Surrey Covid-19 Community Impact Assessment

Black, Asian and Minority Ethnic (BAME) Rapid Needs Assessment

SURREY
COUNTY COUNCIL

November 2020

Executive Summary

Definition: According to the Office for National Statistics, BAME comprises all Mixed, Asian, Black and Other ethnicities. White ethnic groups comprise White British; White Irish, Gypsy or Irish Traveller; and Other White. Recent reports suggest there is clear evidence that COVID-19 does not affect all population groups equally. The PHE review of disparities in the risk and outcomes of COVID-19 published in June 2020 showed that there is an association between being from a BAME ethnic group and the likelihood of testing positive and dying with COVID-19. Although more studies are required to establish the cause, these findings shone a light on pre-existing inequalities that were exacerbated as a result of the pandemic.

Stakeholders and community member engagement

A total of ten interviews (eight) and focus (two) were conducted with key informants and one focus group was held with BAME community members. These interviews and focus groups provided an opportunity to gain a better insight into the factors that may be influencing the impact of COVID-19 on BAME communities at local level and strategies for addressing inequalities.

Common themes

Most stakeholders believed that COVID-19 did not create health inequalities, but rather the pandemic exposed longstanding inequalities affecting BAME groups in the UK.

The community members felt that there was a lack of clear communication of the guidelines at the beginning of the lockdown, which led to confusion about accessing care and support. This was made worth as the lockdown disrupted some of the community networks which were key in supporting certain groups (e.g. older individuals whose first language wasn't English). Some ethnic groups, particularly the Chinese families, were subjected to hate crime and racism as a result of the pandemic. Some also experienced lack of access to finical support as they did not meet the eligibility criteria set by the government. Practicing effective social distancing is often a challenge, as BAME families are more likely to live in overcrowded housing.

Although good progress has been made by organisations to complete risk assessment, there are some concerns by BAME staff about the use of data and its impact on their future job prospect. Historic racism and cultural practices (e.g. respect towards the manger) might have meant that some individuals in BAME groups were less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE).

Stakeholders felt that the disproportionate impact of COVID-19 on BAME groups has created an opportunity for a sustainable change to mitigate further impact.

Priorities highlighted by Stakeholders

- Large scale and transformative change to tackle the **structural causes of equalities and inequalities** (i.e. **societal environments/wider determinant of health** such as deprivation, housing, neighbourhoods, workplace) that contribute to ill health of BAME communities – not solely focusing on individuals.
- Tangible actions by institutions to tackle the **structural and institutional racism** to tackle the drivers of inequality at system.
- Embedding **equality impact assessments** and **meaningful engagements** with the BAME community in the heart of every new policy and intervention to make sure the policies and

interventions are culturally appropriate in order to improve access, experiences and outcomes for this group.

- Investment in BAME charity and voluntary, community and faith sector (VCFS) organisations to enable a meaningful engagement with BAME communities and to build trust.
- Proactive prevention with a focus on BAME maternity services and those with pre-existing physical (such as obesity, CVD, diabetes) and mental health conditions, recognising the diversity withing the BAME population and addressing the health needs within each group.
- Empower BAME communities to reduce delay and stigma in accessing care.
- Improving ethnicity data collection and recording.
- Fund and develop culturally appropriate communication materials to share the latest guidelines and health protection messages through trusted channels (e.g. community and faith leaders) and participatory research.
- Appropriate training for the mangers to carry out the risk assessment for BAME staff and ensure effective mitigation measures are in place to reduce the risk of COVID-19 infection.
- Improving access to testing and PPE to protect the frontline workers.

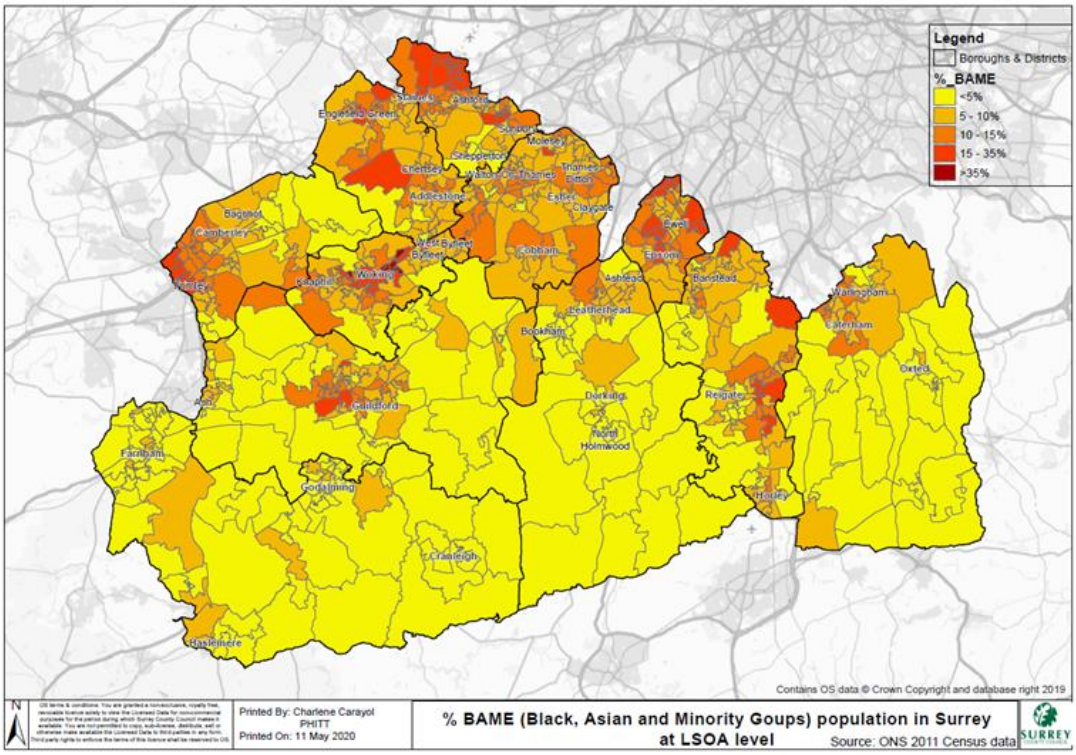
1.Brief definition of group

According to the Office for National Statistics, BAME comprises all Mixed, Asian, Black and Other ethnicities. White ethnic groups comprise White British; White Irish, Gypsy or Irish Traveller; and Other White. Early evidence suggests that people from BAME ethnic backgrounds are disproportionally affected by COVID-19 severe illness and deaths (Institute for Fiscal Studies). Although more studies are required to establish the cause, these findings shone a light on pre-existing inequalities that were exacerbated as a result of the pandemic.

