seekers are at increased risk of contracting COVID-19 through living in close quarters and sharing facilities with others, in addition to issues around access to testing, facilities and support.[73]

People with no recourse to public funds (NRPF) are at high risk of homelessness and destitution because they cannot access mainstream housing, welfare benefits and employment.[74]

Research by the University of Wolverhampton (August 2020)[75] found that:

- There was a lack of information available for people with NRPF: Only 5 of the 151 local authorities in England had publicly-available NRPF policies which were accurate, up to date and contained referral contact details. More than 40 percent of local authority websites did not contain any information at all about NRPF.

- Only 7 percent of local authority websites surveyed in April had information on COVID 19-related support for people with NRPF. When the survey was repeated a month later, this number had increased to 12 percent. 6 out of 10 organisations who responded to the call for evidence had not received updated information from their local authority since the start of the pandemic.

- Numbers of service users with NRPF who had COVID-19 symptoms were relatively small, but those who did have symptoms were particularly likely to die or become seriously ill: More than half of organisations that responded to the call for evidence knew of service users who had been diagnosed with COVID-19. Although most knew of relatively small numbers who were experiencing symptoms, of those who did, more than half had become seriously ill or died.

- People with NRPF struggled to access food, shelter and subsistence support during the pandemic: The most commonly reported impact of the pandemic was not having enough food. More than 8 out of 10 organisations identified this as a concern for their service users.

The study also found that the most commonly reported difficulty across all user groups was being refused support from the local authority. For those already accessing support, the most commonly experienced difficulty amongst children and families was inadequate accommodation for self-isolation. For adults with care needs, it was being unable to get in contact with the local authority. For homeless adults, the most commonly reported problem was having no provision made for their food or subsistence needs.

Homelessness and rough sleepers

People who sleep rough experience some of the most severe health inequalities and much poorer health than the general population.[76] The average age at death for people who experience homelessness is 44 years for men and 42 years for women – accidents (including drug poisoning), suicide and diseases of the liver accounted for over half of all deaths of homeless people in 2017. A University College London study found that a third of deaths among homeless people were due to preventable or treatable conditions such as tuberculosis and gastric ulcers.[77] This is related to exposure to poor living conditions; difficulty in maintaining personal hygiene; poor diet; high levels of stress; and drug & alcohol dependence. Access to primary care is still a major issue, despite homeless people having the right to register with a GP without identification or a fixed address.

Many homeless people have co-occurring mental ill health and substance misuse needs, physical health needs, and have experienced significant trauma in their lives. Data from the Combined Homelessness and Information Network (CHAIN) in London shows that 50% of people sleeping rough have mental health needs, 42% have alcohol misuse needs, and 41% have drug misuse needs.[78] The COVID-19 pandemic therefore presents additional risks not only in terms of infection, but in reducing access to support services for mental health and addiction problems.

Nationally, the pandemic has prompted rapid action[79] on homelessness, with over 90% of rough sleepers now in accommodation. As of the 1st of May across the WMCA region, over 800 potential and actual rough sleepers have been accommodated as part of the COVID-19 response – with almost 150 having no recourse to public funds. Of those coming in from the streets, 10 returned and a further 40 refused offers of help. The WMCA Homelessness Taskforce has observed evidence of greater engagement with the support and services that are offered, and emphasises the need to maintain and build on this trust as we enter the next phase.[80]

Drug and alcohol dependence

Data from the National Drug Treatment Monitoring System for the West Midlands region show that from February 2020 to date, compared to the average of the same periods between February 2018 to January 2020:[81]

- The number of individuals in treatment and the number of deaths in treatment have increased
- The number of new presentations and successful treatment completions have decreased.
- Numbers of individuals with housing needs have also decreased.

People with complex needs and carers

People with disabilities or complex medical needs are significantly more likely to be at risk of complications from COVID-19 and are therefore more likely to be shielding. Parents Opening Doors (PODs) is a peer led charity based in Telford & Wrekin that involves and supports families of children and young people (aged 0-25 years) who have an additional need, or a disability, or SEND. The charity is becoming increasingly concerned by reports from families regarding a lack of support, and families of children with complex needs who are reaching breaking point. A survey of their members carried out in June 2020[82] found that 71% of respondents were shielding; approximately 59% of families said they were 'doing ok', 26% were 'not doing very well' and around half of these said they were 'doing really bad'.

Many families reported positive aspects to lockdown, including more time to spend with their children and on play, and being able to access activities, music and virtual performances online. However, mental health and wellbeing was a major concern for both parents and children, particularly stress and loneliness. Parents had accessed emotional support from a range of sources, including family and friends (88%), the wellbeing line or befriender scheme (26%), social media (25%), mental health professionals (20%) and faith groups (2%). Many felt abandoned by services and the system, with many cancelled appointments, and there were concerns around furlough and economic recovery. Under half had attended virtual meetings, with 35% of these saying it had worked for them and 8% saying it had not. Some parents did not receive their shielding letters and found that local authorities were slow to react, and felt that CCG commissioning changes needed to be communicated more effectively.

Prison population

People who are incarcerated experience a higher burden of chronic illness, mental health and substance misuse (drugs, alcohol and tobacco) problems than the general public, as well as significantly higher risks of infectious diseases including blood-borne viruses such as Hepatitis B. Members of this group often come from already marginalised and underserved populations in the wider community; improving the physical and mental health of people in prison would benefit wider society as well as individuals, including by reducing reoffending rates. As well as an increased risk of infection from coronavirus for those currently incarcerated, spending more time in isolation is likely to have a detrimental impact on mental health and exacerbate existing difficulties.

Gypsy, Roma and Traveller people

It is estimated that between 100,000 to 300,000 Gypsy/Traveller people and up to 200,000 Roma people are living in the UK. While they have historically lived nomadic lives, they have increasingly moved into housing; the 2011 census for England and Wales recorded 74% of Gypsies and Travellers as living in houses, flats, maisonettes or apartments.[83] In January 2020, the number of traveller caravans in WMCA constituent authorities was 232, with the majority (91%) on authorised sites (i.e. with planning permission).[84] The count of travelling showpeople caravans was 37, all of which were on authorised sites.

People from Gypsy, Roma & Traveller (GRT) communities experience some of the poorest physical and mental health outcomes in society, even when compared with other socially deprived or excluded groups, and with other ethnic minorities.[85] Accommodation insecurity, living conditions, social exclusion

and discrimination are among the main causes. Authorised and unauthorised caravan sites are often in environments that promote poor health (e.g. by busy roads or heavy industry), and a lack of recognition by local councils and communities of GRT people's social and legal entitlements to live and work in their areas has a direct detrimental impact on planning decisions, quality of accommodation, and health and wellbeing, as well as education and employment.[86]

The higher prevalence of existing health conditions, and additional risks presented by insecure accommodation or restricted access to amenities as a result of the pandemic, means that people from GRT communities are at a disproportionate risk of experiencing severe illness from COVID-19. Guidance published by Friends, Families and Travellers for supporting people living on Traveller sites, unauthorised encampments and canal boats[87] sets out key recommendations for local authorities, Traveller site managers and organisations managing canals and waterways to ensure that households can isolate safely and securely, and have access to necessary facilities including water, sanitation and rubbish disposal.

Box 3: Impact of COVID-19 on women

The economic impact of the COVID-19 pandemic on women could potentially result in significant reversals of the progress made over recent decades. Research from the Fawcett Society revealed that women are bearing the brunt of extra childcare and housework, and are losing jobs in greater numbers than men.[88] Women are also more likely to become infected due to being more likely to work in health and care settings, and are disproportionately more likely to be victims of domestic violence and abuse.

A survey carried out in the WMCA area by West Midlands Women's Voice and the Fawcett Society[89] found that four fifths of employed women have seen their job change in some way; more than a quarter are struggling to make ends meet; more than a third say their mental health has suffered; yet very few reach out to support networks. The survey noted some differences between how different demographic groups of women have handled the pandemic, but these tended to be small and usually, consistent across all questions, implying something more to do with cultural response biases rather than specific coronavirus-related demographic differences. Many are using an increase in available time to consider retraining and upskilling. Women in the West Midlands reported feeing positive towards their local and combined authorities - they were keen to access services, believed them to be important, and would feel comfortable in using them.

While 41% of women reported having more time for exercise and keeping healthy during lockdown, 31% reported no change in the time available for these activities, and 21% reported having less time. This is consistent with national data showing that women were more likely to be doing less physical activity during lockdown (see Health behaviours above), and is likely to contribute to a widening of sex-based inequalities in physical activity participation overall. In England, almost half of women (42%) are not active enough for good health compared with approximately a third of men (34%).[90]

Increasing risk of harm through violence and exploitation

The additional risks presented by isolation and social distancing measures to people whose homes are not places of safety has been recognised from the outset. The British Crime Survey reports that only 43% of violence is reported to the police;[91] it is therefore important to develop ways of identifying those at risk in other settings where they may come into contact with public service professionals.

Injury Surveillance to Tackle Violence (ISTV) is a multi-disciplinary initiative led by the West Midlands Injury Surveillance System (WMISS) Steering Group, funded by the Police and Crime Commissioner. The group is made up of multi-disciplinary partners with the aim of monitoring the patterns and trends of violence within the West Midlands. WMISS uses anonymised data on injury related consultations in emergency departments, West Midlands Ambulance injury data and West Midlands Police data across the West Midlands, with the aim to identify the root causes to violent related injury and inform local decision making in mitigating these causes.

A major issue with reduced access to face-to-face services during the pandemic is that there are fewer contact points and opportunities for these individuals to be identified and offered appropriate support. Nationally, Refuge reported a 700% increase in calls to its helpline at the start of lockdown, and a 25% increase in calls from perpetrators seeking support to change their behaviours.[92] The Counting Dead Women project recorded 16 domestic abuse killings of women by men between 23 March and 12 April, which is double the average for that period; this rose to 25 women between 23 March and 20 May.[93] Long-term underfunding of the sector means that there are limited resources and refuge spaces to meet this growing demand.[94]

While much of the focus is on victims of domestic violence and abuse, health, emergency and support services also provide opportunities for contact with victims of exploitation, including modern slavery. The most common forms of modern slavery include labour, sexual and criminal exploitation, and domestic servitude. TAs with domestic abuse and violence, modern slavery is a hidden crime where victims may be further isolated and hidden from view during the pandemic. The Home Office sets out guidance for identifying and supporting victims of modern slavery, including during the pandemic.[95]

Box 4: Digital inclusion and the 'digital divide'

The move towards many jobs and services, including healthcare, to online platforms presents an additional risk for widening health inequalities. COVID-19 has highlighted the 'digital divide', with the factors underpinning digital exclusion often the same as those underpinning social exclusion overall – which increase the risk of poverty and poor health. Just under 60% of individuals from lower income groups do not have access to the internet whereas 99% of individuals within higher income groups do.[96] The barriers by which people are excluded fall into three broad categories: accessibility and affordability of technology; lack of confidence; or lack of digital skills and education.[97] As society shifts more towards online systems and phasing out face-to-face interaction, those who face these barriers will struggle to adapt. As a result of this, the inequality gap will widen, with these individuals becoming more excluded and isolated.

In the West Midlands, 3% of the population do not have a bank account and rely solely on cash as a means of purchasing goods and accessing services. Nationally, 7.5% of adults have never used the internet and within the West Midlands Metropolitan area, 13% of residents have never sent an online message or email. In general, disabled individuals are more likely to be digitally excluded compared to those who are not disabled. 95% of non-disabled adults were listed as recent internet users whereas this was only 78% for disabled adults. However, the internet usage of young disabled adults (age 16-14) is similar to that of non-disabled young adults (98% and 99% respectively), suggesting that digital exclusion is more prevalent among disabled older adults. This is consistent with lower internet usage among older adults in general; almost half of people aged 75+ are not recent internet users, and are also more likely to have issues around hearing, manual dexterity or proficiency with technology that may make digital solutions less appropriate for this group.[98]

Even prior to the pandemic, digital exclusion was contributing to widening health, social and economic inequalities with the gradual shift towards online provision of services and goods, including government forms, bill payments and banking. With more and more services publicised and accessed via the internet, those who are digitally excluded are also less likely to access the unlikely to receive the right information or access the right opportunities and even money saving deals: according to recent government estimates, predominantly offline households spend an average of £560 more per year on shopping and utility bills, compared to families which use the internet to compare prices and access better deals.

