Item 20c (to support main agenda item 16 (paper J))

The Impact on Health and Wellbeing in Sheffield of the Covid-19 pandemic and subsequent societal response to it.

A summary report for the Health and Wellbeing Board

24th September 2020

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Chapter 1

Introduction

The Covid-19 pandemic began as a cluster of cases of 'viral pneumonia of unknown cause' in Wuhan, China in December 2019. On the 9th January 2020, the cause became established as a novel (new) coronavirus later named SARS-CoV-2. The virus rapidly spread internationally, with the first case outside of China confirmed in Thailand on 13th January 2020 and on the 23rd January, Wuhan was placed under quarantine. Shortly afterwards, on the 24th January, the first European cases were identified in France.

By the 31st January, SARS-CoV-2 had reached the United Kingdom. 34 days later, the first official death within the UK was reported. Sheffield experienced its first confirmed case on 29th February and first death on 17th March. On the 16th March, the Prime Minister announced social distancing measures, advising against all but essential travel and social contact. Those who could work from home were advised to do so and shielding was introduced for vulnerable individuals. These interventions were shortly followed by the closing of schools (to all except the most vulnerable children and those of key workers), and multiple businesses, particularly in the hospitality sector. On the 23rd March 2020, the UK entered lockdown, permitting only key workers to work and only essential journeys for food, medical need and exercise. These full measures stayed in place for approximately 7 weeks until the 10th May 2020, when it was announced that restrictions would gradually begin to ease. Since April, 9.6 million jobs have been furloughed as workplaces were forced to close. As of the 7th September 2020, the UK has documented 350,100 cases and 41,554 deaths of people who had tested positive for SARS-CoV-2 in the 28 days prior to their deaths.

Covid-19, the clinical syndrome caused by SARS-CoV-2, is typified by cough, fever and loss of sense of taste and smell. It is believed to spread primarily via respiratory aerosols or droplets, or from contaminated surfaces. Precise figures for mortality are difficult to assess due to the fast evolution of the situation and varied approaches to testing internationally and over time. Therefore, case fatality rates range widely from <1% to 19%. Deaths from Covid-19 are disproportionately higher amongst older people, people with known long term conditions, people from deprived areas, men and within the black and minority ethic (BAME) population. The potential longer-term consequences for patients surviving initial infection are still not clearly understood.

Sheffield has a population of approximately 583,000. Whilst broadly similar in age demographics to England as a whole, it is notable for a higher than average number of 20 to 24 year olds, due to a large student population of around 60,000 people.

As of the 2011 census, Sheffield was 81% white British with a growing BAME population. After white British, Pakistani is the second most prevalent ethnic group in Sheffield (4%), followed by mixed (2%), white other (2%), other (2%) and African (2%).

Sheffield is a city of wide variations in wealth, ethnicity and health across the city's 28 wards. More than 40% of households in the wards of Darnall and Burngreave are in poverty, compared to fewer than 14% in areas such as Fulwood and Dore and Totley. In 2011, Darnall and Burngreave were also home to a larger proportion of BAME residents – 49% and 62%, respectively. Overall 38% of Sheffield's BAME community live in areas amongst the 10% most deprived in the country and 15% live in overcrowded housing. This is reflected in the pronounced health inequalities in the city, with a difference in life expectancy of over 10 years between Burngreave and Ecclesall and a 20 year difference in healthy life expectancy between the best and worst in the city.

As of the 7th September 2020, 4,862 positive tests for Covid-19 have been reported in Sheffield and 412 deaths have occurred within 28 days of a positive test.

This Rapid Health Impact Assessment (RHIA) examines the impact on health and wellbeing in Sheffield of the Covid-19 pandemic and the social measures put in place to slow its spread. It can be viewed as 12 'mini' RHIAs examining key areas of concern identified by leaders citywide, from which it is hoped learning can be taken to mitigate against second and subsequent waves of the pandemic and used as an evidence-base for recovery activities. (Guidance for theme authors is included at appendix 1). Taken in its entirety it tells a story of resilient people and communities and agile services but sheds a light on historic inequalities which have been made only worse by the double impact of Covid-19 and then lockdown. By highlighting the experiences of some of Sheffield's most vulnerable communities, this report delivers an opportunity for system-leaders to consider what they want the Sheffield of the future to look like and how to get there.

Chapter 2

Active Travel

Summary

This section of the HIA considered the impacts associated with changes in active travel during the Covid-19 pandemic, how these have exacerbated (or otherwise) pre-existing inequalities in this field and how the emerging picture may influence future transport interventions. It considers other travel modes such as the private motor car and public transport but only insofar as these influence and impinge upon active travel.

During the pandemic, in July 2020 the Government released an active travel vision, named Gear Change[1] which included associated guidance for local authorities. Compliance with these will be a necessity both in order to meet our own Transport Strategy (2019-34) policy to ensure that active travel can be prioritised as it puts greater emphasis on the investment in this infrastructure to promote healthy, inclusive and environmentally friendly travel habits.

The Impacts of Covid-19 on Travel Behaviour

The overarching impact of Covid-19 in the initial stages was the reduced need to travel as a direct result of (enforced) home working and furlough schemes. This, coupled with the closure of much economic and service provision, meant demand for travel both for commuting and other purposes, significantly reduced. Traffic volumes fell by as much as 80% at some locations monitored in Sheffield. However, as the economy unlocked, growth in traffic level steadily increased. Road speeds also increased during the periods of lower traffic volumes.

There was also a significant drop in public transport journeys as the need to travel reduced and people were told not to use it. There is also an underlying element of anxiety around using communal confined spaces and this is likely to continue post pandemic.

There has been some evidence of an increase in cycling, most probably driven by increasing leisure trips judged by the days and times these took place. (It should be acknowledged that this is from an extremely low base, both in Sheffield and nationally). Changes to walking levels are less clear, although footfall in the city centre (and some district and local centres) started to rise as the in threat level reduced, to the point where physical measures to reinforce social distancing were required from June/July (see below)

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/904146/gear-change-a-bold-vision-for-cycling-and-walking.pdf

The Response

In terms of crisis response, as lockdown eased there was an immediate requirement to enable physical distancing in order to limit further infection and help prevent a second surge. Government recognised that social distancing requirements reduced public transport capacity significantly making private motor car travel even more attractive. The dangers of embedding further future car dependence with the associated negative implications for cities, especially as economic activity picked up, would be directly contrary to the Transforming Cities Fund (TCF) required outcomes.

On 9 May 2020 Government announced a package of support to enable local authorities and City Regions to implement improvements to cycling and walking infrastructure, putting particular emphasis on places that have a high dependency on public transport[2]. Providing safe and attractive walking and cycling options for previous bus, train and tram users was seen as important for those required to make essential trips. For Sheffield the aim was to capture the positive and sustainable travel behaviour experienced during lockdown and use this as a platform to harness generational behavioural change towards an increase in active travel.

The Department for Transport produced guidance for local authorities[3] on reallocating road space to encourage cycling and walking and enable social distancing in response to Covid-19 related issues. Officers have looked at various possible interventions that have been implemented across cities in the UK and beyond. A number of schemes were identified for local development.

- Shopping Areas and Pedestrian Safety Zones –additional passing provision at constrained areas of pavement where people wait to access to shops etc.

- Safety Zone Marking at Bus Stops and Crossings – 2m guideline markings for social distancing at bus stops and crossings.

- Road Closures – creation of low traffic neighbourhoods to remove through traffic and create an area suitable for active Travel.

- Re-time Signals – modifications to signals timings to allow a more responsive and longer green man time at pedestrian crossings.

[2] https://www.gov.uk/government/news/2-billion-package-to-create-new-era-for-cycling-and-walking
[3] https://www.gov.uk/government/publications/reallocating-road-space-in-response-to-covid-19-statutory-guidance-for-local-authorities

- Temporary Active Travel Lanes – options are being developed for further investigation and implementation, including a trial lane on Shalesmoor.

Which groups are likely to be differentially affected by this issue?

A report completed by Foresight for the Government Office for Science investigated the 'Inequalities in Mobility and Access in the UK Transport System' (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf) demonstrates that mobility and accessibility inequalities are highly correlated with social disadvantage. This means that some social groups are more at risk from mobility and accessibility inequalities, than others:

- Car owners and main drivers in households are least mobility constrained across all social groups. They make more trips over longer distance for all journey purposes giving them higher levels of access to activity opportunities;
- Lowest income households have higher levels of non-car ownership, 40% still have no car access – female heads of house, children, young and older people, black and minority ethnic (BME) and disabled people are concentrated in this quintile;
- In addition, there are considerable affordability issues with car ownership for many low-income households.

Beyond these accessibility inequalities, low income households and other vulnerable population groups, such as children, the elderly, people with mental disabilities or long-term illnesses are also more exposed to health-related externalities of the transport system:

- People living in disadvantaged areas tend to live in more hazardous environments, with greater proximity to high volumes of fast-moving traffic and high levels of on-street parking and, as such, they have higher levels of exposure to road traffic risk.
- Young people (11–15 years) from disadvantaged areas are more involved in traffic injuries than their counterparts living in other urban areas. The risk is highest on main roads and on residential roads near shops and leisure services.
- Traffic-related air pollution is associated with worse pregnancy outcomes and the risk of death and exacerbation of asthma and chronic chest illnesses in children.

Inequalities in the provision of transport services are strongly linked with where people live, and the associated differences in access to employment, healthcare, education, and local shops. This problem is more to do with land-use and public service planning, which determines the physical location and spatial distribution of these services in relation to low cost housing, than with deficiencies in the transport system itself. However, the lack of private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem in many parts of the UK.

Age and sex influence active travel behaviour significantly, and socio-economic status (SES) is also key to active travel choices. Infrastructure improvements, particularly pedestrian environment quality and safety, including traffic volumes will benefit women, children and older people and enable active travel and independent mobility in these groups.

However, infrastructure improvements alone will not address societal and cultural reasons which particularly account for sex differences in active travel behaviour and which also impact on children's choices. Those who are economically inactive may have no alternative to active travel. Poor quality environments can influence non-travel behaviour and contribute to loneliness and isolation. Therefore higher rates of active travel in lower SES communities should not be a reason against investing in improvements in environmental quality, neighbourhood connectivity and facilities.

The recommendations from the HIA are;

1. **For the City to harness Active Travel** – As a City, we need to change the public's perception of Active Travel and capture the propensity to cycle. This will take time, and the Emergency Active Travel Measures that have been implemented have demonstrated the public's negative response to this and we need to try and understand how we can change this perception.
2. **To continue to support bus services and public transport in the medium to long term** – bus services are the lifeline for many communities and individuals. Although there is a short terms restriction and in some cases a fear of its use, this needs to be understood as a short term issue. The medium and long terms commitment to public transport will help provide social inclusion and reduce isolation, whilst also ensuring a sustainable and inclusive economic recovery
3. **To improve data collection and evidence of localised investment benefits** – this is the fundamental floor in current policy making. There is limited data around the impact of change following the implementation of active travel schemes. This is mainly an issue on a local level as data collection post implementation is often scarce due to the limited nature of resource and funding.
4. **To invest in local areas that support none car based short trips** – The need for communities to look towards local amenities is vitally important post covid. Not only does this support the local economy but it also moves away from longer distance strategic movements that are made by private car. The walkable local neighbourhoods supports social interaction and living streets, but also plays an important role in supporting active lifestyles.

Using these recommendation we will aim to better understand the reasons behind different levels of participation in active travel according to protected characteristics particularly age

and sex. This will help ensure that measures to improve active travel infrastructure does not widen existing inequalities and, if possible, narrows them by encouraging and enabling participating from under-served groups .

In order to deliver this, we will use existing investment programmes such as Transforming Cities Fund, to maximise and promote any behavioural change resulting from Covid-19, this should help enable and promote active travel as part of daily routines and awareness of the need to take regular exercise.

There is also a need to develop an understanding of transport inequality risks as a result of increased remote working along with mental health impacts of reduced social interaction. Appropriate transport solutions and access to outdoor space will provide opportunities for exercise and investment in local and district centres to make 15 minute neighbourhoods more viable will help to remove short car trips, thus promoting active travel and removing vehicle movements within neighbourhoods.

Chapter 3

Employment

Summary
This rapid health impact assessment focuses on the impact the COVID-19 pandemic has had on employment and working environments, with a specific focus on the people of Sheffield.

Before the COVID-19 pandemic, despite many years of strong overall economic growth, there were stagnant earnings for many, cuts to the welfare system and a rise in 'solo' self-employment and 'gig' economy (part time, fixed term and often insecure jobs). There were existing inequalities in employment related to age, ethnicity, gender, income and geography. The COVID-19 pandemic has exposed existing inequalities and further impacted these groups.

Some groups of people are likely to be, or have already been, disproportionately affected by the COVID-19 pandemic. The evidence suggests impacts in areas with existing inequalities, including gender, age, ethnicity, income and health status.

- Young people are more likely to work in affected sectors
- Men are more likely to work in roles which are not amenable to working from home
- Women are more likely to work in health and social care roles
- Mothers are more likely to have quit their job, lost their job or been furloughed
- Those in low income roles were more likely to have had reduction in work hours, lost their job or been furloughed
- Members of the BAME community were more likely to be in keyworker roles when compared to white British people

53,500 employments in Sheffield have been placed on furlough under the Coronavirus Job retention Scheme. The three most deprived constituencies have the most furloughed workers.

74.4% of self-employed people in Sheffield were using the Self-Employment Income Support Scheme. The four most deprived constituencies have claims of a value below the national average for the Self-Employment Income Support Scheme.

Some sectors have been disproportionately affected by the COVID-19 pandemic, including arts/entertainment, hospitality, construction work and retail.

The full effect of the pandemic is unlikely to be clear for some time. More jobs will be lost when the Coronavirus Job Retention Scheme ends in October 2020. Many businesses will be

facing difficulties with cash flow and debt as Government support tapers off, meaning there will likely be insolvency events with resultant further job losses.
Working from home can cause loneliness and stress. It has been highlighted that the lack of demarcation between work and home life is challenging and that dealing with clients alone and in the home environment can be difficult.

The UK has entered a recession, with a drop in GDP by 20.4% in the last quarter. The recovery is likely to be quicker than recessions in recent history, but with sectors recovering at different rates.

Recommendations
Sheffield needs a renewed economic strategy. This should be inclusive and fair, considering inequalities in the city. The City Growth Board should establish the economic strategy; acknowledging that this will not be an easy or simple process and is one which will require time. Within this process the City Growth Board should review:

- How the city should define economic success, considering outcomes other than growth, such as health and wellbeing
- Work with communities of Sheffield, for example via voluntary and community sector organisations, to ensure what matters to people is considered in the development of the renewed strategy
- The Universal Basic Income trial.