2. Population profile: What is the BAME population of Surrey

Main source of information on ethnic groups in general population is from the Census data published in 2011. According to the latest Census data, Surrey is less diverse than England as a whole with 83.5% of the population reporting their ethnic group as White British compared with 79.8% in England. Generally, the BAME population in Surrey is rather disperse across the county (Figure 1). The breakdown of ethnic background per each local area is presented in Table 1. As the data shows Woking is the most diverse local authority in Surrey with 16.4% of its population from non-white ethnic groups. Waverley is the least diverse with 90.6% White British. Spelthorne has the highest proportion of Indian ethnic group (4.2%) and Woking has the highest proportion of Pakistani ethnic group (5.7%).

Figure 1: Demographic distribution of BAME population in Surrey. Source: Census 2011



One of the disadvantages of the Census data is that it is getting out of date. The School census data provides a much more up to data picture of the ethnicity of the population.

Table1. Proportion of BAME per region. *Source: ONS - Population denominators by broad ethnic group and for White British: local authorities in England and Wales, 2017*

Local Authority	*Population*							*Percentage*				
	Mixed	Asian	Black	Other	White	White British	Total	Mixed	Asian	Black	Other	White
Elmbridge	4,201	7,562	1,090	1,308	122,219	107,904	136,379	3.1%	5.5%	0.8%	1.0%	89.6%
Epsom and Ewell	2,376	7,194	1,297	1,150	67,434	61,494	79,451	3.0%	9.1%	1.6%	1.4%	84.9%
Guildford	3,359	7,192	1,814	1,904	133,509	122,801	147,777	2.3%	4.9%	1.2%	1.3%	90.3%
Mole Valley	1,529	2,400	447	408	82,344	77,857	87,128	1.8%	2.8%	0.5%	0.5%	94.5%
Reigate and Banstead	3,973	7,866	2,427	827	131,291	122,658	146,383	2.7%	5.4%	1.7%	0.6%	89.7%
Runnymede	2,105	6,224	957	862	76,735	68,962	86,882	2.4%	7.2%	1.1%	1.0%	88.3%
Spelthorne	3,024	8,152	1,735	967	85,242	78,696	99,120	3.1%	8.2%	1.8%	1.0%	86.0%
Surrey Heath	1,862	5,911	943	681	79,369	74,655	88,765	2.1%	6.7%	1.1%	0.8%	89.4%
Tandridge	2,200	2,385	947	298	81,468	77,360	87,297	2.5%	2.7%	1.1%	0.3%	93.3%
Waverley	1,887	2,440	553	405	119,724	112,892	125,010	1.5%	2.0%	0.4%	0.3%	95.8%
Woking	2,854	12,399	1,512	1,180	83,184	74,303	101,129	2.8%	12.3%	1.5%	1.2%	82.3%
Surrey	29,370	69,723	13,721	9,990	1,062,517	979,582	1,185,321	2.5%	5.9%	1.2%	0.8%	89.6%

Figure 2 shows the demographic of students' ethnicity based on the school survey conducted in 2020. According this survey, seventeen percent of students living in Surrey are from minority ethnic groups. In Surrey, the majority (80.87%) of the student population is of White ethnicity. The second largest ethnicity group are students from Asian backgrounds (7.26%), followed by 6.56% from mixed ethnicity background and 1.78% from Black ethnicities (Table 2). The proportion of students from minority ethnic groups is highest in Woking and lowest in Waverley overall. Although, within each local authority there is variation at a lower level, for example in Waverley there are some smaller geographies with much higher proportions of students from minority ethnic groups.

Although the school Survey is more recent, it only represents details of the ethnicity of students attending Surrey schools who live in Surrey and can therefore only provide a proxy for the ethnicity of families with school aged children.

Figure 2: demographic of school age Children based on school survey 2020

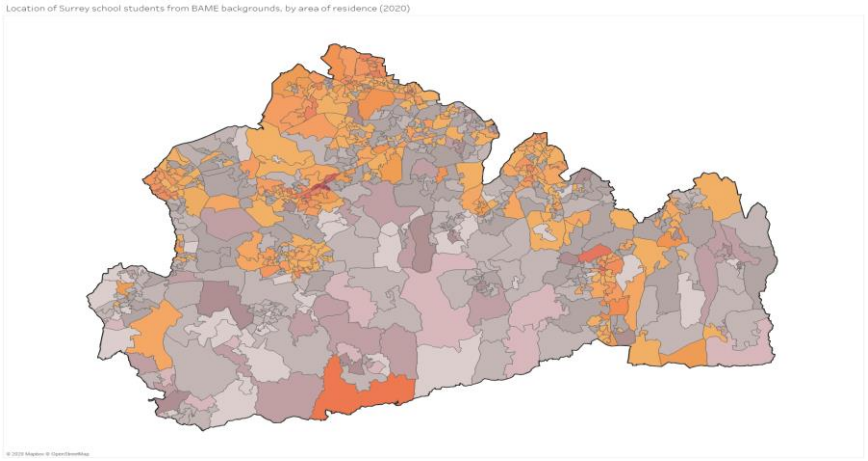


Table 2 Percentage of Surrey School Students living in each local Authority, by ethnicity

