Gloucestershire Health and Wellbeing Board

Report Title	COVID-19 reset: Focusing on inequalities and the role of anchor institutions
Item for decision or information?	Decision and information
Sponsor	Sarah Scott, Director of Public Health
Author	Jennifer Taylor, Lead Commissioner (Public Health) Zoe Clifford, Consultant in Public Health
Organisation	Gloucestershire County Council

Key Issues:

The consequences of COVID-19 are not the same for everyone, and there is growing evidence of how it disproportionately impacts different populations. The virus has exposed the deep inequalities and stark differences in life expectancy that exist between different population groups and areas of the country.

There are growing concerns that the UK's minority ethnic groups are being disproportionately affected. There is evidence that minority groups are overrepresented in hospitalisations and deaths from the virus. As such, there has been a spotlight on this particular area of inequality.

The PHE *Beyond the data: Understanding the impact of COVID-19 on BAME groups* provides clear recommendations for immediate action. One of the key areas of focus in this report is the role of anchor institutions.

Recommendations to Board:

- Review and discuss the recommendations summarised from PHE *Beyond the data: Understanding the impact of COVID-19 on BAME groups.*
- Consider the role of anchor institutions and the Health and Wellbeing Board in addressing the impact of COVID-19 on BAME communities.
- Review and decide the opportunities for local action.

Financial/Resource Implications:

None identified

COVID-19 reset: Focusing on inequalities and the role of anchor institutions

1. Introduction

Pandemics rarely affect all people in a uniform way. The consequences of COVID-19 are not the same for everyone, and there is growing evidence of how it disproportionately impacts different populations. The virus has exposed the deep inequalities and stark differences in life expectancy that exist between different population groups and areas of the country. The Health Foundation has questioned whether COVID-19 presents a watershed moment for health inequalities[1].

This paper aims to provide background to inform discussion on:

- the impact of the coronavirus on health inequalities, with a particular focus on ethnicity
- the role of Health & Wellbeing Board members as "anchor institutions" in mitigating actions
- further opportunities for local action

2. Health inequalities

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

Health inequalities can be considered in four main dimensions, although it is important to note that these often overlap.

- Protected characteristics
- Socio economic groups and deprivation
- Vulnerable groups
- Geography

As the COVID-19 pandemic progresses, the consequences of disruption are likely to impact more on some groups, communities and places than others and result in further increases in health inequalities.

Tackling health inequalities requires long term action but there are also much shorter-term actions which could help mitigate against the impact of COVID-19. There are growing concerns that the UK's minority ethnic groups are being disproportionately affected. There is evidence that minority groups are overrepresented in hospitalisations and deaths from the virus. As such, there has been a spotlight on this particular area of inequality, with some very clear recommended actions.

[1] https://www.health.org.uk/publications/long-reads/will-covid-19-be-a-watershed-moment-for-health-inequalities

3. Are some ethnic groups more vulnerable to COVID-19 than others?

The Institute for Fiscal Studies published their findings at the beginning of May on why some ethnic groups are more vulnerable to COVID-19 than others[2]. The key findings were:

- The impacts of the COVID-19 crisis are not uniform across ethnic groups, and aggregating all minorities together misses important differences.
- Per-capita COVID-19 hospital deaths are highest among the black Caribbean population and three times those of the white British majority.
- Once you take account of age and geography, most minority groups 'should' have fewer deaths per capita than the white British majority.
- After accounting for the age, gender and geographic profiles of ethnic groups, inequalities in mortality relative to the white British majority are therefore more stark for most minority groups than they first appear.
- After accounting for the role of age and geography, Bangladeshi hospital fatalities are twice those of the white British group, Pakistani deaths are 2.9 times as high and black African deaths 3.7 times as high.
- These disparities cannot currently be accounted for by non-hospital deaths.
- Occupational exposure may partially explain disproportionate deaths for some groups.
- At-risk underlying health conditions are especially prevalent among older Bangladeshis, Pakistanis and black Caribbean people.

