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

A report for the Health and Wellbeing Board

24th September 2020

Contents

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[1] later named SARS-CoV-2[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[1,3]. Shortly afterwards, on the 24th January, the first European cases were identified in France[1].

By the 31st January, SARS-CoV-2 had reached the United Kingdom[4]. 34 days later, the first official death within the UK was reported[5]. 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[6]. These interventions were shortly followed by the closing of schools (to all except the most vulnerable children and those of key workers)[7], and multiple businesses, particularly in the hospitality sector[8]. 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[9]. 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[10]. Since April, 9.6 million jobs have been furloughed as workplaces were forced to close[11,12]. 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[13].

Covid-19, the clinical syndrome caused by SARS-CoV-2, is typified by cough, fever and loss of sense of taste and smell[14]. It is believed to spread primarily via respiratory aerosols or droplets, or from contaminated surfaces[15]. 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%[16,17]. 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[18]. The potential longer-term consequences for patients surviving initial infection are still not clearly understood[19].

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[20].

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%)[21].

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[22]. In 2011, Darnall and Burngreave were also home to a larger proportion of BAME residents – 49% and 62%, respectively[21]. Overall 38% of Sheffield's BAME community live in areas amongst the 10% most deprived in the country and 15% live in overcrowded housing[23]. 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[24] and a 20 year difference in healthy life expectancy between the best and worst in the city[25].

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[13].

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.

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Chapter 2

Active Travel

Introduction:

This paper considers some of 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 this emerging picture may influence future transport interventions.

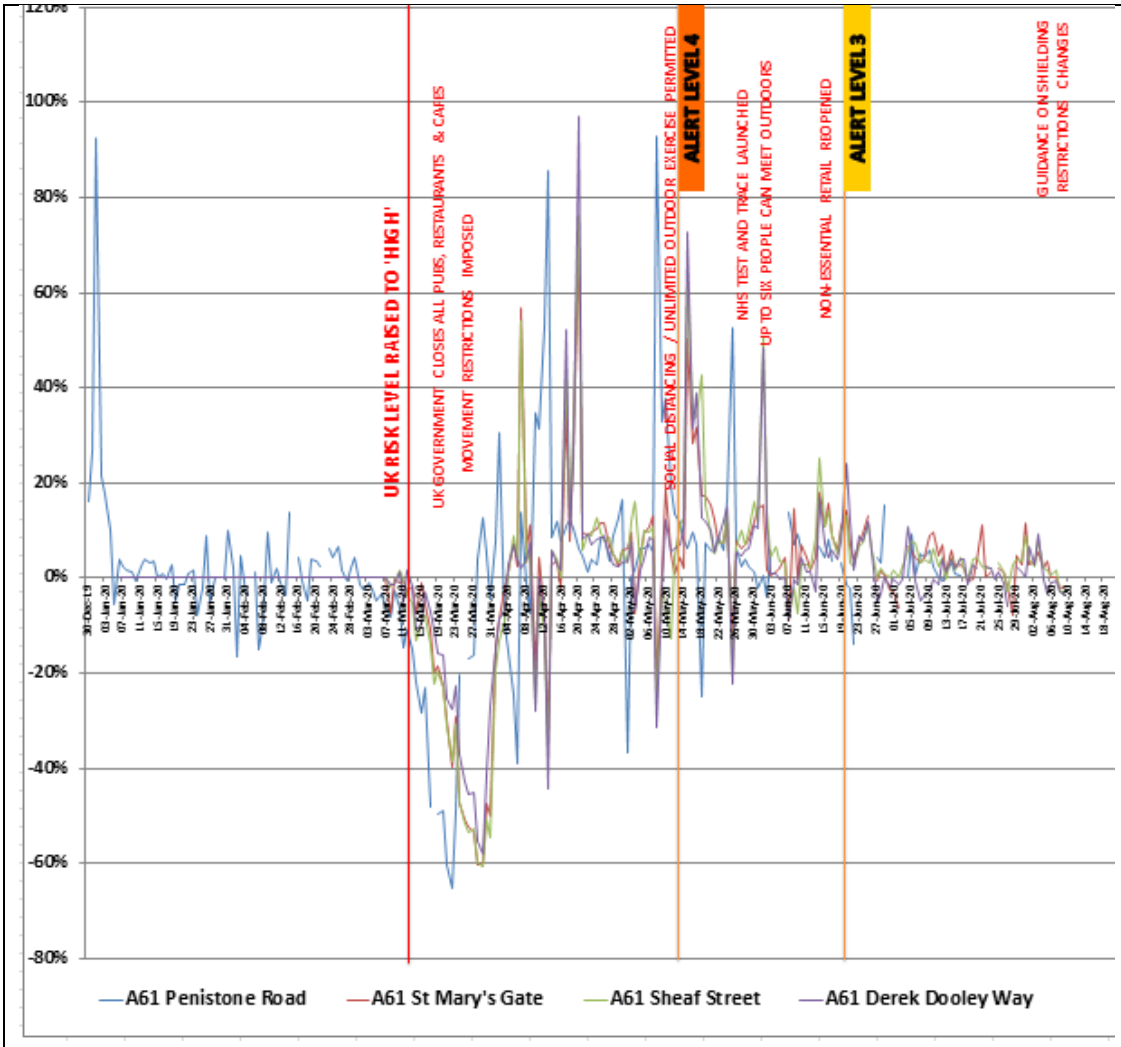
It considers other travel modes – private motor car and public transport – only insofar as these influence and impinge upon active travel.

It does not consider Gear Change[1] (the Government's July 2020 vision for cycling and walking) and the associated guidance for local authorities. Compliance with these will be a necessity both in order to meet our own Transport Strategy (2019-34) policy on "sustainable safety" (i.e. provision of Dutch-style cycling infrastructure) and more recent Sheffield City Region (SCR) funding-based requirements for active travel schemes.

Summary of impacts:

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.

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

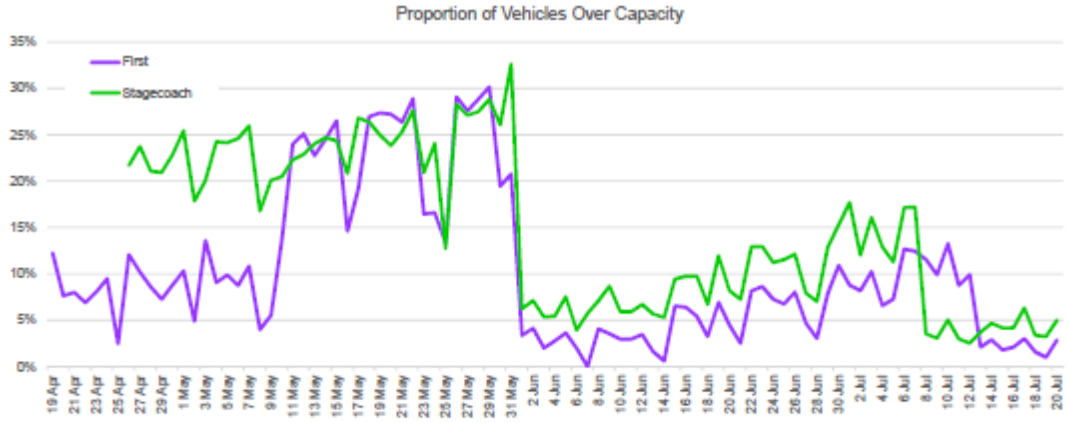


The Covid-19 pandemic has resulted in profound changes to travel patterns and how people are using streets. This can be summarised as

- A significant drop in car and public transport journeys as the need to travel reduced
- 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)
- Similarly, as restrictions on business and services have eased, so car journeys have increased
- Public transport, having been reduced to operating around 50% of bus and tram services at the start of Covid-19 aimed at assisting key workers, is now running almost a normal service although patronage remains low (approx. 20-30% of pre-Covid levels).