	Asian ethnicities	Black ethnicities	GRT ethnicities	Mixed ethnicities	White ethnicities	Other ethnicities	Unknown
Elmbridge	4.56%	1.00%	0.52%	7.47%	83.54%	1.16%	1.74%
Epsom and Ewell	9.53%	1.69%	0.40%	8.71%	76.22%	1.46%	2.00%
Guildford	5.01%	1.21%	1.17%	5.74%	83.80%	1.31%	1.76%
Mole Valley	2.66%	0.83%	0.57%	5.25%	88.71%	0.56%	1.42%
Reigate and Banstead	6.95%	3.53%	0.41%	7.27%	79.40%	0.65%	1.80%
Runnymede	8.04%	1.63%	1.38%	6.47%	80.19%	0.82%	1.48%
Spelthorne	10.62%	2.85%	0.67%	7.73%	75.52%	1.16%	1.44%
Surrey Heath	9.06%	1.81%	0.49%	5.60%	77.76%	1.08%	4.19%
Tandridge	2.19%	1.72%	1.39%	7.33%	85.67%	0.66%	1.05%
Waverley	2.35%	0.45%	0.72%	3.74%	91.27%	0.37%	1.09%
Woking	18.26%	2.14%	0.44%	6.81%	68.57%	1.98%	1.80%
Grand Total	7.26%	1.78%	0.71%	6.56%	80.87%	1.03%	1.80%

NHS is the largest BAME Employer in UK. It is estimate that 19.7% of NHS staff are BAME nationally. In South East the BAME organisation average representation is 19%. The latest analysis on the WRES data suggests that across organisations in Surrey, the average BAME representation is 21% with two individual acute trusts having 39% of their workforce from a BAME background.

3.Relevant legislation/ programmes that support BAME communities

The Surrey Ethnic Minority Forum (SMEF) is the main charity organisation to unify ethnic minority communities from across Surrey. They do this by amplifying their collective voices and aspirations and then sharing this with key agencies and stakeholders in Surrey. SMEF connect 40 plus ethnically diverse community groups to work together to create a more cohesive county. SMEF delivers projects based on the needs identified by its members, some of their projects include issues that hold stigma for BAME communities, reducing isolation of older people and women, active communities, telephone befriending for elderly Nepali women in Woking and weekly drop in sessions for South Asian women to socialise and learn a new skill.

The Surrey Muslim Association (SMA) main aim is to create a platform for Muslim organisations and individuals and to be a voice for the Muslim community in Surrey.
Another key organisation is the Surrey Carers Commissioning Group. This group consists of a number of providers who serve the BAME population specially in Surrey. The commissioning data is collected via Surrey Carers Contract Monitoring – BAME and reported to Integrated Care Partnership (ICP) Board. In 2016, the Surrey Carers Commissioning Group set up a Task and Finish Group to review support offered to BAME carers, to scope current service provision, to identify gaps in service and to make recommendations. The main conclusions were:

- BAME carers face difficulties in accessing and using support services
- Many BAME carers are unaware of the services that exist to support them
- identified a lack of language-matched or culturally appropriate information as amongst the biggest barriers in BAME carers accessing services.
- It also noted a lack of health surveillance around BAME carers in Surrey and that people from the BAME community do not constitute a homogenous group and have diverse support needs.

As a result of the conclusions above a Task and Finish Group in 2017 was established to address the highlighted issues.

There are possibly other small grassroot charity or community group organisations in Surrey who work specifically with BAME population, but these are not currently visible.

4. Changes in services as a result of Covid-19

As the lockdown measure came into place from the end of March 2020, all the direct community-based activities delivered by SMEF and other community groups had to be abandoned. The digital deficit that is common in BAME communities presented a huge challenge, however a network of community leaders looking out for the frail and vulnerable used social media and Telephone befriending services to bridge the gap. The lack of funding and resource available to some of these grassroot organisations partly meant that they were unable to adapt their service provision to offer support remotely.

This was also the case with face to face clinical appointments (including mental health), many of which were either reduced or cancelled altogether. Due to the lack of ethnicity data, it is not clear what proportion of the cancelled appointments in Surrey were for BAME groups. Additionally, although most clinical services were able to offer remote appointments/consultations, we do not

have the data to assess the uptake of theses virtual appointments by BAME groups in Surrey. Having said that, some of the stakeholders highlighted that since not all individuals knew how to access the services during the lockdown nor had the appropriate equipment, it is likely that they were unable to receive the appropriate support that they needed. Some BAME community members also believed that remote consultations were less beneficial than face to face appointments. Additionally, those who didn't speak English were less likely to attend face to face clinic consultation/follow up appointments (where available), as they could no longer be accompanied with their family members/translators due to lockdown restrictions.

5. Risk factors for Covid-19 impact

Recent review of the literature and studies highlighted a number of risk factors for Covid-19 on BAME groups. These are listed in Table 3.

Risk in relation to COVID-19	Description
Underlying health conditions	African Caribbean people have higher prevalence of high blood pressure, and South Asian people (particularly first generation) have higher prevalence of Coronary Heart Disease (British Heart Foundation). South Asian people are up to six times more likely to have Type 2 diabetes (Diabetes UK). African Caribbean, South Asian, and people of Mediterranean origin are also more likely to have Sickle Cell Disease, which is one of the conditions identified by the NHS as being at highest risk of mortality relating to COVID19. Some groups of black and minority ethnic men, such as Bengali men, continue to have persistently high rates of smoking, and are at a higher risk of the respiratory and cardiovascular conditions associated with it.
Risk of exposure	Community: Black and minority ethnic people are overrepresented in some institutional settings including prisons, mental health inpatient units, and homeless accommodation. This potentially puts them at greater risk of contracting COVID19 Occupation: Black and minority ethnic people are more likely to be key workers and/or work in occupations where they are at a higher risk of exposure. These include cleaners, public transport (including taxis), shops, and NHS staff. Bangladeshi women, in particular are more than two times more likely than their male counterparts (43% vs 19%) to be working in a key worker role.
Wider determinants (e.g. income, housing)	Minority ethnic groups also tend to be more likely to live in overcrowded accommodation – even after controlling for region of the country. Fewer than 2% of white British households in London have more residents than rooms; in contrast, this figure is just under 30% for Bangladeshi households, 18% for Pakistani households, and 16% for black African households. BAME groups are more likely to have a low income, be in zero hours contracts and non-salaried jobs than white ethnic groups. Bangladeshi and Pakistani ethnicity were much more likely than those of any other ethnic groups to live in a multi-family household.
Access to health (including maternity)	Black and minority ethnic men tend to have poorer access to healthcare for a range of services, including mental health, screening and testing. Some groups of international migrants in the UK avoid the use of the NHS because of the current NHS charging regime for migrants or through fear of their data being shared with the Home Office for immigration enforcement purposes. Maternal and infant outcomes remain very poor for many women from BAME groups, particularly among those women who have recently migrated to the UK. Women from

	South Asian and Black African communities, women living in poverty, and women seeking refuge and asylum are significantly more likely to die in childbirth compared to their White British counterparts.