4. Stakeholder insights

The PHE *Beyond the data: Understanding the impact of COVID-19 on BAME groups*[3] shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive for and dying with COVID-19. It provides a descriptive summary of stakeholder insights into the factors that may be influencing the impact of COVID-19 on BAME communities.

The report sets four key areas of focus:

- Research and data
- Policy
- Communications
- Anchor institutions

Health & Wellbeing Board partners have a crucial role in responding to the recommendations set out in this report and some of these require rapid action before the possibility of a second peak in the pandemic. In summary, the seven recommendations in the report are:

1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems.

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[2] https://www.ifs.org.uk/inequality/wp-content/uploads/2020/04/Are-some-ethnic-groups-more-vulnerable-to-COVID-19-than-others-V2-IFS-Briefing-Note.pdf

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process.

3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities.

4. Accelerate the development of **culturally competent occupational risk assessment tools.**

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns.**

6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases.

7. Ensure that **COVID-19 recovery strategies** actively **reduce inequalities caused by the wider determinants of health** to create long term sustainable change.

Action to address these recommendations will need to encompass internal organisational changes focusing on employee safety and wellbeing; service delivery changes, community engagement and health promotion; and system wide attention to the key socio-economic and environmental factors that determine people's health outcomes.

Further work is required to fully scope these actions, as set out in the Opportunities for Local Action section below. However, the following section identifies an opportunity to build on discussions held just before the pandemic to address the seventh recommendation of the PHE *Beyond the data: Understanding the impact of COVID-19 on BAME groups* report.

5. Anchor institutions

At the Health and Wellbeing Board in January 2020 and following discussions on the DPH Annual Report 2019 and the draft Health & Wellbeing Strategy, the Board agreed that the concept of anchor institutions needed further exploration and was one that the Board could look at in depth at a future development meeting.

There is an ideal opportunity for the anchor institutions approach to form a key part of the Board's plan to address health inequalities with a particular focus on BAME communities and COVID-19.

Anchor institutions share a number of key characteristics:

- **Geographic immobility**: strong ties to the geographic area in which they are based through invested capital, mission and relationship to customers and employees
- **Size**: anchor institutions tend to be large employers with significant purchasing power. Both these factors influence the level of impact these institutions can have on the local economy
- **Non-profit**: while there are examples of for-profit organisations, these institutions tend to operate not-for-profit.

As anchor institutions, Health & Wellbeing Board partners could play a key role in tackling health inequalities post-COVID-19, not just in terms of interventions or service delivery but also as employers, purchasers, holders of physical assets, and partners within local

economies. GFirst LEP has also expressed an interest in exploring the potential of anchor institutions to contribute to Gloucestershire's economic recovery plan.

In June, the Health Foundation published a blog post titled *'How the NHS can use anchor strategies to build a healthy and sustainable post-COVID-19 recovery'*[4] which set out five areas in which the concept of anchor institutions could tackle health inequalities, including those experienced by minority ethnic groups, during the recovery phase. These are paraphrased in the context of the Gloucestershire Health & Wellbeing Board below.

- **Employment** – The economic downturn following COVID-19 lockdown restrictions has seen the highest number of people claiming unemployment benefits in the UK for 27 years. We know that there is a clear link between good, stable employment and good health and wellbeing and that in Gloucestershire, around 74,000 people were working in the health, care and public sectors in 2015, making up just over a quarter of the local workforce. There is a clear opportunity for Board members to use their role as employers to target volunteering, training and stable employment opportunities at local residents, particularly those furthest from the labour market or most at risk of experiencing health inequalities, e.g. those from BAME populations.