During Covid-19 most services and social interaction shifted to online modes (in some cases with a long-term view to retain this, therefore further widening the digital divide and making accessing services more difficult for the most disadvantaged).

During lockdown primary care and outpatient consultations shifted to online, including mental health and drug & alcohol support services – which required service users to not only have the right equipment and internet access, but a physically and psychologically safe space in which to receive that support. Public libraries and local community centres closed, leaving behind those who previously depended on those places for internet access. The tasks which were previously difficult for people who are digitally excluded became impossible with lockdown. Given that the groups who are most likely to be digitally excluded are also those who are most likely to benefit from public services, this is likely to widen existing inequalities among these groups.

Digital technology has enabled an increase in home and flexible working during the pandemic, which for many has increased opportunities to improve work-life balance – for example, by balancing work with care responsibilities and using the time usually spent commuting to engage in health and wellbeing improving activities. However, not everyone has been able to benefit from this due to the nature of their roles; many key workers have had to continue attending their workplaces, including those in low paid and insecure employment. Moreover, low income and older workers (who are more likely to be digitally excluded) are also more like to lose pay as a result of the pandemic.

Section 1 summary

This first part of the report has described the health of the population of the WMCA, and where COVID-19 has had both direct and indirect impacts on health inequalities.

It shows that, whilst most of the population is healthy, there are very large proportions who are not. It shows that health here is not in general as good as the national average. People live shorter lives here and a greater part of their life is lived in poor health. It shows too that much of the risk of poor health is predictable and is linked to the way people live, and that this in turn is shaped by the places where they live. And it is clear that different groups of people within areas have different outcomes, including those relating to COVID-19. In particular, sex, ethnicity, and deprivation, are all shaping the health outcomes of our residents differently.

There will always be new pressures in our society. Many future health challenges are known. For example, we know that our system cannot easily cope if the numbers of people living with long-term disease continue to rise; we know that we can extend length of life through technological advance but that this can be at the expense of quality of life; we know that a rapidly changing population brings new issues of social cohesion and access to services; and we know that issues such as microbial resistance are emerging. We did not specifically know of the emergence of COVID-19, but we did know that any new pandemic would bring premature death and a threat to our health and care systems. It is important that the impact of COVID-19 is specifically understood so that we can build our future differently. In the short term, services are being expanded and are coping. In the longer term, the impact of the disease has been felt disproportionately by the very sectors of the population who are identified in this report as having the poorest outcomes. Those who are overweight or smoke, the BAME communities, and the lower paid have all had the highest risks of complications and death following testing positive for COVID-19. This is not consistent with our national values of a National Health Service and equality. We must make sure that our approach is 'future proofed' and that actions are taken now which reduce health inequalities in the longer term.

Description brings this informed understanding of our population. But this is only of real value if it enables decision-makers to have impact in bringing improvement. The second part of this report outlines an approach to far-reaching and impactful change.

Section 2

Opportunities for change

Local authorities are ideally placed to develop new approaches for improving population health and reducing inequalities, particularly given their focus on place, wellbeing and cross-sectoral working. Working at a regional level also offers a range of opportunities to amplify, support and add value to local approaches through use of devolved powers, partnership working and networks, pooling of resources and expertise, sharing learning and good practice, and scaling up clear examples of good work in the area.

2.1 Closing the health and wealth gap through radical prevention

To reduce widening and persistent health inequalities, a radical shift is needed to put communities at the heart of public health and build healthy, resilient, connected and empowered communities.[99] Radical prevention means taking action as a whole system to tackle the underlying causes of poor health and health inequalities (the 'causes of the causes'), and shifting to more person and community-centred approaches to health and wellbeing.

Figure 13 illustrates the key concepts underpinning a regional approach to radical prevention, focusing on the relationship between health and wealth. This is reflected in the Marmot policy objectives, which remain as relevant during COVID-19 as they always have been, and in the priority areas identified by Coventry City Council for their 2016-2019 Marmot City programme and

priorities for continuing the programme through 2020-2022.61,62 Action at each stage of the life course has the potential to improve health and social outcomes later on; raising aspirations and mental wellbeing in childhood increases likelihood of good educational outcomes, which in turn facilitates employment and career development (Figure 14).

Early intervention and prevention in the early years can have lifelong impact, as well as yielding significant return on investment. Proportionate universalism is fundamental to Marmot principles: balancing universal action on the wider determinants of health with targeted intervention to actively close the health and wealth gap, and improve the health of the most disadvantaged fastest.

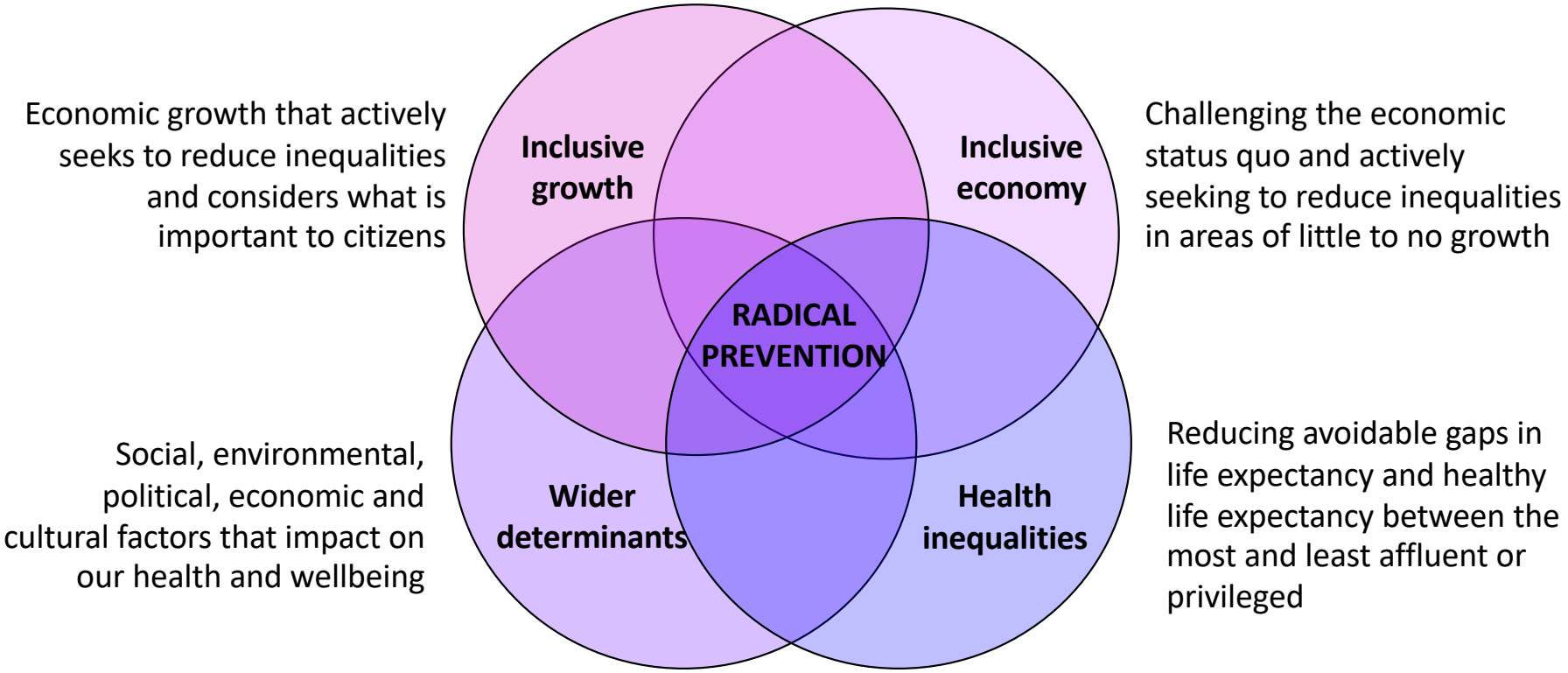


Figure 13: Elements of a radical prevention approach

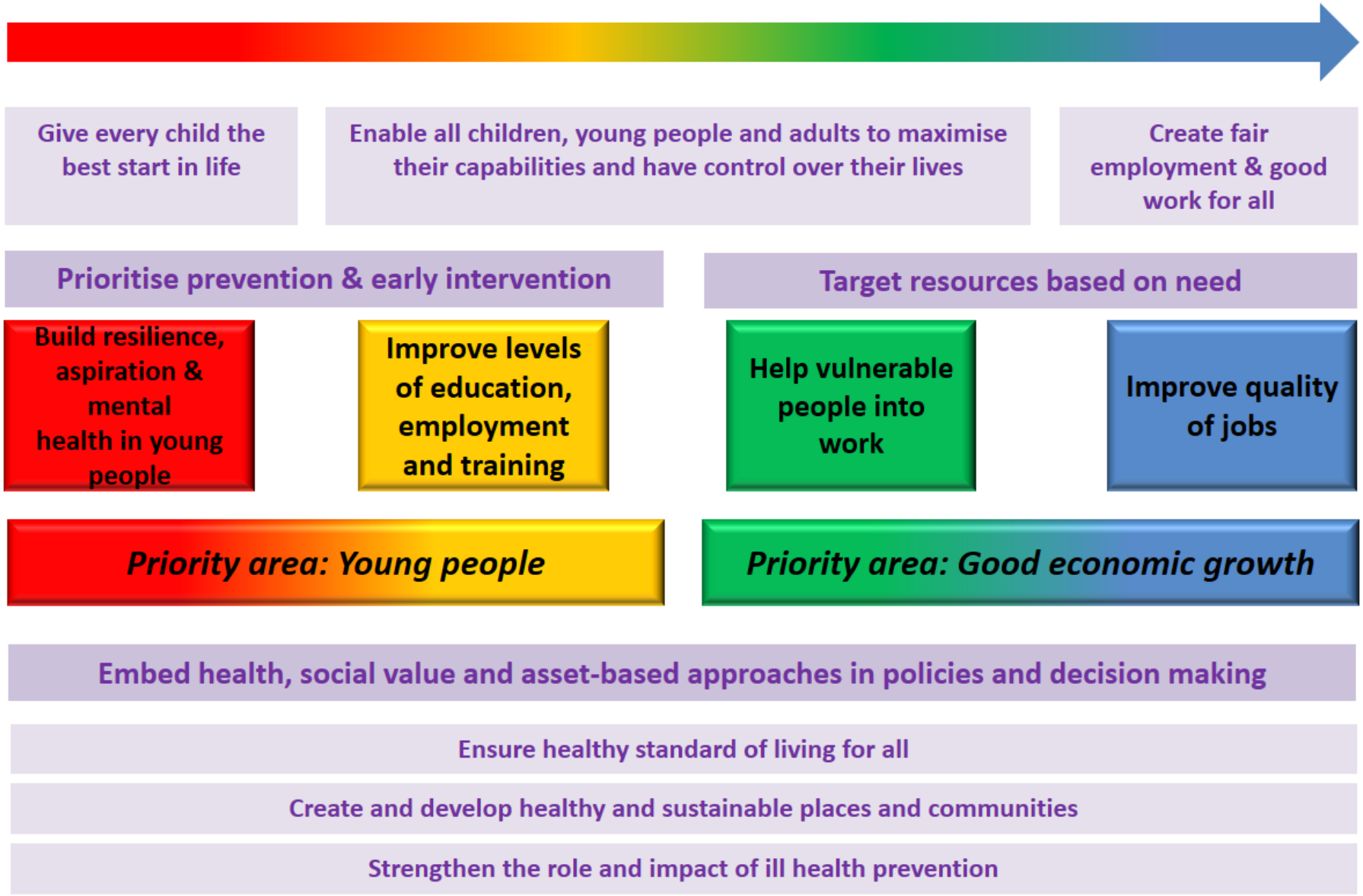


Figure 14: Embedding Marmot policy objectives into economic growth (PHE, 2016)[100]

Many local authorities have taken forward the recommendations and approaches outlined in the 2010 Marmot Review. A survey by the King's Fund conducted in 2011 found that over 75 percent of local authorities had incorporated the approach directly into their health and wellbeing strategies. However, this was in the face of widespread reductions in public spending and intervention in almost all areas, with the poorest areas being the most affected.[101]

Coventry's Marmot City programme is a powerful example of where Marmot policy objectives have been adopted in developing the city and its economy. Evaluation of the programme suggested that the programme helped to mitigate some of the effects of austerity, and that the Marmot City branding facilitated partnership working and embedded consideration of the impacts that Council policies and investments have on health inequalities across the organisation.[102]

The Coventry approach demonstrates the value of cross-sector collaboration and whole-system working, and can be adapted and scaled up to tackle persisting health inequalities at a regional level.

