HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of: Greg Fell, Director of Public Health

Date: 19th June 2020

Subject: Health Inequalities and Covid-19

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Summary:

This paper summarises the key findings of three recent reports considering health inequalities in England:

1) Health Equity in England: the Marmot Review 10 Years On, produced by the Institute of Health Equity and published on 25th February 2020;
2) Disparities in the risk and outcomes of COVID-19, produced by Public Health England (PHE) and published on 2nd June 2020; and
3) Beyond the data: Understanding the impact of COVID-19 on BAME groups (PHE) and published on June 16th 2020

It reflects on the Sheffield position in relation to these, and how this interacts with the current crisis. It also reflects on work underway that is aiming to consider how Covid-19 is impacting on Sheffielders, and how this will contribute to addressing some of the issues raised in these reports, in the short term.

Finally it invites the Board to reflect on how the two reports interact with and inform the Board's strategic commitment to eliminating health inequalities, and what steps should be considered to address health inequalities between specific groups in Sheffield, over the longer term.

Questions for the Health and Wellbeing Board:

The Board are asked:

- Are there any other areas of work that should be explored as part of the work to address health inequalities in Sheffield, both pre-existing and those created and exacerbated by Covid-19?
- How work to address questions of representation and engagement in relation to the Board's work be approached?

Recommendations for the Health and Wellbeing Board:

The Board are recommended to:

1. Note the content, conclusions and recommendations of the Marmot report, and the PHE reports
2. Recognise that work is ongoing to understand the impact of Covid-19 in Sheffield and how this impacts on different groups, with short term actions being put in place as these deliver intelligence
3. Recommit to delivering the Health & Wellbeing Strategy, recognising that the ambitions within it remain the building blocks of healthy lives for Sheffielders, and that the challenge in and importance of delivering on them is greater in the context of the pandemic
4. Commit to delivering at the local level the recommendations laid out in the second PHE report, where we have the powers to do so
5. Agree that responding to the challenges outlined above is not the responsibility of one organisation but of the whole city
6. Use the opportunity of the delayed Terms of Reference review to reflect on questions of representation and ways of working to ensure that the strategies it develops and delivers on reflects the concerns and interests of all Sheffielders, reflecting on this at their July Strategy Development Session and bringing proposals in response to the next Public Committee Meeting
7. Commit to working with all city partners and other bodies in the city on addressing the disparities in the impacts of Covid-19, health inequalities in general, and the root causes of these, in the short and long term, especially recognising the vital role of the VCS, BAME and Faith sector organisations and leads in this approach.

Background Papers:

- *Health Equity in England: the Marmot Review 10 Years On*
- *Disparities in the risk and outcomes of COVID-19*
- *Beyond the data: Understanding the impact of COVID-19 on BAME groups*

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

This paper addresses health inequalities in general and therefore cuts across all ambitions in the Strategy

Who has contributed to this paper?

Adele Robinson, Equalities & Engagement Manager, Sheffield City Council

Health & Wellbeing Board Steering Group

HEALTH INEQUALITIES AND COVID-19

1.0 SUMMARY

1.1 This paper summarises the key findings of three recent reports considering health inequalities in England:

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1.2 It reflects on the Sheffield position in relation to these, and how this interacts with the current crisis. It also reflects on work underway that is aiming to consider how Covid-19 is impacting on Sheffielders, and how this will contribute to addressing some of the issues raised in these reports, in the short term.

1.3 Finally it invites the Board to reflect on how the two reports interact with and inform the Board's strategic commitment to eliminating health inequalities, and what steps should be considered to address health inequalities between specific groups in Sheffield, over the longer term.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 The issues mentioned in this paper are specifically concerned with health inequalities and how they connect with the current crisis.

3.0 SUMMARY OF HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON

3.1 In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy will include policies and interventions that address the social determinants of health inequalities.