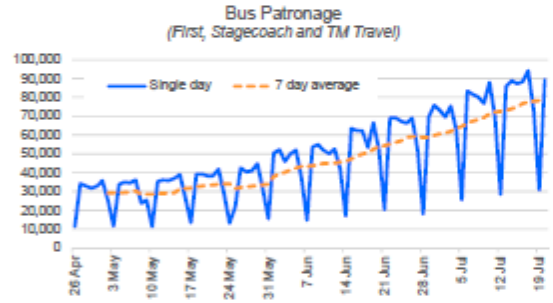
COVID-19 Public Transport Tracking

Updated: 21st July 2020

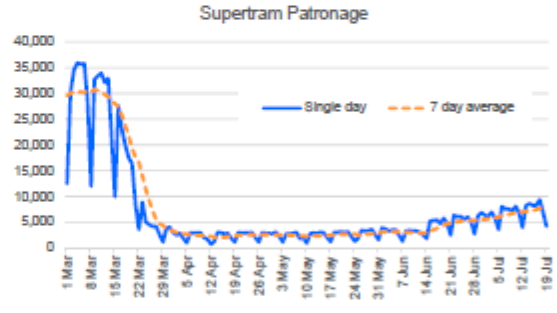


First data to July 20th		
Number over capacity latest day:	40	
Latest day compared to same day last week:	+11	+37.9%
7 day average compared to previous 7 day average:	-84	-78.4%

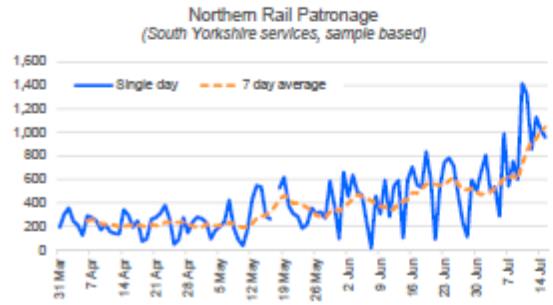
Stagecoach data to July 20th		
Number over capacity latest day:	62	
Latest day compared to same day last week:	+13	+33.3%
7 day average compared to previous 7 day average:	-11	-15.5%



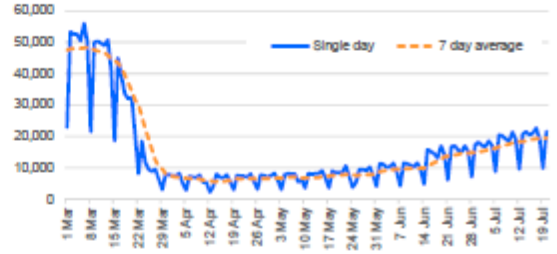
Data to July 20th		
Latest day compared to same day last week:	+3,821	+4.2%
7 day average compared to previous 7 day average:	+6,832	+8.0%



Data to July 19th		
Latest day compared to same day last week:	+202	+5.0%
7 day average compared to previous 7 day average:	+847	+9.2%



Data to July 15th		
Latest day compared to same day last week:	+203	+26.8%
7 day average compared to previous 7 day average:	+411	+86.0%



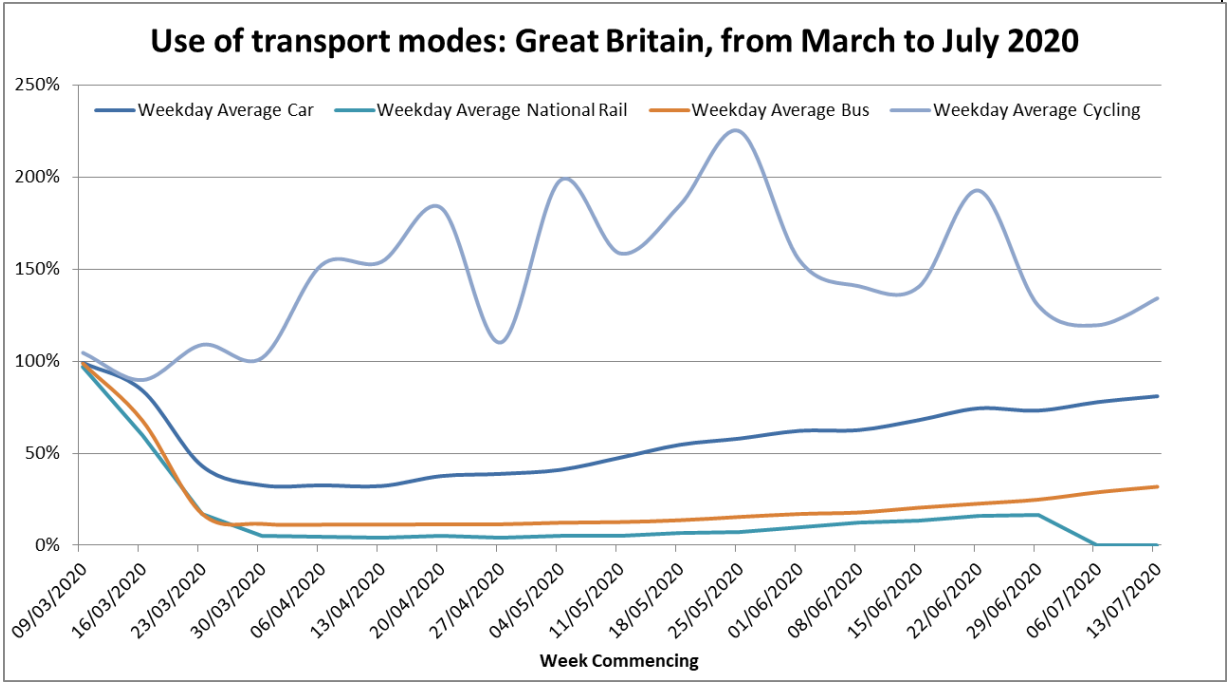
Data to July 20th		
Latest day compared to same day last week:	+804	+4.4%
7 day average compared to previous 7 day average:	+1,108	+8.0%

The data above shows the public transport, across all modes has been significantly impacted by the reduced need to travel but also the restrictions places on capacity. As of 20th August, bus services are operating at around 40% of pre-Covid levels, with train and tram at 30%. As

the schools return and business opens up, this is expected to increase but still not expected to return to pre-Covid levels.

Anecdotal evidence suggests that as more motorised traffic has appeared, so the number of cycle trips has reduced. This reinforces pre-existing evidence, such as in our major public survey in support of the Sheffield Transport Vision: the major impediment to cycling is concern about danger from motorised traffic.

The same is considered to be the case for walking, although to a lesser extent as most people have no choice but to walk at least some distance in order to access other modes and destinations, whereas cycling is more likely to be a choice— and one made by people from higher socio-economic sectors.

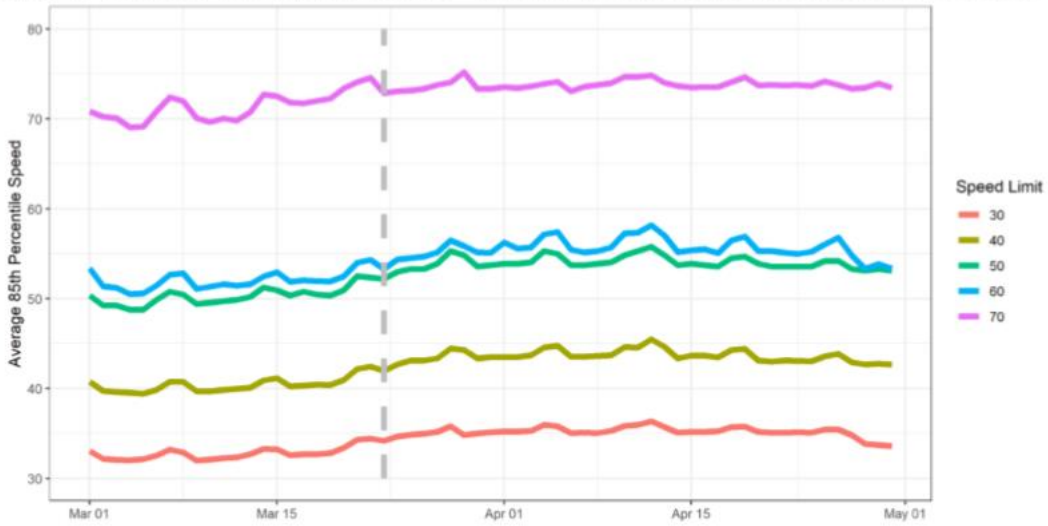


Reduced motorised traffic volumes, in addition to freeing up more highway space for cycling, also resulted in higher vehicle speeds as the quieter road environment and reduced feeling of conflict tends to make driver behaviour more prone to speeding. The main health impact in this instance is a road safety implication rather than an environmental one as, despite higher speeds resulting in higher emissions, the significant reduction in traffic volumes make this insignificant from an emissions perspective. In addition, the absence of congestion resulted in less standing traffic and engine idling.
https://agilysis.co.uk/2020/07/09/new-research-shows-increased-vehicles-speeds-during-Covid-19-lockdown/ - figure 3.