2.2 Inclusive growth within an inclusive economy

Regeneration and economic growth within the region bring a number of opportunities to act on the wider determinants of health. The WMCA defines inclusive growth as "a more deliberate and socially purposeful model of economic growth – measured not only by how fast or aggressive it is; but also by how well it is shared across the whole population and place."

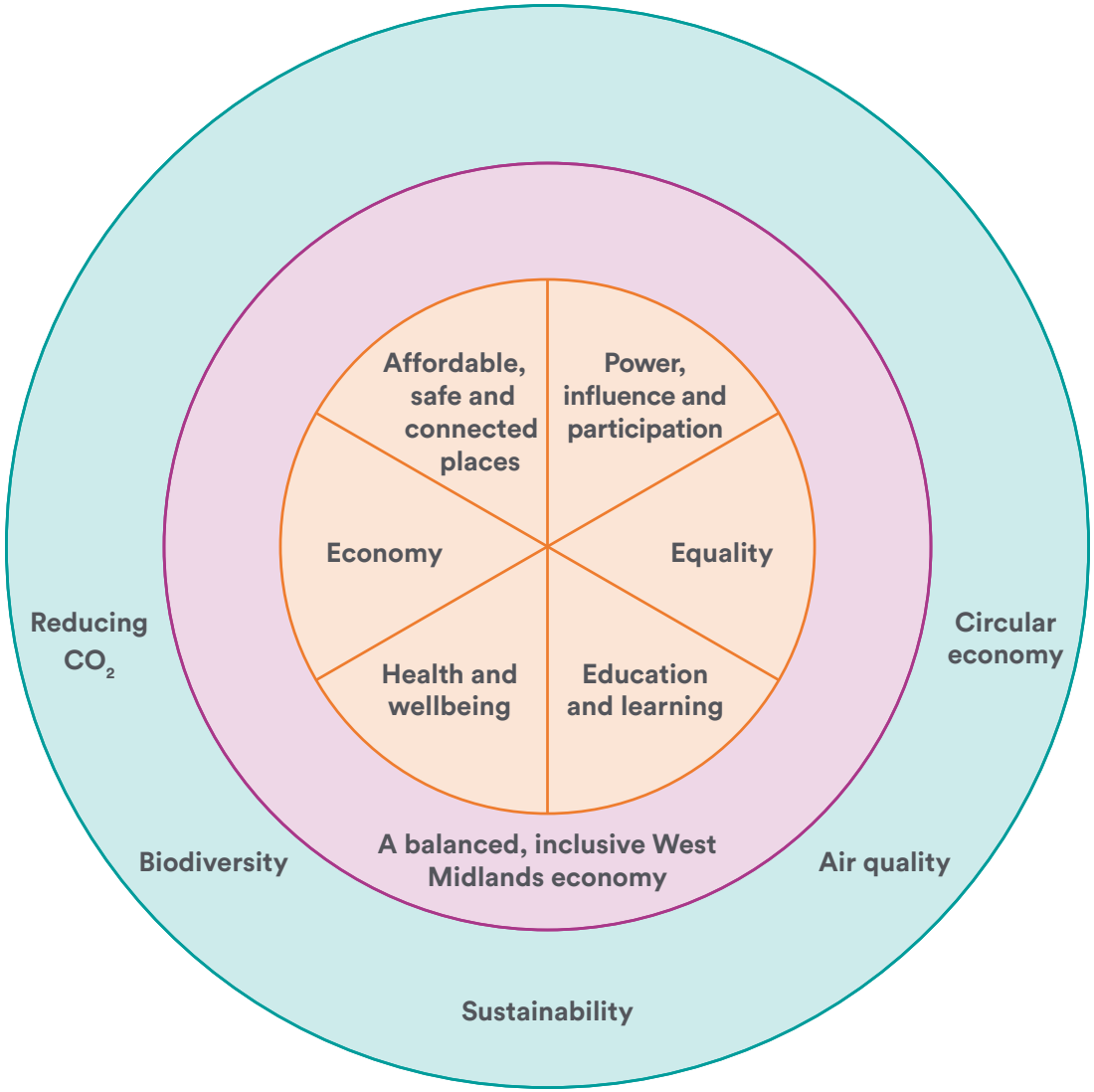
Economic growth has potential to improve population health and wellbeing and reduce health inequalities through improving access to employment, raising income, increasing community safety, improving housing quality and affordability, raising aspirations and improving educational outcomes, providing a high quality local environment and green space, enhancing social relationships and connectedness, and increasing opportunities for participation. A recent report by the Health Foundation found that the COVID-19 pandemic had demonstrated that people's health and wealth cannot be viewed independently and that economic development policies which look beyond narrow financial outcomes as a measure of success can be instrumental in creating more prosperous societies.[103]

In practice, however, people living in deprived communities often see little benefit from economic growth and feel excluded from it. Inclusive growth principles recognise that prosperity is measured not just by Gross Domestic product (GDP) and Gross Value Added (GVA), but by the health and wellbeing of the population and the extent to which everyone benefits from the growth. This means levering current and future policy and investment opportunities in a way that leaves no-one behind, and considering what is important and meaningful to citizens.

It is important to consider inclusive growth within its broader context of an inclusive economy, and to actively seek to reduce existing inequalities across the life course even in areas with little or no current growth activity or where new investment may be limited. An inclusive economy also recognises that not everyone will have or be able to work towards optimal health, but should still be supported to maximise their potential and quality of life. A healthy and resilient population can also be a foundation of creating and maintaining growth, contributing to a virtuous cycle.

Sustainability is a key element of inclusive growth. A balanced, inclusive West Midlands economy (i.e. a fairer, greener and healthier region) is one that balances a thriving economy that meets the needs of all citizens with minimising the environmental impacts of growth, and improving air quality, biodiversity and green space. The #WM2041 strategy[104] sets out WMCA Board ambitions to reach zero carbon 21 years into its 80 year carbon budget, and to address the climate crisis in a way that is fair, inclusive, and promotes economic prosperity within the region.

Figure 15: A Framework for Inclusive Growth
Population Intelligence Hub and Inclusive Growth Unit – based on Kate Raworth, Doughnut Economics (2017)

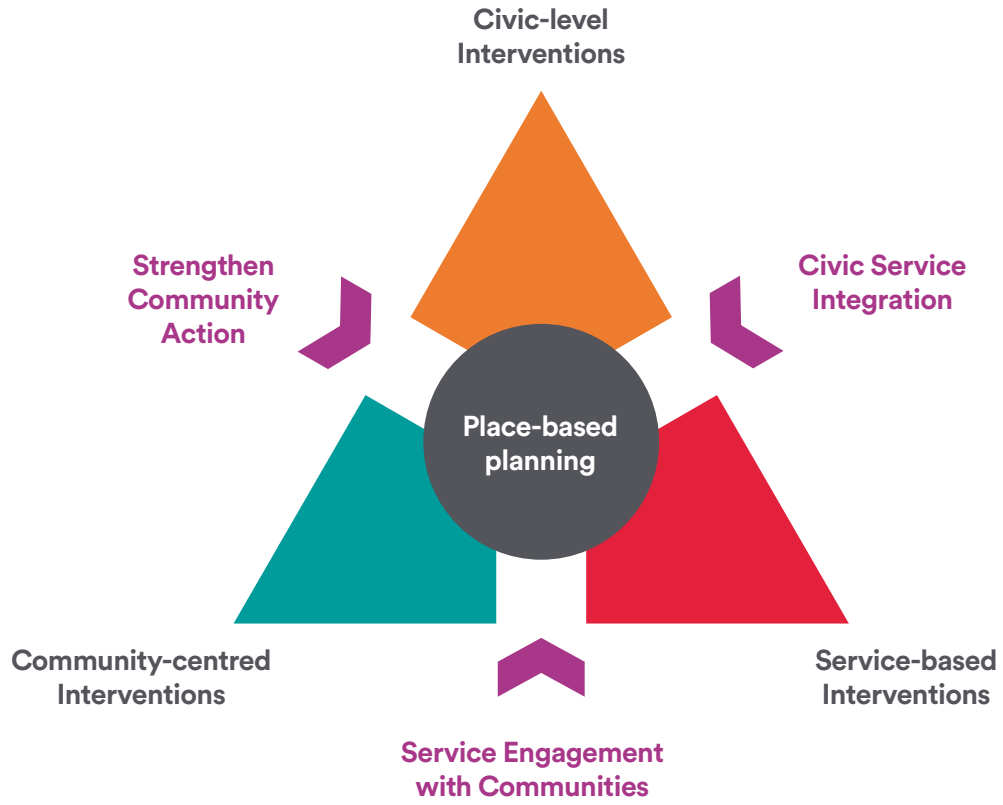


2.3 Place-based approaches and community-centred public health

Areas of high deprivation are often characterised by more transient populations where people move on once they start to do better, so health outcomes appear to show no improvement over time. Focusing on improving places and systems rather than targeting individual behaviour change helps to create environments where people want to live and work, and bring about sustainable positive change.

Place-based working enables the development of system-wide, population level interventions through focusing on engagement between civic organisations, services and communities.[105] This is known as the 'Population Intervention Triangle' (Figure 16). At the civic level, adopting a 'health in all policies' (HiAP) approach can help to embed health improvement and the reduction of health inequalities across policy areas acting on the wider determinants of health.

Figure 16: Components of the Population Intervention Triangle



2.3.1 Anchor institutions

As part of this approach, working with 'anchor institutions' such as the local authorities and NHS Trusts can help to embed innovation and good practice locally. Anchor institutions are defined as large, typically non-profit organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors have 'sticky capital', i.e. their connection to the local population means they are unlikely to move, and have considerable influence on community health and wellbeing.[106] Anchor institutions provide opportunities to look inward in relation to systemic inequalities and discrimination in our own organisations, for example in addressing pay and leadership gaps, and promoting healthy and inclusive working practices.

2.4 Local application and developing opportunities for action

Our interim report and call for evidence identified a range of stakeholder activities in responding to COVID-19, many of which are drawing on these approaches and principles. A summary of these activities is provided below, building on the opportunities for action set out in the interim report and Box 5. Selected case studies provide examples of these activities, highlighting the role of faith, community and voluntary sectors in engaging with local residents, and the importance of partnership working and use of population health intelligence to improve ways of working across systems.

Box 5: Opportunities for action on health inequalities in developing the regional approach to responding to and recovering from COVID-19

1 New **public focus** on **health inequalities** and public health, including the recently launched national strategy for tackling obesity

2 Increased **public awareness** of **infection control**

3 Promoting **physical activity** as an opportunity to be outdoors, socialise, get around safely and improve wellbeing, in line with regional and national strategies.