- **Procurement and commissioning** – The NHS alone has significant purchasing power, spending nearly £30bn a year on procurement pre-COVID-19. Initiatives, such as a local company changing production to provide PPE to NHS and social care organisations, have shown how the health and care and local businesses can work together in ways that were not imaginable pre-COVID-19. Cheltenham-based Kohler Mira produced 12,000 face shields in just two weeks for Gloucestershire Hospitals Trust and a local hospice. Health and Wellbeing Board members have an opportunity to build resilience and increase community benefit by diversifying and strengthening local supply chains, which in turn support local economic recovery through employment opportunities.

- **Estate and workplace –** Public sector partners hold significant physical assets. COVID-19 has forced organisations – particularly those on the front line, such as hospitals – to creatively utilise space. But it has also required partners to reduce the use of spaces through increased remote access to services and consultations and virtual working practices. As these trends are likely to continue, organisations have an increased responsibility to ensure these digital solutions can reach all patients, service users and staff and to tackle digital exclusion. There are also opportunities for partners to ensure spaces can be repurposed in ways that could support local communities.

- **Environmental sustainability –** COVID-19 has had a mixed impact on the environment. The need for PPE has necessitated an increase in single-use plastics with adverse environmental effects. On the other hand, positive benefits of lockdown, such as an increase in walking and cycling, have led to reduced air pollution. In future, partners have an opportunity to promote positive behaviour change and ensure that initiatives are used by all staff and communities, contributing to the delivery of Gloucestershire's Climate Change & Air Quality Strategy.

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[4] https://www.health.org.uk/news-and-comment/blogs/how-the-nhs-can-use-anchor-strategies-to-build-a-healthy-and-sustainable

- **Partnering in a place –** COVID-19 has led to a significant increase in community action and mutual aid groups, which builds on the work done locally through the Enabling Active Communities Board. However, the UK has also seen increased community organising to demand change on related issues such as structural racism and the disproportionate impact of COVID-19 on BAME populations. Learning from and working with local community groups and organisations could help us to better understand the experiences of those most at risk and put in place action to reduce inequalities both in the short term in the event of a further COVID-19 wave or in the longer term.

The Board may wish to consider developing an anchor institution approach that addresses one or more of these strands as part of its approach to tackling health inequalities and particularly those experienced by Gloucestershire's ethnic minority groups.

6. Opportunities for local action

The context in the preceding summary presents a burning platform for addressing the inequality associated with belonging to some ethnic groups. Action is required at a great scale and pace.

- The Director of Public Health report for 2020 will focus on BAME and inequality. Experience of previous reports has shown that this is a really useful tool for engaging the system and shining a spotlight on a particular issue.

- The development of a Gloucestershire Prevention and Health Inequalities Framework will complement the Health and Wellbeing Strategy and provide a clear framework for action.

- Community engagement in this agenda is essential and taking a strengths-based approach in line with the Health and Wellbeing Strategy principles.

- To develop the anchor institution approach, a small working group drawn from interested partner organisations meet virtually to explore:
    i. A shared understanding of what anchor institutions in Gloucestershire are and could be doing to support the local economy
    ii. A clear summary of current anchor institution activity
    iii. An agreed way forward for building on current anchor institution activity.

- The Health and Wellbeing Board can provide system leadership for the recommendations from The *Beyond the Data: Understanding the impact of COVID-19 on BAME groups* report. This recommends "Anchor institutions: scale up prevention services in a targeted and timely way, develop strategies to rebuild trust with health and care services, co-produce solutions with BAME groups and faith leaders, provide safeguards to mitigate risks for all front-line workers." Anchor institutions locally can contribute to the seven recommendations:
    1. Data collection and recording
    2. Community participatory research

3. Improve access, experiences and outcomes
4. Culturally competent occupational risk assessment tools.
5. Culturally competent COVID-19 education and prevention campaigns.
6. Target culturally competent health promotion and disease prevention programmes for non-communicable diseases.
7. COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health

7. Recommendations for the Health and Wellbeing Board

- To note the opportunities for local action, including those which are already underway.
- To commit to developing an anchor institution approach to addressing the seven PHE recommendations.
- To identify representatives for a small working group to agree actions required.