3.2 The Review had four tasks:

- Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action
- Show how this evidence could be translated into practice
- Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy
- Publish a report of the Review's work that will contribute to the development of a post2010 health inequalities strategy

3.3 The review concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

3.4 Following the review being published in February 2010, there was a change in government in May 2010, with Labour succeeded by the Coalition of Conservatives and Liberal Democrats. Initially the new government welcomed the report and accepted all but one of its recommendations, but since that point health inequalities have had a lower priority level for successive governments. Beyond this, the impact of budget cuts to local government have principally been felt in areas focused on the social determinants of health, as Councils have made difficult decisions to protect critical services such as social care.

3.5 Ten years on from the publication of the original report, the Health Foundation commissioned a follow up report to review progress and propose recommendations for future action.

3.6 The report only focuses on five of the six areas identified in the original review. The policy area focused on ill health prevention was omitted as "it has been explored in detail by others since 2010 and there have been many programmes and interventions – led by Public Health England and NHS England and public health teams in local government." However the report emphasised that recommendations from 2010 were still relevant and vitally important, and called for "an increase in public health funding and increased focus on prevention from the NHS."[1]

3.7 The review featured some key new areas for analysis:

- a stronger focus on regional inequalities;
- a greater emphasis on poverty as well as the socioeconomic gradient;
- a stronger focus on ethnicity, recognising that ethnicity intersects with socioeconomic position to produce particularly poor outcomes for some minority ethnic groups

3.8 In relation to the last of these, lack of data remains a limitation in understanding ethnic inequalities in health, and the report made recommendations that this should be addressed.

3.9 The key findings of the report are as follows:

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[1] https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

- Since 2010 life expectancy in England has stalled; this has not happened since at least 1900.
- The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80% of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality. There are marked regional differences in life expectancy, particularly among people living in more deprived areas.
- Inequalities in life expectancy have increased. Among women in the most deprived 10% of areas, life expectancy fell between 2010-12 and 2016-18.
- There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.
- In every region men and women in the least deprived 10 percent of neighbourhoods have seen increases in life expectancy and differences between regions for these neighbourhoods are much smaller than for more deprived neighbourhoods.
- Routinely collected data on ethnicity in relation to health outcomes is in short supply which makes analysis of inequalities in health along these lines challenging; however the data available indicate that there are a range of inequalities associated with differences in ethnicity, such as:
    - Two research studies using area data pointed to those with Pakistani and Bangladeshi ethnicity having the lowest life expectancy and non-British Whites having the highest.
    - Public Health England's survey of quality life by different ethnic groups shows Pakistani, Bangladeshi and White Gypsy Travellers have much lower quality of life than other ethnic groups
    - Some minority ethnic groups have particularly high rates of child poverty. In 2017/18, 45 percent of minority ethnic children lived in families in poverty after housing costs, compared with 20 percent of children in White British families in the UK
    - Data show significant inequalities in attainment 8 scores related to eligibility for free school meals and ethnicity. For each ethnic group described, those eligible for free school meals do worse but there are different levels of attainment related to ethnicity. Chinese, Asian and mixed ethnic background children scored higher than average for Attainment 8
    - White people, married men, people with no disabilities and those with higher qualifications have higher employment rates than minority ethnic groups, women, lone parents and people with disabilities

- Some ethnic groups also face much higher rates of poverty than others, particularly those who are Black and Bangladeshi and Pakistani origin where rates of poverty after housing costs are as high as 50 percent

- The amount of time people spend in poor health has increased across England since 2010.
- Large funding cuts have affected the social determinants across the whole of England, but deprived areas and areas outside London and the South East experienced larger cuts; their capacity to improve social determinants of health has been undermined.
- Cuts to local authorities have been hugely significant; local government allocations from MHCLG declined by 77% between 2009–10 and 2018–19. There have also been large cuts to most other Departments' expenditure. Spending on social protection and education, both vital for health, have declined the most – by 1.5 percent of GDP.
- UK government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010.