4 New ways of working that maximise use of **technology**, enabling more flexibility and improving work-life balance as well as reducing environmental impact – working to ensure equal access to these opportunities and reduce digital exclusion

5 **Changes** to local **delivery models**

6 Role of **communities**, for example in driving a **collaborative** approach to **population health management**

7 Workstreams to ensure that **BAME** inequalities are considered in all aspects of **response** and **recovery**

8 Drawing down resources to help address **structural inequalities**, for example through a formal submission to the comprehensive spending review

9 Understanding **lessons learnt** from the first wave from a healthcare perspective

10 **Pooling** and sharing of **intelligence** and engagement **resources** and analysis as a regional health systems network

Longer term opportunities:

11 Developing a **Health in all Policies** approach to embed consideration of physical and mental health across all WMCA policy areas

12 Using the **Thrive** model to improve workforce health and wellbeing, and to address inequalities in education, skills and employment across the region in line with inclusive growth objectives

13 Maximising the potential of the 2022 **Commonwealth Games** to drive down inequalities and deliver a lasting legacy that undermines inequalities, especially in communities hit hardest by COVID-19

14 Supporting **regional collaboration** to tackling health inequalities, especially for groups such as the homeless and migrant populations

15 Working with communities, and local and national partners, to improve the recording and routine analysis of **demographic data** so that we are actively monitoring inequalities and demonstrating progress across the region (e.g. in relation to death certificates recording of details such as faith and ethnicity)

16 Supporting **local governments** in their ambitions to protect and improve the lives of local citizens and work with them to ensure adequate funding for the public health function that has been so important in responding to the current crisis

17 **Devolution** presents a significant opportunity to co-ordinate action across the system in local recovery to improve the wider determinants of health, working in partnership with stakeholders across localities and sectors

2.4.1 Crisis response

The acute response to the pandemic has, understandably, been the focus of activity across organisations in the region, particularly to ensure that the most vulnerable citizens are supported. However, this has not happened independently of longer-term change to address health inequalities. In many cases, the emergency response has provided the foundations to establish new ways of working and strengthen relationships with communities and partners.

Case Study: Birmingham City Council - Food parcels for clinically shielded & vulnerable people

During lockdown, 7,395 clinically vulnerable people across Birmingham were receiving weekly food parcels, with around half of these provided by Birmingham City Council. A Food Hub was established at Wholesale Markets, where supplies were sourced, stored, packed and distributed via National Express Accessible Transport.

Although initial deliveries were standard food parcels, the council also catered for limited dietary requirements in response to population needs, including diabetic, gluten-intolerance, nut allergy, halal and vegetarian.

The council's Emergency Community Response Hub also ensured that people who were not shielding but still experienced difficulty accessing food supplies were also able to receive emergency food supplies. Those included people over 70, those self-isolating due to illness, pregnant women, and people receiving support through adult social care. The Hub also signposted and connected vulnerable citizens without assistance from family or friends to help and support. Citizens with existing support networks (e.g. family and friends) were asked to continue to use this so that the council could focus on those most in need.

Case study: Birmingham City Council – Supporting rough sleepers and responding to homelessness during the pandemic

A number of challenges and barriers were identified for Birmingham's homeless population, including:

- No beds available in the acute wards for mental health (one specific example found that an ambulance was called but the person was later released with no support)
- The helpline provided did not give the support needed
- The mental health support had been positive when accessed via the health exchange, but if people already had a diagnosed / treated for mental health problem then it was sometimes more difficult to get the support needed from their registered provider
- Many individuals have problematic substance misuse issues
- Drop-in centres closed during lockdown – a Housing Options offer was established at Washington Court which has now moved to Sifa Fireside
- Pre-COVID-19, rough sleeping went down to single figures at height of lockdown; however, numbers have since started to rise again (in the 30-40 age range)

An operation to get rough sleepers inside during the pandemic was largely successful – beds were initially secured with Holiday Inn and accommodation was then found for the majority of people (e.g. some people were moved into BCC flats, supported housing and emergency housing).

It was clear that a change of approach was needed regarding the new housing options offer, as the majority of people were referred into non-commissioned exempt-supported accommodation. Given the number involved, this represents a significant dependency on this sector and should be approached with caution. The Council is working to strengthen its control of standards and a support team is being commissioned to follow up on each person referred.

2.4.2 Community engagement

Across the West Midlands region there has been substantial engagement with communities in local areas, by local authorities, services and the voluntary & community sector to understand how they have been impacted by the pandemic and the support they need. This is not just in relation to COVID-19, but with long-standing health and wider issues that have placed some communities at greater risk of the virus itself and the economic impacts. This is an area where it is particularly important to build on the work that has been done to reinforce relationships and develop networks over the longer term.

Case study: Outbreak Management Plan, Lye

At the outset of the Covid-19 outbreak, it was recognised that migrant communities could be especially vulnerable to the impacts of the virus, particularly over the lockdown period. Within Dudley Borough, Lye has a relatively large Roma population, and so partners acted quickly to consider the challenges for the community and plan a response.

Representatives from community safety, neighbourhood policing, primary care, access and prevention, family support, the local church and Public Health met in March to consider the particular vulnerabilities of the community and the assets that could be called upon to address these. Key concerns included language barriers to understanding health protection messages and access to the resources needed for people to support themselves and their families during lockdown.

An action plan was developed which included:

- Establishing routes for the distribution of food and essential supplies, including a foodbank based within the church and door-step deliveries
- Translation and dissemination of key public health messages through a range of avenues, from word of mouth, recorded messaging on community Facebook pages and leafleting

- Facilitating application processes for benefit claims
- Connecting members of the community to housing support
- Re-establishing elements of the Lye Community Project support to the Roma community in a Covid-safe form

All partners supported implementation of the plan, with Roma community members assisting food distribution efforts. Public Health's Roma Community Development Worker was key. Using her unique relationship with the community and language skills, she provided a trusted source of information and support and facilitated access to services.

The community have been hugely appreciative of the assistance provided. Their feedback suggests that people were enabled to come through the crisis well, that they have felt valued, and could rely on services for the help they needed.

Case study: Legacy WM - wellbeing promotion, physical activity & nutrition for Bangladeshi women107

Legacy West Midlands is a registered charity that has its roots in celebrating the heritage of post-war migrant communities in Birmingham, highlighting their relationship to the industrial, architectural, and cultural heritage of the city. The charity is based at the community heritage site of Soho House in Handsworth, and delivers projects in the northwest inner-city wards of the city.

A research project on food journeys in the Bangladeshi community revealed that the health of first-generation migrants was better than that of their children and grandchildren; funding was subsequently allocated by National Lottery to focus on the health of the local community through a project called Family Fit, which focused on health improvement from the whole family. Women were particularly engaged and keen to participate in health services.

Having the flexibility to go to out to wherever our community are makes it as easy as possible for people to participate in activities, and particularly removes some of the barriers for women – for example, work in schools with mothers after they drop their children off in the mornings. The charity undertakes non-clinical health MOTs and runs various programmes including Zumba, Yoga and Food Nutrition, working at a number of local sites including Aspire & Succeed, Saathi House, Lozells Recreation Centre and Birmingham Asian Resource Centre.

Legacy WM's Zumba sessions for women include a significant number from the Bangladeshi community, with some sessions sometimes having up to 40 participants.

"These women only sessions show the truly multi-cultural aspect of our work, with women entering the sessions wearing their hijab and niqab, and warming up to Ed Sheeran!"

Case study: Mosques and the Muslim Community in Dudley Borough

Engagement with Mosques and the Muslim community in Dudley Borough has been an important strand within the Covid-19 response. The closure and subsequent reopening of places of worship has presented significant challenges across faith communities and many worshippers fall within one or more vulnerable groups.

Proactive contact was made with Mosques at an early stage in the pandemic, with a view to opening channels of communication to share information and respond to any concerns or needs for support. In some parts of the Borough, relationships were already established, in others, this was an opportunity to make a connection.

Public Health's engagement with and support to Mosques has included the following:

- Providing resources and information for Mosque leaders to share with their community
- Remaining in touch with Mosque representatives to ensure any concerns or queries can be raised and addressed
- Responding to requests for specific information, including translation and design of materials
- A virtual meeting for Mosques with Health Protection to provide an opportunity to explore safe reopening
- Joint-working with Brierley Hill Mosque, which has acted as a central contact for several Mosques in the area, disseminating information
- A Mosque representative is part of the Test and Trace Sub-group membership for voluntary, community and faith settings

Overall, representatives from the Mosques have been appreciative of the information and resources shared and the opportunity to liaise with Public Health for support during the Covid-19 pandemic. The connections established have ensured that potential problems can be voiced and that the latest guidance is applied.

2.4.3 Data and intelligence

Improving data and intelligence, particularly around the recording of ethnicity in health and care settings, has emerged as a key priority for longer-term system improvement to address health inequalities, both regionally and nationally. However, activity in this area has also focused on using population health intelligence to understand the relationship between existing inequalities and the impacts of COVID-19, and to address issues with access to services and research. For example:

- **Report on Impact of COVID-19 on Inequalities - Solihull Metropolitan Borough Council** – The report brings together the existing national evidence and analyses the probable impact on different groups. The Council is in the process of developing a targeted Health Inequalities Strategy.

- **West Midlands Language and communication service needs assessment - Health Protection Team, PHE West Midlands** – Report included a descriptive study that aimed to provide a picture of the language and communication need within the health protection response in PHE WM, and the commissioning processes used by other PHE Health Protection teams for language and communications services.

- **West Midlands Air Quality Improvement Programme (WMAir)** - Research supporting the improvement of air quality, and associated health, environmental and economic benefits, across the West Midlands, with rapid analysis of the impacts of COVID-19 related emergency public health measures (March – May 2020) upon nitrogen dioxide (NO2) and particulate matter (PM) levels in Birmingham City.
  - Key findings:
    - Reductions in NO2 concentrations associated with COVID-19 were of greatest magnitude for those living at the inner city and near-roadside locations, including areas of high deprivation.
    - Changes were less marked in the north-east of the city; the location of more affluent (upper income quintile) LSOA areas. Further (ongoing) research is required to better characterise these impacts upon different ethnic groups, including linkage to health outcome measures.

2.4.4 Workforce wellbeing

It is recognised that workforce wellbeing is integral to reducing health inequalities, particularly in anchor institutions. While this is partly about ensuring that staff in health and other public services are equipped to manage the challenges in their roles due to changes in priorities, scope and context, there is also an opportunity in terms of representation and improving the experiences of staff from diverse backgrounds.

- As part of their wider approach to reset and recovery, Sandwell MBC have a **Staff Impact Working Group** led by the Interim Director of Human Resources that has drawn on existing networks, HR data and staff engagement activities to capture experiences, views and thoughts from the workforce. Key messages from the group are that although staff have coped well with adapting quickly to a new working style and maintaining service delivery in adverse circumstances, it is recognised that this style of working has not suited everybody equally for a variety of reasons. The findings from this work will be used to define the new operating model and embed this within the organisation, balancing staff needs with the organisation's needs through continued regular communication and improvement of communication mechanisms in light of remote working - particularly with the frontline and those without remote access.

- **Birmingham & Solihull CCG** are developing updated ways of working with staff and communities, which includes establishing a Health Inequalities Task Group, which has set out priorities for action in the next 1-2 years. This includes using the role as an 'anchor institution' to promote economic prosperity and to support staff.

2.4.5 Innovation and system change

As well as an increased focus on health inequalities, the pandemic has provided opportunities to explore new ways of working and to collaborate across systems to develop interventions and approaches to addressing health inequalities – both within and across organisations.

- **Black Country and West Birmingham CCG Wider Determinants Programme Advisory Group** is undertaking a programme of work including a report looking at the system's response to COVID-19 and lessons learnt; Phase 1 programme looking at wider determinants of health; and Phase 2 programme focusing on designing, appraising, implementing and evaluating interventions.

- **West Bromwich African Caribbean Resource Centre** redesigned its services to support the community during first wave and flagged a lack of funding to increase their offer, especially for second wave. They are working with the local CCG to hold online workshops (report to be published) and make recommemndations for CCGs to carry out Equality Impact Assessments.

