COVID-19 RAPID HEALTH IMPACT ASSESSMENT

TASK AND FINISH GROUP THEME: Black, Asian and Minority Ethnics

Summary of Impacts

This Health Impact Assessment (HIA) describes the impacts of Covid19 on Black, Asian and Minority Ethnic (BAME) Communities in Sheffield. Comparing the local position to national emerging evidence.

Mitigating action taken to date will also be described and recommendations for future action to inform the cities recovery plans.

Out of scope: Migrants and Asylum seekers
Faith Communities and groups

I would like to thank all members of the Black, Asian and Minority Ethnic Sheffield Communities Public Health Group for their invaluable contributions about the lived experience and impact of Covid19. The insight and richness of conversations and solutions provided have ensured we are in a better place as a city to mitigate future impacts from coronavirus and make real sustained change to address long standing health, social, economic environmental and structural inequalities.

Summary COVID19 Health Impact Assessment on BAME Communities in Sheffield

Black, Asian and Minority Ethnic communities have been disproportionality impacted by Covid19, are more likely to be at increased risk of infection and test positive for Covid19 and experience more severe disease and death from Covid19.

Covid19 has exposed and shone a light on existing inequalities and has exacerbated them.

The national position

The PHE "COVID-19: review of disparities in risks and outcomes" highlighted that the risk of dying was higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups.

Risk varies significantly by BAME population. People of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British populations.

During the first wave of the epidemic all causes of deaths were almost four times higher than expected among black males for this period, almost three times higher in Asian males and almost two times higher in white males. Deaths were almost three times higher in this period in black, mixed and other females and 2.4 times higher in Asian females compared with 1.6 times in white females.

The inequalities described largely replicate existing inequalities in death rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups. One of the possible reasons for this is the young population profile of BAME communities. As the risk of death increases with age.

Evidence from the Office of national statistics has shown that when health conditions are included, the difference in risk of death among hospitalised patients is greatly reduced between white and BAME populations. However some BAME populations still remained 1.9 times at higher risk of dying from Covid19 than white populations when health conditions were taken into account.

Data issues

Due to ethnicity not being recorded on death certificates we do not have information on Covid19 deaths at a national and local level by ethnicity. Other than via analysis and the commissioned PHE reports focusing on risk and outcomes for England that the Chief Medical Officer commissioned in May 2020.

Covid19 test outcomes data at a local level vary in quality and completeness by ethnicity therefore we cannot report with confidence on this at the moment and testing outside of hospital was not available during the lockdown period.

In Sheffield data on the number of people hospitalised, with serve disease and number who were in the intensive care unit, number requiring oxygen support and number who died by ethnicity group is not published locally.

Sheffield position

According to the 2011 National Census 19% of Sheffield residents are from BAME communities this equates to around 105,861 people Please see Chart 1 below for a breakdown of Sheffield residents by ethnicity in 2001 compared to 2011 and the England average

Ethnic group	Sheffield 2001	Sheffield 2011	England 2011
White British	89.2%	80.8%	79.8%
White Irish	0.7%	0.5%	1.0%
White other	1.4%	2.3%	4.7%
Mixed	1.6%	2.4%	2.3%
Indian	0.6%	1.1%	2.6%
Pakistani	3.1%	4.0%	2.1%
Bangladeshi	0.4%	0.6%	0.8%
Chinese	0.4%	1.3%	0.7%
Other Asian	0.5%	1.0%	1.5%
African	0.6%	2.1%	1.8%
Caribbean	1.0%	1.0%	1.1%
Other Black	0.1%	0.5%	0.5%
Other ethnic group	0.4%	2.2%	1.0%

Please note there is no data on the Yemini Community and limited information on the Roma Slovak community. The Yemini community are not featured in the national 2011 census data collection so we don't know exactly how many people from the Yemini community live in Sheffield this is estimated to be between 3500 and 5500.

Roma Slovak populations are very difficult to estimate due to the stigma attached to the term, which causes many Roma to feel they need to hide their ethnicity and very few completed the national census.

According research conducted by Migration Yorkshire 2012 there is thought to be around 2,100 Slovak Roma people living in Sheffield. 1,500 Roma Slovak people live in Fir Vale/Page Hall and 550-600 in Tinsley/Darnall.

The current population estimates for Sheffield are our best estimates, it is important to state that this information is 9 years out of date and population changes and migration will have occurred during this time.

There have been significant changes to the demographics and population of Sheffield since the last census and there is a significantly larger proportion of BAME communities made up of the European ascension states particularly Romanian Slovakian, Polish and Eastern European.

This is crucial in terms of how this data is utilised to inform local policy decisions, Covid19 recovery plans and mitigate against worst effects of second and subsequent waves

The next census is taking place in 2021 so we will need to update this impact assessment to reflect the changes in BAME populations.