4.0 MARMOT RECOMMENDATIONS

4.1 The report made a number of recommendations, split into:

- Proposals to support action on health inequalities; and
- Recommendations against five of the six marmot principles

4.2 **Proposals to support action on health inequalities**

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health

    a. Development of a national strategy on health inequalities led by the Prime Minister.
    b. Ensuring a strong focus on social determinants of health in the new strategy and by Public Health England and NHS England.
    c. Establishing a Cabinet Level cross-departmental committee to lead implementation of the work on the health inequalities strategy.
    d. The cross departmental committee to lead prioritisation of equity considerations at the heart of policy formulation and implementation in all sectors

2. Ensure proportionate universal allocation of resources and implementation of policies.

    a. Health inequalities targets to reduce socioeconomic and area inequalities in health. Regional health inequalities should be reduced by achieving proportionately greater improvements in health inequalities in the North.
    b. Strengthen the deprivation components in the Revenue Support Grant to local authorities. The NHS Resource allocation formula should also be increased to better reflect social need.

c. Fund and adopt a proportionate universalist approach to building community resources and involve communities in the design and implementation of programmes to reduce inequalities.

3. Early intervention to prevent health inequalities

   a. Take action on the five areas outlined in the report in the ways set out and summarised here and continue to take action in the sixth area of the 2010 Marmot Review
   b. We also propose increasing spending on public health to seven percent of the NHS budget as set out in the 2010 Marmot Review

4. Develop the social determinants of health workforce

   a. Development of education programmes focusing on the social determinants for a range of workforces
   b. Development of anchor institution approaches
   c. Develop a health system approach to population health, with partnerships to improve population health among a range of sectors, locally and nationally.

5. Engage the public

   a. Government and Public Health England initiate a highly visible and accessible public debate highlighting widening health inequalities and addressing how the social determinants affect health.
   b. Development of appropriate public facing reporting mechanisms for inequalities in health.

6. Develop whole systems monitoring and strengthen accountability for health inequalities

   a. We therefore propose development of targets to bring the level of health of deprived areas in the North up to the level of good health enjoyed by people living in affluent areas in London and the South.
   b. In support of meeting those targets we propose to:
      i. Strengthen accountability mechanisms for health inequalities including through legislation
      ii. Build more effective whole system data sets and improve data for ethnicity

4.3 **Recommendations against the Marmot Principles**

1. **Giving every child the best start in life**

   a. Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
   b. Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
   c. Improve availability and quality of early years services, including Children's Centres, in all regions of England.
   d. Increase pay and qualification requirements for the childcare workforce.

2. **Enabling all children, young people and adults to maximise their capabilities and have control over their lives**

    a. Put equity at the heart of national decisions about education policy and funding.
    b. Increase attainment to match the best in Europe by reducing inequalities in attainment.
    c. Invest in preventative services to reduce exclusions and support schools to stop offrolling pupils.
    d. Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

3. **Creating fair employment and good work for all**

    a. Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.
    b. Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.
    c. Increase the number of post-school apprenticeships and support in-work training throughout the life course.
    d. Reduce the high levels of poor quality work and precarious employment.

4. **Ensuring a healthy standard of living for all**

    a. Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit.
    b. Remove sanctions and reduce conditionalities in welfare payments.
    c. Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
    d. Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
    e. Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive.

5. **Creating and sustaining healthy and sustainable places and communities.**

    a. Invest in the development of economic, social and cultural resources in the most deprived communities.
    b. 100% of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
    c. Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result.

4.4 The report was published shortly before the onset of the Covid-19 pandemic in the United Kingdom, and as such a formal Government response is still awaited. In the main, the audience for the report is national government, but there is much within it that

is relevant to Sheffield, and that should provide a guide for the actions the Board should be interested in as part of the delivery of the Joint Health & Wellbeing Strategy.

4.5 A critical point worth noting is that since the publication of the first Marmot report in 2010, much research has been done around the impact of the Labour Government's approach to reducing health inequalities during its time in office from 1997 to 2010. It is increasingly clear that the approach made an impact, demonstrating that a focused approach to the issue can lead to a closing of the gap.2 The clear lesson is: it can be done.