The figure below shows the average daily speeds and average 85th percentile speeds, both before and after the introduction of lockdown. There are clear increases in speeds leading

up to the introduction of the lockdown, with highest speeds after the 23rd March when traffic flow was at its lowest. There is also a slight reduction in speed towards the end of April, as traffic flows started to increase.

FIGURE 3 – OBSERVED CHANGES IN AVERAGE 85TH PERCENTILE SPEEDS BEFORE AND AFTER THE LOCKDOWN



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, agreed with the Cabinet Member for Transport and Infrastructure and consistent with the Transport Strategy, 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.

Investing in safe and attractive infrastructure for walking and cycling forms part of an environmentally sustainable recovery for the city, whilst proactively encouraging more physical activity helps deliver on wider public health objectives. Alongside clean, high quality public transport, it will enable access to employment to support the economy and

[2] https://www.gov.uk/government/news/2-billion-package-to-create-new-era-for-cycling-and-walking

contribute towards the achievement of carbon and NO2 reduction targets.

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

Two specific scoring mechanisms were used; social distancing and cycle routes. Social distancing interventions are scored on the objective to meet social distancing guidance, impact on residents and scale/size of local centre. The cycle routes have been selected on the grounds of nationally agreed methodology, to determine where there is good potential for people to cycle to work, based on census reported commuted habits, trip length and topography but also, where an expected level of connectivity will be required as a result of lower capacity public transport operation.

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). It identified that the published academic and policy evidence for this specific topic is quite sparse. Much of the future scenario and visioning work that was reviewed for that report does not explicitly consider the consequences of future transport innovations on current inequalities.

This is a serious problem because the review shows that many people in the UK may not be able to access important local services and activities, such as jobs, learning, healthcare, food

[3] https://www.gov.uk/government/publications/reallocating-road-space-in-response-to-Covid-19-statutory-guidance-for-local-authorities

shopping or leisure as a result of a lack of adequate transport provision. Problems with transport and poor links to opportunity destinations can also contribute to social isolation, by preventing full participation in these life-enhancing opportunities. The worst effects of road traffic can also lead to reduced quality of life due to high levels of exposure to pedestrian casualties and fatalities, and traffic-related air and noise pollution, especially in dense urban areas.

The report 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.

It should be acknowledged that a weakness in traditional transport planning approaches is over-reliance on Census data to understand trip patterns and demands. This can overstate the importance of the generally straight-forward home to work journey at the expense of the more complex "chain trips" more typically made by women, to meet the needs of childcare, looking after other family members and other household functions.

https://www.sustrans.org.uk/media/7377/cycling_for_everyone-sustrans-arup.pdf

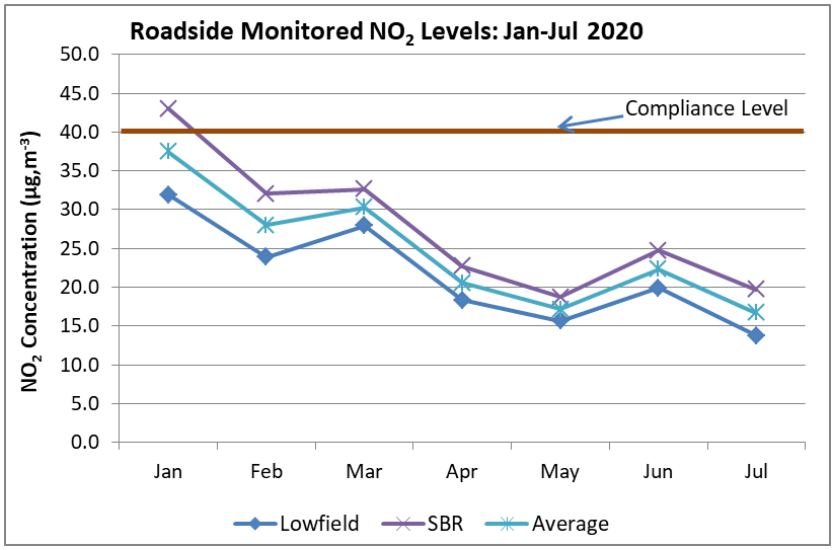
In relation to active travel on a general level, De Nazelle et al[4] reviewed available literature regarding health impacts from policies that encourage active travel, to help decision-makers propose better solutions for healthy environments. Policies that increase active travel are likely to generate large individual health benefits through increases in physical activity for active travellers. Population-wide benefits accrue through reductions in air and noise pollution, particularly for those in more deprived areas where heaviest motorised traffic levels tend to be concentrated. Depending on conditions of policy implementation, risk trade-offs are possible for some individuals who shift to active travel and consequently increase inhalation of air pollutants and exposure to traffic injuries.

Public transport users have specifically been negatively impacted due to the capacity restrictions placed on buses, trains and trams and the greater risk involved in travelling by this mode. The need to find alternative transport if available to them would have placed a degree of expense, stress and anxiety as well as in some cases isolating them from key

[4] Audrey de Nazelle et al., "Improving Health through Policies That Promote Active Travel: A Review of Evidence to Support Integrated Health Impact Assessment," Environment International 37, no. 4 (May 2011): 766–77, doi:10.1016/j.envint.2011.02.003.

community services.

Those living close to the key road network, along the key arterial routes into the city have witnessed short terms improvements in air quality and less noise pollution, as traffic has reduced and active travel has been promoted. The key implication is how to maintain this positive shift throughout and after lockdown when there is the potential for car use to increase, especially if people previously using public transport switch to private vehicle.



People with access to a bike (about 60% of the population nationally) have had the opportunity to benefit from lockdown as reduced traffic has made cycling more attractive. The SES more likely to own a bike and/or have the available resources to spontaneously purchase one, were thus better placed to capitalise on the quieter roads.

This may have exacerbated pre-existing inequalities in relation to the lower take up of cycling (as opposed to walking) by people from lower SES, Black, Asian and ethnic minorities and women.

https://www.sustrans.org.uk/media/7377/cycling_for_everyone-sustrans-arup.pdf

People who are eligible to work from home may have experienced a decrease in physical activity as their commute to work, whether it is active travel, or active travel as part of another mode (walking to the bus stop for example). It is highly likely that working from home has been new for many people and the importance of the physical activity associated with the daily work routine may not have been replicated elsewhere in their new regime.

The greater opportunity to work from home in desk bound jobs as opposed to those in the generally lower paid care, health, transport, distribution and retail sectors can also amplify transport inequalities. In the medium term the disparity in opportunities for remote working may mean generally better off households are more able to reduce time and money spent travelling to work with the consequent improvement in quality of life and living standards.

Some households will reduce car dependence (and car ownership also) as a consequence. Conversely, some of those who have stopped using public transport during the pandemic will not return to that mode and find that the competitive price of second hand cars is more attractive. These trends are important as they are likely to have a much greater bearing on inequality in transport and health than a marginal, but desirable, uplift in active travel.

In terms of temporary active travel infrastructure, a similar dichotomy arises as with proposed permanent interventions, namely: where to prioritise interventions given the choice may be between locations where there is a noticeable wealth (and therefore) health gap. The former may tend to provide a greater uptake and therefore a greater quantum of health benefits (not to mention a positive example of significant usage to others), thus widening health disparities. The latter may struggle to match levels of uptake, especially without 'wrap around' support to 'normalise' cycling, but bring greater health benefits for individuals, not to mention the spin-off positives from investing positively in making the local street scene more people friendly.

What is the scale of the impact now? Can we predict what it will be in the medium and long term?

The scale of impact is unclear, given there is a trade-off between fewer active travel journeys to work as a result of remote working/furloughing as opposed to increased active travel for leisure purposes. It is uncertain how this will change as traffic levels increase and the impact of changing working routines, such as working from home, play a role in shaping future travel patterns. Investment programmes such as TCF and any specific Covid-related emergency funding as a result will help prioritise sustainable transport both now and into the long term.