Why have BAME communities been hit harder by Covid19 and what is driving these disparities?

The PHE report "Beyond the data understanding the impact of Covid19 on BAME populations" outlines many deep rooted and fundamental issues of health and society that need to be addressed both in Sheffield and across the UK.

The unequal impact of COVID-19 on BAME communities may be explained by a number of factors ranging from: social and economic inequalities, historic racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, CVD and asthma. Unpacking the relative contributions made by different factors is challenging as they do not all act independently.

Due to the lack of local data on the impacts of Covid19 by ethnicity it has been very important to work in partnership with BAME communities to understand their lived experience of how the negative impacts have manifested and what we needed to do to mitigate these

Sheffield BAME Communities lived experience of Covid19

The BAME Public Health Communities group was established by Sarah Hepworth (Public Health) and Shahida Siddique (Faithstar) to understand the lived experiences of BAME communities/organisations and what the positive & negative impacts of Covid19 have been locally during the epidemic.

Twenty five BAME organisations attend the meeting (see appendix A for details) and represent the following communities:

Black - African, Caribbean and Somali
Asian – Pakistani, Bangladeshi and Chinese
Yemini
Minority Ethnic – Roma Slovak

The impacts the group have described are as follows:

The disproportionate impact on BAME communities has been compounded by longstanding structural and health inequalities, discrimination and racism in already vulnerable communities.

BAME communities in Sheffield are more likely to be at increased risk of exposure to the virus due to living in densely populated urban areas, in overcrowded housing (average household in the Roma Slovak community is 6 and Bangladeshi community 4.2 compared to city average of 2.3). Overcrowding has been a major issue in housing for BAME communities as culturally they live in multigenerational families and or extended families who live within a very close proximity to each other. This makes it harder to self –isolate and means intergeneration's (children/grandparents) can transmit the virus more easily between each other due to the lack of space for recuperation, however a positive side is that there is a wider support network of family and friends for those who do fall ill or have long term health conditions to be supported . Around 15% of BAME households in Sheffield have at least one fewer bedroom than they require, compared to the citywide average of 5%. (Sheffield Community Knowledge Profiles 2015).

Overcrowded Housing Impacts on Health

Children in overcrowded housing are up to 10 times more likely to contract meningitis than children in general. Children living in overcrowded and unfit conditions are more likely to experience respiratory problems such as coughing and asthmatic wheezing. Overcrowded housing conditions during childhood are linked to long term impacts on health. Growing up in overcrowded conditions has been linked to respiratory problems in adulthood and children missing school. Poor housing affects children's ability to learn at school and study at home. These factors exacerbate the risks of Covid19 (a respiratory disease) for families who live in overcrowded homes.

Poverty, Income and Employment

The job and careers available to BAME communities has quite often meant that they are in precarious employment; many are on zero hour contracts and in vulnerable employment sectors. BAME communities are more likely to be in jobs (social care, nursing, taxis and chefs) - where you have more contact with others and are less able to work from home during lockdown and are more likely to need to use public transport to get to work. Therefore; are at increased risk and exposure to the virus. BAME communities are also more financially vulnerable due being more likely to be in less secure job roles that are at increased risk of being shut down during the epidemic.

Many people from BAME communities are self-employed and own their own businesses; Some people from BAME communities may have less information about the financial support available (e.g. UC) and are wary of authority and therefore less likely to engage in order to get that support. Although central government has made funding available for those in self-employment - they didn't announce it until sometime into lockdown and they have made the application process increasingly complicated which in turn increases the barriers for those whose business structures may be less formal.

This position was confirmed by the group, who reported that a high number of people had lost their jobs and a number of self-employed people were not getting enough support such as, taxi drivers and chefs.

Career and employment opportunities for members of the BAME community are compounded by their lack of access to job opportunities and continued professional development in their

careers. This is reflected in the fact that across the city when it comes to the leadership positions in the NHS, Council, University and VCF sectors they do not reflect the diversity of the city.

This is also compounded by the fact that many young BAME people also leave the city to look for job opportunities and careers elsewhere in the country travelling too larger cities such as Birmingham, London, Manchester, Leicester and Leeds to find job opportunities for themselves.

The cumulative impact of this is that many BAME communities then lose younger generations of people that could support the development and growth of those communities in the city.

Citizens Advice Sheffield stats show that the pandemic is having a disproportionate impact on incomes of BAME communities. 40% of the people they have helped over the last few months describe themselves as from BAME communities.

Health Conditions

Severe disease outcomes and death from Covid19 are strongly linked to economic disadvantage, which is strongly linked to the prevalence of smoking and obesity, cardiovascular disease, hypertension and diabetes. These health conditions are more common among certain ethnic groups. These patterns of ill health are replicated across Sheffield with higher rates of health damaging behaviours and associated diseases in poorer areas.