5.0 SUMMARY OF THE PHE REPORT "COVID-19: REVIEW OF DISPARITIES IN RISKS AND OUTCOMES"

5.1 The PHE report "COVID-19: review of disparities in risks and outcomes", published 2nd June 2020, was initially commissioned by the Chief Medical Officer (CMO) and Government on 16th April to review the disproportionate impact of coronavirus on BAME communities. This was following reports of patients admitted to intensive care that showed around 1/3 were from people of BAME background[3] as well as NHS and media reports of deaths of keyworkers in health and social care which showed that many were from BAME groups, often born outside the UK. A HSJ analysis of 106 reported deaths found that 63% were from various BAME backgrounds[4].

5.2 However the government asked for the scope of the review to become broader during April and May as a wider number factors were emerging as important for Covid19 risk, severe disease and death. Therefore this report now takes into account disparities in COVID19 risk and outcomes by age, sex, deprivation, region and ethnicity.

5.3 **Key findings of the report include:**

- The largest disparity found was by age. Among people already diagnosed with COVID-19: people who were 80 or older were seventy times more likely to die than those under 40
- Males were twice as likely as females to die;
- Those living in the more deprived areas were twice as likely to die as those living in the least deprived areas; with the same risk amongst men and women.
- The risk of dying was higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups
- Risk varies significantly by BAME population. People of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British populations.

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[3] https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports

[4] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

- Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.
- Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This proportion was higher in all BAME groups when compared to White ethnic groups
- Local authorities with the highest diagnoses and death rates are mostly urban. This is likely explained by close proximity in which people live and work.

6.0 LIMITATIONS OF THE REPORT

6.1 The report did not analyse or take into account the effect of occupation, comorbidities or obesity on infection rates, severe disease or death rates. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both.

6.2 Also the report does not explore and therefore doesn't explain how the combination of risk factors (specifically occupation, obesity and co-morbidities) impact on the level of risk of infection from Covid19, risk of severe disease and death and how this differs between groups. The report also focuses on diagnosed hospital cases so does not account for what is happening at a community level and does not cover all those who get infected.

6.3 The report states it is important to note also that other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced between white and BAME populations. However some BAME populations still remained 1.8 to 3 times at higher risk of dying from Covid-19 than white populations. This remaining risk has yet to be fully accounted for scientifically. However from the emerging evidence, likely explanations include differences in socioeconomic factors, housing (multigenerational), occupation and cultural factors. The risk and exposure to Covid-19 infection appears to be multifactorial for BAME communities and therefore our response must be multifaceted to address these risk factors effectively and reduce inequalities.

6.4 The report found particularly high increase in all cause deaths (not just Covid-19) among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes. These are essentially lower paid, non secure, key worker jobs which people in disadvantaged communities and BAME communities are more likely to occupy and therefore were less likely to be able to work from home during the lockdown period and have more exposure to others.

6.5 The inequalities described in the report largely replicate existing inequalities in death rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups.

7.0 CONCLUSIONS OF THE REPORT

7.1 The report concluded that relevant guidance, certain aspects of recording and reporting of data, and key policies should be adapted to recognise and wherever possible mitigate or reduce the impact of COVID-19 on the population groups that are shown in this review to be more affected by the infection and its adverse outcomes (e.g. workplace risk assessments, implementing government and PHE guidance on Covid19 across all sectors, PH Covid19 related communication campaigns).

7.2 As the numbers of new COVID-19 cases decrease, monitoring the infection among those most at risk will become increasingly important. It seems likely that it will be difficult to control the spread of COVID-19 unless these inequalities can be addressed.

7.3 The report did not make specific recommendations and was widely criticized for this.

7.4 At the time of the publication of this report the Government failed to publish work by Professor Kevin Fenton on behalf of PHE, which was due to outline findings from engagement with over 4000 individuals and organisations within the BAME community to understand their views, concerns and ideas in relation to the impact of Covid19 on communities. This would provide insight and recommendations into what action was needed to further protect BAME communities.