Sheffield Transport Strategy (2019-34) modelling used the Propensity to Cycle (PCT) tool. Assuming a 'Go Dutch' scenario i.e. sustainable safety measures to segregate cycling infrastructure where the volume and type of motorised traffic necessitates it and given the necessary levels of investment and political and public support, cycling has potential to grow 570% over 2015 levels by 2035. Modelling also suggested that Increases in walking were likely to be marginal as Sheffield already has above average rates of walking to work as indicated by Census returns and because experience from elsewhere shows that many cycling trips will switch from walking. Our approach has been to target cycling infrastructure improvements on enabling access to employment from residential areas to the city centre and Lower Don Valley/Greater AMID area. This is consistent with TCF outcomes, but in prioritising schemes it is possible to consider a wider view and the changing situation we now face.

The short term restrictions on public transport have had a major impact on its use, along with the active travel associated with this mode. However, as lockdown eases and restrictions are lifted, public transport remains a valuable asset to the city with the ability to

move many more people than active travel and over longer distances. The greater access for public transport over and above private cars in the city centre gives it a real advantage in winning mode share. The same may be said for cycling.

Increased investment in, and use of, public transport has been linked with increased physical activity, reduced vehicle emissions, and improved access to services, amenities and opportunities. Availability of good quality public transport is linked to lower car ownership and higher levels of physical activity. As such it is pivotal to a sustainable and inclusive economic recovery, although declining patronage exacerbated by impacts of Covid-19, longer term funding and the regulatory position remain unclear.

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?

Continued and escalating investment in active travel infrastructure will help contribute to wider public health and wellbeing objectives, especially given its role in creating more liveable and attractive neighbourhoods. The potential to create high quality walking and cycling routes to public transport hubs as part of a better planned city, offers a realistic alternative to increasing use of motor cars. This is especially so if linked to "15 minute neighbourhoods", where traffic volumes are managed downwards to enable local trips by active means and where higher population densities can support services in the city centre as well local and district centres.

To ensure equalities are better addressed a wider approach is necessitated that looks to how neighbourhoods can be transformed by remaking the street scene overall in a much more people friendly way. This involves not just the creation of cycling routes or low traffic neighbourhoods but finer detail safety and access measures; dropped kerbs, handrails, alternatives to steps, along with spaces offering shelter and shade all play a part. These are both of practical value in improving access to public transport and local services for more people by more sustainable means, but also serve to make neighbourhoods more attractive in themselves. This, in turn, helps deliver improvements in personal safety which is a key barrier to being active, disproportionately falling on women, people of colour and lower SES. It also offers greater opportunities for disabled people to contribute more fully and access employment and services on a more equal basis.

Work with local communities to build on our existing knowledge, such as the small scheme public request list held by Transport Planning, will be essential to fine tune such measures to gain maximum benefit across neighbourhoods.

What local, community-level intelligence do we have to substantiate our findings?

There is little evidence available due to the granular nature of this type of data collection.

We have cycle counter data but this is fundamentally quantitative and doesn't provide any further insight into wider and related information, such as demographic segmentation of users. Assumptions can be made based on associated census data but there is a margin of error and this is confined to travel to work journeys. A SCC survey might be helpful in understanding these behaviours. Use Paul's data?

Work with third parties, such as the universities, cycle Sheffield, Sustrans, businesses and research companies (the Floow) could be helpful in providing secondary data that has a more qualitative focus. As areas are confirmed for TCF led schemes it will be important to identify and involve anchor community organisations which can help us develop our understanding, provide a conduit into the local area and ideally co-produce proposals. It should be acknowledged that the challenging delivery timescales set by Government around TCF are working against this approach but the ambition remains. The risks involved in being seen to go in over the heads of the community are very real and as much engagement as possible will be the aim.

How can we use this information to ensure negative impacts are mitigated in our future decision-making?

Any increase in walking and cycling as a result of these interventions will be monitored to ensure that evidence is collated which confirms the wider benefits of investing in active travel. Benefits realisation reporting will be required under the Transforming Cities Fund appraisal requirements. These findings will be very helpful in securing the strategic and economic case for future investment in active travel interventions but also provide a sound reasoning for wider policy change.

Recommendations:

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 support social interaction and living streets, but also play an important role in supporting active lifestyles.

How can we/the city prevent or mitigate any negative impacts?

- Better understand the reasons behind different levels of participation in active travel according to protected characteristics particularly age and sex
- 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
- Use existing investment programmes such as Transforming Cities Fund, to maximise and promote any behavioural change resulting from Covid-19
- Consolidate temporary measures to support active travel into permanent scheme where monitoring and evaluation shows this is appropriate
- Enable and promote active travel as part of daily routines and awareness of the need to take regular exercise
- Develop understanding of transport inequality risks as a result of increased remote working along with mental health impacts of reduced social interaction
- Secure investment in sustainable modes – active travel and public transport – to offer a realistic alternative to increasing car use
- Maximise involvement of local communities in formulating interventions that prioritise access and safety as part of enabling active travel
- Invest in local and district centres to make 15 minute neighbourhoods more viable

How might our services/approach flex to meet the needs identified here to aid recovery?

Covid-19 has shown the potential for greater interaction with more localised community areas and facilities. This suggests a greater need for investment to be focused in local and district centres, and access to them. Rebuilding communities from within requires greater understanding, consent and people participation. Whilst Covid-19 may restrict the channels which can be utilised it remains important to maximise such involvement. Where anchor

community organisations assist this process they will require appropriate remuneration.

For transport our approach will require more controls and restrictions on kerbside parking, removal of footway parking, closures of roads to motorised vehicles to limit the routes that they may use and restrict non-local 'through' traffic. These, along with the finer grain safety and access measures, are essential to the creation of conditions that make active travel safe and neighbourhoods more attractive.

What are the good things happening that we want to keep? How could we do this?

The temporary, although now rising, lower traffic levels have resulted in a number of benefits from a public health perspective. There is a need for these benefits to be captured, by either promoting new sustainable travel behaviour through active travel initiatives or such as remote working.

In order to do this there needs to be continued investment in active travel and a long term commitment to improving public transport post the social distancing period is required. The Council is committed to this through existing capital investment programmes but is also mindful of the recent SCR commissioned Bus Review recommendations, the subsequent impact of Covid-19 and the need for a step change in the way that public transport meets the needs of people in the changed situation which is emerging.

If there's no such thing as business as usual any more, what are the opportunities for more radical change?

It is unclear how the public will respond to the short, medium and long term implications of Covid-19. As transport is a derived demand the impact on travel, and active travel in particular, will depend on how the wider economy and its related functions respond. As schools, market segments and social distancing policy changes, there will be both incremental and step change alterations to travel patterns. Transport interventions will need to prioritise seizing opportunities for positive change.

Transport has a key role to play in changing life for the better – whether that is in support of health, environmental, economic or equality outcomes, provided that the necessary long term investment is secured and used to deliver sustainable futures.

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 and during this time there has been significant resource within the team directed towards to the implementation of the temporary active travel measures. These measures have in many respects been in response to the recommendations of this HIA, as the Council is seeking to maximise the encouragement of more active travel as a result of providing the correct level and type of infrastructure to support this behavioural change.

Data and information has been scarce. As a result, data has been used from local and national sources, including other relevant case studies. This report contains qualitative and quantitative data, as well anecdotal evidence.

Limitations

The work could have benefited from wider consultation, to include representatives from communities and business.

Obtaining local quantifiable information on the impact will be very difficult given the need for specific data collection. Where possible, nationally collected data resulting from similar schemes developed and implemented across the country will be used to give a proxy understanding of the implications, both positive and negative. Although within this there is an appreciation that local characteristics will be a contributory factor to conclusions.

There a gaps in the qualitative element to these impacts on a local level. It is hoped that the general impacts of Active Travel schemes can be used.

Chapter 3

Employment

Introduction

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China[1]. A novel coronavirus (SARS coronavirus-2) was subsequently identified from patient samples[1]. This novel coronavirus has since been termed SARS-CoV-2 and the associated syndrome of symptoms is termed Covid-19. The disease spread internationally and on 11 March 2020 the World Health Organisation (WHO) declared the situation as a pandemic[2]. Since that time, guidance and media have referred to the situation as the Covid-19 pandemic.