A higher proportion of BAME communities live in areas of deprivation in the Sheffield (38% vs 23% city average) including Burngreave, Firvale, Page Hall, and Darnall, Sharrow - these are amongst the 10% most deprived in the country. These areas of the city have experienced a greater burden of disease from Covid19 than more affluent parts and have seen some of the highest death rates in the country.

Data on the proportion of people who had severe disease and an underlying health conditions and either recovered or died is not available locally by ethnicity. This means we are unable to review this data in comparison to the national picture.

Data on the prevalence of health conditions (diabetes, hypertension and cardiovascular diseases) by ethnicity group is not available at a city wide level only at a GP practice level and this is not routinely published. Smoking and obesity prevalence is available at a citywide level but not by ethnic group.

The lack of complete, accurate local and national annual data surveillance on disease prevalence and health behaviours makes it more challenging to target resources, services, tackle inequalities in health and monitor progress.

Had this data collection been in place, in line with the requirements of equality and diversity legislation, Sheffield and other areas could have more effectively addressed the disparities from Covid19 as these would have been noted earlier allowing a more timely response.

Health Behaviours

Diet and Obesity

There is evidence that people who are obese have a higher risk of catching Covid 19 and a higher risk of being severely ill with it. In a study of nearly 17,000 hospital patients with Covid-19 in the

UK, those who were obese - with a body mass index (BMI) of more than 30 - had a 33% greater risk of dying than those who were not obese

In the year to November 2019, 62.3% of all adults (people aged 18 and over) were overweight or obese, a similar percentage to the previous year (62.0%). Nationally higher than average rates of obesity are also seen in White British and Black ethnic groups (63% vs 73%). Adults from the Chinese ethnic group were the least likely out of all ethnic groups to be overweight or obese (35%). The percentage of adults in the Asian (56%) and mixed (57%) ethnic groups who were overweight or obese was lower than the national average. However it is important to note People often underestimate their weight and overestimate their height. This means their self- reported body mass index (BMI) is known to be lower than it actually is and thus these figures could be higher. Those with physical disabilities that cause mobility problems; those with learning disabilities; and those with severe mental illness are more likely to be obese at higher rates than the national average (NICE, 2014).

Maintaining a healthy diet is part of supporting a strong immune system there is evidence of weight gain, poorer eating habits and increased food insecurity particularly affecting the BAME community. Fewer BAME communities have accessed the weight management service for support in lockdown than previous years. This needs to be reviewed on an ongoing basis.

Individuals following religious diets may have had difficulties accessing some foods at the start of lockdown when there was panic buying. Shopping restrictions may also have impacted during Ramadan. Also there may be negative emotional wellbeing impacts of not being able to follow usual customs regarding shared meals and celebrations during Ramadan and Eid

Food security is discussed later on in the paper.

1.

Physical activity: Activity levels are already typically lower for people in lower socio-economic groups and people from BAME communities and this is likely to remain the case (Sport England). People from a White background were most likely to have been active for at least 30 minutes on five or more days, and those from a Black background least likely during lockdown.

Tobacco use: People have been responsive to messages on quitting - we must continue to capitalise on this. However, some report smoking more and children may have been at increased risk of secondhand smoke exposure due to being at home more. Access to Nicotine replacement therapy has been problematic for some groups in the city, especially pregnant women. Referrals into the adults stop smoking service for BAME populations and number of quit dates set and quits achieved have remained largely the same during the pandemic.

During lockdown Smokefree Sheffield delivered a range of communication campaigns, QuitforCovid, Quit Shisha and Quit for Ramadan these were widely advertised across social media and via community organisations and saw high engagement. However it is not known at a population level how many people tried to quit or quit as a result of this engagement by ethnicity groups.

Smoking prevalence data is not available at a local level by ethnicity only by geography and certain sub populations: such as mental health and routine and manual workers. However we

know that this is problematic as national evidence indicates the some ethnic groups have a high proportion of smokers. Our services and communications need to be tailored to meet these needs effectively.

Smoking in pregnancy

Data from 2020, shows the percentage of black and ethnic minority (BAME) women engaging with the smoking in pregnancy service has reduced between 1st March and 31st May in 2020 compared to the same period in 2019. This is concerning as BAME pregnant women are x8 more likely to be admitted to hospital with Covid19 symptoms. Anecdotal evidence from the local community is telling us that BAME populations are not accessing care for fear of being infected with Covid19 if they do.

Alcohol: consumption has increased during Covid-19. The impacts of Covid-19 (unemployment, anxiety, isolation etc) may lead to an increase in problematic drinking. People in 'socio-economic group' ABC1 were more likely to says they had been drinking more than people in group C2DE (32% compared to 24%). It is not understood at a local level how alcohol consumption has varied by ethnicity as there is no data collection on this.