The Employment Skills and Training Team have prioritised the following: young people, sector routeways (supporting those to retrain who have been made redundant), Intermediate Labour Market and Health and Wellbeing. These priorities are supported by the evidence in this document and should be pursued.

Contributors
This rapid health impact assessment has been completed within the constraints of time while responding to the pandemic. This report was compiled between 20 June 2020 and 21 August 2020. It has involved the input of Jaimee Wylam and Edward Highfield. Data and information have been received and used from local and national sources. This report contains qualitative and quantitative data, anecdote and case studies. Data was received/sourced locally from Sheffield City Council, Sheffield City Region, Citizen's Advice Sheffield, Sheffield City Council, Sheffield CCG, Great Places Housing Association, the University of Sheffield and Sheffield Hallam University.

Limitations
The work could have benefited from wider consultation, to include representatives from communities and business. This work could have also benefitted from inclusion of:

- the impacts for shielding individuals

- the musculoskeletal impacts of working from home
- local data on the protected characteristics of furloughed workers

Chapter 4

Health Behaviours

The illness Covid 19 has disproportionately affected those experiencing socio-economic disadvantage and a number of other sub-populations including age, sex, disability and especially BAME populations. The increased prevalence of preventable chronic health conditions amongst these sub-populations is an important factor in this.

Health damaging behaviours such as smoking, poor diet, physical inactivity and excess alcohol consumption are significant contributors to the development of chronic health conditions. These behaviours are more prevalent in communities that experience socio-economic deprivation and in communities that are more likely to experience discrimination and marginalisation.

The response to Covid-19 has further increased pre-existing inequalities in health behaviours for economically disadvantaged communities and some sub-populations. The implications of this for everyone's health, the city's economy and wider city life will be felt both now and for years to come if action is not taken.

Covid-19 makes it vitally important that prevention is a priority – but so does every other year when 40% of avoidable deaths are as a result of tobacco, obesity, inactivity and alcohol harm.

Impacts for specific health behaviours:

- **Diet and obesity:** evidence of weight gain, poorer eating habits and increased food insecurity particularly affecting children and young people, the BAMER community, those living with disabilities, low income households
- **Physical activity:** although initially activity levels held up relatively well during lockdown, below the surface familiar inequalities are being exacerbated and as restrictions are being lifted, on the whole activity levels are decreasing
- **Tobacco use:** people have been responsive to messages on quitting – must continue to capitalise on this. However, some report smoking more and children may have been at increased risk of secondhand smoke exposure. Access to Nicotine replacement therapy has been problematic for some groups in the city, especially pregnant women.
- **Alcohol:** consumption has increased during Covid-19. The impacts of Covid-19 (unemployment, anxiety, isolation etc) may lead to an increase in problematic drinking

- **Breastfeeding:** possible overall positive impact through increased awareness of the protective benefits and increased time spent at home. Must maintain this.

- **Gambling:** closure of betting shops and pause of sporting events during lockdown has led to switching to online gambling and unknown sports. Most people are gambling less but problem gamblers are spending more time/money. Young gamers may have increased screen-time and exposure to gambling-like products. The longer term impacts of Covid-19 (financial security, loneliness, boredom, isolation) may exacerbate gambling-related harms.

RECOMMENDATIONS

1. **Seek to influence high-level strategic conversations about recovery and next steps for the city:** The difference in risk of illness and death from covid 19 is an immediate issue that has shone a spotlight on long standing health inequalities that must be addressed both in responding to the current pandemic and for the longer term.

2. **Existing public health strategies must be implemented and investment maintained or in some cases increased to enable maximum impact amongst high risk populations**

    - High risk populations are those who have been most disproportionately impacted by Covid19 and where inequalities in health behaviours have been exacerbated by the response to Covid19

    - The increased prevalence of health damaging behaviours in some sub-populations is not simply a result of poor lifestyle choices or a lack of health education. The underlying factors are structural, economic and environmental. This is reflected within existing public health strategies and must continue to be reflected in any further actions and strategies, ensuring a whole systems approach that encompasses, prevention, policy and treatment at a population level

    - There will be resource implications and ideological and structural barriers to much of this and this has historically slowed our progress. However, **the long term financial and human costs to doing nothing are far greater,** as the Covid19 pandemic has shown.

3. **Accelerate efforts to develop culturally competent health promotion and disease prevention programmes.** These include a range of services for non-communicable diseases and health behaviours including promoting healthy weight, physical activity, smoking cessation, alcohol treatment, gambling treatment, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

4. **Policy leads and commissioners need to ensure the voices of all communities are heard in the development of strategies and interventions; in particular the BAMER community, those experiencing socio-economic disadvantage and those living with disabilities**; to ensure that all public health interventions and campaigns are relevant and resonate with target populations (i.e. those with the greatest need)

5. **Enhance messaging around the connection between a range of health behaviours and physical health and mental well-being**. During lockdown there have been clear messages about the added risk smoking and obesity (a result of poor diet and physical inactivity) pose to those who contract COVID-19. There is evidence that there is an increased appreciation of the importance of physical activity and of the importance of maintaining good health in general. *It must however be noted that this in isolation (without the actions above) will not sufficiently address the issues highlighted in this HIA.*

6. **Ensure that gambling is reflected as a contributory factor in relevant strategies including for poverty, mental wellbeing and other addictions**

GAPS IN KNOWLEDGE / FURTHER WORK REQUIRED

Greater understanding of how impacts are distributed amongst all sub-populations in Sheffield would add value to this work, particularly using a mix of data and lived experience.

COLLABORATORS AND SOURCES OF INTELLIGENCE

A range of stakeholders have fed into this series of HIAs by providing input and/or by receiving drafts for comment and feedback

- Local service providers including weight management, tobacco control services, drug and alcohol services, 0-19 service, maternity services

- Local VCF organisations including Food banks and emergency food providers (via Together Sheffield network), community anchor organisations, CAB, Shelter, The Corner, Project 6, Shine

- Relevant Boards and governance structures – Move More Partnership, Tobacco Control Board, Drug and Alcohol Strategic Board, Food and Obesity Board, Problem Gambling Stakeholder Group, Association of Directors of Public Health Yorkshire & Humber Problem Gambling Working Group

Chapter 5

Education

Summary of impacts:

Covid-19 has impacted on the education and skills on children and young people in Sheffield in a range of thematic areas (summarised below).

- Attainment
- Emotional Wellbeing and Mental Health.
- Home Education
- Return to School Attendance
- Vulnerable Groups
    - SEND
    - BAME
    - Poverty/Free School Meals
    - Young Carers.
    - English as an additional language/asylum seekers

The impact of each area on individual children appears likely to follow existing health inequality lines.

Attainment

- Children have engaged with home learning to significantly varying degrees.
- A child's home learning environment will substantially impact on their ability to engage in learning and maintain progress.
- This suggests that children in homes of high occupancy or housing in poor condition are likely to have moved substantially backwards in their learning.
- Children who have parents with additional needs are also at risk of falling behind in their education, as their parents may struggle to help teach the subject.
- Children of parents who have jobs with long hours, shift patterns etc may also receive less support as a result of parents needing to work.
- Children who already struggled to engage in full time schooling are also likely to have fallen behind in their education.
- Some children may have progressed well in their education. For example if they were being bullied and have a parent at home full time, they may actually make substantial progress. However it is expected that this will be a small minority of students.
- Research from the Sutton Trust indicates that private school students are twice as likely as state school students to be accessing online lessons every day.

Summary of Impact on Attainment

1. Significant variation in academic progress during lockdown, likely along lines of existing inequalities.
2. Children with parents with additional needs or long working hours, shift patterns etc. may be disproportionately negatively affected.
3. A generation of children may experience reduced attainment and career prospects without additional support.

Emotional Wellbeing and mental health

- It is highly likely that the current crisis has had an impact on emotional and mental health of children.
- Below are a number of mental health issues whose incidence is likely to have increased;
    - Anxiety
    - Bereavement
    - Depression
    - PTSD
- Children who have lost relatives to Covid-19 or have parents who have seen their employment status change are at greater risk.
- Lockdown is likely to have led to an increase in stress within families and incidents of Domestic Abuse, further contributing to a likely rise in the above issues.
- Children are also likely to have spent an increased time on social media, potential exacerbating existing social issues, stress and anxiety associated with this.
- Some children may have found the lockdown period beneficial if school was having a negative impact on their emotional wellbeing and mental health. These children may need increased support to return to school.
- When children return to school, it likely that a number of pupils will display behaviours which could lead to fixed term and permanent exclusions, when their cause is one of the above issues.
- It is also likely that children will seek additional mental health support through resources such as counselling, online support and CAMHS.
- Children will living in an uncertain time for at least the next 12-18 months, those who have existing mental health problems or conditions such as Autism will be at greater risk of experiencing further mental health distress.

Summary of Impact on Emotional Wellbeing and Mental Health

1. Likely increase in issues such as anxiety, bereavement and depression as a result of traumatic events taking place during lockdown, social isolation and uncertainty.
2. Risk of increased exclusions when pupils return to schools due to behaviours which

may be a result of emotional wellbeing issues.

3. Likely to see increased demand on mental health services at all levels.

Home Education

- As some children may have had a positive experience of lockdown and preferred home learning, it is possible that the number of families choosing to educate their children at home will increase.
- This will present risks in terms of impacts on the LA to ensure that children are being appropriately home educated.
- In the long term, there may be a larger than usual number of children becoming adults who have been outside of school and the social environment that comes with it for a long period of time. This may have unintended consequences such as young adults struggling to engage with further education and increased demand on adult mental health services due to young adults struggling to engage in adult life.
- It is likely that children with SEND are more likely to opt for home education post lockdown.
- Consideration needs to be given to increasing LA resources to support children in home education and to also encourage a return to school if a child was not home educated prior to lockdown.
- Families with children with SEND may require additional support and engagement to return to the school environment.
- There is a risk that more families of children with SEND may seek a specialist or independent placement, on the basis that a quieter environment closer to what home is like, is what they require in school. This presents a significant financial risk to the LA.

Summary of Impact of Home Education

1. Potential increase in numbers post-lockdown.
2. May trigger increased requests for specialist or independent placements for children with SEND.
3. Longer term impact on further education and adult health services.

Vulnerable Groups

BAME

- BAME pupils, staff and communities have been disproportionately affected by Covid 19.
- BAME children and young people are disproportionately from lower income backgrounds and overcrowded homes. Children are more likely to be living with elderly relatives at greater risk from the virus.
- This group of children are more likely to have experienced loss and bereavement.

- Restricted access to religious festival's such as Ramadan may also have a detrimental impact on the wellbeing of BAME children.

Poverty/Free School Meals

- Children from the most disadvantaged backgrounds are less likely to have engaged with online learning.
- These pupils are less likely to have their own devices, reliable broadband or a quiet, suitable place to study at home.
- The cancellation of exams and assessments has led to a reliance on predicated grades. These grades can be inaccurate, and tend to favour those pupils from more advantaged backgrounds
- Reduced access to FSM during lockdown will have impacted on families, with FSM children likely to have eaten more unhealthy food than their peers (Northumbria University)

SEND and children with medical conditions

- The gap for children with SEND may have widened further without the specific interventions and differentiation of learning
- Lack of face to face assessment of SEN needs has impacted the ability to complete EHC Plans and ensure that provision identified is appropriate.
- Children with already severe and profound mental health and anxiety around school attendance due to SEN needs, particularly Autism, have reported some easing of anxiety from being in a home environment.
- However, this is likely to see increase as they return to school leading to requests for smaller school and specialist facilities.
- Gaps in provision identified in EHC Plans will have had a negative impact on some children's ability to learn and make progress
- Gaps in ongoing therapeutic intervention due to prioritisation of those at greater risk will have impacted areas such as speech and language and occupational therapy
- Transition for those with SEN for September 2020 has been impacted meaning that many are not prepared for their new learning environment, particularly those moving from primary to secondary. This will potentially lead to further mainstream school breakdown and increased demand on specialist placements.

Young Carers

- The loss of the routine of attending school is likely to have impacted heavily on Young Carers. School is often a place of respite from caring responsibilities.
- These children will have found it more challenging to try to balance the demands of home learning with their caring responsibilities
- They may not have an extensive and strong friendship group to rely on due to time

spent on their caring responsibilities and as a result may feel more isolated than other children.
- They may have experienced increase stress and anxiety due to the fact that their relatives are much more likely to be shielding.

EAL (English as an Additional Language) children , Asylum seekers, refugees and new arrivals,

- Families & children with EAL will have found accessing and engaging with home learning complicated by language barrier.
- Asylum seeker/refugees may have suffered past trauma which is unaddressed and compounded by Covid19.
- Supplementary or home language schools are also affected reducing development of home language and community support.
- Many of our EAL learners have existing gaps these will have increased, particularly Roma pupils.
- Families & children with EAL will have found accessing and engaging with home learning complicated by language barrier.
- English acquisition skills may be affected due to reduced opportunities to use and develop the language.
- Admission into schools and settings will have been either hampered and/or delayed.
- Y10 & Y11 EAL New Arrivals already puts a significant strain on some schools and settings; this will now be compounded and could result in very vulnerable young people without suitable placements.
- Access to Post 16 provision already difficult for EAL pupils this could be further compounded, particularly for specific BAME groups such as the Roma community
- Those New Arrivals that entered the school system without records of prior attainment are at greatest risk of inaccurate predicted grades.
- The EAL pupils acquiring English are at a disadvantage as they may be judged on their language level and not their academic ability

Return to School Attendance

- The Covid-19 lockdown may present difficulties in returning children to school when schools return.
- Children may be reluctant to attend due to fears about their own health or members of their family. Children in homes with a multi-generational occupants or existing health problems, such as parents with disabilities or respiratory problems may be at higher risk of not returning to school.
- Children with issues such as anxiety may also have greater difficulty returning to school.