Table 3: Risk factors for Covid-19 infection

The latest analysis of data in relation to impact of covid-19 suggests BAME populations have an increase expected death rate from Covid-19 compared to people from White Ethnic groups (Table 4). After accounting for the effect of sex, age, deprivation and region, 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[1]. The evidence also has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced.

Table 4 Increase risk of death as a result of Covid-19 infection per agender and ethnicity

Group	Male	Female
Asian	2.9 increase in expected death rate from 5yr average Asian baseline	2.35 increase in expected death rate from 5yr average Asian baseline
Black	3.85 increase in expected death rate from 5yr average black baseline	2.89 increase in expected death rate from 5yr average black baseline
Mixed	2.50 increase in expected death rate from 5yr average Mixed baseline	2.74increase in expected death rate from 5yr average Mixed baseline
Other	2.28 increase in expected death rate from 5yr average Other baseline	2.84 Increase in expected death rate from 5yr average Other baseline
White	1.74 increase in expected death rate from 5yr average White baseline	1.61 increase in expected death rate from 5yr average White baseline

Source: *Beyond the data: Understanding the impact of COVID-19 on BAME groups, Public Health England.*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

Local data

Obtaining local and up to date has been really challenging as there are significant gaps in collecting ethnicity data across the services. This is not exclusive to Surrey and has been recognised as a national issue. However, efforts are underway to improve gaps in ethnicity data collection at local, regional and national levels.

Socioeconomic

Currently data on housing conditions, economic inactivity per ethnicity are available at South East region level (PHE, publication in progress). According to the data, 1.6% of 'White: British' households

[1] *Beyond the data: Understanding the impact of COVID-19 on BAME groups, Public Health England.* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf*

experienced overcrowding, compared with 30.6% of Bangladeshi households (the highest percentage). 'White: British' households were less likely to be overcrowded than households from all other ethnic groups (Figure 3A). In the South East economic inactivity (Figure 3B) was higher in the Other ethnic group (26.5%) than in the White ethnic group (17.2%). The economically inactive include: the long-term sick or disabled, the temporary sick (with no employment), people looking after family/home, students, and retired people.

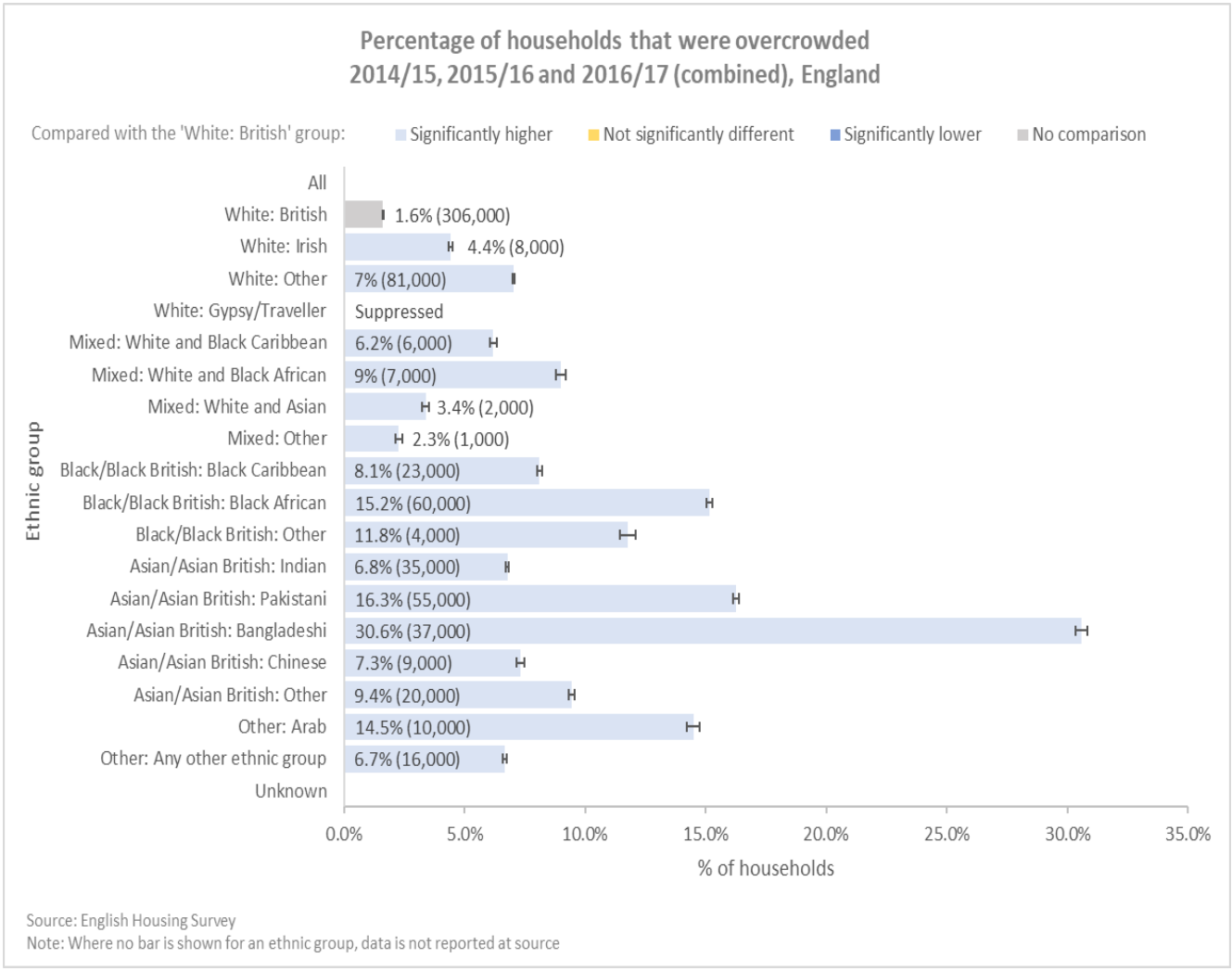
Woking, Spelthorne and Guildford have the highest proportion of job seekers claimants from BAME ethnic backgrounds (Figure 3C).