As a result of the Covid-19 pandemic significant measures were taken to limit the spread of the disease. On 16 March 2020, the Prime Minister of the United Kingdom announced social distancing measures, including the need to stay at home and work from home wherever possible[3]. These measures lead to closing of all non-essential services and radical changes to the way people worked and lived.

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

Aims

1. To collate and review the available and emerging evidence to identify the impacts, and potential impacts, of the Covid-19 pandemic on employment and working environments, and consider this in the context of the people of Sheffield
2. To systematically review the likely impact of Covid-19 on the Sheffield population, both in the short and long term and identify sub populations at particular risk of being affected
3. To make recommendations which the city could consider to mitigate the impacts on health and wellbeing

Key Lines of Enquiry

This health impact assessment will consider:

- The Coronavirus job retention scheme
- The self-employment support scheme
- Which groups are most affected by the Covid-19 pandemic with regards to employment
- What impacts there have been on working environments

Background (Pre-pandemic)

The decade before the pandemic , despite many years of strong overall economic growth, saw stagnant earnings for many, large cuts to the welfare system and an increase in 'solo' self-employment and 'gig' economy (part time, fixed term and often insecure jobs)[20]. There were existing inequalities in employment in the United Kingdom. The hourly wages of women are a fifth of that of men[20]. There are substantial differences by ethnicity, between and within genders. For example, white British individuals have employment rates of 80% for men and 73% for women, whereas Pakistani and Bangladeshi individuals have employment rates of 75% for men and 39% for women[20]. There were differences in stability based on income, with about 30% of low-income household's pre-crisis saying they could not manage one month if they were to lose their main source of income. This group were also spending a high fraction of their income on necessities.

The pay and employment of young adults were impacted by the Great Recession (2007-2009) which has led to economic inequality between generations. Leading up to the pandemic young people aged between 16 and 29 years were the most likely to report their working arrangement as a zero-hours contract, with 5% of employed young people reporting this in the last quarter of 2019 (October to December) compared with 3% of people aged 60 years and over and 1% of people aged between 30 and 59 years[29]. Reduced home ownership also means that young people today have less wealth than previous generations.

There were also geographical inequalities, with a north south divide in educational attainment and earnings. The Annual Survey of Hours and Earnings (ASHE) showed that levels of income within Sheffield for full time workers are lower than nationally[8]. The average full-time employee in Sheffield earned £26,097 in 2016. This compares to a figure of £28,503 across England as a whole. Weekly breakdown of the average gross pay for someone working full time in Sheffield was £505.30, compared to £544.70 nationally. The average weekly gross pay for part-time workers in Sheffield stood at £179.40 in 2016. This is higher than the national average of £177.20.

The unemployment rate in Yorkshire and Humber was 4% between Feb – April 2020[15]. Unemployment measures people without a job who have been actively seeking work within the last four weeks and are able to start work in the next two weeks. It is therefore not representative of the total population not in employment. The unemployment rate estimate for people aged 16 years and over for the UK was 4% in the same period (meaning Yorkshire and Humber was in line with the national figure) and this rate is largely unchanged compared with the previous quarter (November 2019 to January 2020)[15].

Findings

During lockdown

- **Population**

This health impact assessment will consider the population of Sheffield. The nationally available data relating to the employment and economic impacts of Covid-19 predominantly considers the local level using constituencies. In Sheffield, we have five parliamentary constituencies: Sheffield Hallam, Sheffield Heeley, Sheffield Brightside and Hillsborough, Sheffield South East, and Sheffield Central. Table 1 shows the population in each of these constituencies broken down by age and gender. The constituency with the largest proportion of the working age (18-65) population is Sheffield Central.

Table 1 Sheffield Population by Constituency[7]

	Sheffield Brightside and Hillsborough	Sheffield Heeley	Sheffield South East	Sheffield Central	Sheffield Hallam
Total Population (all ages)	112,812	95,132	94,686	133,660	92,196
0-17 years	30,441 (27%)	18,851 (20%)	20,614 (22%)	19,223 (14%)	17,124 (19%)
18-65 years	67,684 (60%)	59,997 (63%)	57,409 (61%)	103,876 (78%)	56,901 (62%)
66+ years	14,687 (13%)	16,284 (17%)	16,663 (18%)	10,561 (8%)	18,171 (20%)
Male	54,909 (49%)	46,163 (49%)	46,042 (49%)	70,960 (53%)	45,394 (49%)
Female	57,903 (51%)	48,969 (51%)	48,644 (51%)	62,700 (47%)	46,802 (51%)

The Indices of Deprivation are a relative measure of deprivation used in small areas across England. The Indices of Deprivation is the collective name for a group of 39 indicators measuring different aspects of deprivation, which are grouped into seven domains[8]: income, employment, health and disability, education, skills and training, barriers to housing and services, crime, and living environment. Generally, the small areas considered are called Lower Super Output Areas (LSOAs), which are based on an average of 1,500 residents. Given the national data is focused on constituencies the deprivation data has been mapped to these in Table 2. When considering Indices of Deprivation by constituency they are ranked from 1 to 533, with 1 being most deprived and 533 being least deprived.

Table 2 Sheffield Constituency Indices of Deprivation rankings 2019 [9]

	Sheffield Brightside and Hillsborough	Sheffield Heeley	Sheffield South East	Sheffield Central	Sheffield Hallam
Indices of deprivation	12	79	127	173	526
Income deprivation	12	78	129	222	529
Income deprivation affecting children	13	66	150	118	533
Income deprivation affecting older people	51	117	130	50	504
Employment deprivation	12	70	124	323	515
Education, skills and training deprivation	5	74	66	209	530
Number of LSOAs in district	69	60	59	67	53
Number of highly deprived LSOAs (in top 10% of IMD) in district	42 (61%)	18 (30%)	9 (15%)	11 (16%)	0 (0%)

- **Universal Credit**

Since the start of the coronavirus (Covid-19) pandemic, there has been increased demand for Universal Credit. From 1 March to 16 June 2020, Department for Work and Pensions (DWP) has received 3.3 million individual declarations to Universal Credit. Universal Credit is further considered in the income health impact assessment and is therefore not explored further here.

- **Coronavirus Job Retention Scheme?[4]**

This scheme is commonly referred to as the 'furlough scheme'. It was announced by the Government on 20 March 2020 as a support for employers who had been unable to undertake their normal activities through the period of restrictions related to Covid-19. Under the scheme, employers were able to claim support for the period starting 1 March 2020, where employees had already been furloughed from that date. The scheme provides employers with financial support up to 80% of salary, up to a maximum of £2,500 per month per employee, plus the associated Employer National Insurance contributions and pension contributions (up to the level of the minimum automatic enrolment employer pension contribution) on that subsidised furlough pay (at the time of writing). The scheme is based around the HMRC PAYE system; with an employer needing to have created a PAYE system by 19 March 2020 to qualify.

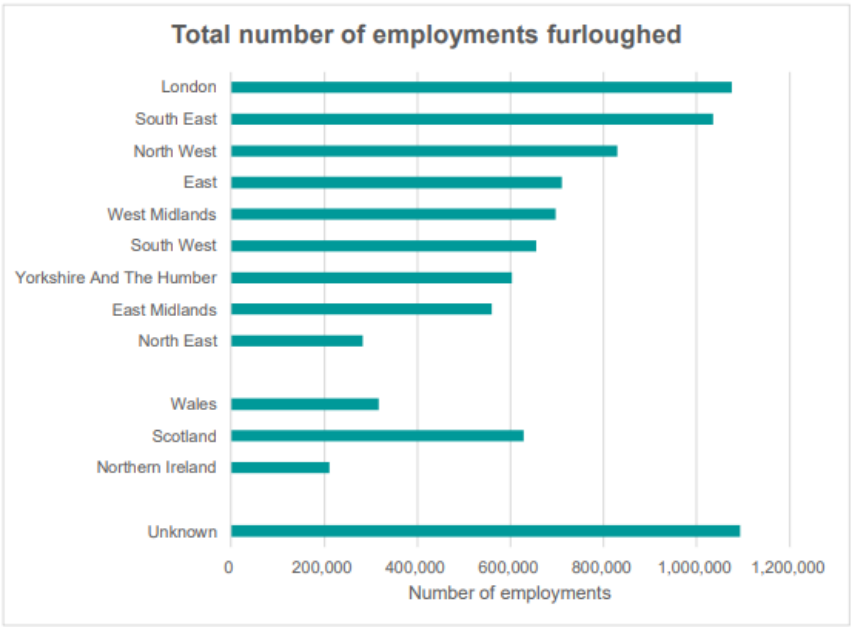
Nationally, 1.07 million employers have made at least one CJRS claim (until 31 May 2020) and 8.7 million employments have been supported via these claims. 2.5 million of these employments were related to 6300 larger employers (250 or more employees). 5.2 million of these employments were related to smaller employers (less than 250 employees). The remaining employments are related to as yet unclassified employers.