Recommendations:

Mitigating actions

- **Attainment:** Consideration should be given to supporting pupils' home education that are required to isolate, with enhanced support targeted along lines of existing inequalities.
- **Return to school:** Consideration should be given to working with schools to provide additional reassurance and support to children from families with disabled relatives or health problems which may present greater risk in relation to Covid-19**.**
- **Home education:** Revised strategy to prevent avoidable specialist or independent placements.
- **Emotional Wellbeing and Mental Health:**
    - Increasing provision of counselling and online mental health services which are easy and quick to access.
    - Targeting of resources at families who are more likely to have experienced changes to their employment status or are already known to services.
    - Ensuring children who may have been happier at home and not in school are given support and encouragement needed to return to school, with support from relevant agencies if there is a problem such as anxiety which requires additional support.
    - Promotion of practical self-help approaches such as exercise e.g. walking to school, running & taking time to talk to friends and family.
    - Schools should be encouraged to adopt more flexible behaviour policies to prevent needless exclusions.
    - Schools should be encouraged to work with children to support them to adapt to this period of uncertainty, particularly those with autistic needs, and be prepared for further restrictions.

- **BAME:** Targeted anxiety and bereavement support.
- **FSM:** Enhanced return to school support.
- **Return to school:** Targeted support and reassurance for children who have Covid-19 vulnerable parents.
- **SEND:** Ensure support is provided as required under a child's plan, trigger annual review if required due to significant change in need.
- **Young carers:** Additional support if year group/bubble is required to self-isolate.
- **EAL:** Targeted anxiety and trauma support.

Service Flex to meet need:

- Regular communication from Education and Skills to ensure latest Covid-19 guidance is provided to all schools.

- Completion of Covid-19 risk assessment with all schools.
- Consultation and engagement with parent groups to ensure right level of support is being provided to families.

Good news stories from lockdown

- **Festival of Fun, virtual challenges and online ceremonies.** The Sheffield Children's University team has continued to flourish during lockdown quickly adapting the service to go online. The team has developed a series of 98 fun, downloadable home learning challenges for children (and families) to take part in: https://www.youtube.com/watch?v=UBFJVAFjjS8. These have been very well received by children, families and schools alike. (Other LAs in the UK have requested access to these challenges) A summer Festival of Fun featuring seventy plus free online and face to face activities for the children of Sheffield has just been launched. Over 2000 children were invited to virtual Gold Award Graduation Ceremonies to celebrate their participation in at least 100 hours of extra learning in their own time. Children were invited to complete an accompanying home learning challenge, to create their own staging area and invites for family members.
- **Virtual Sports Day and more.** Schools across the city took part in an online inter-school sports day organised by the city-wide Points Learning Network. 5561 pupil took part from 103 Sheffield Schools. The network has also provided staying active at home ideas – such as daily challenges, active bingo and links to activity websites and is also supporting school PE co-ordinators with Covid safe lesson planning for September
- **Bags of creativity** have been delivered to all our Looked After Children. These bags have been developed by a team of artists are full of creative activities and resources. The activities will also be online on the Create Sheffield website as part of the Sheffield Adventures tab so others can access them too.
- **Baking Book** has been written by Looked After Children. As well as being full of recipes (including basic recipes and showstoppers), baking has been linked to other subjects. In the booklet, there are some tips on how to link baking to Maths and Reading and for older children, to start thinking about life skills.
- **Speech and language booklet** for foster carers. An easy guide to support Speech, Language and Communication at home has been developed. Working with NHS Speech & Language services the Virtual School has put together a simple approach for support from carers/adoptive parents. It includes simple tips and advice along with some developmental markers.
- **Wake Me Up video** was launched via YouTube by the Music Service in June which features hundreds of young musicians in a moving group online performance https://www.youtube.com/watch?v=kN9aHdxtHIQ
- **16 Outdoor Activities booklet.** Two booklets have been developed by the

Thornbridge Education Team one for schools and one for families describing a series of outdoor learning activities including: den building, scavenger hunts, orienteering and many more.

- **EAL/New arrivals training.** The EAL team has continued to support schools and settings in Sheffield and other local authorities throughout lockdown. The EAL training package has been delivered through a variety of online platforms, in addition to bespoke training the team created to support the specific needs of EAL learners during lockdown. The team has also worked closely with NHS colleagues to ensure that the key document to support children's mental health (beat the boredom) was translated into community languages and distributed across the city including to key community groups, such as City of Sanctuary and other refugee support groups.

(NB: This is only a sample of the good practice undertaken in Education and Skills colleagues and partners between March and July 2020)

Chapter 6

Income and poverty

How the Covid-19 crisis has impacted on poverty and income

- **Financial insecurity is significantly more widespread and more severe since the beginning of the pandemic**. Demands on food banks increased four-fold during the initial crisis, the number of people who are on Universal Credit in Sheffield have doubled to 44,000 and rent arrears have increased.

- Although many people have been able to take a breath after the initial crisis, **we expect people's financial situation to get increasingly worse over the autumn and beyond** as creditors are able to start recovery action again, the job retention scheme is phased out and the economic recession hits.

- There was a significant decrease in people accessing many types of financial support and advice during lockdown, particularly disability benefits and debt advice. However, the **demand for advice is now increasing rapidly** and is expected to rise by 30% over the next few weeks and months.

- Barriers to accessing services and support have exacerbated poverty: **many people have not been able to afford to get online** at a time when digital access is more crucial than ever; some people with complex, chaotic lives have suffered because even the best remote services is not the same as face-to-face support; people who rely on cash who have struggled to buy essentials in places where only cards are accepted; and the pandemic has left many increasingly vulnerable to crime and exploitation.

- After ten years of austerity and welfare cuts, **many people were already struggling before the pandemic** leaving them with few resources to cushion the crisis. There is a strong link between low income and ill health.

- **Certain groups have been disproportionately affected** by the financial insecurity caused or exacerbated by the crisis. Poorer people and those in deprived communities have been hit hard, and we've seen many people newly entering the benefits system. Tenants in private-rented accommodation, people from black, Asian and minority ethnic communities, refugees and asylum seekers, women, people with disabilities and health conditions, and younger people (both adults and children) have all been disproportionately negatively affected by the financial impacts of the pandemic.

What we think we should do about it

Poverty and low income is a huge and complex issue that has been the focus of work in the city for many years. The pandemic has thrown many more people into financial difficulty and tipped those who were just about managing into poverty or in some cases outright destitution. Solutions to this, particularly within the context of ten years of austerity, a continuing global pandemic and an increasing economic crisis, will never be straightforward. However, this impact assessment has provided us with some areas to focus on.

- **Plan for poverty and demand for support services to increase**; the first wave of the pandemic may have passed, but the financial impacts are only just starting.

- **Build on the strong partnership working on the ground** that the city has demonstrated throughout the crisis, including by maximising ways for people to access different services without having to move between many buildings (e.g. exploring a video/phone link to Citizens Advice within Council buildings as they start to open).

- **Prioritise making digital access available** to disadvantaged people and communities in the city, including devices, internet and skills/confidence.

- **Increase take-up of benefits and support in the city,** including Council Tax Support, Universal Credit, and support for businesses, particularly among more marginalised communities and private-rented tenants. Also **explore introducing 'financial healthchecks'** for households in response to the crisis.

- **Seek to influence high-level strategic conversations about recovery and next steps for the city**, articulating the importance of tackling poverty to influence city and city-region conversations around what our economic recovery should look like.

- **Ensure a collective, city-wide approach,** involving stakeholders and the wider community in developing next steps which will be part of a Tackling Poverty action plan for the city.

How has this impact assessment has been developed

This Poverty and Impact theme has been written by the Sheffield City Council Strategy and Partnerships team **in close partnership with the many services, organisations and networks in the city with an interest in this area.** We have organised workshops to gather information about impacts and to shape recommendations, joined discussions within networks or organisations to further add to the impact assessment and sought feedback on various iterations of the impact assessment.

Stakeholders include SCC services, Citizens Advice Sheffield, Voluntary Action Sheffield, Shelter, South Yorkshire Police, DWP, housing associations, Sheffield ACP, Community Hubs members, People Keeping Well networks, Local Community Response Teams, Sheffield CCG,

food banks, Sheffield City Partnership Board, MCDT, SOAR, Zest, Disability Sheffield, SAYiT, ShipShape, Firvale Community Hub, Good Things Foundation, Sheffield Carers Centre, and smaller community organisations/networks. Many of these have contributed directly; others have been included as part of their contributions to other discussions/publications.

The content and insights presented throughout are 'owned' by a wide-range of partners and contributors, who have shaped both the ideas and the recommendations, and we will continue to work together as this programme takes on new iterations and moves into the next phase of devising actions.

Chapter 7

Loneliness and Social Isolation

The negative health impacts of loneliness and isolation should not be underestimated, research prior to covid describe loneliness as *damaging as smoking*.

Covid has worsened many of the structural and health inequalities experienced by people in Sheffield. But in listening to many of the stories, it would be true to say almost everyone (people, communities and staff) have been impacted in the form of isolation by the lockdown. Inevitably personal 'resilience' and access to technology mitigate many of the issues.

This negative impact, for some, will be compounded by developing poor habits such as overeating, smoking or using alcohol and drugs more, due to feeling isolated or lonely. There is widespread concern about the effect social isolation and distancing will have on mental health. There are reports of higher levels of anxiety, depression, stress and other negative feelings

Patterns are not equally distributed across the population but based on the available data, children and adults who are socio-economically disadvantaged, those living alone, widowed or separated, and people in poor physical and mental health are at particular risk. The easing of lockdown restrictions will potentially alleviate some of the feelings of loneliness and isolation for various sub-populations, however, local information indicates that older people (especially those who are extremely clinically vulnerable) are reluctant to re-engage in social activities. Furthermore, those older people that do wish to socialise with others may face additional barriers e.g. digital exclusion, reduction in organised activities like lunch clubs, concerns about using public transport etc.

Recommendation 1: Invest in the VCF sector to build Resilient Communities – empowering people to build the community and place they are proud of and want to live in.

To drive the new Sheffield and reduce loneliness and social isolation we need to create the right environment for people to thrive and build their own ***resilient communities*** and the system has to **TRUST** communities to have the answers for themselves

What does this mean practically:

a. *Short term:* Build more capacity in the VCF workforce to undertake more 'check and chat' call
b. *Longer term:* Create an environment for people in their communities to become leaders:
    i. Recruit, develop and support more people to peer support each other

ii. Support people to develop social activities (digital and COVID-19 safe face to face) – a reason to get together with meaning and purpose to people eg knitting, sporting memories

c. *Short to medium term:* The pandemic saw a community response in way we haven't before, we need to support mutual aid groups to flourish and find a place post the immediate crisis

Further Recommendations

2. Workforce and the system recognise that Loneliness (separator or lack of social connection) is trauma in children and adults. All staff across the system need to be trained to recognise this
3. Help people and families manage the risk of covid so that they are not too frightened to re-engage in their life
4. Reduce digital exclusion
5. Support small community and volunteer led building and activities to reopen or start activities in a sustainable and covid safe way
6. Support people to develop the tools to manage living by themselves (needs to connect to the work of the mental wellbeing HIA

Authors; Emma Dickinson, Lee Teasdale-Smith, Fidelma Guinan

Thank you to all the people that came and told their stories and that of people of Sheffield

GAPS IN KNOWLEDGE / FURTHER WORK REQUIRED

Greater understanding of how impacts are distributed amongst all sub-populations in Sheffield would add value to this work, particularly using a mix of data and lived experience.

Chapter 8

Domestic and sexual abuse

Domestic and Sexual Abuse are likely to be impacting greatly on people as a result of the pandemic because these issues are often (but not always) perpetrated by people in the family home. The pandemic has meant:

- Increased time at home
- Increased time in close proximity to the person causing harm
- Increased emotional and financial stress
- Increased isolation
- Reduced family and social support
- Increased risk of debilitating illness

Access to support was difficult for people during lockdown and referrals to domestic and sexual abuse services dipped initially. However since June, as lockdown eased, referrals to IDAS, the provider of the city's helpline and community based support services, have risen by 11% compared to last year, with cases assessed as being at high risk of serious harm or homicide up by a quarter. Sexual abuse and violence referrals to services also fell initially but have started to return to normal levels.

The lockdown that began in March had the unintentional effect of enabling perpetrators of domestic abuse to increase their control over their victims/survivors, and their children (many of whom were not at school), as their tactics of isolation, removing independence and regulation of behaviour, usually backed up by threats and intimidation, were now effectively legitimised by the state. People living in domestic abuse situations will have felt that their routes for accessing support had been closed off – they could not contact agencies, see the professionals they may have been in touch with, family and friends were out of bounds, they may have been working from home or furloughed and the perpetrator may have been too. This form of abuse, **Coercive Control**, **has long lasting impacts on victims/survivors and their children but is often not identified** when incidents of abuse are reported to the police or other agencies. Professionals then tend to take the view that if there hasn't been another reported physical incident then the abuse must have stopped.

As lockdown eased in June referrals rose as victims/survivors began to make contact with agencies again and / or worried friends, family and neighbours alerted services. **Indications are that this upward trend, although uneven, will continue as lockdown continues to ease**. High risk cases showed the biggest rise in June – up by over a quarter on the previous year. This indicates that the severity of domestic abuse has increased in lockdown and it is likely that situations have escalated more rapidly during this time as well.

COVID itself has been used to victimise people. Spitting at people, using the threat of infection, flagrant breaching or threats to report people to authorities for breaching stay at home guidance and depriving them of their liberty have all been more common factors raised at Multi Agency Risk Assessment Conference meetings (that consider people at high risk of serious harm or homicide because of domestic abuse) since lockdown.

- Although many people have been able to take a breath after the initial crisis, **we expect people's financial situation to get increasingly worse over the autumn and beyond** as creditors are able to start recovery action again, the job retention scheme is phased out and the economic recession hits.
- There was a significant decrease in people accessing many types of financial support and advice during lockdown, particularly disability benefits and debt advice. However, the **demand for advice is now increasing rapidly** and is expected to rise by 30% over the next few weeks and months.
- Barriers to accessing services and support have exacerbated poverty: **many people have not been able to afford to get online** at a time when digital access is more crucial than ever; some people with complex, chaotic lives have suffered because even the best remote services is not the same as face-to-face support; people who rely on cash who have struggled to buy essentials in places where only cards are accepted; and the pandemic has left many increasingly vulnerable to crime and exploitation.
- After ten years of austerity and welfare cuts, **many people were already struggling before the pandemic** leaving them with few resources to cushion the crisis. There is a strong link between low income and ill health.
- **Certain groups have been disproportionately affected** by the financial insecurity caused or exacerbated by the crisis. Poorer people and those in deprived communities have been hit hard, and we've seen many people newly entering the benefits system. Tenants in private-rented accommodation, people from black, Asian and minority ethnic communities, refugees and asylum seekers, women, people with disabilities and health conditions, and younger people (both adults and children) are all more likely to be negatively affected by the financial impacts of the pandemic.