Health and behaviour

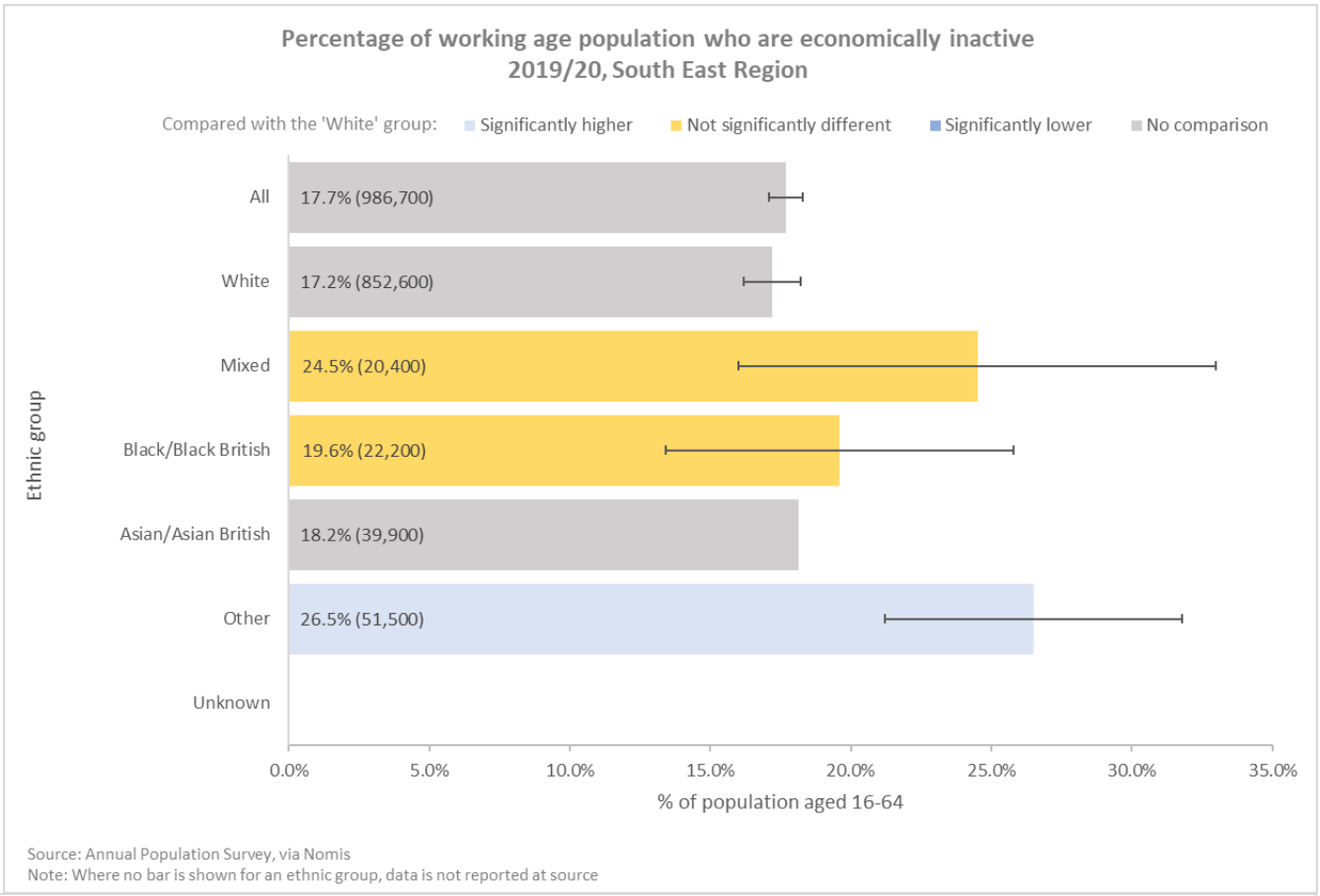
The most recent data on health and behaviour per ethnicity was only available at South East region level (PHE, publication in progress).

NHS health Check uptake: For PHE South East (in 2017-18), Black/Black British (55.9%), Other (57.6%) and Unknown (85.5%) ethnic groups had higher percentages of patients not attending their NHS Health Check than the White (50.4%) ethnic group. The Asian/Asian British (47.9%) ethnic group had a lower percentage of patients who did not attend their NHS Health Check. 21.6% of invited patients are counted in the Unknown ethnic group. The Unknown ethnic group includes ethnicities with a small number of patients.