Yorkshire and Humber have furloughed 603,600 employments, of which 53,500 are in Sheffield. We can see this broken down by constituency in table 3. The constituency with the lowest proportion of workers places on furlough is Sheffield Central. The three most deprived constituencies have the most furloughed workers; this reduction in income may further perpetuate deprivation. However, nationally, according to the latest Business Impact of Coronavirus Survey (BICS) collected 15 to 28 June, 68% of furloughed workers were receiving wage top-ups from their employer in addition to the CJRS[13].

Table 3 CJRS access via parliamentary constituency[10]

Location	Total number of employments furloughed[10]	Percentage of the working age population furloughed[7]
Sheffield Brightside and Hillsborough	10,200	15%
Sheffield Heeley	9,700	16%
Sheffield South East	10,600	19%
Sheffield Central	10,100	10%
Sheffield Hallam	7,000	12%

Figure 1: CJRS Furloughed employments by region and country



Source: HMRC CJRS and PAYE Real Time Information

The data for this chart can be accessed from the spreadsheet accompanying this bulletin.

- **Self-Employment Income Support Scheme SEISS?**[5]

This scheme provides support for self-employed individuals whose business has been adversely affected by Coronavirus. From 13 May eligible self-employed individuals could claim a grant worth 80% of their average monthly trading profits, paid out in a single instalment covering three months' worth of profits, and capped at £7,500 in total. SEISS was extended to allow a second and final grant. This will be a taxable grant worth 70% of average monthly trading profits, paid out in a single instalment covering three months' worth of profits, and capped at £6,570 in total.

The scheme was open to self-employed individuals and members of a partnership who met the following criteria:

- Traded in the tax year 2018 to 2019 and submitted their Self-Assessment tax return on or before 23 April 2020 for that year
- Traded in the tax year 2019 to 2020
- Intended to continue to trade in the tax year 2020 to 2021
- Had trading profits less than £50,000
- Carried on a trade which had been adversely affected by coronavirus

A business could be adversely affected by coronavirus if they were unable to work because they:

- Were shielding
- Were self-isolating
- Were on sick leave because of coronavirus
- Had caring responsibilities because of coronavirus

or they have had to scale down or temporarily stop trading because:

- Their supply chain has been interrupted
- They have fewer or no customers or clients
- Their staff are unable to come in to work

Nationally, 3.4 million self-employed individuals were identified as potentially eligible for the SEISS scheme. This means that they met the income and trading activity criteria for the scheme based on Self-Assessment returns from 2018-19 and earlier years. However, some of these businesses will not have continued trading since 2018-19 or will not have been adversely affected by Coronavirus so will not ultimately be eligible. By 31st May, 2.4 million of the potentially eligible population (70%) had claimed a SEISS grant. The average value per claim was £2,900.

74% of self-employed people in Sheffield were using the SEISS scheme (above the national average)[28]. Four constituencies have claims of a monetary value below the national average (Sheffield Brightside and Hillsborough, Sheffield Heeley, Sheffield South East and Sheffield Central).

Table 4 SEISS in Sheffield[11]

Area	Total potentially eligible population	Total no. of claims made to 31/5/20	Total value of claims made to 31/5/20 (£)	Average value of claims made to 31/5/20(£)	Take-Up Rate
Yorkshire and the Humber	241,000	172,000	469,000,000	2,700	72%
Sheffield	23,100	17,100	46,300,000	2,700	74%
By Parliamentary constituency					
Sheffield Heeley	4300	3200	9,000,000	2,800	75%
Sheffield Hallam	3300	2300	7,100,000	3,000	69%
Sheffield Brightside and Hillsborough	4500	3300	8,000,000	2,400	75%
Sheffield South East	4500	3500	9,500,000	2,700	78%
Sheffield Central	4000	2800	6,900,000	2,400	70%

Nationally, men make up two-thirds of the potentially eligible population nationally (2.3m). Males have a higher take-up rate than females (72% compared to 66%) and their average grant value (£3,200) is 39% higher than the average for females (£2,300). Take-up of the SEISS grant is lowest for those aged over 65 (55%) and those aged 16 to 24 (62%).

- **Employment**

Unemployment remained at 4% nationally in June 2020, with 9 million employments furloughed[25]. However, the number of weekly hours dropped by 9% on the previous year and there was a record fall in job vacancies between March and May 2020[25]. A number of large employers, such as Capita, The Restaurant Group and Nissan, reported planned job losses during the lockdown period[25]. Locally, there have been reported job losses at Sheffield City Hall, Flybe DSA arena, Ponds Forge and the University of Sheffield. The latter is important as it is estimated 20,000 jobs in Sheffield are impacted directly or indirectly on the universities[37].

Sectors

Certain sectors of the economy have been more affected than others. Non-essential retail, tourism and hospitality, and arts and leisure services had to close, and travel was greatly impacted by stay at home advice[20]. Sales in hotels and out of home food sectors dropped by 88% between March and April 2020 and 81% of these types of businesses stopped trading[34]. The CJRS saw 73% of employees in these sectors furloughed[34].

The CJRS has seen a large number of claims from the wholesale and retail sector, accommodation and food services, construction sector, and manufacturing sector[4]. The construction industry had the largest potentially eligible population for the SEISS[5]. Other sectors with higher numbers of eligible individuals for the SEISS included transportation and storage, and administrative and support services[5].

The business sector has seen disproportionate impact in some areas. The arts, entertainment and recreation industry has seen a high proportion of the sector (40%) stop trading completely and of those businesses still trading there was a high reported stop/lowering in capital expenditure (57%)[14]. In Sheffield this will be relevant to entertainment venues such as the crucible, Lyceum theatre, Showroom cinema, the Light Cinema and so on.

Some businesses have seen a positive impact, with 18% of businesses in private sector human health and social work activities reporting capital expenditure was higher than normal[14].

Inequalities

The direct and immediate impact has been concentrated among those working in the aforementioned sectors. Workers with less secure working arrangements (e.g. zero hours contracts and self-employed) are more likely to report being negatively affected[20]. Impacts appear to be felt more by groups already experiencing inequality pre-pandemic. Economic hardship has an impact on health and there is therefore a risk lockdown, and the subsequent economic impacts, will widen existing health inequalities[17].

- Age

Those working in affected sectors are disproportionately more likely to be young[20]. Workers under the age of 25 are twice as likely to work in affected sectors as those over the age of 25[20]. A survey at the end of March found that young workers were more likely to have lost their job or had a reduction in earnings[20]. Education is especially likely to be protective of the jobs of young workers (see below).

The ONS reported that “over three in four (76%) of those aged between 25 and 29 years old who were worried (somewhat or very) about the effect of the coronavirus on their lives

reported that the coronavirus has affected their work"[29]. This was significantly higher than those aged 30 to 59 years (65%), possibly reflecting their less secure status in the labour market and the types of jobs they are likely to do[29]. Those aged 16 to 19 years were significantly less likely to report this (36%), likely reflecting the proportion of this age group in full-time education.

Amongst young people (aged 16 to 29 years) who reported that the coronavirus was affecting their work, the most commonly reported impacts were a reduction in hours worked (21%), concerns about health and safety at work (18%) and having been asked to work from home (19%)[29].

- Gender

Mothers are more likely to have quit their job, lost their job or been furloughed since the start of lockdown[20]. Women are twice as likely as men to work in key working roles which have not been involved in lockdown. Women are four times more likely than men to work in health and social care roles[20]. However, men are more likely to work in job roles which are less amenable to working from home, such as construction[20].