What we think we should do about it

Poverty and low income is a huge and complex issue that has been the focus of work in the city for many years. The pandemic has thrown many more people into financial difficulty and tipped those who were just about managing into poverty or in some cases outright destitution. Solutions to this, particularly within the context of ten years of austerity, a continuing global pandemic and an increasing economic crisis, will never be straightforward. However, this impact assessment has provided us with some areas to focus on.

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- **Prioritise making digital access available** to disadvantaged people and communities in the city, including devices, internet and skills/confidence.
- **Increase take-up of benefits and support in the city,** including Council Tax Support, Universal Credit, and support for businesses, particularly among more marginalised

communities and private-rented tenants. Also **explore introducing 'financial healthchecks'** for households in response to the crisis.

- **Seek to influence high-level strategic conversations about recovery and next steps for the city**, articulating the importance of tackling poverty to influence city and city-region conversations around what our economic recovery should look like.
- **Ensure a collective, city-wide approach,** involving stakeholders and the wider community in developing next steps which will be part of a Tackling Poverty action plan for the city.

The pandemic has highlighted the importance of understanding the dynamics of coercive control when responding to domestic abuse. This is abuse that removes the victim's/ survivor's 'space for action'[4] through the micromanagement of everyday life and which creates a state of hypervigilance that is described as 'walking on eggshells'. This liberty crime[5] has long lasting impacts on victims/survivors and their children but is often not identified when incidents of abuse are reported to the police or other agencies. Professionals then tend to take the view that if there hasn't been another reported physical incident then the abuse must have stopped.

The lockdown that began in March had the unintentional effect of enabling perpetrators of domestic abuse to increase their control over their victims/survivors, and their children (many of whom were not at school), as their tactics of isolation, removing independence and regulation of behaviour, usually backed up by threats and intimidation, were now effectively legitimised by the state. People living in domestic abuse situations will have felt that their routes for accessing support had been closed off – they could not contact agencies, see the professionals they may have been in touch with, family and friends were out of bounds, they may have been working from home or furloughed and the perpetrator may have been too.

the impact of coercive control in the pandemic: people who were isolated because of domestic abuse already are likely to be more so during a lockdown. They are less visible to services and less able to seek help. Victims/survivors of sexual abuse are also less likely to report.

Initially the lockdown meant a reduction in referrals for support locally – both to domestic and sexual abuse services.

As lockdown eased in June the data above demonstrates that referrals were being made by professionals as victims/survivors began to make contact with agencies again and / or worried friends, family and neighbours alerted services. Indications are that this upward trend, although uneven, will continue as lockdown continues to ease. High risk cases showed the biggest rise in June – up by over a quarter on the previous year. This indicates that the severity of domestic abuse has increased in lockdown and it is likely that situations have escalated more rapidly during this time as well.

Spitting at people, using the threat of infection, flagrant breaching or threats to report people to authorities for breaching stay at home guidance and depriving them of their liberty have all been more common factors raised at Multi Agency Risk Assessment

[4] Liz Kelly, 2003
[5] Evan Stark, 2009

Conference meetings (that consider people at high risk of serious harm or homicide because of domestic abuse) since lockdown. The high number of high risk cases has meant that extra day long MARAC meetings have had to be scheduled during July and August.

woman told Women's Aid her abusive partner threatened her with COVID - that he would make sure she got it, as she had other health issues she was worried, but her next door neighbour supported her get help.

Data for Sheffield from SYP shows that reports of Domestic Abuse rose from 1852 in the 8 weeks from 15th March, to 2024 in the 8 weeks from the 10th May to the 4th of July, an increase of 170 reports or 9.2%.

the National Helpline signposts to local services rather than making referrals which makes local data capture problematic and also suggests that take up of signposting options from the National Helpline has not been high. It is therefore important that local helplines are promoted as these can ensure victims/survivors are linked up quickly with local support services.

Other local third sector support services have also reported a rise in referrals e.g. Ashiana and Roshni – both specialising in support for BAME women, Shelter – who work with domestic abuse survivors through their homelessness prevention and resettlement support service, and the Together Women Project who support women offenders and deliver young women's engagement projects.

Homelessness presentations from March to July this year where the main reason was loss of home due to domestic abuse rose by 28.4% from the same period last year: 211 presentations in 2019 and 271 in 2020.

The Sheffield Safeguarding Hub – the Council's front door for reporting concerns about children – saw a reduction in contacts from 2130 in February this year to 1682 in May. However domestic abuse cases rose from being 22% of contacts in February to 29% in May.

Sheffield Rape and Sexual Abuse Centre saw referrals for both its counselling service and to it's Independent Sexual Violence Advisors (who support victims/ survivors through the criminal justice process if they choose to pursue a conviction), dip and then begin to recover by June

access to therapeutic and mental health support became difficult during lockdown which will have consequences down the line as people have not had the support they need to help them recover from the trauma of abuse.

Sexual abuse, assaults and violence are usually perpetrated by someone the victim/survivor knows, and this can be a partner, ex-partner, family member etc. as sexual abuse is also a feature of domestic abuse and therefore lockdown will have impacted on victims/survivors in similar ways.

Lockdown has meant that for those who were already in support / treatment their recovery has been interrupted and for those traumatised during lockdown they face an even longer wait than before to access therapy or counselling.

issues with lack of capacity and unclear local pathways in relation to therapeutic support for survivors of domestic and /or sexual abuse

A key pressure during lockdown and since has been the difficulties in accessing safe accommodation.

Refuge spaces and move on accommodation, including the additional temporary dispersed capacity commissioned locally and then expanded as part of the CV19 response, are mostly full up.

Health services such as the Emergency Department at the Teaching Hospitals Trust initially reported a slump in domestic abuse cases coming through however domestic abuse related presentations have risen again as lockdown has eased.

Voluntary sector support services have all responded quickly to the lockdown and found creative ways of maintaining contact with clients e.g. through the use of zoom, WhatsApp, through socially distanced walks etc. Staff continued to be onsite at the refuges during lockdown to offer reassurance and support.

IDAS have increased their offer of webchat facilities and introduced webchat for professionals wanting to discuss a case. These options have been promoted on social media along with the silent 999 option for alerting the Police if it is too dangerous to speak. They have also been able to bid for substantial government funding that was not available to local authorities

Digital exclusion is a key concern - while some service users have welcomed WhatsApp calls etc. (refuge residents have their own whatsapp groups etc. to combat isolation) others do not have access to equipment, cannot afford to use it or do not have Wi-Fi, do not have the skills, or perhaps most importantly for this client group - do not have somewhere safe and confidential to use it.

even if you have the equipment and skills, if you are isolated at home with your abusive partner you may not be able to use online means to access support. -0 also impacts on young fpeople

During lockdown long term emotional harm risk to children is a concern due to them living with domestic abuse and not having access to normal support mechanisms (school, friendship groups, family members etc.). A new process of checking child protection cases against domestic abuse service records has started during lockdown and this has established that 80% of families discussed at child protection conference have had some history of involvement with domestic abuse services indicating the scale of the overlap between the two issues.

teachers to recognise the impact of abuse and how they can adopt a more trauma informed approach in managing behaviours

A new model of working with families affected by domestic abuse has started to be introduced during lockdown because of the concerns that domestic abuse would be escalating for some families, at the same time that engagement was becoming more difficult. Therefore professionals needed to increase their skills and become more domestic abuse informed in the current circumstances. Dr Emma Katz is clear that 'responsibility for the impacts on children of coercive control-based domestic violence should be placed with the perpetrator (usually fathers/father-figures) and not with the victimised parent (usually

mothers)'[6]and the Safe and Together model that children's and domestic abuse practitioners have started to be trained on in spring / summer 2020 is one that is a child centred; a strengths based approach that seeks to develop the capacity and understanding of practitioners to safely respond to domestic abuse by partnering with the non-abusing parent.

It strengthens the ability of services to understand how the perpetrator is creating harm or the risk of harm to children. This perpetrator pattern based aspect of the model ensures that fathers who are perpetrators will be held to the same standard of parenting expectations as mothers.

- Young people are lacking access to privacy and activities that help them to manage their mental health and wellbeing and for those unable to communicate remotely, professional support has also stopped. This means that for some the progress they had made in dealing with destructive feelings and behaviours has been eroded and as a result mental health is suffering with increasing in depression, anxiety, poor self-care and a lack of motivation - some CYP that were accessing support have become withdrawn.
- Safe people and contacts are no-longer accessible, particularly those that found school and or social, sport or friendships groups - the places where they would find people to talk about their worries and/or make disclosures of significant harm.
- The NSPCC also make the latter point in relation to disclosure of sexual abuse – these are less likely in lockdown situations especially if the abuser is a family member.[7]
- SAYiT the local specialist LGBT+ young people's service report that LGBT young people have been more at risk of abuse when living in lockdown with homophobic family members.

There have also been concerns raised, particularly by the Children's NHS Foundation Trust that child to parent abuse has risen during lockdown – systems are not in place to quantify this however.

Older people are more likely to have other health conditions, be disabled or be shielding. They are also more likely to be living with a perpetrator who is also at home if they are a partner / spouse.

The proportion of referrals where the perpetrator was identified as an adult child of the victim / survivor has increased in quarter 1 from 4.6% last year to 6% during lockdown. this rise in referrals during lockdown emphasises the need agencies to be alert to adult family violence as a form of domestic abuse.

The proportion of males presenting as homeless due to domestic abuse has risen during lockdown by 71% from 24 to 41 between March and July. The SafeZones dispersed safe accommodation project has enabled 3 men to access safe housing during the lockdown period

Midwifery services have however reported that they have seen some increase in disclosures during scan appointments etc. as partners are now not allowed to accompany women to

[6] Emma Katz ibid
[7] NSPCC ibid

these appointments. Conversely, where appointments have been at home there have been more issues seeing women alone in order to ask routine enquiry questions.

The proportion of IDAS service users that identified as lesbian, gay or bisexual increased during lockdown compared with last year: from 2.6% to 3.8%. This may be linked to the work that SAYiT have been conducting for the city through the Call it Out project which aims to increase awareness of LGBT+ people's experience of domestic abuse and increase the skills and confidence of professionals – specialist and non specialist in responding.

In 2019/20 34.4% of IDAS service users were BAME. In Q1 of 20/21 the proportion is 27.4%. 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 more be more isolated and have less access to usual supportive agencies and / or technology to help them access support. Language barriers translations

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.

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.

During lockdown, staff that are experiencing domestic abuse may be more at risk due to isolation and the abuser using lockdown to control them further

The pandemic has made it clear how important it is that agencies have policies in place to support staff affected by domestic abuse – Business in the Community updated their toolkit for employers in April.

National evidence[8] tells us that disabled people are at higher risk of serious harm due to domestic abuse in non lockdown circumstances. During lockdown, for people with disabilities who were experiencing domestic abuse isolation will again have increased, and risk and severity of abuse are likely to have increased as well. Specific disabilities will result in unique issues during lockdown e.g. people with hearing difficulties will face further barriers when support is offered by phone or zoom unless they have specialist equipment.

The proportion of victims/ survivors supported by IDAS identified as problematic drinkers or drug users increased this quarter compared to last year: from 4.9 to 5.2% for alcohol users, and 2.9% to 3.7% for drug users, as substance misuse is a coping mechanism for some victims/survivors this is another possible indication of the stresses of lockdown.

8

The impact of lockdown is likely to be felt for some time for people impacted by domestic and sexual abuse; we are expecting that service capacity will be under pressure for several months at least. Voluntary sector services and specialist teams in statutory services (e.g. the Strengthening Families domestic abuse team) have been responsive and flexible during the pandemic. However domestic and sexual abuse were not created by the pandemic, and while these issues have no doubt had terrible impacts on individuals of all ages during lockdown but they did so beforehand as well. We need to continue with developing joined up multi agency responses to domestic and sexual abuse that take heed of emerging best practice and take a whole family approach.

Chapter 9a

Access to Healthcare

Approach

A Task and Finish group was established to co-produce this chapter in the RHIA. It must be acknowledged that the ability to commit to provide resource and time to input has been difficult for some members of the group as we remain at level 3 of the pandemic at time of writing. However, everyone approached has acknowledged the importance of the work and have been very willing to participate as best they are able, we thank them for this. The core group membership is indicated in the table below but each will have reached out beyond their individual areas and/or organisations for further input to this document.

Whilst there are further changes which have been implemented as immediate responses to the pandemic the group has focussed on the individual service changes developed and implemented which are planned to continue or expand going forward into the recovery phases and beyond.

Data and Information Used

This report contains a mixture of local quantitative and qualitative data, patient feedback and literature reviews. In addition, and particularly where local information gaps exist, appropriate regional and national data and report analysis has also been utilised.

Service-level intelligence and data from all sector providers identifies emerging issues, demands and the capacity of providers to respond to needs. Where possible, data has been broken down demographically to identify any differential impacts on certain population groups, particularly those with protected characteristics and known high-risk groups.

Group Membership

Name	Job Title	Representing	This report will be submitted to
Richard Maxted	Acting Assistant Chief Operating Officer	Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)	TBC
Jude Stone	Associate Director	Sheffield Children's NHS Foundation Trust (SCHFT)	Quality Committee
Linda Cutter	Head of Commissioning, Elective Care **(RHIA Lead)**	NHS Sheffield CCG (SCCG) Elective Care	SCCG Senior Management Team (SMT) ICS Elective Board ACP Elective Board
Chris Lomas	Cancer Lead & RHIA Project Manager	SCCG Cancer Services	
Alastair Mew	Head of Commissioning, Urgent Care	SCCG – Urgent Care, Yorkshire Ambulance Services, Homeless	

		Community	
Ceri James	Commissioning Manager LTC/Primary Care	SCCG – Long Term Conditions and Primary Care	
James Barsby	Primary Care Commissioning & Contracts Manager	SCCG Primary Care *(note: Primary Care Locality Managers input awaited and will be added once received)*	
Richard Crosby	Referral Variation Lead	SCCG – Referral Activity	
Andy Eames	Information Manager	SCCG – Referral Activity	
Helen Mulholland/ Richard Kennedy	Patient Experience subject matter expert	SCCG - Patient Survey Application and Analysis	

RECOMMENDATIONS:

1. **Hold up a mirror to how well we have delivered equity of access to health and social care in Sheffield: Engage with Experts:** Seize this as an opportunity to implement truly equitable services going forward: We must acknowledge that not all voices are heard equally and the impacts for some groups are not well known.