7.5 The Government announced on the 4th of June that Kemi Badeoch, Minister of Equalities will take forward this work via the Government's Equality Hub and the terms of reference were published. This mainly involved more investigative and inquiry into the issue[5].

8.0 SUMMARY OF PHE REPORT "BEYOND THE DATA: UNDERSTANDING THE IMPACT OF COVID-19 ON BAME POPULATIONS"

8.1 The PHE report "Beyond the data: understanding the impact of Covid-19 on BAME populations" was finally published on the 16th of June following public outcry and an open letter from the BMA. This was also in the context of a number of Black Lives Matter protests taking place across the UK and around the world, which arose out of the feelings that little was being done to protect BAME communities from Covid19 when they were clearly being disproportionately affected. This was further compounded by the unlawful killing of a Black man, George Floyd by a US police officer.

8.2 This report outlines many deep rooted and fundamental issues of health and society that need to be addressed both in Sheffield and across the UK.

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[5] https://www.gov.uk/government/news/next-steps-for-work-on-covid-19-disparities-announced

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

8.4 The report states that stakeholders consistently expressed deep concern and anxiety that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to Covid-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention in relation to Covid19. Future waves of the disease could again have severe and disproportionate impacts. The report calls for urgent, collaborative and decisive action to avoid a repeat of this in the future and makes seven very helpful and tangible recommendations for immediate action.

8.5 **Recommendations for action include:**

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of Covid-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of Covid-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.
5. Fund, develop and implement culturally competent Covid-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
7. Ensure that Covid-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

9.0 GENETICS AND COVID-19

9.1 Neither PHE report reviewed the inherent genetic or biological risk of BAME communities and Covid-19; we have considered this locally. Whilst this can't be ruled out completely, it is still probably one of the least likely explanations. There are not many genetic factors that all BAME groups have in common with each other and not with people of White British heritage. Further, if genetics were a risk factor for infection and/or deaths from Covid-19, we would expect to see increased infection and death rates in countries such as India, Pakistan and Bangladesh; this is not something that is borne out by the evidence at the moment. However the evidence on this is not definitive and we will keep this under review.

10.0 LINKS BETWEEN THE THREE REPORTS

10.1 The three reports cover much of the same territory and as a result there are a number of consistent messages that come through strongly, as well as links between them:

- Inequalities remain a major cause of disparities in health outcomes within and between groups;
- Many of the drivers of disparities identified in the PHE reports have their roots in inequalities identified by the Marmot Review;
- Disparities and inequalities occur across many groups and can be viewed through a range of different frames: addressing them properly requires recognising all of these; and
- Disparities in outcomes are in large part a consequence of structural inequalities in our country, not of something inherent in individuals or groups.

10.2 From this, it is clear that making a difference in these areas is the responsibility of everyone and all organisations in Sheffield and England, and the city will need to work together to do so.

11.0 WHAT SHOULD THE SHEFFIELD RESPONSE BE?

11.1 There is no reason to suspect that the national picture described by the two reports summarised above is not reflected in Sheffield; indeed previous experience suggests

that we can expect this to be the case. However, we need to do more work locally to understand the detail of the picture in Sheffield and what action we need to take, and this paper now summarises some of that activity.

12.0 WHAT'S GOING ON IN SHEFFIELD?

12.1 In relation to the broader challenge of health inequalities, this is already the primary aim of our Joint Health & Wellbeing Strategy, with a specific commitment to address these within and between groups as well as on a geographical basis. It is heartening to see that the territory the Strategy covers is similar to that which the Marmot Review reiterates as crucial: this indicates the Board are trying to operate in the right space. **The Joint Health & Wellbeing Strategy should remain the mechanism by which these challenges are addressed, and the Board must continue to drive change in this space.**

12.2 Successful delivery is the key, and it is acknowledged that the pandemic and the consequences of the necessary response will make achieving the nine ambitions set out in the Strategy harder. The Board is actively working to consider how the crisis has changed the challenge facing Sheffield and how delivery of the Strategy might need to change as a result.