We need to understand more about how the impacts of Covid19 has affected health behaviours of BAME populations and further understand how these are distributed across sub-populations e.g. by age and sex, deprivation, disability and mental health. The Sheffield population questionnaire on the impacts of Covid19 will hopefully provide further insights into the latter.

Food Security

Vulnerability to food insecurity has worsened for the economically vulnerable under COVID-19 conditions. The COVID-19 crisis has also created new economic vulnerability for people experiencing income losses and self-isolation (Food Foundation). Poverty accounts for the remainder of those reporting food insecurity under Covid 19. The groups most affected include adults who are unemployed, adults with disabilities, adults with children, and Black and Ethnic Minority groups**.**

Free School Meals.

Children's entitlement to a Free School Meals (FSM) is used as a proxy indicator for family income and deprivation. In Sheffield 24.7% of school children claim FSM. However when this is broken down by ethnicity the data reveals stark variation in the proportion of families who are entitled to FSM**.** 20.5% of families with white children claim FSM compared to significantly more children in all BAME groups. The highest proportion of FSM entitlement claims are amongst Roma families with 58.8% of Roma children claiming FSM, followed by 47.1% of Yemini children and 45.7% of Somali children, 32% of Black African children and 22.8% of Pakistani children. This further highlights the disparities in income and deprivation of different communities in the city.

Local anecdotal evidence that FSM vouchers may not be suitable if a family does not live near a participating shop, lacks cooking equipment, knowledge, time skills etc.

Some vulnerable children are in school and can still access meals. A small number of schools are doing food parcels rather than vouchers. FSM vouchers have been extended to cover school holidays including over the summer which should help families financially. In Sheffield there is

also “Healthy Holidays” a DFE funded programme to provide targeted additional healthy meals to families identified by schools as in greatest need.

Of the 6088 children who attended Sheffield Schools during the lockdown period around 25% were from BAME communities. However very few children from the Somali, Bangladeshi, Yemini and Roma communities attended school during this time. This means a larger number of vulnerable children will have missed a nutritious meal which is some cases could have been there only hot meal of the day. The demand for emergency food parcels and foodbanks has been significant during this period.

Emergency Food Parcels

As of the 2nd of August 2020 Sheffield City Council had distributed 532 emergency food parcels to eligible residents who required food (within 24 hours) and were self-isolating or shielding due to coronavirus, and had no support network that could help them. Only 5% (30) of emergency food parcels were delivered to people who identified themselves as from a Black, Asian or from an ethnic minority. This programme of support went live on the 3rd April 2020 however data on the ethnicity of residents requesting parcels was only collected from the 11th of May so we do not have a complete picture.

This request for data collation to monitor the ethnicity of people asking for emergency food parcels came about due to the need to ensure BAME communities were receiving the support that they needed.

This meant many of the vulnerable BAME community members had to rely on BAME community organisations to meet their needs at a grassroots and local level. BAME community organisations delivered hundreds of food parcels, some also provided hot meals to vulnerable people during that time and also during Ramadan - Frontline workers were also included in the response. Sharrow Community Forum, Faithstar, Darnall Wellbeing, Pakistani Muslim Centre delivered significant food responses.

Much emergency food support in the city during the crisis has been associated with religious institutions, including churches and mosques - the support is open to people of any or no religion.

The community organisations sighted the following reasons for why they think the community turned to their services rather than use the council service

- Lack of cultural appropriate food boxes
- Lack of awareness of the service and language barriers
- Lack of trust in the council to meet their needs due to past experiences
- Already established trusted relationships with community organisations or places of worship

Communications, mixed messages and misinformation

Confusing and mixed communications from national and local government led to many BAME communities to look to none credible sources for information on Covid19 during the epidemic – this was further reinforced by complex and confusing national guidance. BAME communities looked to friends and family on social media or WhatsApp rather than the NHS, council, government or PHE websites. People also looked to their country of origin at times for guidance; this is problematic as advice could be very different, depending what point in the epidemic countries were at.

Communities told us about the following that people were frightened to attend appointments at the hospital for fear of getting Covid19.

Hoax rumours circulating included:

- BAME communities being used as Guinee pigs for vaccination research,
- If BAME people go to hospital for treatment for any condition you will get Covid19, they will inject you with it
- If you go into hospital due to COVID19 you won't come home again
- White people will be given preferential treatment if oxygen supplies are limited in hospital
- Covid does not even exist – just a way to control BAME communities

Communities reiterated the importance of simple, clear messaging and the use of various media channels to more effectively reach BAME communities such as local shops, mosques, closed WhatsApp groups, podcasts, posters with joint logos on to demonstrate local partnership approaches between the council and community organisations and the use of community radio.

Greg Fell's video updates have been a great success and well received by BAME communities. Translation of information into relevant languages including materials, social media and videos was cited as something that needed to be addressed in order to effectively reach BAME communities.