We therefore strongly recommend that this document be made available to sub-population subject matter experts in order for an impact rating to be allocated against each development area (for example, voluntary sector, carer/patient groups, condition support groups).

Transparency: Subject-matter experts should be requested to contribute to detail around impact and mitigating actions which could be implemented to ensure equity across our population.

One potential approach would be to implement a website dedicated to consultation with all groups whereby major health and social service changes would be required to be reviewed. Individual groups would be responsible for providing a response for the population they represent. An ICS level approach would ensure consistency and avoid duplication of effort. Such a resource would be valuable in many areas beyond health and social care.

2. **Collect the data:** A significant issue for this RHIA is the gap in data and intelligence gathered within healthcare for the protected characteristics. To truly identify if we are meeting the needs of the whole of our local communities we must collaboratively agree what data must be collected and how best to do this. Suggest we agree an ICS model for minimum data collection which can be replicated at each individual place level.

3. **Seek to influence high-level strategic conversations for future system integration and provision of integrated patient services.** The pandemic has further highlighted the need to prioritise service integration and to establish system mechanisms to facilitate whole patient journey commissioning including shared patient responsibility, appropriate contracting and funding flow mechanisms.

4. **Building on new ways of working and lock-in the benefits** COVID-19 has accelerated system changes which have been under consideration for some time. 2021/22 work programmes at ICS and place level should reflect the 'locking in' of these going forward. The ICS should monitor to ensure post-pandemic developments are consistently and equitably implemented across the South Yorkshire and Basset Law Region.

5. **Address digital exclusion:**

The pandemic has turned some of the ways patients have, and will continue, to experience NHS healthcare on its head. For example, the previous default position of secondary care seeing all patients referred to them in a face-to-face clinic has now been replaced with a default of virtual appointments via video or telephone.

Collaboratively design and provide accessible internet and telephone citywide locations: We find that a significant number of patients/carers do not have access either to a telephone or to internet to undertake telephone or video appointments. We recommend that service providers, including adult health, child health, community services, and social services collaboratively develop a plan to implement digital service points patient can easily access. Locations could include a specific room within the GP practice or other appropriate locations such as schools, pharmacies, libraries, etc. Joint working would define the most appropriate model, the equipment required (computer, telephone, etc.) and options for how an extended service could wrap around the facility (e.g. self-care education, personal support when accessing healthcare information, etc.)

Build on the changes to the way the population has lived their lives during the pandemic to address the top cited reason why people do not have access to the internet at home, namely ' no need, not useful' .

Prioritise a local response to the digital divide including the identification of novel/bespoke solutions for individual communities/populations (including appropriate off the shelf or bespoke Apps).

6. **Expand Community Services:** Jointly develop an expanded model of diagnostic and service provision which builds on the success of the drive through/walk through phlebotomy service, e.g., mobile chemotherapy, etc.

Understand the make-up and needs of the population and develop community services which respond to the individual needs of the local community and site accordingly.

7. **Primary Care Networks (PCN)** development model has been accelerated. Implementation and development of new roles to support personalisation and the value of non-medicalised interventions should be acknowledged and developed i.e. Social prescribing ; HWB Coaches; Care Coordinators . Utilisation of resources and guidance from NHSE and PCI.

8. **Increase Rates of 'hear/see and treat' via Yorkshire Ambulance Service**: Ambulance services have limited flexibility. Review ability for information to be provided upon receipt of call in order to identify if 'see and treat' likely to be an option and therefore

record any factors which may limit ability for this to be undertaken and can be addressed (e.g. arranging telephone translators for non-English speakers/carers.

9. **Equitable access to face-to-face appointments:** Where it is clinically appropriate for a patient to be seen in a hospital or other clinic settings we must ensure this offer is made to all relevant patients. Care providers should engage with 'expert' organisations and staff education undertaken in order to ensure offers of face-to-face appointments are made appropriately and no-one is disadvantaged.

10. **Review and respond to evidence developed during the pandemic**: Long-term conditions, The King's Fund report of August 2020: 'Technology and innovation for long-term health condition'

11. **Implement a programme to embed patient self-care within clinical pathways:** Provide easy access to published resources and agree appropriate point in pathway for 'referral to self-care' by primary and secondary care clinicians.

12. **Personalised Care:** NHSE have a Memorandum of Understanding (MOU) with SYB ICs re personalisation which links to the transformation plan. Includes links to universal model of personalised care : Shared Decision Making ; Supported Self-management (stratifying and segmenting the population depending on their knowledge skills and confidence); Choice ; Personalised care and support planning ; Changing the Conversation (Health and well-being coaching skills) ; Social prescribing. Action should be taken to identify the system level work already in train and as a result agree and respond to any gaps, particularly in regard to provision across the protected characteristics populations.

13. **Homelessness:** Implement learning from the citywide partnership work supporting rough sleepers and the homeless during COVID. Establish improved links and communications between city wide agencies and teams (health, social care, voluntary sector, emergency services, etc.). Robust joined-up communications would have a significant positive impact with regards to supporting the majority of vulnerable people across the city.

Noted Gaps in this RHIA

This has been a *rapid* review conducted in addition to existing full-time commitments. From the outset it was identified that a fully comprehensive report would require time and dedicated resource to produce. We note the following are gaps in this report.

- Limited information has been included in relation to the operation of Community Clinics.
- Direct input from individual GP Practices has not been possible at this time. Note: additional primary care input is in production at the time of submission of this document version.
- Dental services have not been included

Chapter 9b

Access to Social Care and Support Services

In the context of this Rapid Health Impact Assessment, Access to Care and Support includes provision, access, delivery and management of social care, whether formally or informally, that is intended to meet the care and support needs of people.
Face to face contact with people who have care and support needs has largely halted. This has been replaced with telephone or online contact.

For people identified as vulnerable by ourselves or the government shielding list, there was a focus on undertaking wellbeing calls and checks. This meant telephone contact to check on people's situations and identify if they had any issues that needed addressing or if there were risks that need managing. As a consequence, some people will have had more contact with us than previously, others less.

Social distancing has impacted the capacity for prevention work by changing the way we have conversations, financial assessments and provide support.
The demographic profile of those receiving adult social care (ASC) services is skewed – 58% of people receiving services are female, 60% are older adults (65+), 84% are White, 36% belong to a denomination of Christianity (52% have no religion recorded). This demographic profile, however, does vary significantly across different types of support. As a result of this, changes to care and support due to Covid-19 have impacted different sub-populations in different ways. The different sub-populations are not mutually exclusive; there are interactions and cross overs between them meaning many changes have affected multiple sub-populations.

Groups initially identified as being disproportionately affected by Covid-19 are:

- **Older people (65+)** – as they are more likely to be receiving social care services. The pandemic and specifically the rate infection in care home has had a devastating effect on people living in Care Homes. The experience of residential settings has suffered, with less freedom of movement and reduced ability to receive visitors. This has been particularly felt by those with dementia, who often have less understanding of the situation. The gender split is also significant as 62% of people in care homes are female.
- **Carers** – the lack of respite care, as well as closure of/changes to day services have increased pressure on families and informal carers. Again, this is linked to gender, as two thirds of carers recorded on our system are female. The cared for person in these cases – it is predominately people with physical or learning disabilities who have respite care or day services as part of their support – would have been particularly impacted by these service changes.

There are also concerns that people with learning disabilities struggle to understand restrictions and social distancing, potentially putting themselves at increased risk.
Self-neglect is a major issue for ASC that predates Covid-19. There is not yet a definitive picture of the extent to which self-neglect has been affected by the lockdown. It is probable some people will have fallen into self-neglect whilst other people who were self-neglecting might now be more receptive to intervention because of the unprecedented circumstances they find themselves in.

It is important to recognise that impacts from changes may be positive as well as negative. For instance, there have also been some positive experiences for care recipients where to family members and informal carers have spending more time at home during lockdown. Some adults with learning disabilities have reported that changes to the provision of day services have improved their experience of these services.

Where negative impacts have been identified, council teams and service providers have responded with mitigation measures to try and reduce these, for example:

- A package of support for care homes including staffing support, tablets with SIM cards to enable residents to connect with family/friends, the introduction of 'Wellbeing Reviews' for new care home residents.
- Regular phone contact with people and their carers.
- Alternative approaches to the delivery of day services ranging from bake offs via Zoom to the delivery of activity packs.
- Alternative approaches to funding, e.g. temporary payment increases to support providers.
- Working with Disability Sheffield on a range of issues including PPE, testing, and the provision of information. As well as creating an emergency PA register.
- Contacting over 1,100 people on the government shielding list to discuss needs and offer support.

HealthWatch, Disability Sheffield and other community-based organisations in Sheffield have provided invaluable feedback from people receiving care. This insight has been used to improve our response.

Recommendations

- Identify and address the medium and longer-term impacts of Covid-19 on the viability and structure of the existing model for provision of adult social care in Sheffield.
- Support existing whole system initiatives to enable more people to be cared for in their own homes where that is their wish.

- Promote nurture and support community led initiatives to facilitate a broad range of provide a range of informal care and support activity in those neighbourhoods building on the excellent work of the VCF sector through the pandemic.
- Adopt a health and social care whole system approach to the identification and provision of assistive technology to help meet health and social care needs across the city.
- Utilise and consolidate the upsurge in the use of virtual communication channels and tools to achieve the right levels of contact with people who have care and support needs to monitor ensure their wellbeing.
- In preparation for the anticipated upsurge in Covid-19 cases through Autumn and into Winter and beyond prioritise building in resilience. Specifically continue to increase the care and support staffing capacity to ensure excess demand can be met across all sectors, including independent providers.
- Use the RHIA as a primer for a concerted effort to understand and tackle inequality. This to include a programme to directly address inequality experienced by BAME people and within BAME communities.
- Learning from the experiences of partnership working across the health and social care sector during this crisis to redesign processes and practice that previously inhibited the ability of the system as to deliver holistic joined up and straightforward – care and support to people who need it.
- Concerted drive to improve recording of demographic data across all service areas, to help identify and mitigate any impacts on sub populations where there are currently intelligence gaps.

Chapter 10

Housing

The purpose of this paper is to provide a summary of the Rapid Health Impact Assessment document. The themes identified in this summary provide an overview of the overall assessment and highlight the main outcomes requiring further considering or action to be taken.

The building in which we live fulfils countless roles. At its very fundamental level, a home provides shelter and warmth: two of the five basic needs. At the other end of the spectrum, a home can be a possession of great worth: a demonstration of personal attainment. The reality is that for many of us, most major life events are anchored to the home.

Under normal circumstances we rely on our homes to provide us with shelter, security and sanctuary: a familiar 'port' to return to after a long day, a comfortable environment reflecting our personalities. During lockdown, the home became much more than this. It became a workplace, a school, a nursery, a medical centre, a gym, a playground, a park, a pub, a mini community hub. For larger families or groups these could all be happening concurrently.

With some compromises, many residents of Sheffield could make these emergency arrangements work for them. There may have been a few heated words or arguments over who uses what facility in the home and when. But what happened when the home was unable to adapt to the circumstances of lockdown? What happened if it was essential to leave home and find new accommodation, or if you did not have a home to begin with?

Unsuitable or unhealthy accommodation

The impacts of an overcrowded home with no access to its own outdoor space were well known before lockdown, but during this period became inescapable for the occupants. Those living alone faced isolation from personal contact, especially if they did not have access to social technologies.

Studies show that living in a damp, overcrowded or otherwise unhealthy home has long term effects right from early childhood. These effects will have been exacerbated and distilled during lockdown, especially if there was 'no escape' to an outdoor space.

Inability to move

During this period it was necessary for some people to move home. Some wanted to return to the family at the start of lockdown, from shared housing or student accommodation and many were able to do this.

But for others a move was not possible. For those people wanting to bid on council properties, the Choice Based Lettings system was suspended at the start of lockdown and only 41 'general needs' households were able to move into council properties during this period, when well over a thousand similar lets would normally have taken place. Once the CBL system is brought back online there is a need for new ways of working around associated functions such as accompanied views and repairs.

Some people required re-housing over this period to escape violence in the home. There was a large increase in people accessing information on how to take these steps since lockdown. There was limited access to suitable accommodation meaning when people have reached a decision that leaving an abusive situation is their best option it is very hard to find them somewhere suitable to move to. Limited options may mean people return to abusers.

Homelessness

People who are homeless or at risk of homelessness are usually the most vulnerable with individuals presenting multiple complex needs, some of which can manifest as personal barriers to accepting or self-sourcing support.

At the start of lockdown, all local authorities were instructed to provide emergency accommodation to rough sleepers and Sheffield City Council with our partners mobilised quickly to action this, and to provide effective wrap-around support to the cohort.

The emergency accommodation provided a unique opportunity for us and our partners to engage with rough sleepers with increased intensity. As relationships with partner organisations and service users solidified and strengthened, we have seen outcomes of collaboration and innovation in the form of new models and initiatives that will leave a lasting positive legacy.

Recommendations

Implement immediately

- Reinstate Choice Based Lettings and associated activities
- Review and modify communications strategies in light of the 'new normal'

Next Steps

- Adopt and adapt governance structures to embed true partnership working into all housing projects and programmes going forward
- Ensure frontline workers have the tools to provide a person-centred approach to services
- Identify gaps in order to provide a complimentary suite of housing options
- Modify relevant project initiation processes to ensure it is business-as-usual to embed service users at the centre of service development

Chapter 11

End of Life

What was the situation before Covid-19?

- End of Life care is defined as NHS England as care provided in the 'last year of life'
- Examples of exemplary end of life care were recognised across Sheffield in both health and social care, the voluntary sector and in private care homes. However, services were not consistently meeting the national standards required to fully address inequalities.

What we have seen happen so far

- The end of life system has had to function above normal levels, with both Covid deaths and excess deaths, particularly care homes and acute settings
- This in turn increased the need for high-quality, rapid, responsive, personalised and compassionate end of life care across the city
- Increased demand and the need to reduce virus transmission meant the new ways of working were rapidly developed
- Covid-19 restrictions and infection prevention and control measures have had a negative impact on the end of life experience across all settings, notably in care homes and hospital. Minority groups and groups with particular religious and cultural practices around the end of life have been particularly negatively impacted.