- Ethnicity

Pakistani and Bangladeshi workers are heavily concentrated in affected sectors, including transport and food and beverage sectors[20]. They are also more likely to be sole earners[20]. Black people are more likely to work in jobs which are less amenable to working from home[20]. Members of the BAME community, particularly black people, were more likely to work in keyworker roles than White British people[20].

- Educational attainment

Those with higher levels of education are more likely to be in roles in which they can do their work from home[20]. Those with a degree level or higher across all ages are more likely to be in positions which can work from home than those with a-levels or equivalent. Both of these groups are more likely to be in positions which can work from home than those with GCSE level or lower.

- Key workers[20]

Key worker roles included health and social care, security, some wholesale, some retail, teaching and other public services roles. While keyworkers were in roles which meant their jobs were protected, they were often put in a position where they continued to work despite the risk posed by the virus. Those working in health and social care roles have been shown to have higher rates of infection during random swab testing. Keyworkers are disproportionately in low income groups.

- People with disabilities

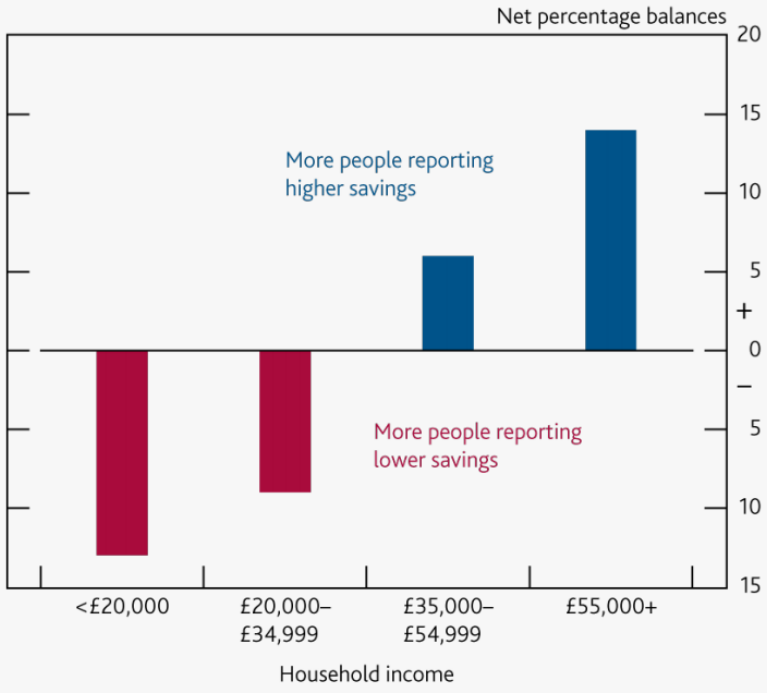
We know that disabled people are much less likely to be employed than non-disabled people and although the gap has been narrowing there is a risk that this trend will be reversed[17].

- Income

Those working in affected sectors are disproportionately more likely to be in low income roles[20]. Employees in the bottom 10% of weekly earnings are 7 times more likely to be furloughed than those in the top 10%[20]. Those on low incomes were also more likely to have lost their job or had a reduction in earnings[20]. Those with low incomes already spend the majority of their wages on necessities, making it difficult for them to cut back on spending[20]. On the other hand, high income workers spend a higher proportion of their income on sectors which are no longer functioning (e.g. retail, hospitality) and therefore may be making substantial savings as a result of lockdown restrictions[20] (see Chart C via ONS[37]). Those in high income roles are much more likely to be in roles which allow them to work from home.

Chart C More lower income households report having run down savings, while others have built them up

Reported changes in savings due to Covid-19[(a)]



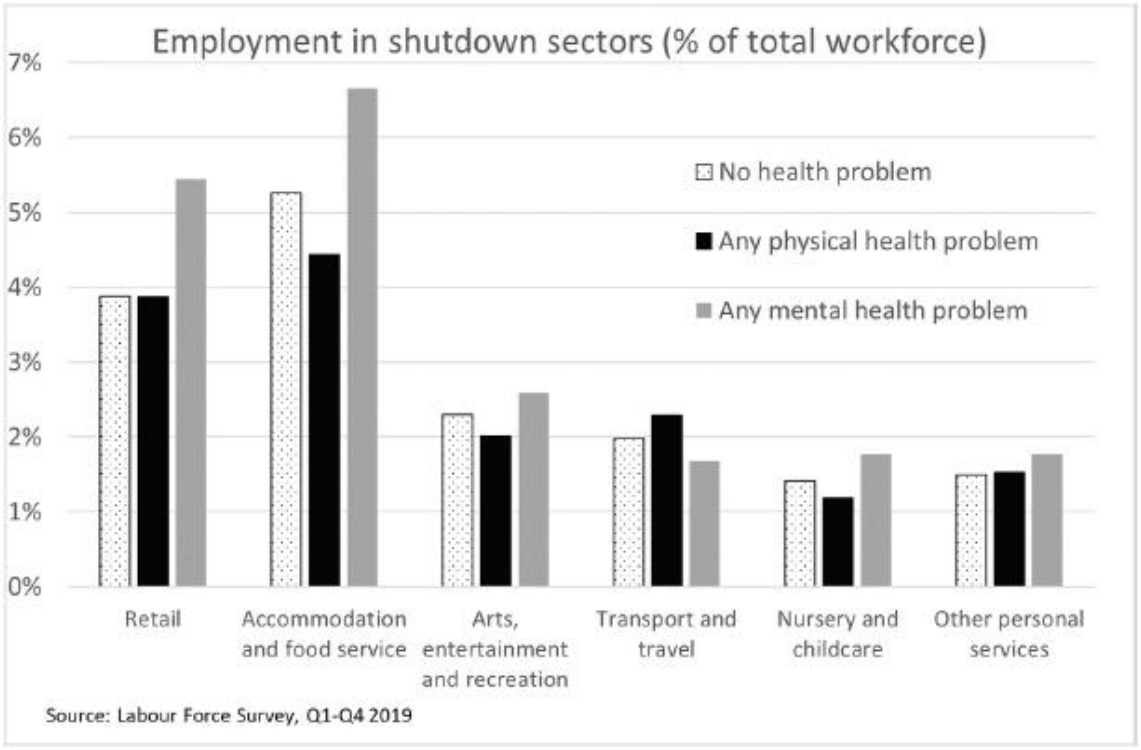
- Carers[18]

Working carers already balance work with their caring responsibility; Carers UK has estimated that 5 million people in the UK were working alongside providing unpaid care for an elderly, ill or disabled relative. A Carers UK survey found that the Covid-19 pandemic had

already had a significant impact. 70% of 1230 respondents were providing more care due to the outbreak. 17% of respondents reported they were no longer being paid due to losing their job, giving up their job or being unable to work due to social distancing rules. 13% had been furloughed. 41% were working from home, which was associated with its own pressures on juggling work and caring, as well as on mental health.

- People living with mental health problems

Those people living with mental health problems are more likely to be employed in some of the most affected industries, such as retail, accommodation services and the arts than those without mental health problems (See graph)[17]. They will therefore be disproportionately affected.



Working Environments

- Mental Health

The Health Foundation report that the likelihood of poor mental health was higher if families had experienced a deterioration of their finances during lockdown or expected one in the next 3 months[23]. In the poorest 20% of families almost three-quarters (72%) reporting a worse financial position had poor mental health, compared to around half (48%) in the richest 20%[23]. Those "who were still working or had been furloughed were less likely to report poor mental health than those who had lost their jobs since lockdown"[23]. "Retaining a job through being furloughed may have helped prevent a rise in unemployment-related mental health problems"[23].

It has been identified that increased workloads and the possible increase in work related anxiety and stress for health and care workers could have adverse consequences on the mental health of these workers[24].

- Key worker risks

Keyworkers are more likely to be exposed to the virus by simple virtue of them being out of their home whilst others are staying at home or working at home.

There have been over 540 health and social care worker deaths in the England and Wales, which is the second highest recorded number of health worker deaths in the world[24]. In the UK data has shown "elevated rates [of death] among some of the individual health care professions" as compared with the general working population, including male and female nurses, male nursing auxiliaries and assistants, male and female social care workers and male health care workers[24]. Other key worker occupations with raised death rates for men included taxi drivers and chauffeurs, bus and coach drivers, workers in factories, and security guards[24]. BAME populations have been disproportionately affected by the pandemic, with higher rates of infection and death[24].