Case study: Emergency Active Travel Funding to Transport for West Midlands

As part of the Department for Transport's allocation of its Emergency Active Travel Funding to Transport for West Midlands, the WMCA invested Active Black Country* to deliver an 8 week social prescribing of walking and cycling programme in collaboration with its 4 Primary Care Networks (PCNs).

The programme focused on testing the effectiveness of different methods in getting health care professionals to signpost people to walking and cycling and based on 3 stages.

- **Recruitment:** Each PCN identified a group of 10 patients who they felt would most benefit from getting them to walk and cycle. This included people with hypertension and from migrant communities and those who practices identified as pre-diabetic, 67% of participants across the 4 PCNs were from BAME communities and predominately male.

- **Advice and Guidance:** A consultation with the patients and provision of an e-resource providing details on local walking and cycling opportunities and the benefits of taking part.

- **Activation funding:** a £50 personal budget for half of the patients involved in the programme to see if this provided greater incentives to get walking and cycling e.g. footwear, bikes and travel passes.

The 8-week programme is coming to an end and has evidenced that 70% of patients taking part reported an improvement in physical health, 67% improvement in mental health and 93% stated they planned to continue being active.

The programme also identified the importance of companionship in encouraging people to be active and the importance of health care and physical activity sectors working better together. There are many lessons learnt including greater collaboration with PCNs and an opportunity to secure additional funding longer term.

Michael Salmon, Head of Insight, Health and Wellbeing for Active Black Country said:

"Active Black Country is working hard to ensure that all health care professionals, along with dedicated social prescribers, have the knowledge and resources required to signpost patients and clients to community solutions where appropriate. The resource that we have developed is a great way to encourage patients in primary care to access the wonderful parks and open spaces already available within their local community for the benefit of their health and wellbeing."

***Active Black Country is one of the national network of Sport England funded Active Partnerships and is the strategic lead for sport and physical activity across the Black Country**

Case study: St Margaret's Unity Hubb[108]

This is a church supported project that uses church premises, but has been set up as a non-faith trust. Running out of a beautiful church building whilst meeting the needs of the very diverse local community, working specifically with women, was something Unity Hubb was excelling at before lockdown. They have managed to rethink their activities. They started by delivering seeds, plants and compost to local families; in the first week to 43 families and then for some weeks to 15-20 families.

They transferred many of their activities onto Zoom. For example, they have delivered:

- A cook together eat together event
- Family crafting sessions where they delivered craft packs and an artist helped them over Zoom to be creative
- Chai and chats

Rashta Butt, the Development Worker has also carried out one to one chats on the doorstep to a few of the most isolated of their participants. They have promoted the church's food bank, but also built on the goodwill in the community and collected for the Feed Birmingham campaign with a box outside the church.

Recognising how much the women were loving planting and also how many of the older generation had grown up in agricultural communities and had skills to pass on Rashta set about persuading the local allotment team and the existing plot holders that they could take over a plot. Thus, the "Diverse Garden" started in lockdown. The plot has been divided into ten so each participant can manage a small area, but take pleasure in what they can achieve. Other planting and crafting activities take place on a Tuesday. The next plot has been handed over, which is testimony to the project's success.

Even on a rainy Tuesday in October, 14 women turned up; three with children to plant, chat and do other activities. That is real indication of what has been created; a diverse community with connection and purpose.

Case study: Redeemer Church, Northfield - Supporting the Local Community[109]

This church has adapted its offer to meet a wide variety of local needs. This has included food shops, food parcels, connecting people to the local food bank, pharmacy runs, gas and electric vouchers, referral, and one off events such as an alternative Halloween party for children with activity and snack packs and supporting the Northfield VE Day on your Porch initiative. They have made regular welfare calls and stayed in touch with their usual participants to check what they may be needing, even doing some of these at a distance in the front garden. They have made a point of celebrating events such as delivering a birthday cake or holding a mini birthday party.

They have used available funding to buy a few participants' tablets and have worked with them to get wifi access and to be able to join activities. Their approach has also not just been delivering services, but creating connected communities. One example is of two men who had previously met at a Redeemer Church event. They connected them up; co-ordinated one to do the other's shopping, and covered volunteer expenses.

Through lockdown, they ran a virtual coffee morning each week, which some people attended every week. Since then they have managed to restart their Place of Welcome, working within the social distancing restrictions. They are working on a community craft project: embroidered bunting for the centre they use to remember this year! They have also organised some get togethers of over 50's picnic lunches (5 guests and one from the church team) in their garden.

Since lockdown lifted, they have been holding a mobile coffee morning which has enabled them to find and connect with more isolated and vulnerable people on the estate. It has also meant they have been able to effectively signpost and partner with local organisations, referring people on for help with social care, foodbank, gardening and more. They go out with a car, individually wrapped pastries and coffee and tea and knock on every door of a chosen street. They serve people a drink and have a chat on the doorway, in a socially distanced way. They also have activity packs for children to distribute to under 5s. In addition, in the first three weeks they made two referrals to Adult Social Care, three to a local project, Futureproof, bought a bed for an elderly man, an oven for an older woman.

Finally, they are running an all generation's outdoor fitness group and a running group to ensure there is a safe way for local residents to get fit and healthy.

In addition to providing support to people on their local estate they feel they have ended up connecting more deeply with the area and working alongside council organisations in a way they would not have done otherwise.

Case study: St Germain's Church, Edgbaston[110] – Food distribution project

St Germain's Covid-19 Community Response Team was established in April 2020 to meet the growing needs of the local community. Initially they delivered food to those in need. They have also provided a cooked meals service as they found many households in need did not have facilities or were unable to cook food. A volunteer cook can produce halal food and culturally appropriate meals and there is always a vegetarian option.

Once lockdown lifted they encouraged those in need to come to the church to collect food and are open three days a week. They give out 60-80 food bags each week, feeding around 160 people.

They have not found the demand going away and even by October half term were cooking 180 meals each session so 360 each week, feeding around 160 households each week. They work closely with four hotels and a couple of hostels in the immediate vicinity which are current home for people who are homeless, have been subject to domestic abuse and are asylum seekers. As with other vulnerable households they delivered food to many of these families in lockdown and latterly encouraged them to come into the church.

They recruited over 30 volunteers of all faiths and none. People come to the front door asking for help and they are encouraged to become volunteers too. In October 2020 six of the volunteers had been recruited in this way. They also have support from members of the local community and many faith groups. They have regular donations, for example, from a Sikh gurdwara, a group of Muslim women who collect and deliver tins of food and church groups which organise street collections for them.

The approach they take is broader than just food. They help connect their families to other services too. One example is the asylum seeking family of nine, soon to be ten. One of the volunteers who can speak Arabic has helped secure a school place, has ensured the hostel moved them from a small single room to two rooms, made a referral to the babybank for the forthcoming baby and introduced them to Migrant Help.

They have collected resources, for example, winter coats and shoes and to pass on to people. If they find that people need a particular thing they do a shout out to the community and can usually source what they need.

In the summer they opened for an additional day in the summer for families to come in. they provided different activity packs every week to take away. They were able to spend more time with people and tailor support to their needs.

Finally, they have an emotional wellbeing service which is non-Christian counselling and also referral to other services such as drug and substance recovery. This service operates three days a week.

As well as providing support to hundreds of people they suggest it has exposed is a level of need that people did not know about previously.

Section 2 summary

There is a two-way relationship between health and wealth on both an individual and population level. Inclusive growth and its role in reducing health inequalities needs to be considered in its broader context of an inclusive economy and wider determinants of health. Radical prevention means taking action as a whole system to tackle the underlying causes of poor health and health inequalities and shifting to more person and community-centred approaches to health and wellbeing, in line with inclusive growth principles.

Tackling health inequalities at a regional level means understanding how to lever current and future policy and investment opportunities in a way that benefits everyone, and actively seeks to reduce existing inequalities across the life course. However, the relationship between civic organisations, services and communities at the local and regional levels is crucial to understanding the unique populations, needs and assets in each area, and where working as a regional collective might enable us to amplify and add value to local approaches.

Despite the obvious challenges, the coronavirus pandemic has also highlighted ways to work differently and opportunities for positive change across the whole system – particularly in relation to engaging with communities and learning from the excellent work of the voluntary and community sector in understanding what is important to our citizens and the challenges they face. The final part of this report considers these opportunities in the context of the key issues underpinning disparities in COVID-19 outcomes and wider inequalities in health and wellbeing, identifying commitments to action by local and regional stakeholders and recommendations for national government that would act as a catalyst for this change.

Section 3

Commitments to action and recommendations

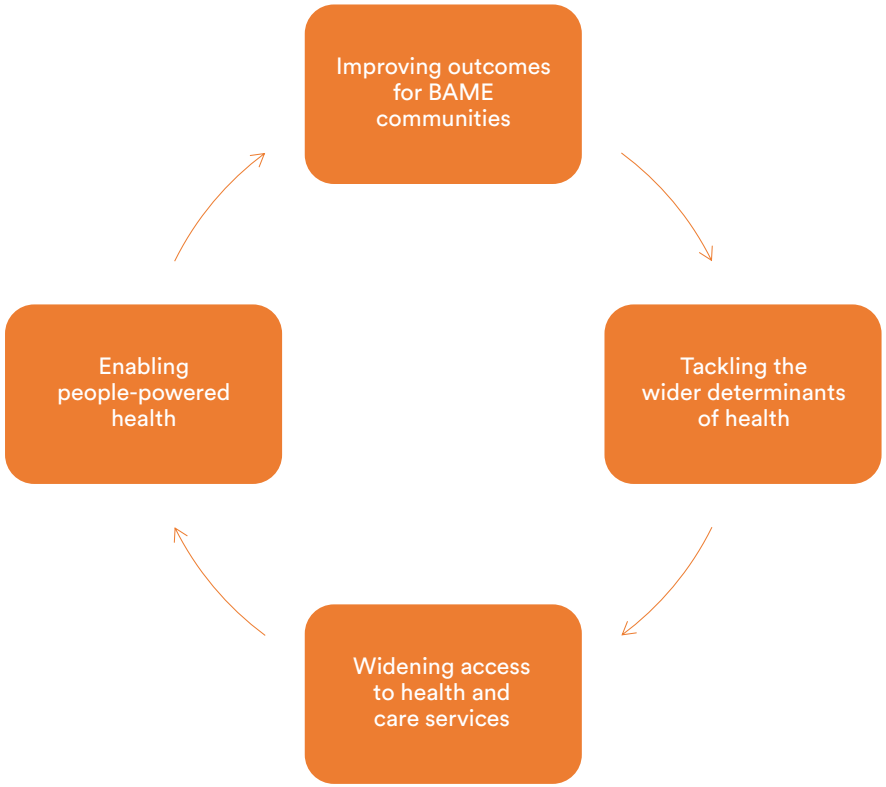
Public Health England has produced two significant reports on the impact of COVID-19 on particular communities. Its first report confirmed that COVID-19 has replicated and, in some cases, increased existing health inequalities. And in its report on BAME communities, it identified a number of reasons why death rates have been significantly higher amongst Black and Asian ethnic groups. Both reports emphasised the role of prevention through improving the wider determinants of health, and more equitable access to health and wider services.

This is in line with the issues highlighted by WM Citizens' Panel, which identified accessing healthcare and improving physical health as key components of community recovery. Alongside concerns about how to keep safe from coronavirus, panellists were particularly concerned that the healthcare system could get back on track to diagnose and treat people. They also identified the importance of preventative issues – promoting healthy living to reduce demand on services and tackling the deeper causes of poor health.

This final section of the report is framed around 4 big challenges that arise from this analysis.

- We must begin with the urgent task of **improving outcomes for BAME communities**. Targeted and immediate action to tackle structural racism is an urgent and immediate priority.
- But lasting change will only happen when we take a systemic approach to **tackling the wider determinants of health** and dealing with the structural inequalities we find in our economy, housing market, education, justice and transport systems.
- Similarly, we must tackle inequalities in the health and care system and **widen access to health and care services**. This requires a fundamental rebalancing of funding and focus on primary and preventative care.
- These challenges, in turn, will create the conditions in which **people-powered health** can flourish and healthy lifestyles can become the norm.