What we might expect to happen next

- The need for end of life care and bereavement support is likely to increase once again if Covid-19 cases continue to rise
- Covid related restrictions are likely to remain in place and continue to impact on the end of life experience. This may lead to a wave of complex social and bereavement issues, which may themselves add to future morbidity and mortality
- With improvements in cross agency working the system is better equipped to address challenges as they arise or resurface
- Supporting and enabling patients, families and carers to optimally manage 'self-care' may be a necessity during future waves of Covid-19 and as we move into winter. There is a need to strike a balance between overburdening unprepared carers and managing capacity in healthcare services
- Increased pressure and emotional impacts on staff working in end of life settings are likely to persist and may worsen should there be a second wave of Covid-19 and 'lockdown' may have a negative impact on local and national third sector partners, their capacity to generate income and their contribution to end of life care in Sheffield. This needs to be better understood.

Chapter 12

'Long-Covid'

Summary

This rapid health impact assessment is focused on the medium-to-long-term health impacts of Covid-19 infection, so-called 'long-Covid', and their potential consequences for the Sheffield population.

Increasing evidence is coming to light that Covid-19 is not exclusively an acute illness. Many people report prolonged, debilitating symptoms that continue for months after initial infection. Covid-19 is also associated with a number of complications with potential longer-term consequences, such as blood clots and cardiac injury. Furthermore, for those that had severe Covid-19 requiring intensive care and ventilation, recovery and rehabilitation is likely to be protracted.

Within the inequality of impacts, three further broad themes emerged:

- Inequalities in those vulnerable to getting long-Covid
- Inequalities in the impact of having long-Covid on employment and finances
- Potential inequalities in access to post-Covid services

Findings – summary of impacts

Prolonged Covid-19 symptoms – 'long-Covid'

It has been suggested that there are two entities of long-Covid: those who have been severely unwell who are recovering but with some residual impact and those who started with a relatively mild illness, which is ongoing[5].

For people who have been admitted to hospital with Covid-19, persistent symptoms are very common. Research from a small single-centre study in Bristol indicates that, of people admitted to hospital with Covid-19, three quarters (74%) have ongoing symptoms, mostly of breathlessness and fatigue, three months after admission[1]. In Sheffield, this could translate to anywhere between 58 and 728 people dealing with debilitating, prolonged symptoms following hospitalisation since the start of the outbreak.

However, those hospitalised with Covid-19 represent only a very small proportion of those who have had Covid-19 (possibly only 1-5%) and data from hospitalisations could therefore underestimate the overall symptom burden. The COVID Symptom Study estimates that overall approximately 10% of people with Covid-19 experience symptoms lasting over three weeks[6] (potentially over 3,000 people so far in Sheffield). For some, symptoms can last several months[7-9].22 Most recent estimates are that 1-2% of people who have had Covid-19

have symptoms lasting three months or more[6]. For Sheffield this would mean 300-600 people overall.

Those with prolonged symptoms have reported a fluctuating syndrome comprising fatigue, shortness of breath, headaches, cough, loss of sense of smell and taste, sore throat, delirium/cognitive issues, chest pain, dizziness, muscle and joint aches and pains, weakness, gastrointestinal upset and rashes, among others[1]. It is important to stress that many of the people describing this syndrome had a mild initial infection and therefore were never tested or confirmed to have had Covid-19.

Complications of Covid-19

Though the long-term effects of Covid-19 on lung function are not yet known, it is believed that Covid-19 survivors, particularly those with acute respiratory distress syndrome (ARDS), could have persistent impairment of lung function[1]. The degree of impairment is likely to be related to patients' age, comorbidities, severity of acute disease and medications given in the acute phase[10]. At three-month follow-up of hospitalised patients in the Bristol DISCOVER study, the prevalence of pulmonary fibrosis was 2%, much lower than that seen in other coronavirus outbreaks. Alterations in lung function were seen in 11% and reduced oxygen saturation on standing was seen in 14%. 14% of patients also had persistent changes on chest X-rays. All patients with persistent lung problems had moderate to severe Covid-19 in the acute phase[6]. Translating these results to the Sheffield population, could see between 2 -20 additional cases of pulmonary fibrosis so far and around 11-137 patients with evidence of lung damage or dysfunction three months after infection.

Covid-19 is associated with a high incidence of thromboembolic complications (blood clots), particularly in those admitted to ICU, where it is around 50%[11-13]. Of these, pulmonary emboli (blood clots in the lungs) are the most common[12,13]. In hospitalised Covid-19 patients as a whole, one study found symptomatic blood clots in 25%[11]. Blood clots are associated with an increased risk of death from Covid-19 at two to five times that of those without clots[11,12]. If similar numbers were extrapolated to Sheffield, this could mean anywhere between 20 and 246 patients requiring treatment for Covid-related blood clots.

Cardiac involvement is reported in approximately 20% of patients hospitalised with Covid-19[14-16], with asymptomatic involvement likely to be even more common[1,19]. Cardiac complications include myocardial infarction (heart attack), myocarditis (infection or inflammation of heart muscle), arrhythmias (irregular heart rhythms) and heart failure[14,15,17-19]. In Sheffield, this could mean 16-197 people being affected by heart complications from Covid-19. However, like clots, heart complications are associated with an increased chance of dying from Covid-19[16] and therefore the number of people living with these complications after their infection could be much lower.

Vascular events in the brain, including stroke, are the most common neurological complications of Covid-19[20]. The estimated incidence of ischaemic stroke in hospitalised patients is 2-3%[21]. Rarer, but serious, neurological complications include possible central nervous system infection and inflammation, Guillain-Barre syndrome (a syndrome of ascending muscle weakness that can cause respiratory failure) and seizures[20-23]. These rare complications are too infrequent to quantify at this point in time. In Sheffield the numbers of people living with the consequences of stroke following Covid-19 could be around 2-30.

Liver and kidney dysfunction are both common in acute Covid-19[24,25]. While there is limited evidence, it appears that liver injury from Covid-19 tends to resolve in most cases[26]. The longer term effects on kidney function and risk of developing chronic kidney disease from Covid-19 are not yet known[27].

There is currently little evidence around the longer-term psychiatric and psychological consequences of having Covid-19. However anxiety, panic attacks, insomnia, delirium and other cognitive issues have been reported[1,6]. Specifically within Sheffield, the Covid-19 Recovery Pathway Patient Group in Sheffield (via CCG Community Insight Log) reported: issues with cognitive function and memory; anxiety and depression; feelings of vulnerability and anxiety over transmission to family following hospitalisation with Covid-19[28].

Recovery and rehabilitation after intensive care

Those surviving ICU admission are at risk of post-intensive care syndrome, a syndrome of impaired physical, cognitive and psychological functioning, which occurs commonly (30-40%) in patients who require prolonged invasive ventilation[29]. Further potential complications known to affect patients who were invasively ventilated include critical illness polyneuropathy/myopathy (46-96%), which can last for up to 2 years, causing weakness and loss of function[30]; chronic pain (75%)[31]; anxiety/depression (50%); post-traumatic stress disorder (25%)[30,32]; and persistent cognitive impairment (20%)[30]. Other problems facing those discharged from ICU include swallowing and speech problems[33]

Chapter 13

Mental Health

Summary prepared for SH&WBB

What we have seen happen so far?

Psychological distress and levels of mental illness are rising as a consequence of Covid19. NHS England anticipates an increase in emotional and mental health problems associated with C-19 of up to 40%.

People from BAME communities have been disproportionately impacted by Covid-19. This has coincided with the BLM protests and a greater awareness of the impact of structural racism on the mental health of people from BAME communities.

Clinical staff & care workers have suffered the effects of burn out, psychological distress & bereavement.

Social isolation and increased levels of stress and anxiety has led to the exacerbation of existing mental health conditions as well as leading to new problems arising.

Primary Care survey data indicates a 60% increase of consultations related to depression and anxiety, 50% for alcohol related problems and a clear recognition of the deterioration for those living with existing complex mental health problems.

Over 60% of responders to a survey conducted by Sheffield Flourish reported that their mental health had worsened during the pandemic.

In the early days of the lockdown, referrals to IAPT dropped by 50% and to CYP MH services by 40%

Recent ONS analysis has found that that depression has doubled during the pandemic in the adult population to 1 in 5 with those aged 16-39, being female, challenged financially or being disabled being more likely to experience depression.

Worsened physical health – long term condition management; exercise; diet and weight gain. People living with SMI and LD are already likely to die 15 to 20 years earlier than the general population from preventable causes.

Covid-19 has revealed and confirmed the health and social inequalities that were already known. These inequalities drive poorer mental health outcomes across all population groups

What we might expect to happen next?

National forecasting would indicate that the pandemic would increase the number of people experiencing mental health problems by approximately 500,000 in the UK. This

would likely mean an increase of between 3.5-5 thousand additional people seeking help for mental health problems in Sheffield.

Need for mental health services was very likely to have been 'supressed' during the pandemic. As services open up, this will re-emerge alongside demand ‘generated’ as a result of the pandemic resulting in increased demand

Particular groups of people have and are facing higher risks to their mental health and wellbeing due to the pandemic. The extent of this is still emerging

Recommendations

- If the city is going meet the demand for mental health services that existed prior to the pandemic and adapt to the predicted upsurge in demand following the pandemic, greater investment will be required in the coming 18 months – 3 years. System leaders should strive to increase the proportion of healthcare spend on mental health services from the current 12%. This investment should also be disproportionately allocated in order to tackle inequalities and support prevention.

- The VCS sector should see additional resources to enable an ongoing community conversation between the people of Sheffield and the health system. A strengthened VCSE sector would help us to develop a framework for rapid and progressive commissioning of mental health services which enables a timely response to changing community mental health support needs and service demands.

- Given the disproportionate impact of Covid-19 on BAME communities, it is imperative that we work with and invest in BAME-led VCSE organizations to understand community needs, develop partnerships based on trust and develop culturally competent services.

- The H&WBB is asked to support the identification of Public Health intelligence capacity to work with commissioners, expert providers and experts by experience to quantify the predicted increase in demand. This is necessary to assess the city’s ability to meet need, map the projected resource gap, and to support a city-wide public health response to the pandemic.

- Sir Simon Steven’s letter to NHS organisations in August 2020 emphasises the need for investment in early intervention and prevention support for mental health as part of the phase 3 response to Covid-19. H&WBB is asked to support the continued investment in & development of a Primary Care MH & Wellbeing Offer including IAPT & social prescribing and encourage greater working with the VCS sector to further development interventions that de-stigmatise & encourage easy access to wellbeing support.

- Covid-19 has provided an urgent and timely opportunity to review the provision of bereavement care in Sheffield. One of the work streams of the Sheffield Psychology Board was tasked with this review and at bereavement. H&WBB is asked to support the establishment of a comprehensive bereavement offer for Sheffield in line with the recommendations of the SPB work stream.

- H&WBB should oversee the preparation across the system for both a V-shaped and a W-shaped recession during the next five years, with resources (financial and human) to respond either to a single, deep recession this year or to a series of economic shocks each of which will create additional need for mental health support.

- The impact of the pandemic on the mental health and wellbeing of children and young people has been substantial and is increasing, leading to further pressure on the city-wide problem of waiting lists and under funding of young peoples' mental health services. The H&WBB is asked to recognise the range of mental health services delivered by the VCS and support them to work with mental health care providers to develop a coordinated and youth-led provision across the city that prioritises early intervention, prevention and emotional wellbeing, and to support the call for increased funding to children and young people's mental health services.

- Recognising that COVID-19 is a multi-system disease that affects both physical and mental health it is essential that mental health and psychological interventions are embedded in post-COVID care, support and treatment pathways.

- This RIA has demonstrated the massive shift to digital delivery of mental health and wellbeing services and interventions since the start of the lockdown. Despite some easing of restrictions, there is still the potential for further lockdowns during any subsequent waves of Covid-19 spread meaning that digital delivery of services is planned to continue in the 'new normal'. There needs to be a review of the level of engagement with digital technology, particularly of people with severe and enduring mental health issues. Digital inclusion is not just about whether people have access to technology, it is also about whether or not they are able to engage with services via technology. H&WBB is encouraged to resource the VCSE sector to carry out community research on access to MH services and to ensure that the patient experience is considered in future service development plans

Chapter 14

Black, Asian and Minority Ethnic (BAME) Communities

Summary

Black, Asian and Minority Ethnic communities have been disproportionality impacted by Covid-19, are more likely to test positive for Covid-19 and experience more severe disease and death from Covid19. Covid19 has shone a light on existing inequalities and has exacerbated them.

Sheffield position

According to the 2011 National Census 19% of Sheffield residents are from BAME communities this equates to around 105,861 people. 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.

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 BAME Communities' lived experience of Covid19

The BAME Public Health Communities group was established 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.

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 and in overcrowded housing.

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 and grandparents) can transmit the virus more easily between each other, however a positive side is that there is a wider support network of family and friends for those who do fall ill.

Poverty, Income and Employment
The jobs 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 where you have more contact with others, are less able to work from home during lockdown and are more likely to need to use public transport to get to work, putting them at increased risk of 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.

Citizens Advice Sheffield stats show that the pandemic is having a disproportionate impact on incomes of BAME communities.

Health Conditions
Severe disease outcomes and death from Covid-19 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 Covid-19 than more affluent parts and have seen some of the highest death rates in the country.

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. Nationally higher than average rates of obesity are seen in Black ethnic than white ethnic groups (73% vs 63%).

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.

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. However, some report smoking more and children may have been at increased risk of second-hand smoke exposure due to being at home more.

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.

Smoking in pregnancy

Data from 2020, shows the percentage of black and ethnic minority (BAME) women engaging with the service had reduced between 1st March and 31st May compared to the same period in 2019. This is concerning as BAME pregnant women are 8 times 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 Covid-19 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 say they had been drinking more than people in group C2DE (32% compared to 24%). However it is unclear how this was represented by ethnicity.

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). The groups most affected include Black and Ethnic Minority groups**.**

Free School Meals.

21% of families with white children claim FSM compared to significantly more children in all BAME groups (59% of Roma children, 47% of Yemini children, 46% of Somali children, 32% of Black African children and 23% of Pakistani children).

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.

Of the 6,088 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 their only hot meal of the day.

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 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 noncredible sources for information on Covid-19 during the pandemic. 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.

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

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.

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.

Mental Health and Wellbeing, Loss and Bereavement

Mental Health remains a taboo subject for many within BAME communities.

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.

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.

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.

Isolation and loneliness

According to British Red Cross research, BAME groups are at a higher risk of being isolated/lonely and can often face greater barriers to accessing support.

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"

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 interrogate the data more fully 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 were the ones that needed us the most.

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.

Funding and lack of BAME community infrastructure

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. The virus has just shown the services that have been decimated and this is a real issue.

Organisations felt that there needs to be training and support for BAME VCF organisations. 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".