3A



3B



3C

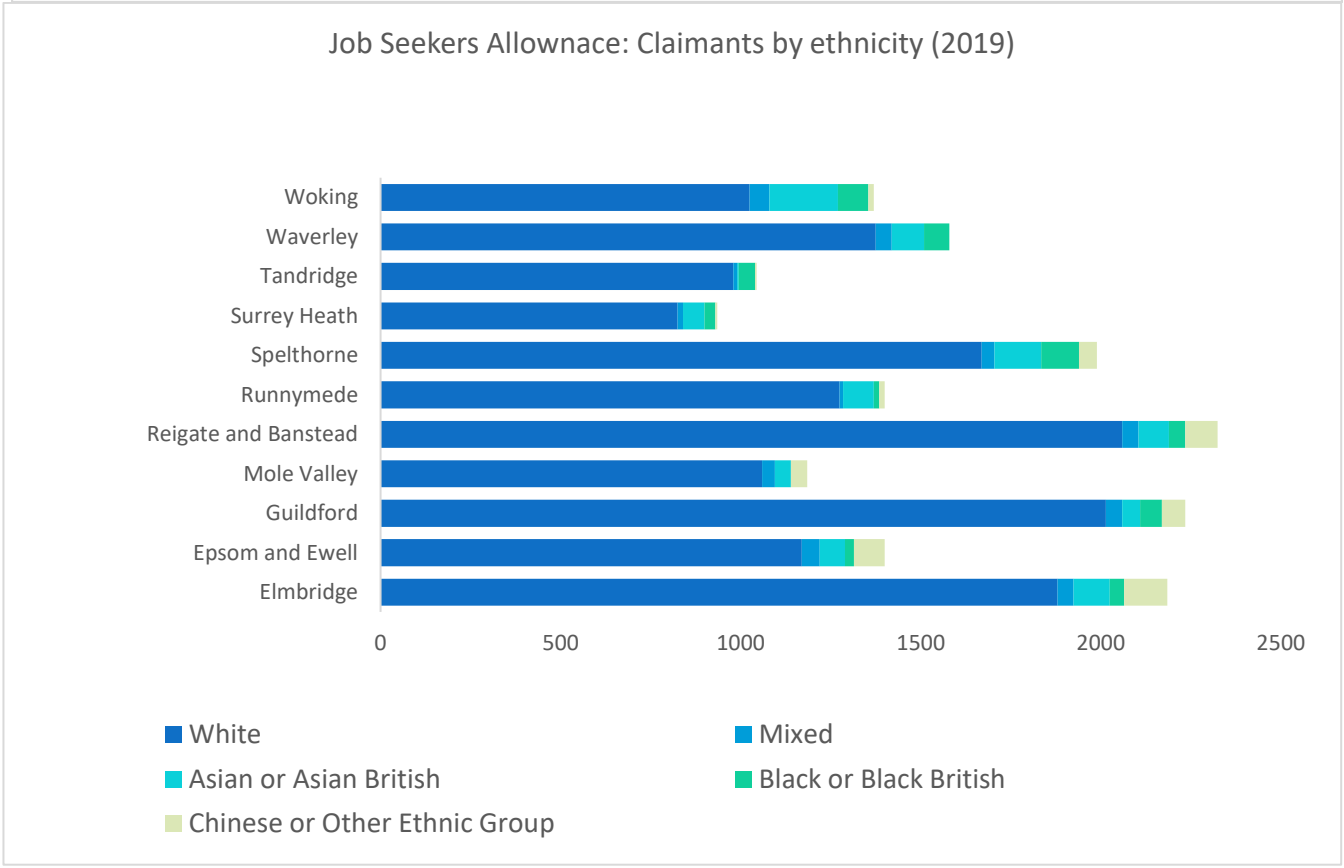


Figure 3: **Socioeconomic data per ethinic groups**: A: Percentage of households that were overcrowded (South East region); B: Economic inactivity (South East region). C: Job Seekers allwance (Surrey local Areas, 2019)

Smoking Prevalence: in the South East (2017-19), 13.2% of White adults are estimated to be current smokers the data for the Chinese (7.4%), Asian/Asian British (7.8%) and Black/Black British (8%) ethnic groups were lower than the percentage for White.

Physical activity: Overall, in 2017/18, 65.2% of people aged 16 years and over in the South East were classed as 'physically active' – that is, they did 150 minutes or more of moderate intensity physical activity a week. people of Mixed ethnicity (73.1%) were the most likely out of all ethnic groups to be physically active people from the Asian/Asian British (60.1%) ethnic group were less likely than White (65.7%) to be physically active.

Low life satisfaction: in England (in 2028/19) the Asian/Asian British (3.2%) ethnic group had a lower percentage of survey respondents with a low 'life satisfaction' score than the White ethnic group (4.2%). Mixed (7.8%) and Black/Black British (6.4%) ethnic groups had higher percentages of survey respondents with a low 'life satisfaction' score than the White ethnic group (4.2%). Bangladeshi communities are also more likely than other ethnic background to report bad or fair health by an increase in age from 30 and above.

BAME Carers

The recent local commissioning data (by GP BAME Carers Registration) suggest that there is significant increase in the number of BAME carer registration from 1442 in 2016/17 to 2086 in 2019/20 (a percentage increase of 30.87%) in Surrey.

6. Reason for perceived exclusion of group

The word cloud below summaries are the most talked about themes drown from the focus groups with Surrey BAME community members. These are disused in more details below.

Lack of voice and representation: Before the pandemic there was little visibility of the BAME population in Surrey with inadequate engagement and connectivity. Most of the stakeholders that we spoked to mentioned that the disproportionate impact of Covid-19 on the BAME population reflects the pre-existing inequalities before the pandemic. Despite this, both the stakeholders and the BAME community members who took part in this Rapid Need Assessment agreed that the pandemic has created a good opportunity to address some the pre-existing inequalities affecting the BAME population in more co-ordinated way.

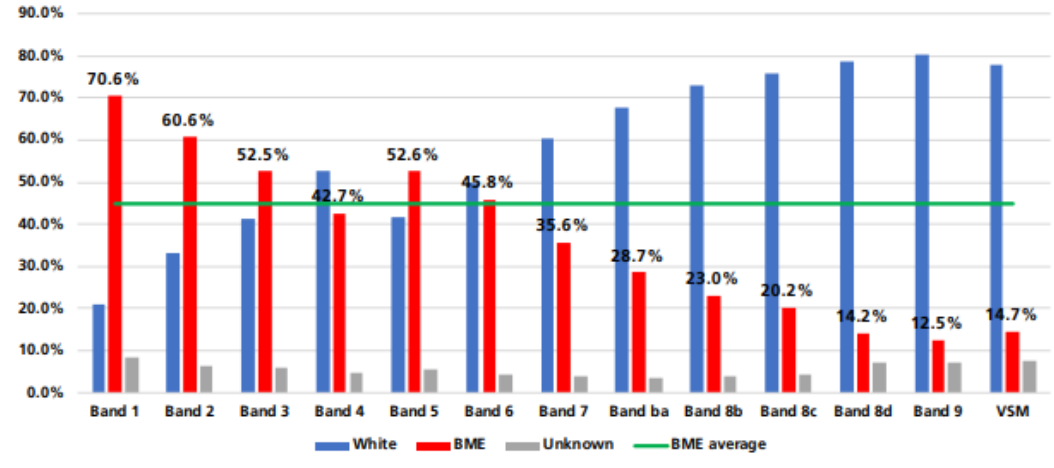
Lack of knowledge about financial support: according to a recent survey by Runnymede Trust, while around nine in ten white people (88%) had heard of the furlough scheme, only around seven in ten BAME (69%) people had. People of Bangladeshi origin were the least likely (at 61%) to be aware of any of the government's economic measures during Covid-19. Fewer than half of BAME people were aware of the measure to allow those out of work due to the crisis to claim Universal Credit (44%, vs 62% of white people). Equally, only around a third of BME people had heard of the measure making Statutory Sick Pay (SSP) available from the first day of self-isolating (34%, vs 52% of white people).