The 4 challenges are set out in the diagram below.



In the final section of this report, we take each of these challenges in turn and address two responses:

- Commitments to action – these are the activities that key stakeholders in the region are already undertaking, or are planning to undertake, that are seeking to address the challenges that have been identified – these are divided into commitment on the part of the WMCA and commitments made by other stakeholders.

- Recommendations to government – these are changes required of central government in order to unlock change in the region.

1. Improving outcomes for BAME communities

This report has shown clear evidence that the coronavirus pandemic has both exposed and exacerbated longstanding inequalities affecting black and minority ethnic (BAME) groups. The risks of catching COVID-19 and dying from it have been shown to be higher for BAME groups than in White ethnic groups. There are several inter-related factors that might contribute to this disparity. Individuals from BAME groups may be more likely to suffer from other chronic conditions; they are more likely to work in occupations with higher risk to COVID-19 exposure and more likely to use public transport to travel to their places of work; and the risks of transmission and morbidity can be exacerbated by the housing challenges faced by some members of BAME groups. Pervading all of this, BAME communities experience systemic discrimination and racism on a daily basis which directly affects physical and mental health and has been shown to affect access to health services.

A whole-system approach to responding to and recovering from COVID-19 must address these issues head on. All public institutions need to monitor and evaluate the extent to which systemic discrimination affects their services and working practices. BAME groups must be better represented in their workplaces and NHS and other health and care bodies should commit to relevant race equality standards.

WMCA Commitments

- The WMCA's independent Leadership Commission will make advancing opportunity and mobility within the health and care sector a key priority in its new implementation plan and work with partners on action to achieve this.
- WMCA will develop a targeted Thrive mental health programme co-designed with BAME employers and employees.
- WMCA will carry out rigorous equalities impact assessments of all of its directorates and wider agencies.
- WMCA will hold Mayor's WM BAME roundtable meetings every 6 months to monitor steps that been taken by WMCA and wider regional partners in relation to the Health of the Region commitments to action.

Partner Commitments

- The new multi-agency Midlands System Transformation Recovery (STaR) Board will carry out an evaluation of regional NHS programmes through a Black Lives Matter and post-COVID lens.
- PHE West Midlands will develop a BAME and Disparities workplan to ensure improving health outcomes for BAME communities is a cross cutting consideration across priorities of health and wellbeing programmes; and undertake analysis to determine the extent of inequalities and impacts of COVID-19 on black and minority ethnic communities.
- Black Country and West Birmingham CCG Equality & Diversity leads group across the BCWB STP to ensure a consistent and unbiased approach in supporting BAME colleagues and delivering BRAP training for all STP board members. The Health Inequalities and Prevention Board will also improve our ethnicity data collection and use of ethnicity data and work to understand and address inequalities between different ethnicity groups
- Royal Wolverhampton NHS Trust is committed to making progress on the Workforce Race Equality Standards (WRES) and are currently on track to meet the 2028 target for leadership diversity.
- Birmingham and Solihull STP will:
  - Routinely produce data to support restoration and recovery broken down by sub-analyses of socio-economic factors, including ethnicity and levels of deprivation
  - Deliver various initiatives to support people with diabetes, including a marketing plan being developed with our BAME diabetes patient champions and provider Weight Watchers (WW), to be delivered in communities and in different languages
  - Implement the NHSEI perinatal mental health support for BAME women
  - Recruit a STP Inequalities Lead, STP Workforce and Inclusion Director and STP Workforce and Inclusion Convenor to support delivery
- Solihull Metropolitan Borough Council will work to adopt the PHE Heat Tool as part of a health in all policies/integrated Equity assessments across Council
- Dudley Group NHS Foundation Trust will launch a health and wellbeing strategy for staff, supported by their BAME inclusion network, which provides a 12 month calendar of culturally appropriate health and wellbeing initiatives to support staff from a physical and mental wellbeing perspective.
- Aston University is developing 'Inclusive Aston' which includes working towards a Race Equality Charter award
- West Midlands Police are working to look more like the people they serve and have set a target of recruiting 1,000 BAME officers over the next three years.
- The Walsall Together Partnership is committed to the Workforce Race Equality Standard and seek to hear BAME views through engagement and through Walsall for All and Healthwatch partners
- Healthwatch WM will conduct targeted work to gather views and experiences of patients and the public, especially from underrepresented groups.
- The West Midlands Fire Service will continue to take positive actions and make the the service more representative of the communities they serve.

2. Tackling the wider determinants of health

In order that we might be more resilient to future pandemics, we need to make sure we create a society in which everybody can lead a healthy lifestyle. This means looking not just at the causes of ill health, but the causes of the causes: getting a good start in life, educational attainment, our jobs and incomes, our homes and where we live, our friendships and sense of purpose and belonging. These wider determinants of health have been shown to be the main drivers of health inequalities which in turn have led to some communities being more badly affected by COVID-19 than others.

In responding to and recovering from the pandemic, the health and wider system must put a strong focus on these root causes. Perhaps one of the most important initiatives though that will help to achieve this is through a Health in All Policies (HIAP) approach. HIAP encourages every public agency to consider the health implications of every decision it takes to find opportunities to promote wellbeing, avoid causing harm, and reduce inequality between groups. Another initiative to encourage this systemic approach would be to become a Marmot city region to galvanise our shared commitment to preventative health and wellbeing and build a more collaborative system for achieving it.

WMCA Commitments

- WMCA will work with partners to become a Marmot City-Region and develop a 3-year action plan for change.
- WMCA will incorporate a Health In All policies (HIAP) approach into its Inclusive Growth Framework.
- WMCA will continue to pay the Real Living Wage and ensure its contractors do so too.
- WMCA will target underrepresented groups for training programmes to support access to jobs, particularly where groups are under-represented in the workforce – for example, our work with Black CodHers helps black women gain digital skills and careers.
- WMCA will capture health outcomes in our zero-carbon initiatives.
- WMCA will work closely with public health colleagues on planning applications to embed public health expertise within our Housing and Land team.

Partner Commitments

- The new multi-agency Midlands System Transformation Recovery (STaR) Board, working with PHE WM, will establish a Health Inequalities Working Group which will:
  - support Integrated Care Systems to plan and be held accountable for addressing health inequalities within the populations they serve;
  - provide standards, guidance and tools to ensure health inequalities are considered in the design and evaluation of new NHS services.
- NHS Confederation has called for both local authority and NHS commissioners to work with wider system partners to integrate and embed employment support alongside clinical services to improve access, integration and visibility of employment support.
- Birmingham and Solihull STP are implementing a system leadership programme for 500 leaders who will receive bespoke learning on meeting the needs of vulnerable citizens and tackling key inequalities. It will also support vulnerable people through shielding, particularly in the context of a local 'lockdown', with additional support delivered through our partner organisations.
- The Police and Crime Commissioner (PCC) will continue to work with partners to identify additional opportunities for intervention and prevention in reducing the harm caused by drugs, gangs and violence. For example, the New Chance programme provides a whole system approach to keep low level female offenders out of the criminal justice system.
- The directors of public health share the ambition to reduce health inequalities and address the wider determinants of health. In particular, they are committed to working with partners and the WMCA to address these disparities through inclusive growth, leadership and coordination.
- Black Country and West Birmingham CCG Health Inequalities and Prevention Board has a Wider Determinants sub-group which steers the Wider Determinants of Healthy Life Expectancy (WHoLE) programme. Phase 1 of the programme has just completed and Phase 2 will design, appraise, implement and evaluate interventions.
- The West Midlands Fire Service will focus on tackling the wider determinants of health during their Safe and Well visits as they are also the underlying causes of fire risk.
- The Dudley Group NHS Foundation Trust will commit to working with partners including the Local Authority and Dudley College to explore how they can ensure more employment opportunities for local people, in particular those who have found it hard to get employment in the past
- WM Violence Reduction Unit keep a continued focus on reducing inequalities through the place-based pilots, and through a new inequalities 'champion' who will work closely with theme leads, the data analytics team and the commissioning lead to embed efforts to reduce health inequalities systematically across the VRU.
- WMCA Homelessness Taskforce will develop a Commitment to Collaborate toolkit to prevent and relieve homelessness, which will provide a framework to tackle the systemic inter-related issues which drive homelessness and work closely with health colleagues to provide access to health related interventions for those with poorest access.
- University Hospitals Birmingham will work with CLES and Pioneer Housing on a project to retrain hospitality workers to work within UHB hospitals.
- The Black Country Consortium will work with developers on the incorporation of the Black Country Garden City principles into future housing pipeline.
- Sandwell and West Birmingham NHS Trust are committed to deploying a minimum of 2% of its future annual budget with local suppliers and to paying all staff at or above the 'living wage'.
- The Walsall Together partnership will ensure that Housing, the Community and Voluntary sector is represented on the Partnership alongside health and other statutory partners and that its plans are informed by evidence of the holistic needs of the population.

3. Widening access to health and care

The responses to our call for evidence have brought into sharp focus the inequalities in healthcare provision caused by disparities in access to good quality healthcare, especially for poorly managed conditions in vulnerable groups. Lockdown has made things considerably worse as the NHS seeks to deal with a significant backlog of non-COVID related morbidity and it is likely that the effect of this will widen existing health inequalities and lead to avoidable cancer death as a result of diagnostic delays. Across the UK it was estimated that by August 2.1 million people have missed out on screening, while 290,000 people with suspected symptoms have not been referred for hospital tests . And this is just cancer. Other concerns include access to mental health services (see next section); the future of care homes and domiciliary care; and the implications of moving towards a system that relies more heavily on 'telehealth'.

'Recovery' presents the opportunity for a radical rethink of the ways in which people access health and care services. Primary care services could be much better integrated within local neighbourhoods with clinics, pharmacies, housing officers, voluntary and community groups working together as we have seen in the crisis – particularly focusing on those who most need support and access. We need to exploit the opportunities created by the switch to virtual consultations and ramp up digital screening services but in doing so place a big focus on supporting those who don't have digital devices or good connectivity or the confidence and skills to make the most of telehealth services. And we need a new vision for adult social care, addressing the crisis facing the care home sector and finding new ways to support people to live at home with connections to their wider community.

WMCA Commitments

- WMCA will train and support healthcare professionals to refer disabled citizens to physical activity as part of its IncludeMe initiative.
- WMCA will amplify its Thrive into Work programme to a further 450 people living with poor mental and physical health. It will focus on those out of work and those at risk of leaving employment due to their health condition.
- WMCA will continue to support the utilisation of transport hubs as digital screening centres and for 'pop up' heart / CV checks, breast screening, sexual health etc.

Partner Commitments

- The new multi-agency Midlands System Transformation Recovery (STaR) Board will ensure that the differential experience of access and delivery of services is an intrinsic part of service design and evaluation.
- PHE West Midlands have carried out a WM-wide needs assessment and literature review to inform regional and local commissioning of language and interpreting services in the West Midlands and informed commissioning of an interpreting service for the Health Protection function in the West Midlands.
- University Hospitals Birmingham will use digital transformation to reduce health inequalities by enabling people to access health care and information in a more accessible and a timely way and ensure its staff are advocates for digital inclusion including creating community diagnostic hubs in local neighbourhoods.
- Black Country and West Birmingham CCG will develop an Academy to provide population health management capacity to the system. It is developing a number of population health management projects that will widen access to health and care including early diagnosis of cancer in vulnerable groups.
- Birmingham and Solihull STP will develop population health management within Primary Care Networks (PCNs) and ensure its primary care estate is under one digital domain by March 2021 promoting digitally enabled care for staff to work together in virtual multi-disciplinary teams.
- The Dudley Group NHS Foundation Trust will commit to working with colleagues in Dudley to explore how to collectively make a difference to cancer outcomes, with a particular focus on parts of the Borough where outcomes are poorer. This will include ensuring screening services provided by the Trust are delivered in a way which encourages uptake from more vulnerable people and how cancer services are culturally sensitive and more person centred.
- Aston University would like to develop a Health Hub at Aston that would be open to the local community.
- University Hospitals Coventry and Warwickshire and Coventry University want to develop a community diagnostics centre in the city centre that would improve access to such facilities to the local community.
- Healthwatch WM will provide advice and information about access to services and support for making informed choices.
- Walsall Together Partnership will understand the inequitable take up of health and care services and working through the Partnership and wider community networks to address the causes.
- The West Midlands Fire Service, as a key part of their Safe and well visits, will refer people on to other partner agencies to gain access to services that can tackle wider health and care issues.