Cultural and language barriers - to accessing information and services (literacy, translation and cultural appropriateness). People with language barriers are less able to access services remotely, even if they have the digital access due to the latter.

Education

Families & children with English as an additional language will have found accessing and engaging with home learning complicated due to the language barrier. The group told us

"Education is key and the children are suffering, not all parents are able to home school during this time, parents may not understand the systems in place"

"Children are falling behind with their education and we wanted to know how to bridge the gap and how will they catch up"

Also BAME Children have an increased likely hood of being bereaved impacting their emotional and mental wellbeing.

Due to the multi-generational extended families that many BAME communities live in the added worry and pressure of sending children back to school and the implication this may have on more vulnerable members of the family in terms of increased infection risk and bring the virus into the home from school. This led to poor mental health, anxiety and depression because they had to take into account the higher risks of infection due to the disproportionate impact of COVID-19 on BAME communities.

This compounded the fear in BAME communities about having to make choices about sending their children back to school .The additional impact of these decisions also related to the fact

that many BAME parents work in frontline job roles and therefore had to take into account the implications of falling ill themselves.

Digital inclusion and poverty - Access to technology is limited due to poverty and being unable to afford the equipment. This has prevented some communities from being able to key in touch with loved ones. Has worsened feelings of isolation and loneliness among the elderly.

Many young people within BAME communities have not had access to the digital technology to enable them to access educational facilities and online lessons as many families may only have one laptop per family. This has put schools under a lot of pressure to provide additional tech for families that may need this. Digital poverty has compounded many of the structural inequality that BAME communities face.

Mental Health and Wellbeing, Loss and Bereavement

Mental Health remains a taboo subject for many within BAME communities, although not in denial, there are issues around expressing and understanding mental health conditions and accessing the support that is available. Covid-19 has further compounded these issues.

Many BAME communities have lost friends and family colleagues, and the impact on communities has been significant. People have felt dismay, anger, loss and fear about the emerging data and realities for BAME populations**.** The restrictions imposed on funerals and other religious ceremonies have further complicated the bereavement process, as many people who have lost friends and family members have been unable to grieve in a normal and healthy way.

Many BAME communities have not been able to undertake life events marked in a culturally and religiously appropriate manner as BAME communities are very close knit in Sheffield and rely very heavily on social cohesion within families and communities.

This has meant that social restrictions due to COVID-19 have directly impacted lifestyles in a much more profound way as many bame communities rely on social cohesion to overcome many of the barriers they face in Society.

For example: social interaction is used as a way to find out information, gain knowledge access support and maintain contact rather than use of trusted sources such as government websites or the news.

Grassroot community organisations identified that mental health issues within BAME communities were not being picked up enough by statutory services. This has meant that BAME community organisations had to help pick up people with serious mental health conditions. They felt unequipped to deal with the demand and did not know what support was available for people. It was felt that mental health resources have gone to the same organisations and structures have not been responding to the needs of communities.

Where referrals have been made to statutory services, the waiting lists are prohibitive, and the community workers have no choice but to do their best at the front line. A Lack of interpreters is another challenge faced by many people within BAME communities in accessing mental health

treatment and support. It was cited that free Mental Health First Aid Awareness training for staff and volunteers in the community would help enormously and was urgently needed.

It was felt that organisations like SCC and CCG and VAS do not always take into account context, on the areas that BAME organisations are working with people - these cases are highly complex and they are dealing with multiple factors.

Organisations are working with young people who are victims of violence, & some of this violence is racially motivated. They are constantly dealing with people who are traumatised, and said they were traumatised before lockdown and the situation is much worse now. It was felt that community based projects deliver the best outcomes for people who are traumatized and experiencing high levels of stress and anxiety because they are trusted spaces by the community.

Mental Health Services need to understand the religious and cultural impact and lived experiences that may not necessarily be rooted in western mental health recovery. For example many BAME communities come from faith communities who may view mental health through the lens of faith. The issues of mental health can be hard to overcome if this is not understood. For example the Chinese medical practice, African Caribbean health practises eastern medical practises. Some BAME communities view medical practises as very invasive and extreme and contradictory to their beliefs.

There is also an engrained fear of medical practices and fear of being experimented on and tested on by BAME communities which further compounds people's willingness to access mainstream support.

Isolation and Mental Health

Fear of infection was highlighted as a concern by the BAME Inequalities Community Group, where it was reported that some people had stopped going out and in some cases given up work for fear of infection and leaving their children without parents. This has led in many cases led to increased stress, anxiety and feelings of isolation.

The impact of isolation on many BAME communities has been particularly detrimental amongst older members. They rely very heavily on extended family for support and interaction and due to covid and have found themselves very isolated.

Loneliness has triggered mental health issues and more resources and support are needed. There needs to be links with GP's and all BAME organisations and communities need to be a part of the programme and supported.