Domestic Abuse

In 2019/20 34% of IDAS service users were BAME. In Q1 of 20/21 the proportion was 27%. The most significant reductions were in relation to people identifying as: Arabic (8% to 5%), Asian other (i.e. not Bangladeshi, Pakistani, Indian or Chinese: down from 6% to 5%) and Black other (i.e. not African or Caribbean down from 5% to 4%). The pandemic and lockdown have potentially increased barriers to accessing support amongst the BAME community.

Shelter have reported that people without regularised immigration status fleeing domestic abuse are also experiencing problems accessing emergency accommodation. 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.

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:

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.

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)

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.

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.

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.

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.

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

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.

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).

Chapter 15

Crosscutting themes

Whilst the people and communities of Sheffield have shown themselves to be resilient and compassionate, and its workers, highly committed and agile, the pandemic has had a terrible impact across the city and particularly on our most vulnerable. Whilst examining the impact on specific, areas of concern, the themed reviews have highlighted a number of crosscutting issues which are described briefly here.

Inequalities

The key thread which dominates all the RIAs is how Covid-19 has exposed and widened the existing health and structural inequalities in our city. There has been a disproportionate impact of Covid-19 on different cohorts in Sheffield (e.g. BAME communities; people on lower incomes, carers, people with existing health conditions and disabilities) which must be reflected in commissioning and provision priorities going forwards.

Neighbourhood and Community

Throughout lockdown and beyond the community response (by the public, the voluntary sector and other local infrastructure) has been integral to supporting people in or close to their own homes when travel was limited (traffic volumes fell by 80%) and access to normal support networks was cut off.

Community hubs were established, often building on existing community assets to support food drops and wellbeing calls. Continuing to build on and invest in local assets and infrastructure and the VCF is a key recommendation of several of the RIAs. Investing in local areas and supporting none car based short trips not only supports the local economies but reduces pollution, supports increased social interactions and plays an important role in active lifestyles

Digital Inclusivity

Peoples access to, ability to use and motivation to use technology through the pandemic has had an impact on their access to support, ability to work and to study through the pandemic. People who were unable to engage with the new remote services being provided have missed out on support leading to widened inequalities in service provision. A significant number of people do not have access either to a telephone or the internet to undertake telephone or video appointments. Addressing this digital divide as a city comes through many of the reports as a key issue. Sheffield should be prioritising access to devices and broadband for our most disadvantaged people and communities (as well as working to improve people's skills confidence and motivation to use digital services).

Mental Health

Social isolation through Covid-19 and increased levels of stress and anxiety has led to the exacerbation of existing mental health conditions as well as leading to new problems arising. Over 60% of responders to a survey conducted by Sheffield Flourish reported that their mental health had worsened during the pandemic. This is unlikely to improve in the near future as there will inevitably be a period of adjustment through September and October (and beyond) as people return to work and school with ongoing uncertainty about future disruption through 2020/2021.

The pandemic has for many been and remains a traumatic event and has increased children's exposure to adverse incidents and increased levels of domestic violence. The need for improved access to mental health services and trauma informed care and support (across all sectors) has never been greater. It is anticipated that as unemployment increases and school and universities return latent demand for mental health support will begin to come through.

Access to Health and Care Provision

The pandemic has brought health and social care; statutory and voluntary services together and examples of excellent system working have come out of this period. New (remote) ways of delivering services have been developed, many of which will continue post-Covid. Anecdotal feedback has highlighted that non face-to-face contact can be very effective. However limitations in our ability to share information between different IT systems and between organisations has, at times, hindered delivery.

Access to remotely provided services has not been equitable; people with English as their second language or with sensory or cognitive impairments have often struggled to engage with remote services increasing existing inequalities of access during this time.

Staff working across the system will also need ongoing support; many are exhausted, trying to learn new ways of working and often working in isolation at home. The need to focus on staff wellbeing to ensure resilience in the workforce across all sectors, including independent providers is clear if we are to maintain services through the coming months.

Employment and Poverty

Financial insecurity is significantly more widespread and more severe since the beginning of the pandemic. Demand on food banks has increased and the number of people on Universal Credits has doubled in Sheffield. There has been a disproportionate impact in some areas of the city and in some cohorts. For example refugees and asylum seekers, women, younger people and people with disabilities are just some of the groups disproportionally affected by the financial impacts of Covid and the three most deprived constituencies have the most furloughed workers.

Levels of unemployment and poverty are expected to continue to increase over the coming months as the job retention scheme ends in October (53,500 employees in Sheffield have

been placed on furlough). As a city we need to plan for this and ensure adequate levels of support and advice are available. We need to ensure uptake of benefits in all those eligible to do so, especially those which may never have had experience of using the benefits system before.

Communication and Engagement

The need for ongoing, consistent and culturally competent public health messaging is clear. There was decreased use of services throughout the period (Citizens Advice, health care, social care support) and although footfall is now increasing many people are still not accessing the services they need or would benefit from (either through fear or lack of awareness).

It is clear that messages need to be coproduced to ensure cultural appropriateness and will need to be delivered in multiple ways (need to move away from one size fits all wherever possible).

Limitations and Gaps

The information which has informed these assessments generally is limited to the last 3-4 months, which in many cases is too soon to see significant change. It is important that this work is ongoing to understand the full impact of Covid-19. Latent demand for support is starting to come through and more is likely to surface as schools and universities return and the job retention scheme ends in October. Impacts on educational attainment, employment levels and physical health (particularly for people who have had Covid-19 or had other pre-existing conditions) are not yet able to be predicted or measured.

Not all voices are heard equally and impacts for some groups are not well known. In many cases there is poor (or no) data available to enable breaking down information to subpopulations or protected characteristics, often reliant on census data which is 10 years old. Improved data capture and use to better understand inequalities in access and provision of services is a gap which needs to be addressed going forwards.

Much feedback about the services provided through the pandemic is anecdotal; there is limited formal evaluation of the effectiveness of new services and delivery models at this stage. Although Sheffield Children's Foundation Trust has undertaken an extensive staff and patient survey of non-face to face appointments (https://view.pagetiger.com/a-whole-new-world/2020).

Dental services and were not specifically covered by any of the reports.

Chapter 16

Tabulated theme recommendations

A total of 103 individual recommendations have been made. Different task and finish groups have taken different approaches to recommendations and thus whilst some are duplicates of each, they are broad in their reach and vary in their style. They can be summarised as follows:

- Green – already happening or are being dealt with elsewhere
- Orange – require immediate action in light of second wave, may need assurance they are being actioned
- Blue – Longer term/strategic recommendations. Some may map onto the H&WB strategy ambitions; some may be the responsibility of other boards or organisations

Theme	Suggested recommendations	New recommendation or linking to existing strategy(ies
1. Active travel	1.1 For the City to harness Active Travel	Existing – this is being done through existing work programmes. Transforming Cities Fund and the Emergency Active Travel Fund are examples of capital investment that are helping the city develop a cycle network. E-Bike trials, cycle events and training are other programmes of work that utilise revenue funding to help establish behavioural change for active travel use.
	1.2 To continue to support bus services and public transport in the medium to long term	Existing – working with the transport operators and SYPTE, SCRMCA to establish how physical improvements to the highway network can prioritise public transport and the use of shared marketing and promotion material in the medium term to build confidence in public transport use.
	1.3 To improve data collection and evidence of localised investment benefits	New
	1.4 To invest in local areas that support none car based short trips	Existing – with our transport habits potentially changing, there is a need to invest in local transport

		solutions. This is being undertaken through the Transport Capital Programme, but also the Council's own funded Road Safety Fund to support accessibility within local communities.
2. Employment	2.1 How the city should define economic success, considering outcomes other than growth, such as health and wellbeing	New
	2.2 Work with communities of Sheffield, for example via voluntary and community sector organisations, to ensure what matters to people is considered in the development of the renewed strategy	New
	2.3 The Universal Basic Income trial	New – this has been previously discussed but there is now greater emphasis
3. Health behaviours	3.1 Seek to influence high-level strategic conversations about recovery and next steps for the city	New
	3.2 Existing public health strategies must be implemented and investment maintained or in some cases increased to enable maximum impact amongst high risk populations	Existing strategies – Food, Tobacco Control, Move More, Alcohol, Great Start in Life
	3.3 Accelerate efforts to develop culturally competent health promotion and disease prevention programmes.	Links to existing (as above). But with increased emphasis
	3.4 Policy leads and commissioners need to ensure the voices of all communities are heard in the development of strategies and interventions; in particular the BAMER community, those experiencing socio-economic disadvantage and those living with disabilities.	Links to existing (as above). But with increased emphasis – we should be doing this but are we doing it well enough
	3.5 Enhance messaging around the connection between a range of health behaviours and physical health and mental well-being.	Existing strategies - Food, Tobacco Control, Move More, Alcohol, Great Start in Life
	3.6 Ensure that gambling is reflected as a contributory factor in relevant strategies including for poverty, mental wellbeing and other addictions	New
4. Education and skills	4.1 Continue to provide a wide range of support and advice to schools and families and make sure those services are Covid secure	Existing
	4.2 Continue clear communications with schools, providers and other settings – including developing a resource library so that schools can access key documents	Existing – e.g Director's bulletin
	4.3 Maintaining the school enquiries and complaints service	Existing

	4.4 Maintaining links with DFE and Ofsted to ensure schools have the latest information and guidance	Existing
	4.5 Ensure Sheffield schools have access to any grants from government for summer schools and additional catch up lessons	Recently started and ongoing
	4.6 Learn Sheffield will also continue to support schools	Existing
	4.7 Provide support needed for children at key moments of transition	Existing
	4.8 Ongoing support to families from the SEND team. This includes focussing on the process and resource for assessment of needs so that schools can understand the impact on learning and put appropriate provision in place. This will require support from those with greater expertise e.g. Educational Psychology, specialist teachers, locality SENCOs	Existing
	4.9 Encouraging schools to targeting resources for catch up for all pupils but especially those with SEND or those who are in a vulnerable group where the gap has widened	Existing
	4.10 Development and training on catch up curriculums so that schools ensure that they address needs beyond the teaching and learning e.g.: managing mental health and trauma	New: Begun with support of Learn Sheffield
	4.11 It is also likely that even next academic year there will be a combination of home learning and face to face teaching in schools. It is important that the LA acts to share best practice across our schools as to the best way to support our young people in this new learning environment. For example when children return, schools could build a display/symbol/stories about the period of home learning. Schools could become the hub for recovery within their community.	New: Begun with support of Learn Sheffield We plan to develop an Education and Skills online resource library where this sort of information can be securely shared via Schoolpoint.
	4.12 Continue to provide a wide range of support and advice to schools and families and make sure those services are Covid secure	Exisiting – e.g through support of H and S team.
5. Poverty and income	5.1 Ensure a collective, city-wide approach to developing responses to poverty	New
	5.2 Plan for poverty and demand for support services to increase	New
	5.3 Build on and nurture good partnership working on the ground	New
	5.4 Prioritise making digital access available to disadvantaged people and communities in the city	New (ish) We have known about this issue for a long time – there have been projects i.e. BCIS; infrastructure, skills but not with people in communities
	5.5 Increase take-up of benefits and support in the	New

	city. Also explore introducing 'financial healthchecks' for households in response to the crisis.	
	5.6 Plan, predict and disseminate widely: we should focus on how this work can continue to evolve and inform wider activities across the city, as well as future responses.	New
	5.7 Seek to influence high-level strategic conversations about recovery and next steps for the city	New
6. Loneliness and social isolation	6.1 Invest in the VCF sector to build Resilient Communities a. *Short term:* Build more capacity in the VCF workforce to undertake more 'check and chat' call b. *Longer term:* Create an environment for people in their communities to become leaders: i. Recruit, develop and support more people to peer support each other ii. Support people to develop social activities (digital and COVID-19 safe face to face) – a reason to get together with meaning and purpose to people eg knitting, sporting memories c. *Short to medium term:* The pandemic saw a community response in way we haven't before, we need to support mutual aid groups to flourish and find a place post the immediate crisis	New (ish) a. New b. New but we are talking this in the emerging Early Help Strategy c. New
	6.2 Workforce and the system recognise that Loneliness (separator or lack of social connection) is trauma in children and adults. All staff across the system need to be trained to recognise this	New
	6.3 Help people and families manage the risk of covid so that they are not too frightened to re-engage in their life	New
	6.5 Reduce digital exclusion	New (ish) We have known about this for a long time – there have been projects ie BCIS; infrastructure, skills but not with people in communities
	6.6 Support small community and volunteer led building and activities to reopen or start activities in a sustainable and covid safe way	New
	6.7 Support people to develop the tools to manage living by themselves (needs to connect to the work of the mental wellbeing HIA	New
7. Domestic and sexual abuse	7.1 Invest in services for all those impacted by domestic abuse – victims / survivors, children and perpetrators, and increase capacity where needed to	Links to existing Domestic and Sexual Abuse Strategy. But with increased

	ensure needs are met	emphasis on capacity
	7.2 Ensure there is adequate provision of good quality, safe, appropriate emergency accommodation with specialist support	Links to existing (as above). But with increased emphasis on increasing capacity
	7.3 Improve responses from agencies and employers	In existing strategy (as above).
	7.4 Prevent domestic and sexual abuse in the future by increasing understanding of the dynamics of abuse and the impact of trauma, and by branding Sheffield as a city where we foster healthy relationships	Links to existing (as above). But with increased emphasis re. city branding aim
	7.5 Work with organisations such as the Local Government Association to raise national issues	
8. Access to health and care services (Healthcare)	8.1 We therefore strongly recommend that this RHIA document be made available to sub-population subject matter experts in order for an impact rating to be allocated against each development area (for example, voluntary sector, carer/patient groups, condition support groups). Transparency: Subject-matter experts should be requested to contribute to detail around impact and mitigating actions which could be implemented to ensure equity across our population. One potential approach would be to implement a website dedicated to consultation with all groups whereby major health and social service changes would be required to be reviewed. Individual groups would be responsible for providing a response for the population they represent. An ICS level approach would ensure consistency and avoid duplication of effort. Such a resource would be valuable in many areas beyond health and social care.	New – and important to achieve
	8.2 Develop MDS for protected characteristics via an ICS model for minimum data collection which can be replicated at each individual place level.	New
	8.3 Seek to influence high-level strategic conversations for future system integration and provision of integrated patient services.	New Opportunities
	8.4 Building on new ways of working and lock-in the benefits. ICS should monitor to ensure post-pandemic developments are consistently and equitably implemented across the South Yorkshire and Basset Law Region.	New
	8.5 Address digital exclusion Establish digital access points in GP practices/schools/suitable venues. We recommend that service providers, including adult health, child health, community services, and social services collaboratively develop a plan to implement digital service points patients can easily access .	New -
	Identify and implement appropriate off the shelf or	New