12.3 In relation to the impact of Covid-19 on Sheffield's population, there is a range of work underway to build up local intelligence and start to develop the city's response:

- **Vulnerability "quilts"**: the Council's public health intelligence officers produced an analysis of vulnerability to Covid-19, which demonstrated that pre-existing inequality was the biggest risk factor, backing up some of the discussion above.
- **Rapid Health Impact Assessments**: as set out above, it is well understood 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, and that these are disproportionately spread across Sheffield's population. To address this the Health & Wellbeing Board has agreed that 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.
- **Population wide questionnaire**: to understand people's specific experiences (positive and negative) of Covid-19 and lockdown and what support is needed locally in response to this as lockdown restrictions are eased.
- **Sheffield BAME Inequalities Communities Group (Public Health)**, developed to:
    - Seek views, experiences from the BAME communities/organisations on what the impacts of Covid19 have been locally during the last 4 months (positive & negative)

- Identify what are the current concerns in relation to the impact of Covid19 on BAME communities and the immediate need and response in Sheffield?
  - Identify what local public sector services (inc. Council, Health and Care) and voluntary services could do better to ensure they engage and communicate effectively with BAME communities as part of this process.
  - Help reduce the barriers to accessing services and support now and in the future.

- **Sheffield Race Equality Commission**: Sheffield City Council are in the process of establishing an independent Race Equality Commission to look at structural inequalities in Sheffield, hearing evidence and proposing recommendations in response;
- **Healthwatch Sheffield survey**: Healthwatch Sheffield is currently running a general survey about the impact of Covid-19 and people's experiences of it and of other services, which will report at the end of June/early July.
- **SpeakUp Grants**: a small grants programme run by Healthwatch to support smaller community groups to find out about the health and social care concerns of their communities, which has been re-purposed to find out about Covid-19 experience.
- **Ongoing engagement work**: In addition, surveys, interviews and engagement is being carried out by Healthwatch Sheffield with excluded communities for example refugee and asylum seekers, disabled people, carers and with BAME people & others about their particular experiences of COVID and of service changes, improvements etc.
- **Emergency response**: there has been a wide range of activity by partners across the city working to address the most immediate impacts of Covid-19 on the most vulnerable in Sheffield.

12.4 This demonstrates that work is underway to generate detailed qualitative and quantitative understanding of the Sheffield picture, which will be used to guide action in the short and long term.

12.5 However, the reports detailed above, and witnessing the disproportionate impact of Covid-19, suggest that we need to ask ourselves whether we have made anything like the sort of progress that we would want to on these issues. Like most other places and cities, we probably haven't.

12.6 So, while we should recognise that 'fixing' some of the issues in these reports will require a national government response, there are things that we can do within Sheffield. We need to decide how we are going to address these issues with renewed purpose, and to move from focussed discussion and intent, to tangible action and impact.

12.7 In doing this, it is important to reflect on the work referenced above, that found that the national Health Inequalities Strategy had made a measurable impact: again, it is

possible to make a difference with the right focused, coordinated approach and appropriate investment. But this also makes the clear depth of the challenge: there is not one, two or even three projects the city needs to undertake to make the change. Instead, the solution is to be found in coordinating the activity of all partners in the city around the aim of reducing health inequalities for all, building organisational machinery in support of this.

12.8 There is also a need to consider some risks and opportunities in relation to this work:

- **The dangers of medicalisation**: there is a risk that a focus on health inequalities leads to solutions based around a medical model. This approach will not address root causes.
- **The importance of community**: communities are where health is built, and Marmot underplays the importance of investing in communities, and embedding this approach across all services and organisations;
- **Devolution**: this will bring further opportunities to shape investment at the local level, and tie this to the inequalities challenge described in this paper;
- **Rate limiting steps**: these include things such as national policy, especially as it relates to the resources in local places; the dichotomy between redistribution and "levelling up"; and challenge involved in shifting resources around the system.

12.9 The other important thing to consider in looking at inequalities is the underlying legislation, The Equality Act 2010, is designed to protect people from discrimination in the workplace and in wider society.