During lockdown Muslim children have not been able to celebrate Ramadan in their usual way, funeral rituals have been prevented and faith schools which children access on evenings and weekends have been closed – all of these factors will have impacted on the wellbeing of families.

Isolation and loneliness

COVID-19 will likely exacerbate isolation and loneliness in Black, Asian and Minority Ethnic groups. According to British Red Cross research, BAME groups are at a higher risk of being isolated/lonely. The research shows that people from BAME backgrounds are more at risk of experiencing certain factors that cause loneliness and can often face greater barriers to

accessing support. When we feel we belong, we feel less alone - feeling valued, included, safe and able to join in community activities helps to tackle loneliness.

People from BAME backgrounds often feel less able to access community activities and support – 'not having enough free time' and 'affordability' are barriers to accessing support that are more commonly cited by all minority ethnic groups than by White British groups. 'Lack of confidence' and 'not feeling welcome' were the most common barriers for all groups, but White British groups were far less likely to feel unwelcome or as if a service is 'not for them'.

Loneliness and stigma – stigma is a significant issue, surveys highlight that many people worry about what people would think if they admitted to feeling lonely – this was felt more starkly by BAME groups.

The BAME community groups reported having witnessed deterioration in the mental health of older people in my community, there are examples of extreme social isolation due to fear of catching the virus. "I visited a woman in her 70's and then realised I was the first visitor she had seen in 5 months. Her life included watching TV and sleeping and very little else, with shopping dropped off at the door and living off packet rice. She felt she had no choices and felt that everything was blocked. She was clearly depressed and lonely"

Black, Asian and minority ethnic groups that meet up via lunch clubs are also at risk of being increasingly isolated, with some attendees being unable to speak fluent English. This can be a social barrier and it is why activities like the Chinese Healthy Eating Lunch Club are so important. Attendees feel a sense of community and belonging. COVID-19 restrictions will cause additional isolation for groups who are already at risk of being marginalised due to language barriers.

Places of worship were closed during lockdown, so for some, not being able to socialise or talk with people will have led to them feeling more isolated/lonely. Some services have been online but not everyone is able to access them due to digital exclusion. There doesn't seem to be specific research on religion/isolation and loneliness
Social isolation and loneliness are risk factors for poor mental and physical health (Santini, 2020). A study (Steptoe, 2013) highlights isolation as one of the main risk factors that worsen pre-existing conditions, comparable to smoking. Research has found that feeling lonely, being physically isolated or living alone were each associated with a risk of early death (Holt-Lunstad, 2015)

Carers

Many professionals and society do not recognise unpaid family carers and even many carers do not define themselves as a carer. Many of the issues that carers face, and that contribute to carers experiencing poorer health than non-carers, go unseen. This is more marked in BAME communities where caring is a traditional part of culture and family life.

Caring for longer and a greater number of hours has a detrimental impact on a person in terms of continuing to work, health, access to replacement care for a break. These impacts are more marked in BAME communities as a lower proportion of the BAME community ask for support outside the family or take up residence in care homes in the city.

The city-wide data about carers from BAME communities comes from the 2011 Census. Though not up to date, it gives one indication of the numbers of BAME carers. At that time, 11% of carers (just over 7,000 people) in Sheffield were from BAME communities, one third of whom were of Pakistani ethnicity. This is an underrepresentation of the 16% of the total population who were from BAME communities, and suggests that many BAME carers did not recognise their caring role and/or did not respond to this question in the Census.

In the three quarters up until March 2020, on average 9.3% of the carers who registered for the first time with Sheffield Carers Centre and for whom there is ethnicity data were from BAME communities. In the quarter April – June this dropped to 5% (the total number of new registrations also dropped in that quarter). New BAME carer registrations climbed again to 10% of the total in July-September. Thirty seven percent were of Pakistani ethnicity, and the remainder Bangladeshi, Indian, Black Caribbean, Somali, African and Yemeni.

New carer registrations is only one part of the picture, however, and only a small part of the picture of how Covid impacted on BAME carers. A sample of the service that has been delivered since Covid has shown that many of the BAME carers who accessed support were already registered and were needing further support. The records show that a full range of support was accessed, including Tier 1 Carers Needs Assessments, new and reviewed Tier 2 Carers Needs Assessments and Personal Budgets, Time for a Break grants, individual hardship funds (to purchase essential household items such as washing machines and cookers), income maximisation (provided by the partnership with Citizens Advice Sheffield), and general casework with issues such as packages of care for the looked-after-person. BAME carers were also included in the list of carers assessed as being at highest risk at the beginning of the pandemic, and who were contacted for 'check-in' calls. A detailed piece of work would be required to more fully interrogate the data and BAME carer issues from the casework records.

The City needs to work collectively to identify carers earlier and support them to remain well.