	bespoke Apps.	
	8.6 Expand Community Services	Existing strategy
	8.7 Primary Care Networks (PCN) Implementation and development of new roles to support personalisation and the value of non-medicalised interventions should be acknowledged and developed	New
	8.8 Increase Rates of 'hear/see and treat' via Yorkshire Ambulance Service	New/existing
	8.9 Ensure equitable access to face-to-face appointments	Existing
	8.10 Review and respond to evidence developed during the pandemic e.g. on use of technology	New
	8.11 Implement a programme to embed patient self-care within clinical pathways	New
	8.12 Personalised Care: Action should be taken to identify the system level work already in train and as a result agree and respond to any gaps, particularly in regard to provision across the protected characteristics populations.	New element of an existing strategy
	8.13 Homelessness - Implement learning from the citywide partnership work supporting rough sleepers and the homeless during COVID. Robust joined-up communications would have a significant positive impact with regards to supporting the majority of vulnerable people across the city.	New
9. Access to health and care services (social care)	9.1 Ensure that the whole system partnership approach cemented during the pandemic is maintained into business and usual working and included within the strategy review of all Adult Social Care Services.	New
	9.2 Enable discussions, which including individuals and their advocates at each stage, to use the learning from the pandemic around alternative approaches and locations for service delivery to create tailored responses to care needs.	New
	9.3 Promote nurture and support community led initiatives to facilitate a broad range of informal care and support activities within localities and neighbourhoods building upon the excellent work of the VCF sector linked to localised demographic need.	New
	9.4 Adopt a health and social care whole system approach to the identification and provision of assistive technology to help meet health and social care needs across the city	New
	9.5 Utilise and consolidate the upsurge in the use of virtual communication channels and tools to achieve the right levels of contact with people who have care and support needs to monitor ensure their wellbeing	New
	9.6 Create additional resilience within services in preparation for the anticipated upsurge in Covid-19 cases through Autumn and into Winter. Specifically	New

	ensure the appropriate care and support staffing capacity to ensure excess demand can be met across all sectors, including independent providers.	
	9.7 Increase data capture and conversations to better understand and tackle inequality in access and provision of service delivery, particularly where this is felt by BAME people and within BAME communities.	New
	9.8 Learning from the experiences of delivery partners working across the health and social care sector during this crisis to redesign processes and practice that previously inhibited the ability of the system as to deliver holistic joined up and straightforward care and support to people who need it throughout a person's pathway.	New
10. Housing and Homelessness	10.1 Immediate: Reinstate Choice Based Lettings and associated activities	New – but now in progress – CBL coming back online
	10.2 Immediate: Review and modify communications strategies in light of the 'new normal'	New – will be utilising existing Steering Groups to review
	10.3 Longer term: Adopt and adapt governance structures to embed true partnership working into all housing projects and programmes going forward	New – will utilise existing and newly-formed Steering Groups
	10.4 Longer term: Ensure frontline workers have the tools to provide a person-centred approach to services	Already in strategy – Prevention Toolkit – to be started shortly
	10.5 Longer term: Identify gaps in order to provide a complimentary suite of housing options	Already in strategy – In progress now via Housing Options subgroup
	10.6 Longer term: Modify relevant project initiation processes to ensure it is business-as-usual to embed service users at the centre of service development	Already in strategy – recent co-production survey and new Steering Groups are moving this forward
11. End of Life	Establish effective reporting of End of Life Care Need and Developments within the Accountable Care Partnership and Health and Social Care Governance structures.	
	11.1 Where financially viable consider retaining or reinitiating pandemic response to end of life care in acute hospital, community services and specialist palliative care in the event of further COVID-19 wave and phase 3 response.	
	11.2 Continue to enable development of care home, adult social care and Primary and Community Care Communities of Practice as a means of training, reflection and support through Primary and Community Care Project ECHO work and Care Home VOICES Care Home Manager's Forum, Care Home and Domiciliary Care Group.	
	11.3 Support maintenance of alternative approaches to care enhancing communication with the general public to support understanding and access to the	

	range of options and enhanced multi-disciplinary working.	
	11.4 Maintain and develop a representative Citywide End of Life Care Group	
	11.5 Develop Sheffield End of Life Intelligence collaboration	
	11.6 Implement a public health approach to end of life care (expanding the health care focused approach to include the community as genuine partners). Continue to develop the Compassionate Communities and Compassionate Cities approach to this and consider synergies with the STH Flow Coaching Academy End of Life programme.	
	11.7 Consider the findings of the *Supporting adults bereaved in Sheffield: bereavement care pathway, gaps in provision and recommendations for improved bereavement care* (August 2020). Support delivery of recommendations through the End of Life Group and Compassionate Cities approach where appropriate.	
11. Mental Wellbeing	12.1 If the city is going meet the demand for mental health services that existed prior to the pandemic and adapt to the predicted upsurge in demand following the pandemic, greater investment will be required in the coming 18 months – 3 years. System leaders should strive to increase the proportion of healthcare spend on mental health services from the current 12%. This investment should also be disproportionately allocated in order to tackle inequalities and support prevention.	
	12.2 The VCS sector should see additional resources to enable an ongoing community conversation between the people of Sheffield and the health system. A strengthened VCSE sector would help us to develop a framework for rapid and progressive commissioning of mental health services which enables a timely response to changing community mental health support needs and service demands.	
	12.3 Given the disproportionate impact of Covid-19 on BAME communities, it is imperative that we work with and invest in BAME-led VCSE organizations to understand community needs, develop partnerships based on trust and develop culturally competent services.	
	12.4 The H&WBB is asked to support the identification of Public Health intelligence capacity to work with commissioners, expert providers and experts by experience to quantify the predicted increase in demand. This is necessary to assess the city's ability to meet need, map the projected resource gap, and to support a city-wide public health response to the pandemic.	

	12.5 Sir Simon Steven's letter to NHS organisations in August 2020 emphasises the need for investment in early intervention and prevention support for mental health as part of the phase 3 response to Covid-19. H&WBB is asked to support the continued investment in & development of a Primary Care MH & Wellbeing Offer including IAPT & social prescribing and encourage greater working with the VCS sector to further development interventions that de-stigmatise & encourage easy access to wellbeing support.	
	12.6 Covid-19 has provided an urgent and timely opportunity to review the provision of bereavement care in Sheffield. One of the work streams of the Sheffield Psychology Board was tasked with this review and at bereavement. H&WBB is asked to support the establishment of a comprehensive bereavement offer for Sheffield in line with the recommendations of the SPB work stream.	
	12.7 H&WBB should oversee the preparation across the system for both a V-shaped and a W-shaped recession during the next five years, with resources (financial and human) to respond either to a single, deep recession this year or to a series of economic shocks each of which will create additional need for mental health support.	
	12.8 The impact of the pandemic on the mental health and wellbeing of children and young people has been substantial and is increasing, leading to further pressure on the city-wide problem of waiting lists and under funding of young peoples' mental health services. The H&WBB is asked to recognise the range of mental health services delivered by the VCS and support them to work with mental health care providers to develop a coordinated and youth-led provision across the city that prioritises early intervention, prevention and emotional wellbeing, and to support the call for increased funding to children and young people's mental health services.	
	12.9 Recognising that COVID-19 is a multi-system disease that affects both physical and mental health it is essential that mental health and psychological interventions are embedded in post-COVID care, support and treatment pathways.	
	12.10 This RIA has demonstrated the massive shift to digital delivery of mental health and wellbeing services and interventions since the start of the lockdown. Despite some easing of restrictions, there is still the potential for further lockdowns during any subsequent waves of Covid-19 spread meaning that digital delivery of services is planned to continue in the 'new normal'. There needs to be a review of the	

	level of engagement with digital technology, particularly of people with severe and enduring mental health issues. Digital inclusion is not just about whether people have access to technology, it is also about whether or not they are able to engage with services via technology. H&WBB is encouraged to resource the VCSE sector to carry out community research on access to MH services and to ensure that the patient experience is considered in future service development plans	
12. BAME Communities	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.	

Appendix 1

The Health Impact of the Covid-19 Pandemic in Sheffield
Rapid Health Impact Assessment - Framework and Guidance for Contributors

Context

We know that Covid-19 and the actions taken in response to it will have long-term effects on people's health in addition to their current experiences. Those impacts are disproportionately spread across Sheffield's population. Recording and formally recognising them (quantifying if possible), is vital if we are to be successful in mitigating the detrimental effects and building on the positive.

It has been agreed by the H&WB board that a rapid health impact assessment (HIA) should be produced in order that stakeholders can focus their work in the most impactful places to minimise the long-term, negative, health impact and maximise the many positive changes that have come from the crisis.

This rapid HIA is underpinned by the view that communities in Sheffield have shown incredible levels of resilience during this pandemic and that the central purpose for conducting this assessment is not to quantify an assumed surge in demand for 'business as usual', but to identify and target mitigating and preventive actions and interventions that will strengthen communities, and to learn from innovative developments in order that they can be expanded and shared more widely as the city moves into its recovery and recalibration phases.

It is proposed that the end product of the rapid HIA project will be comprised of a number of chapters, each of these a 'mini-HIA' on a specific theme, raised as an area of concern by partners across the city. The themes are listed at appendix 1. These HIAs are intended to be of benefit beyond commissioning and service planning. They have the potential to add to similar work which is already underway by providing intelligence that can be widely used to aid recovery planning and decision-making. It will be important to use the rapid HIA data and narrative to influence the city's economic strategy so that the impact on health and wellbeing is considered alongside business and financial recovery plans, and reduce the risk of further adverse effects on deprivation and inequality.

Under the Equality Act, our statutory requirements are to appropriately evidence impact and our mitigating actions by protected characteristic and other communities of interest. This therefore should be inherent in how this work is approached and presented.

Each HIA chapter will be produced by an individual task and finish group. It is proposed that each of these will follow the outline framework below to provide a degree of uniformity. The framework will act as a guide and structure thoughts/trigger discussion but is not set in stone, individual task and finish groups may apply their own expertise and decide to deviate from the framework.

Task and finish groups will comprise a small number of individuals with knowledge and expertise on the given theme, supported by the Public Health Intelligence team and the Rapid HIA Steering Group. This impact assessment process will rapidly review data and intelligence to help identify the key risk factors for deteriorating health and wellbeing and any widening of health inequalities during the Covid-19 pandemic.

Framework

1. **Theme**
2. **Lead**
3. **Brief rationale for inclusion of this theme**
4. **Summary**
5. **Aim**

To understand local people's experiences of the pandemic including their hopes and concerns about the future in order to help statutory, voluntary and informal providers focus their efforts in areas of greatest need and on interventions which are most impactful and sustainable. In order to:

i. minimise the long-term negative health impact
ii. maximise the many positive outcomes that have come from the crisis
iii. further strengthen and develop individual, household and community resilience
iv. aid recovery planning and decision-making
v. influence the city's economic strategy
vi. reduce the risk of further adverse effects on deprivation and inequality.

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6. **Objectives**

i. To rapidly collate and review the available and emerging data and provider intelligence to help identify key risk factors for deterioration in health and wellbeing during the pandemic and the sub populations (appendix 2) that are most likely to be affected.
ii. Gather the views of local people to better understand their experience of, and reaction to, both the pandemic and the measures to manage it and its impact on their futures.
iii. To predict and quantify where possible the likely health impact of Covid-19 on the Sheffield population, in the short, medium and long term and identify groups at particularly high risk.
iv. To collate current supportive and preventative mechanisms in place across the city to alleviate this impact and to identify any gaps which require input to further strengthen communities.
v. To identify capabilities, opportunities and motivations which may help to embed positive behaviours, initiated as a reaction to the pandemic and its management, as permanent.
vi. To make recommendations to relevant commissioners and providers on interventions the city could put in place to mitigate the risks to health and wellbeing and minimise the impact on services across the city.

7. **Methods and Sources of Intelligence**

The rapidity of these HIAs and need for urgent, local action means they are unlikely to be made up of large, published data-sets (although such may be included if relevant), but a mixture of local quantitative and qualitative data, anecdote, case studies, stories and literature reviews. Service-level intelligence and data from all sector providers will help to identify emerging issues, demands and the capacity of providers to respond to needs.

Where possible, data should be broken down demographically to identify any differential impacts on certain population groups, particularly those with protected characteristics and known high-risk groups.

8. Key Lines of Enquiry

i. What are the overarching impacts relating this theme brought about by Covid-19 and the response to it?
ii. Which groups are likely to be differentially affected by this issue?
iii. How is each of the identified groups being differentially affected?
iv. What is the scale of the impact now? Can we predict what it will be in the medium and long term?
v. What services/support is already in place (including community response) to mitigate any negative impacts? Can any judgements be made about the sufficiency (i.e. effectiveness and comprehensiveness) of this?
vi. What interventions can be identified to promote wellbeing and prevent ill-health, which can be sustained or developed as we move on from the crisis response phase?
vii. What local, community-level intelligence do we have to substantiate our findings?
viii. How can we use this information to ensure negative impacts are mitigated in our future decision-making?

9. Scope

The purpose of this intelligence necessitates rapidity and responsiveness and thus large, data-driven, surge-capacity modelling is out of scope. That said the output from this work is likely to sit well alongside intelligence developed by other partners which should be identified in the 'links' at section 12.

10. Timeline

- First draft of themes to steering group ASAP – by 23rd June 2020 at the latest
- Early report to H&WB board – End of July 2020
- Final report for H&WB board – Aug 2020 latest

11. Contributors

It is expected that as wide a group of stakeholders as necessary/practicable contribute to this rapid HIA including new/ad hoc/informal providers. They may also need to speak to a number of individuals not directly involved in the task and finish group as part of the information gathering process.

12. Links

Please document other relevant work that may be happening, for example: work commissioned by the CCG, outreach community-based intelligence being undertaken by VAS, Healthwatch etc.

13. Recommendations

Points to consider:

- How can we/the city prevent or mitigate any negative impacts?
- How might our services/approach flex to meet the needs identified here to aid recovery?
- What are the good things happening that we want to keep? How could we do this?

- If there's no such thing as business as usual any more, what are the opportunities for more radical change?
- Other work that is in the planning or early implementation stage, that might add substantial information to his HIA that may change the recommendations or mitigations we currently believe to be appropriate?
- What more do we need to know?