Ineffective communication of guidelines: The community members felt that there was a lack of clear communication of the guidelines at the beginning of the lockdown, which led to confusion about

accessing care and support. This was also reported in the recent survey by Runnymede Trust. This survey reported that while just under nine in ten white people (87%) had heard of the request for people to 'Stay Home, Protect the NHS, Save Lives', the proportion among BAME people was even in ten (69%). The same pattern holds for the request to 'Stay Alert, Control the Virus, Save Lives' (84% vs 66%). Additionally, none of the government guidelines and announcements were available in other languages. This impacted the older generations whose first language wasn't English and relied on their community network for support. The BAME community members who took part in one of the focus groups emphasised the importance of effective communication. Some indicated that due to the lack of clarity they were looking at information published on social media or abroad who different set of guidelines to the UK.

Racisms and discrimination: The stakeholders that we spoked to highlighted that the issue of racism and discrimination is experienced by most BAME groups throughout life course. Some stakeholders reported an increase in hate crime towards Chines families at the beginning of the pandemic, particularly experienced by school age children. They believed that exposure to racism and discrimination can be experienced at early years by school age children which could have long-term impact on their future development at all levels. The issues of racism and discrimination was identified as the root cause of mistrusts and pre-existing (social, economic and health) inequalities impacting the BAME population during the pandemic.

As described above, NHS is the largest BAME Employer in UK. In South East the average representation BAME across the NHS 19%, however a much lower proportion compared with staff from White ethnic background are in senior and leadership roles. A recent review of the Workforce Race Equality Standards (WRES) data (2019) in the South East showed that White Applicants are still 1.46 times more likely to be appointed from shortlisting compared to BAME applicants. BAME staff are 1.22 times more likely to enter a formal disciplinary process. Percentage of BAME staff experiencing harassment, bullying or abuse from staff is 5% higher than number of white staff. Only 69% of BAME staff believe their organisation provides equal opportunities for career progression compared to 86% of white staff (Figure 4). BAME staff are more than twice as likely to experience discrimination at work from a manger, team leader or other colleague compared to white staff and finally, 23% of Trusts in the South East do not have a BAME board member.



Data source: 2019 WRES data submissions.

Figure 4: Percentage of staff according to Agenda for Change Pay band and ethnicity.

We acknowledge that the data presented above is for the NHS workforce and that further insight is required to obtain a more comprehensive picture across the workforce. However, this relies on robust and consistent collection of ethnicity data by the employers, which needs improving.

In a recent podcast Kings' Fund [2]on *How is Covid-19 repeating patterns of existing health inequalities*, Professor David Williams emphasised that is crucially important to acknowledge the role of racism in shaping the lives of ethnic minority people and therefore shaping their experiences of health. This require a robust grasp about what drives ethnic inequalities in health. In this podcast he highlighted three types of racism:

1. Structural racism: which basically shapes people's access to resources
2. Interpersonal racism: the everyday slights, the insults, the violence that undermine one's identity, threaten one's security and produce disadvantages
3. Institutional racism: which shapes the BAME encounters with key institutions which then influence the outcomes of their life; health, employment, education, policing, etc.

Both, the structural and institutional racism highlight that in order to tackle the drivers of inequalities, the polices and their subsequent interventions need to target the way the system operates, rather than looking solely on what makes the BAME communities different compared to other groups in the society.

Barriers in accessing services: Most stakeholders reported that people from BAME population access the services less compared with the rest of the population. Various reports have been published to describe some of the underlying causes. According to these report access barriers include; dissatisfaction with the service experience by the BAME group, stigma associated with a diagnosis and lack of awareness about how to access the services [3,4,5].

7. Severity of Covid-19 impact

The stakeholders highlighted that some of the pre-existing social, economic and health inequalities have been widened as a result of the pandemic. In particular, the economic and mental health are likely to have a significant long-term impact on BAME population. Having said that, it is important to recognise that there is diversity within the BAME population. Therefore, further engagement is required with each group within the BAME population to tease out the differences and better understand the need and ongoing impacts of the pandemic on each of the sub-groups.

The focus group with the community members also highlighted the severity of impact on certain vulnerable groups (e.g. older, living in deprived areas) that relied on community connections and support. For instance, due to the lockdown a number of religious (e.g. the Eid celebrations at the end of Ramadan and Easter) and cultural events were cancelled. Such events are quite significant as they are often used to share food and support the disadvantage groups within these communities. Although huge efforts were undertaken t deliver food parcels, some stakeholders reported the content of the food parcels were not appropriate for some families with specific cultural/ religious backgrounds.