12.10 The Public Sector Equality Duty, which is part of the Act, means that public bodies should consider all individuals, especially those who share protected characteristics, when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to our employees. It requires that we have to pay due regard to the need to: eliminate discrimination; advance equality of opportunity and foster good relations between different people. It also notes that compliance with the duty may involve treating some people more favourably than others.

12.11 The Act covers the protected characteristics of: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and marriage or civil partnership status (only in relation to unlawful discrimination).

12.12 The PSED also has some Specific Duties to publish information annually to demonstrate its compliance with the duty in relation to citizens and staff; Publish Equality Objectives every 4 years; Report on the Gender Pay Gap annually and to publish in a way that is accessible to the public.

12.13 The broad purpose of the Duty is to integrate consideration of equality into the day-to-day business of public authorities. If you do not consider how a function can affect different groups in different ways, e.g. via an equality impact assessment, it is unlikely to have the intended effect. This will contribute to greater inequality and poor outcomes. These impact assessments need to be done early, robustly and consistently if they are to work.

13.0 HOW SHOULD THE BOARD RESPOND?

13.1 Although the work described is underway, this does not mean the Board should wait until it is complete before taking action. As discussed above, the Board is already reflecting on how its approach to delivering the Joint Health & Wellbeing Strategy might need to change to address the changing challenge presented due to the crisis, and to build on some of the positive work that has taken place in Sheffield as part of the pandemic response.

13.2 As part of this work, and reflecting on the discussion above of the Marmot and PHE reports, the Board should consider what it can do to better understand those challenges from the point of view of the people affected. This covers questions of engagement, but also of representation in Board conversations.

13.3 This in turn indicates a potential need to reflect on the Board's membership and approach to its work, and how this is set up to ensure that the Board's discussions, and the strategy that emerges from them, fully reflects the needs and aspirations of the city as a whole. This will need to balance:

- The need for the Board to ensure it engages effectively with the health and wellbeing system in Sheffield, covering key stakeholders across a range of agencies and organisations;
- The need to ensure that those contributing to Board conversations are representative of the city and in particular of those affected by the issue under discussion at a given time; and
- The need to maintain manageable working arrangements so that the Board is effective.

13.4 The Board was scheduled to conduct a review of its Terms of Reference in the first half of 2020, which was postponed as a result of the pandemic. The Board may wish to use this opportunity to consider some of the issues raised above, and how these could be addressed by a combination of working practices as well as membership, aiming to report with recommendations for the way forward as soon as possible.

14.0 QUESTIONS FOR THE BOARD

14.1 The Board are asked:

1. Are there any other areas of work that should be explored as part of the work to address health inequalities in Sheffield, both pre-existing and those created and exacerbated by Covid-19?
2. How work to address questions of representation and engagement in relation to the Board's work be approached?

15.0 RECOMMENDATIONS

15.1 The Board are recommended to:

1. Note the content, conclusions and recommendations of the Marmot report, and the PHE reports
2. Recognise that work is ongoing to understand the impact of Covid-19 in Sheffield and how this impacts on different groups, with short term actions being put in place as these deliver intelligence
3. Recommit to delivering the Health & Wellbeing Strategy, recognising that the ambitions within it remain the building blocks of healthy lives for Sheffielders, and that the challenge in and importance of delivering on them is greater in the context of the pandemic
4. Commit to delivering at the local level the recommendations laid out in the second PHE report, where we have the powers to do so
5. Agree that responding to the challenges outlined above is not the responsibility of one organisation but of the whole city
6. Use the opportunity of the delayed Terms of Reference review to reflect on questions of representation and ways of working to ensure that the strategies it develops and delivers on reflects the concerns and interests of all Sheffielders, reflecting on this at their July Strategy Development Session and bringing proposals in response to the next Public Committee Meeting
7. Commit to working with all city partners and other bodies in the city on addressing the disparities in the impacts of Covid-19, health inequalities in general, and the root causes of these, in the short and long term, especially recognising the vital role of the VCS, BAME and Faith sector organisations and leads in this approach.