4. People-powered health

The coronavirus crisis has reminded us all of the importance of our own physical and mental wellbeing. Not only have we seen the clear relationship between having pre-existing health conditions and the risks of dying from the virus, lockdown has reminded many people of the benefits of daily exercise and how an appreciation of nature can be so good for our mental health. This apparent silver lining is something we should not lose. How we all look after our physical and mental wellbeing must be central to community recovery.

People-powered health is an approach to wellbeing that puts people and prevention first. This could be as simple as encouraging people to walk or cycle more through safer streets and active travel schemes. It involves initiatives to tackle childhood obesity, build public awareness about healthy eating and tackle food poverty in poorer neighbourhoods. As we look forward to the Commonwealth Games it means making sure there is a clear legacy around sport in the community and physical activity. But it also involves putting people at the heart of decision-making and the co-design of our health and care services.

WMCA Commitments

- WMCA will continue to develop its Include Me WM programme to engage disabled people and people with long term health conditions to be physically active.
- WMCA is committed to increase cycling from 3% to 5% of mode share by 2023 through the delivery of the WM Cycling Charter and extending cycling and walking routes.
- WMCA will work with other Commonwealth Games Delivery Partners to develop a long lasting physical activity and wellbeing legacy for the region.
- WMCA will endorse a Making Every Contact Count approach amongst its employees and encourage and influence other anchor institutions / businesses / employers to support people-powered health in their workplaces
- WMCA will standardise inclusion of social value in our single commissioning framework MoU's to include Wellbeing and work together to maximise and measure outputs in the communities that we work in.
- WMCA's Young Combined Authority Board will continue to encourage and challenge the West Midlands Combined Authority and its partners to listen to the voices of citizens when shaping policies which will affect their lives.

Partner Commitments

- PHE West Midlands are working with national colleagues and NHS Midlands advocating for community centred and asset based approaches, providing resources, tools and products to enable 'people-powered health' including support and leadership for the Regional Social Prescribing Network, promoting the role of the NHS as an anchor institution, maximising opportunities through volunteering (including PHE staff role modelling this) and landing social marketing campaigns.
- Black Country & West Birmingham CCG PCNs will have recruited 63 social prescribing link workers, 38 care coordinators and 12 Health and Wellbeing Coaches by March 2021 and plan to recruit more than 200 posts by March 2024. These new roles focus on people-empowered health. The learnings from the Personalised Care Demonstrator site are being embedded in our workstreams. 9 PCNs are joining the Dartmouth PCN development programme in 2020/21.
- Birmingham and Solihull STP will support behaviour change for staff and community leaders through various wellbeing initiatives including a targeted campaign on flu vaccination with a focus on the most vulnerable and those disproportionately affected by COVID-19.
- The West Midlands Fire Service will continue use the incentive of firefighting as a means of tackling wider health and wellbeing issues for young people through their programme of Fire Cadets. The service will also utilise their schools education and work at Safeside to tackle wide range of safety, health and wellbeing issues that underpin long-term risk of fire.
- Black Country Consortium is supporting the 'Tribe Project' - a social prescribing campaign, supporting prevention and increase community resilience; and supporting a whole system approach to reducing childhood obesity from early years through to secondary schools.
- Aston University are working in partnership with Aston Villa Foundation to go into local schools to deliver workshops about eye health, conduct eye screening and eye tests for those that need it, and working with children and parents on childhood eating habits.
- Coventry University will create a number of fully funded PhD studentship opportunities which focus on themes related to COVID-19 and the post-pandemic future.
- Healthwatch WM will promote and support involvement in commissioning of health services and provision of care services.
- The Walsall for All Board will raise public awareness about the support available to improve mental and physical wellbeing through the Walsall Together partnership.
- Police and Crime Commissioner (PCC) have re-established police cadets to support young people and reduce inequalities. In addition, the PCC and West Midlands Police are rolling out units in our most diverse and challenging areas, focusing on young people who need the most support.

Recommendations to Government

1. Improving outcomes for BAME communities

- Government should produce a clear and comprehensive action plan setting out how it will work with local and regional partners to take action on race disparities and associated risk factors.
- Government should commission further data, research and analytical work at the local and regional level to understand the geographical and place dimensions of race disparities in health.

2. Tackling the wider determinants of health

- The NHS should make local action on tackling health inequalities the focus of the NHS 'Phase 4 Letter' on Covid19.
- Government should make health and well-being outcomes a key driver of economic development and levelling-up policies including industrial strategy and local industrial strategies; the UK Shared Prosperity Fund; Towns Fund; and future devolution deals.
- Government should double the proportion of health and social care spending focused on prevention and public health from 5 to 10 percent over time.

3. Widening access to health and care

- Government should ensure that Local Authorities have sufficient powers to improve public health and reduce health inequalities, with Mayoral Combined Authorities providing support where they can add value (Devo WP Submission).
- Government should support the WMCA's proposal to establish digital screening hubs in high footfall transport locations.
- Government should do all it can to close the gap in primary care provision between the most and least deprived neighbourhoods in terms of funding per patient and serving GPs.
- Government should look to widen its plans and increase its investment to tackle digital poverty with a particular focus on those who do not access health and care services online.

4. People-powered health

- Government should invest in the WMCA's Radical Health Prevention Fund to drive forward innovation, social prescribing and other initiatives to tackle health inequalities in the region.
- Government should pilot the Kruger report's Community Right to Serve provisions for health and social care in the West Midlands.[111]

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Appendix 1

Call for Evidence Submissions

Name of evidence	Name of organisation	Abstract
Ethnicity and risk of death in patients hospitalised for	University Hospitals Birmingham NHS Foundation Trust	Quantitative study exploring whether ethnic groups more at risk of worse outcomes from COVID-19 infection, including death? Conclusions: There were more admissions from South Asian patients to our hospital than would be expected based on our local population. These patients were admitted with a worse severity of COVID19 related respiratory compromise without a significant delay in presentation and experience a higher level of mortality even when differences in age, sex, deprivation and key comorbidities were taken into account. South Asian ethnicity may form another 'at risk' population from COVID-19 and further studies are needed to identify any treatable factors to improve outcomes as well as to refine our understanding and communication around non-modifiable risk factors
West Midlands Inquiry into COVID-19 Fatalities in BAME communities	Labour Party – West Midlands	West Midlands Inquiry into COVID-19 Fatalities in BAME communities report included: • Gathering testimony • statistics • recommendations
Cabinet report - reset and recovery	Children's Services Sandwell Metropolitan Borough Council	Evidence explored the Covid Impact Assessment on the following activities: • community impact • economy impact • staff impact

Comments from CCG on updated ways of working with staff and communities	Birmingham & Solihull CCG	Comments from CCG on updated ways of working with staff and communities included for example: • Establishing a Health Inequalities Task Group, which has set out priorities for action in the next 1-2 years. This includes using our roles as 'anchor institutions' to create economic prosperity and to support our staff.
CCG Health Impact Assessment	Warwickshire County Council, Coventry City Council, NHS CCGs	The aim of the HIA was to identify key factors that may affect the population's health and wellbeing as a direct result of the COVID-19 outbreak. Key findings included: • An integrated recovery is needed as health and wellbeing has been deeply impacted on. The implication is that recovery cannot just be contained to one sector and has to be connected across all four to have the biggest chance of success. • The double impact: harm from COVID-19 has been unequally distributed across the wider impacts from the pandemic and lockdown will fall more heavily on communities most directly affected by the disease itself. This analysis shows the potential harm for more deprived areas of Coventry and Warwickshire
West Midlands Language and communication service needs assessment report	Health Protection Team - PHE West Midlands	Report included the following: • Descriptive study that aimed to provide a picture of the language and communication need within the health protection response in PHE WM. • Commissioning processes used by other PHE Health Protection teams for language and communications services
Report on the experiences of families who have a child with a disability or additional need	Parents Opening Doors Charity	Report on the experiences of families who have a child with a disability or additional need included the following: • survey of members of the group- parent carers forum for disabled children. • emotional health and mental health was a big factor • furlough was a worry • cancelled appointments • parents feel abandoned • Some didn't get shielding letter and local authorities slow to react. • Recommended to ensure CCG commissioning changes are communicated effectively

Update on the research BVSC is undertaking	BVSC	Update on the research BVSC is undertaking included: • WMCA Social Economy Rapid Evidence Review – being delivered in partnership with University of Wolverhampton and University of Coventry, to draw out key innovations from the social economy during Covid19 • NNS Impact Assessment – Over-arching impact assessment of the NNS structure, commissioned by Birmingham City Council. • Birmingham City University – Research into the response from the sector to Covid19 and what this means for BCU as an anchor organisation, focussing particularly on emergence of Mutual Aid Groups – • Violence Reduction Unit Evaluation – Ongoing piece being delivered in partnership with UOB, UOW and Community Researchers; early evaluation has reflected on the impact of Covid19.
Key points from report on Local Authority Responses to people with no recourse to public funds during the pandemic	University of Wolverhampton	Key points from report on Local Authority Responses to people with no recourse to public funds (NRPF) during the pandemic included: • There was a lack of information available for people with NRPF • Numbers of service users with NRPF who had COVID-19 symptoms were relatively small, but those who did have symptoms were particularly likely to die or become seriously ill • People with NRPF struggled to access food, shelter and subsistence support during the pandemic
Impact upon people who have experienced rape or other sexual abuse	Coventry Rape & Sexual Abuse Centre	Impact upon people who have experienced rape or other sexual abuse included: • more isolated / locked in with perpetrator • heightened anxiety • lack of access to first responders who refer at risk people to service • challenges with online / telephone service • waiting time for service significantly increased • exacerbated existing inequalities faced by clients e.g. lack of access to financial services • short term funding from COVID specific funds is ineffective for increasing staffing levels • control measures limiting service capacity

Comments on the disproportionate impact of COVID-19 on BAME communities	Sikh Doctors Association	Comments on the causes of disproportionate impact of COVID-19 on BAME communities included: 1 Deprivation and poverty 2 Discrimination and systemic racism 3 Cultural variations in disease prevention and understanding 4 Over exposure to high Covid areas, such as front-line work in the NHS, care homes, cleaners in the hospitality sector.
Comments setting out the programme being undertaken by the Group	Black Country and West Birmingham CCGs Wider Determinants Programme Advisory Group	Comments setting out the programme being undertaken by the Group included: • System report to be published looking at the system's response to COVID-19 and lessons learnt. • Phase 1 programme looking at wider determinants of health • Phase 2 programme focusing on designing, appraising, implementing and evaluating interventions.
Report on Impact of COVID-19 on Inequalities	Solihull Metropolitan Borough Council	The report brings together the existing national evidence and analyses the probable impact on different groups. The Council is in the process of developing a targeted Health Inequalities Strategy
Blog on the contribution to new ways of approaching inter-faith and business support through community organising as a result of the pandemic	Citizens UK Birmingham	Blog included findings on concerns felt by BAME communities including hate crime, disproportionate impact on their communities and faith and income
Report on Regional Health Impacts of Covid-19	Transport for West Midlands	The report focused on the Regional Health Impacts of Covid-19, and the role of public transport and active travel in this, especially concerning continued access to health care and TfWM role in keeping the region staying active and healthy. Evidence also included the following: • Public opinion survey results • WMCA Board report on the Review of the West Midlands Local Transport Plan (LTP) to support a Greener, Fairer, Healthier Recovery • Equality impact Assessment on the transport needs of vulnerable groups during the pandemic