BAME Communities and Trust with the Public and VCF sector

In Sheffield for at least the last 15 years BAME community organisations have survived due to national funding and little or no local funding.

This has meant that many members of the BAME community organisations have felt alienated ignored and marginalised as they do not see themselves reflected in the decisions made in the city. The disproportionate impact of covid meant that the very communities that had little trust in the council, NHS and Universities and VCF sector we're the ones that needed us the most.

Community organisations felt that no one cared and the council and NHS have neglected them and the communities they work with, even though this may have not been intentional. They also felt that VAS and other anchor community organisations do not represent them or their needs.

They felt that the NHS and the council needed to listen and learn and engage better with BAME community organisations.

Organisations were/are wary of the Council and other organisations but wanted to move forward and work collaboratively together. There was a huge amount of mistrust between the communities and public and VCF sector bodies. Covid19 has shone a light on the decimation of BAME VCF sector services. Many have volunteered and used their own funds to support communities with food and self isolating and accessing services during lockdown.

BAME organisations felt that the reason people access community services is they don't have to fully explain their needs "we understand their cultural, language and religious needs – where mainstream services fail".

"There is indirect unconscious bias as they don't see themselves reflected in services so they don't feel confident and welcome"

It has been critical to re-establish trust, rebuild dialogue and reaffirm relationships and networks. Ensuring timely information and communications. Formulating strong links with the leadership in the city and communities. Ensuring decision makers could hear and see the lived experience of BAME community members.

All of the above actions were absolutely vital to restoring and re-establishing of trust. The direct health impact of not doing so under such unprecedented circumstances would have meant that many more lives would have been lost.

Racism directly due to epidemic

The Chinese community in Sheffield have been directly targeted during the epidemic with racial abuse – specifically around being seen as responsible for bringing covid into the country and also for wearing face coverings before others had been asked to wear face them – or it was mandatory practice.

Funding and lack of BAME community infrastructure

LA funding has been reduced with the impact of austerity by 50% and some very difficult decisions have had to be made which have impacted on communities in Sheffield.

Lack of resources and community infrastructure, was an overarching theme of the BAME Inequalities PH Community meetings. Community organisations feel that there is an unequal access to community funding for BAME organisations in the city and this has led to many being under resourced and less equipped to deal with the epidemic. They have used their own money and volunteers to respond. It was felt that there has been chronic underfunding of BAME infrastructures in the city and capacity building.

Organisations felt that there needs to be training and support for BAME VCF organisations re: applying for funding; they are so busy delivering services that some VCF organisations neglect giving funding applications the priority they need.

There's a huge amount of frustration that the issues that impact on BAME organisations are well known, yet there is still a "lack of confidence in us" "we would like to see more acknowledgement (from SCC and NHS) of how we have risen to the challenge. BAME

communities have been hit harder with covid than other communities, it's a double whammy when you factor in deprivation and racial abuse"

Many BAME community groups have reported that their services are exhausted; they simply do not have the resources, infrastructure or capacity to deal with the increased demand.

Organisations also stated that there is nothing to be done about the past but we can help shape the future. BAME communities and organisations have solutions that can help, with a lot of experience and talent. They have been heroic in their efforts in the city and undoubtedly saved many lives.

Domestic Abuse

In 2019/20 34.4% of IDAS service users were BAME. In Q1 of 20/21 the proportion is 27.4%. The most significant reductions were in relation to people identifying as: Arabic (8.3% to 4.6%), Asian other (i.e. not Bangladeshi, Pakistani, Indian or Chinese: down from 5.7% to 5%) and Black other (i.e. not African or Caribbean down from 4.7% to 3.9%). The pandemic and lockdown have potentially increased barriers to accessing support amongst the BAME community.

Specialist agencies have reported that some BAME women are likely to be more isolated and have less access to usual supportive agencies and / or technology to help them access support. Some of the problem will be in relation to language barriers. The majority of social media messages have been in English however at the time of writing a card translated into community languages is being printed for distribution via food banks and other community outreach provision.

Shelter have reported that people without regularised immigration status fleeing domestic abuse are also experiencing problems accessing emergency accommodation. And the higher level of incidence of COVID 19 in the BAME community has also raised issues – a local health trust reported a recent case involving a BAME staff member where the risk of isolation and coercive control by their family members was heightened as they argued that the victim/survivor should not leave the household to go to work for fear of them being exposed to COVID in the community or workplace and potentially bringing the virus back to the home.