---

[2]**Racism, discrimination and the impact they have on health (King's fund, July 2020)**
https://www.kingsfund.org.uk/audio-video/podcast/covid-19-racism-health-inequality

[3] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/access-to-health-care-minority-ethnic-groups-briefing-kings-fund-february-2006.pdf

[4] **Improving access for all: reducing inequalities in access to general practice services:**
https://www.england.nhs.uk/wp-content/uploads/2017/07/inequalities-resource-sep-2018.pdf

[5] **Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England**: https://bmjopen.bmj.com/content/6/11/e012337

As descried earlier in this report, working in front-line roles are likely to increase the risk of Covid-19 infection. Therefore, access to appropriate PPE and testing and a robust risk assessment are key in reducing the impact on front-line workers from BAME population. In recent survey of the healthcare staff, it was reported that:

- BAME Staff have felt less protected (RCN Survey 40% of BAME staff reported not receiving PPE training compared to 31% of white staff)
- BAME voiced concerns they have not received adequate PPE (43% of BAME respondents said they had enough PPE compared to 66% of white staff)
- BAME voiced concerns they have been disproportionality assigned to high risk areas ("BAME staff feel that they are being put on Covid wards and exposed to patients with Covid over and above their colleagues," Birmingham)
- Lack of trust between BAME staff and line managers to complete risk assessments

8. How has Covid-19 further affected service access

One of the fundamental factors that was highlighted in this report was about the **lack of trust** between the BAME population and authorities. The lack of trust has resulted in the emergence of conspiracies theories about targeting the BAME groups for being at a higher risk of Covid-19 infection. Lack of trust may to some degree influence the BAME 's engagement with health and wellbeing services and may affect the uptake of coivd-19 vaccination when it becomes available. Lack of trust was also noted during staff risk assessment, as many staff members felt that findings of the risk assessment may have an impact on their future career prospect and development.

Another access barrier has been the perceived uncertainty around the safety of accessing health services during the pandemic. For instance, available evidence has long shown that maternal and perinatal mortality rates are significantly higher for BAME women and their babies than for white women[6]. Additionally, emerging evidence from the UK Obstetric Surveillance System at Oxford University shows that women from a BAME background make up more than half (56%) of pregnant women admitted to hospital with COVID-19 [7]. The research indicates that Asian women are four times more likely than white women to be admitted to hospital with COVID-19 during pregnancy, while Black women are eight times more likely. This in combination with reduced assess during the lockdown means extra efforts are required to ensure NHS maternity services are fully engaging with women from these groups and reassure pregnant women and new parents that seeking help from the NHS is safe. This is also the case for others with other pre-existing long-term health and mental health conditions.

As more services are being delivered remotely, addressing **digital exclusion** amongst the BAME population is essential, as most may not have access to appropriate phone or laptops. This could further barriers in service uptake. Additionally, generally the GP websites that offer on-line appointments tend not to make any provision for people for whom English was not their first

[6] **MBRRACE-UK (2019) reports: www.npeu.ox.ac.uk/mbrrace-uk**

[7] **Knight Marian, Bunch Kathryn, Vousden Nicola, Morris Edward, Simpson Nigel, Gale Chris et al.** Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study BMJ 2020; 369 :m2107. ww.bmj.com/content/369/bmj.m2107.full

language. Most website asks the users to describe their symptoms which requires the ability to write clearly and fluently. Although the patient can still phone the surgery, they were encouraged to book on-line.

9. Resilience- evidence of recovery,

Most stakeholders believed that COVID-19 did not create health inequalities, but rather exposed the longstanding inequalities affecting BAME groups in the UK. Stakeholders felt that the disproportionate impact of COVID-19 on BAME groups has created an opportunity for a sustainable change to mitigate further impact.

There has been a significant amount of robust partnership working across the system. Although there were challenges at the beginning of the lockdown, communities have really pulled together to support each other. There has been a lot more engagement with the BAME communities through faith and community leaders since the beginning of the pandemic to disseminate key health protection messages.

In response to the recent report by PHE two specific steering groups have been set up at ICP level to bring different partners from across the system to tackle the impact of Covid-19 on BAME population. These are: the BAME workforce and BAME population steering group, overseen by the BAME Alliance. Both the BAME population and workforce steering groups have representatives from Primary Care, Secondary Care, Surrey Minority Ethnic Forum (SMEF) and Public Health. The aim of the BAME population group is to implement the seven recommendations by PHE to reduce the impact of Covid-19 on BAME communities. The BAME workforce steering group ensures that staff risk assessment is implemented across the organisations in a meaningful way. It also provides a forum for organisations to share learning specifically in relation to the implementation of staff risk assessment and completion of the NHS Workforce Race Equality Standards (WRES) data. Both these groups report to BAME Alliance, whose remit also includes addressing other issues such as racism and discriminations that have emerged as key contributing factors associated with the disproportionate impact of Covid-19 on BAME population.

10. Recommendations

- Large scale and transformative change to tackle the **structural causes of equalities and inequalities** (i.e. **societal environments/wider determinant of health** such as deprivation, housing, neighbourhoods, workplace) that contribute to ill health of BAME communities – not solely focusing on individual.
- Tangible actions by institutions to tackle the **structural and institutional racism** to tackle the drivers of inequality at system.
- Embedding **equality impact assessments** and **meaningful engagements** with the BAME community in the heart of every new policy and intervention to make sure the policies and interventions **are culturally appropriate in order to improve access, experiences and outcomes by this group.**
- Investment in BAME charity and voluntary, community and faith sector (VCFS) organisations to enable a meaningful engagement with BAME communities and to build trust.
- **Proactive prevention** with a focus on BAME **maternity services** and those with **pre-existing physical (such as obesity, CVD, diabetes)** and **mental health conditions**, recognising the diversity withing the BAME population and addressing the health needs within each group.
- **Empower BAME communities** to reduce delay and stigma in accessing care.
- Improving **ethnicity data collection** and recording.

- Fund and develop culturally appropriate communication materials to share the latest guidelines and health protection messages through trusted channels (e.g. community and faith leaders) and participatory research.
- Sustained measurable improvements in visible senior BAME leadership in health and social care organisations which creates diversity and inclusion which in turn also leads to prioritising improvement in the health, wellbeing and life chances of BAME communities and staff in health and social care.
- Appropriate training for the mangers to carry out the risk assessment for BAME staff and ensure effective mitigation measures are in place to reduce the risk of COVID-19 infection.
- Improving access to testing and PPE to protect the frontline workers.

11. Lessons learned

- Effective communication via culturally appropriate comms to convey key public health messages as well information about accessing care and finical support
- Better data collection on ethnicity
- Use the opportunities, learning, research, evidence that exist due to COVID-19 and before COVID-19 to make demonstrable and sustainable change for and with BAME communities
- Closer engagement with the local communities, greater insight about local assets and existing grass-root community support architecture.