Parliamentary evidence on the disproportionate impact of COVID 19, and the UK government response, on ethnic minorities and women in the UK	Department of Sociology and Policy, Aston University	Key findings from evidence included the following: Ethnic minority people: • Scarcity and unreliability of PPE sources for frontline staff/key workers disproportionately puts people from ethnic minority backgrounds at higher risk of infection Women: • lack of access to contraception means and abortion • maternity services - some of them are/ were not available Care during labour: • partners are not allowed to be present during labour to support, especially when baby needs care, or woman need help communicating in English Women asylum seekers: • can't use remote services due to limited English language. No interpreters available • reduced access to charity services
Blog on health inequalities	Legacy West Midlands	Comments from the charity included: • The impact of Covid 19 has had a devastating impact in Lozellls and the neighbouring areas. • There has been a limited response from public sector agencies but Birmingham Director of Public Health has held zoom meetings with members of the Bangladeshi Community

The role of faith communities	Nishkam Civic Association	Comments from Nishkam Civic Association included: • essential role of communities, particularly faith, in COVID response and this must not be forgotten • need to develop policy setting / community engagement process for decisions making • we cannot expect communities to self-finance and leave them to their own devices Taraki COVID Report – Executive Summary and full report (Mental Health / Wellbeing) can be accessed here: https://tinyurl.com/yykk6x6j COVID 19 – Response and support initiatives by Nishkam Organisations can be accessed here: https://www.taraki.co.uk/covid19-research Following evidence provided: • Covid Crisis Reflections - Bhai Sahib Mohinder Singh OBE KSG, Chairman Nishkam Civic Association • How Covid-19 has impacted the Sikh Community – Sikh network • Sikh Network Covid19 Survey Report • Taraki COVID Report – Executive Summary and full report (Mental Health / Wellbeing) • Birmingham Council of Faiths role during COVID-19 and its impact • case studies on how Faith Communities Stepped up in the Pandemic • Birmingham Scouts and Guides activities • COVID 19 – Response and support initiatives by Nishkam Organisations • Examples of Muslim and Christian organisations in Birmingham (x 7)
Key activities from the Council	Coventry Council	Key activities from the Council included: • Call to Action to address health inequalities has been agreed by the Coventry Health and Wellbeing Board • Reset and Recovery approach, which includes specific external programmes on Regeneration and The Economy; Tackling Inequalities; and Communities and New Social Enterprises. The aim is for health inequalities to be embedded into all of these pillars, using One Coventry values (working together and involving the right people)

Reports on COVID-19 activity impact	Birmingham City Council	Evidence included the following: • An overview of activity to mitigate the impacts of COVID-19 on BAME communities • Combined presentation: (1) scale of the food offer for shielded and vulnerable people in Birmingham (April 2020) and (2) insight from TAWS (May 2020) • An overview of the impact of COVID-19 across the life course • Neighbourhood Development Support Unit commissioned report – "Birmingham's Collaborative Neighbourhoods" by Locality • Executive Business Report – an update on BCC's response to COVID-19
Range of evidence provided, including responses to the call for evidence questions, case studies, report and infographic	Dudley Metropolitan Borough Council	Evidence included the following: • case studies on engagement exercises with the BAME and other communities • Health & Adult Social Care Scrutiny Committee report on the council's and partners response to Covid • infographic of the support the council has provided to residents and businesses
Comments on the impact of COVID-19 and activities of CCG	West Bromwich African Caribbean Resource Centre	Comments on the impact of COVID-19 and activities of CCG included the following: • online workshops held by CCG with report to be published • recommended for CCGs to carry out Equality Impact Assessments • The charity redesigned its services to support the community during first wave and flagged lack of funding to increase offer especially for second wave.
Research supporting the improvement of air quality, and associated health, environmental and economic benefits, across the West Midlands	The West Midlands Air Quality Improvement Programme	Research on rapid analysis of the impacts of COVID-19 related emergency public health measures (March – May 2020) upon nitrogen dioxide (NO2) and particulate matter (PM) levels in Birmingham City. Key Findings: • Reductions in NO2 concentrations associated with COVID-19 were of greatest magnitude for those living at the inner city and near-roadside locations, including areas of high deprivation. • Changes were less marked in the north-east of the city; the location of more affluent (upper income quintile) LSOA areas. Further (ongoing) research is required to better characterise these impacts upon different ethnic groups, including linkage to health outcome measures.
Comments on key activities during COVID-19	Birmingham Mind	Key activities during COVID-19 included the following: • Working with BAME communities and finding increased anxiety, mistrust and language barriers • Community Development Worker Service re-engaged with communities and supporting remotely and have been working with CCG to deliver key messages to communities

Appendix 2

Thematic analysis of qualitative evidence submitted to RHIC Call for Evidence, Sept 2020

In addition to reports and quantitative data from formal engagement exercises or research, a number of local partners and stakeholders submitted qualitiative responses to the call for evidence. These included civic, academic and voluntary & community sector organisations,[112] reflecting insights from community engagement as part of their regular practice.

A thematic analysis was carried out to identify key themes relating to experiences of COVID-19 and its impact on communities, and the challenges, barriers and support needs identified in improving accessibility. This is summarised in Table A.

Table A: Thematic analysis of qualitative evidence submitted

Experiences of COVID-19 and impact on communities

Theme 1: Exacerbation of existing inequalities

Exacerbation of existing health and social inequalities was a consistent theme, with responses identifying impacts relating to people (i.e. protected and marginalised groups), and places (i.e. wider determinants of health).

1.1 Impact on protected and marginalised groups

BAME communities, women, asylum seekers and rough sleepers (including those with substance use issues) were highlighted as key groups affected by both long-standing inequalities and COVID-19. Impacts cited included those on mental health and wellbeing (e.g. through anxiety and bereavement due to COVID-19) and not just the physical consequences of infection. This sub-theme intersects across other thematic areas, with these groups identified as being disproportionately affected by the health and economic impacts of control measures. Underlying health conditions were also cited as a factor in existing and exacerbated inequalities.

1.2 Wider determinants of health

This sub-theme is divided into impacts of wider determinants on individuals and communities, and impacts on environments and places. The former highlights the two-way relationship between COVID-19 and health inequalities: while the disproportionate effects on people living in deprived areas and the increased risk of transmission in certain sectors are recognised, impacts on wider determinants are also cited as consequences of the pandemic (e.g. increasing homelessness). However, a number of positive environmental impacts were also identified, namely improved air quality, reduced carbon emissions and reduced noise. A reduction in road traffic accidents was also noted.

Table A: Thematic analysis of qualitative evidence submitted continued

Theme 2: Impacts of control measures

This theme relates specifically to the impact of measures taken to control the spread of COVID-19 rather than the effects of the virus itself. These are split broadly into impacts on health and wellbeing, and those on the economy – however, the two are closely linked and intersect with the exacerbation of existing inequalities.

2.1 Health and wellbeing impacts

Health and wellbeing impacts cover direct and indirect impacts on mental health and wellbeing, as well as psychological and social impacts. These included isolation and loneliness through lockdown and shielding; anxiety, frustration and bereavement; uncertainty around employment or immigration status; and the impact of loss of income. Disproportionate impacts on BAME communities and asylum seekers/refugees were again emphasised, e.g. women asylum seekers reported an exacerbation in loneliness.

2.2. Economic impacts

This subtheme concerns the impact on the economy and employment sectors as well as on individuals and families. Small businesses and the faith sector were highlighted as bearing major impacts of loss of income – particularly small businesses that did not operate online and were therefore unaware of or unable to access Government funding, or where employment type was not covered by the furlough scheme.

Table A: Thematic analysis of qualitative evidence submitted continued

Theme 3: Culture and behaviour

While this theme overlaps with other thematic areas, it was clearly a theme in its own right, with two distinct sub-themes: the general shifts in culture and behaviour that have occurred as a result of the pandemic and control measures (linking with Theme 2), and where specific cultural characteristics have interacted with these measures to impact disproportionately on certain groups (linking with Theme 1).

3.1 Shifts in culture and behaviour

This subtheme was predominantly concerned with changes in transport use and physical activity – specifically, decreases in transport use and increases in walking and cycling, which relates to the environmental impacts noted in 2

3.2 Relationship between culture and COVID-19 impacts

This sub-theme included increased risks presented by culture-specific behaviours (e.g. increased risk of transmission due to cohabitation with elders; traditional Bangladeshi diet increasing risks of obesity) and the impacts on way of life (e.g. enforced restrictions on places of worship that are central to way of life, such as Sikh Gurdwaras. However, an increased appreciation of the role of faith and faith communities was also noted, suggesting that culture may play a protective role in maintaining wellbeing during the crisis (see 2.1).

Table A: Thematic analysis of qualitative evidence submitted continued

Theme 4: Safety

This is again a theme that overlaps across a number of areas, but was prominent enough to be a theme in itself. The theme is divided into concerns relating to the risk of infection, and those relating to unintended consequences of lockdown (see Theme 3).

4.1 Fear of infection

Direct concerns about infection risk focused mainly on a lack of confidence in social distancing measures, either because it was felt other people were not respecting these measures, or because circumstances and/or environments made it difficult to follow guidance, e.g. using public transport, attending school, or using narrow high streets). Women asylum seekers reported feeling unsafe in their accommodation as other residents were not respecting self-isolation and social distance rules.

4.2 Unintended consequences of lockdown

Concerns around indirect impacts on safety included victims of domestic violence being isolated with their abusers, and reduced access to services (see Theme 5).

Table A: Thematic analysis of qualitative evidence submitted continued

Challenges, barriers and needs

Theme 5: Access to services

Access to services was a prominent theme in responses relating to community challenges, barriers and needs during the pandemic, with the disproportionate impacts on BAME and marginalised groups evident in both subthemes: the availability and distribution of health and care resources, and experiences of these services.

5.1 Availability and distribution of resources

This sub-theme picked up issues around accessing specific services and/or resources, and wider issues around recovery funding. Reduced capacity and contact was noted both generally (e.g. lack of access to first responders and GP appointments; increased waiting times) and in relation to issues affecting specific groups (e.g. women's reproductive health & care including lack of access to contraception, abortion & maternity care). Scarcity and unreliability of PPE sources for frontline staff/key workers was a key concern in relation to increasing risk among BAME workers (see Theme 1). A lack of funding and staffing overall was highlighted, as well as inequitable distribution of these resources: white-led organisations and a lack of trust established in local communities were cited as reasons why residents from BAME communities were not benefitting from available funding in some areas.

5.2 Experiences of care

Overall, this sub-theme reflects poorer experiences of care for people from BAME groups and women, linking to the disproportionate impacts on these groups outlined in Theme 1.1. Language barriers and challenges with using online or telephone services were cited as a key issue, particularly for women asylum seekers who were unable to use remote services with no interpreters available. Women who were alone while giving birth were cited as particularly vulnerable, particularly where their babies required special care or they had interpretation needs.

Table A: Thematic analysis of qualitative evidence submitted continued

Theme 6. Stigma and trust

In addition to the practical barriers identified in 5.1, which related predominantly to service provision not being appropriate to community needs, there were also factors which made people unwilling to seek help. Stigma around help-seeking was identified as being a particular issue in refugee and migrant communities; there was also a lack of trust in services and the government, with misinformation and a lack of clarity cited as an issue.

Table A: Thematic analysis of qualitative evidence submitted continued

Theme 7: Information

This theme relates to information provided to individuals and communities during the pandemic, and information gathered by health and other public services.

7.1 Communication and messaging

Uncertainty and inadequate communication was a key concern among service users and communities, both generally around risk (e.g. why BAME communities are more affected) and specifically within services (see 5.3). This sub-theme is strongly linked to lack of trust (Theme 6).

7.2 Lack of data and visibility

The lack of data on ethnicity and faith was highlighted as a general concern. However, even where data are available, the categories are broad and some communities are consistently 'invisible' (e.g. the Sikh community).

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