Local specialist services – Ashiana and Roshni have reported a rise in referrals and while their overall referral levels are low compared with IDAS this may indicate that more could be done to work jointly with BAME specialist organisations to safeguard and support victims/survivors. The proportion of people referred to IDAS who described themselves as being at risk due to forms of abuse more prevalent in certain cultures (i.e. Forced Marriage, so called 'Honour' Based Abuse and Female Genital Mutilation) has not changed over lockdown. Some victims/survivors with no recourse to public funds have faced additional barriers to access support: one survivor was trafficked into the country as a child. As well as experiencing domestic abuse she had been sex working to support her children and maintain the privately rented flat. With Coronavirus she had to stop working and sought help from school who helped her access a refuge. Another woman with one child said her husband told her she wasn't allowed to leave because the government won't allow it due to COVID, she would have her child removed and she would be arrested. The woman was from Iran, English was her second language, so she believed him. Children's Social Care got involved and she was then able to leave.

Positive aspects occurring due to the epidemic

People in BAME communities have mobilised and have helped in a huge way and saved many lives and supported each other. Food banks have been set up in a matter of days and the communities have come together to ensure people were protected.

The formulation of the BAME Community Public Health Group has led to a very positive relationship developing between the public sector and BAME VCF sector. The BAME community organisations themselves have further enhanced relationships and connected more.

At the last meeting we took stock and reviewed the journey with the group and next steps, this is what they told us:

This is one of the only safe spaces in the city for us to have these important and difficult conversations.

- ***The collaborative, participatory approach has been excellent***
- ***Brilliant collaborative and reflective approach to community work.***
- ***We have felt really heard***
- ***It has been such a powerful and important space***
- ***This journey has been epic, such a good practice model and should be replicated in other spaces in the city***
- ***I have grown in confidence and it has been important for my own journey. I have access to more professionals than ever before this has strengthened my work and my own practice. Also we (the community organisations) are collaborating working to understand how we can work better together. Lots of us had not done this in years,***
- ***Pro-activeness and participation has been key going forward well done everyone***

Recommendations:

1. Outline how the city will implement the 7 recommendations from the PHE "Beyond the data understanding the impact of Covid19 on BAME populations" report and HWB strategy and ACP recommendations – develop clear specific action plans and review progress against these to aid recovery from the first and subsequent waves of Covid19 and disparities it highlighted.

2. Commit to developing, collecting and analysing ethnicity data on a range of health, environmental and economic and social impacts. Use this information on regular basis to inform decision making, strategies, policy and service development - annual publication – review barriers to sharing data across council and NHS systems (intersectional data by ethnicity and other equality characteristics should also be collected)

3. Continue to invest in community engagement that is reflective of BAME and Faith communities in the city, ensure this is undertaken as equal partners in all aspects of this process

4. Commit to working with BAME organisations and support the transition of the BAME PH community group into existing structures i.e. equality partnership - to ensure the dialogue remains open, further trust and relationships are established

5. Policy leads and commissioners should empower and involve BAME voices from the community in the development of strategies, services/interventions, policy, communications and health education campaigns that involve them

6. Support and develop capacity building within BAME community organisations and invest in the infrastructure of BAME community organisations in the city to enable them to be more resilient and deliver effective frontline services

7. Ensure NHS and Council services are representative, culturally appropriate and inclusive (including relevant training across the system)

8. With immediate effect in light of a second wave of covid approaching- invest in and accelerate efforts to develop culturally competent health promotion and disease prevention programmes in collaboration with NHS, council and VCF sectors. These should include a range of services for non-communicable diseases and health behaviours including promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

9. Existing public health strategies must be implemented and investment maintained or in some cases increased to enable maximum impact amongst BAME populations - where inequalities in health behaviours have been exacerbated by the response to Covid19.

    - Ensure a whole systems approach that encompasses, prevention, policy and treatment at a population level and addresses the underlying structural, social, cultural, economic and environmental factors (Especially for smoking and obesity – the other epidemics we face and risk factors for Covid19).

GAPS IN KNOWLEDGE / FURTHER WORK REQUIRED

There are huge gaps in data by ethnicity across a spectrum of information and what we do have is out of date and therefore not accurate. This makes it very difficult to develop services and policies that effectively meeting the needs of Sheffield's BAME communities. Our ability to fully understand the level of impact of Covid19 on inequalities in the city, address these adequately and monitor progress has been inhibited greatly by this lack of data.

The population level questionnaire will fill some of the gaps in data but routine surveillance from all statutory organisations is required.

COLLABORATORS AND SOURCES OF INTELLIGENCE

COVID-19: review of disparities in risks and outcomes (2nd June) Epidemiological data
https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

Beyond the data understanding the impact of Covid19 on BAME populations PHE June 2020 (16th June)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

Sheffield JSNA and Sheffield Community Knowledge Profiles
https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=96383090af4149b49112b66dadf2ea3a

Black, Asian and Ethnic Minority Public Health Community Group (Lived Experience)
SCC Community Response Team
Sheffield Carers Centre
Sheffield Citizens Advice
Sheffield Health Impact Assessments (Poverty, Health Behaviours, Isolation, Domestic Abuse)

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Ghazala Razzaq, Roshni Sheffield
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