The British Medical Association (BMA) carried out a survey with over 16,000 doctors regarding PPE in April 2020. About 48% of the respondents reported buying PPE for their own use, or that of their department, or using donated PPE, due to the lack of supplies where they worked and 65% of doctors said they felt either "partly or not at all protected"[24].

- Working from home

There are positive and negative impacts associated with working from home. Sheffield City Council employees reported[27]:

- Work related stress - due to the lack of demarcation between work and home life, a tendency to have back to back virtual meetings and the challenges of redeployment
- Feeling isolated – solo decision making without informal office support, lack of social contact
- Impacts on home environment – not enough space to work at home, juggling schooling and working
- Unhealthy behaviours – missing breaks, exercising less, not sleeping well
- IT issues – poor connectivity causing stress, being unable to switch off, sharing IT equipment within family
- General anxiety about Covid-19 and its impacts on life and society

Sheffield Citizens Advice Bureau staff[30] shared some reflections on working from home including:

- It is difficult to work from home if not "good at IT"
- Living alone and working from home can be lonely
- It is tough not having separation between work and home, particularly if dealing with a difficult or abusive client
- It can feel frustrating and intense working alone, particularly with clients with mental health problems
- It takes a lot of energy and skill to actively listen, provide empathy and ensure a client leaves a conversation in a positive frame of mind
- Good working relationships have helped to transition to remote working
- It has been a big learning curve transitioning to new roles and new legislation and schemes
- There are good and bad days working from home

Local Sheffield Intelligence

Businesses

A survey was carried out in Sheffield called the Business Survey – Impact of Covid-19[19]**.** This survey was completed by 457 businesses, of which 72% were small businesses (employing fewer than 10 people). Only 5 large businesses (over 250 employees) responded. A variety of sectors were represented; notably 22% were from retail and hospitality and 21% were from digital, manufacturing and professional service sectors. Most businesses (86%) had significantly reduced operations or ceased trading temporarily because of lockdown. Four businesses had ceased trading entirely. The businesses surveyed were most concerned about "impact on cash flow" (79%) and "impact on customer demand" (75%). Businesses have displayed resilience in response. 44% have taken proactive steps to manage relationships with existing customers and 40% enabled staff to work from home. 54% of businesses had used the CJRS. 69 businesses (15%) had made staff redundant or were planning to do so. Businesses expressed frustrations at their ineligibility for grants, the actions of landlords with regards to rent holidays and the fact that some insurance schemes were not paying out for business interruption.

Sheffield City Council launched the Coronavirus Business Grants Scheme to support those who may not be eligible for government grants[21]. There are 2 main schemes, which are both government grants, but administered locally.

1) The Business Rates Grant for businesses who were eligible for small business rate relief or the expanded retail, leisure, hospitality relief. This is a 'mainstream' government grant, administered via local authorities.
2) A discretionary fund of 5% of the main fund (lobbied for by Sheffield City Council), because there were businesses who should have benefitted from the main business

rates scheme but were excluded on technical ground (such as business incubation centres where the business pays it business rates through an all-inclusive rental charge rather than directly itself)

The Business Rates Grant receive 8,807 claims, of which 7,944 were eligible applicants, and 7,825 had received payment (At the time of the figures being produced) [36]. The total amount paid via these grants is £92,800,000[36]. The discretionary fund received 813 claims, of which 617 were eligible, and 168 had received payment (At the time of the figures being produced)[36]. The total amount paid via these grants is £871,600[36].

CCG Covid-19 Community Insights Log[22]

The Sheffield Carers centre reported informal carers did not have access to PPE in early April 2020. Healthwatch also identified concerns about carers being at risk due to the pressure associated with being a sole carer without systemic support or caring 24/7.There were examples of tensions related to being unable to go out to have a break or people with dementia becoming distressed by changes in routine.

Terminus Initiative (23 April 2020) shared that care workers had reported exploitation at work with reported unreasonable demands including being made to work up to 6 successive night shifts causing child care issues for a lone parents meaning children were passed around neighbours. Healthwatch (15/5/20) also reported care homes were struggling with staff shortages at the beginning of lockdown, which seemed to gradually improve for many. Related to this, some staff members told Healthwatch they felt under pressure to go into work when they were unwell or shielding. There were anecdotal reports from the community swabbing service regarding care home staff being driven to a test centre by a manager, or getting tested on their way to work. There were concerns from care home staff about PPE supplies and how easy these were to source. Staff members also found it difficult to get tested.

SayIT Sheffield (01/05/2020) reported that social isolation and lack of employment, income or savings may mean that many LGBT+ people have little option but to move back in with parents or family who may be LGBT phobic or otherwise unaccepting of their identity. This was a particular concern for younger LGBT people.

Healthwatch (1/5/20) have received reports of people getting slower response times from health and social care professionals due to home working.

Disability Sheffield (19/5/20) has expressed concerns about the long-term impacts of furlough arrangements on disabled people and their future employment. There is a fear that disabled people will be more negatively impacted by redundancies as a result of economic slowdown following Covid-19 pandemic.

A Better Recovery for Yorkshire – TUC document[26]

The Trade Unions Council (TUC) has produced a report calling for:

- Fair work environments (including a Fair Work Charter based on an example in Liverpool City Region)
- A worker centred transition to a low carbon regional economy
- A 21st century public transport network which incorporates green options
- Focus on equality

Citizen's Advice Sheffield [33]

Citizen's Advice Sheffield saw over 7000 queries in a 2 month period (a rise on last year) with a rise in employment related queries. These were around claiming benefits, redundancy, in work employment rights and the CJRS. There was also a reduction in queries related to disability benefits, debt, immigration and housing. 29% of clients are from the BAME community and 39% were disabled or had long term health conditions. There were more young clients, with 33% under the age of 34 years (compared to 25% last year). There are more clients from the poorest areas of Sheffield reflecting that they are likely disproportionately impacted by Covid-19.

Citizen's Advice Sheffield workers[30]

There were several examples given of situations faced in Sheffield:

- An asylum seeker with right to remain applied for universal credit in March 2020 did not receive payment until end of June 2020
- There has been reduced access to employment related legal aid due to the legal workers being on furlough
- Women have been affected by the lack of cleaning work
- Shielding people have been unable to work
- People who do not have English as a first language have struggled to understand new rules and regulations
- Employers have not been putting people on furlough despite eligibility
- Agencies have been highlighted as providing particularly bad treatment; no contracts given, not paying workers, not putting people on furlough. This has particularly affected the Polish community.
- One care worker refused to enter the home of a person with symptoms of coronavirus and was told if they wouldn't go inside they wouldn't be given any more shifts
- Job Retention scheme has not guaranteed job protection and there are cases of people being made redundant while furloughed.
- Pregnant people were affected by confusion about their vulnerability

WorkingWin Learning[31]

WorkingWin provides employment support for people with mild to moderate health conditions to help them to remain in or find work. The evaluation of this programme in Sheffield showed that local co-design of activities was considered to add value and create a shared sense of ownership and trust. WorkingWin has a key ambition to integrate health and employment systems. Over half (51%) of referrals came from GPs, IAPT and musculoskeletal services. There was success from co-locating employment specialists with clinical teams. WorkingWin is a local example of employment support systems which could be drawn upon.

Great Places Housing Association[32]

Great Places have shared examples of clients applying for their hardship fund as a result of reduced income or employment difficulties:

- Individual struggling to cover food and fuel costs alongside rent due to delay in furlough payments
- Missed debt repayments due to reduced income
- Financially difficulties as a result of being unable to access cheaper goods from shopping around
- Unable to make debt payment because children are at home and the extra cost of food has impacted on family finances
- Unable to afford food and essentials alongside rent due to 80% income on furlough

Easing of lockdown restrictions

Working from home

According to the latest Opinions and Lifestyle Survey (collected 25 to 28 June), the proportion of working adults travelling to work nationally increased to 49% (up from 44% the previous week)[13]. The proportion working from home had dropped to 29% (from 33% the week before)[14].

Businesses

The Business Impact of Coronavirus Survey (BICS) carried out nationally showed that between 1 and 14 June 2020, 86% of businesses were trading[14]. Of the businesses trading, 6% of their total workforce had returned from furlough in the two weeks prior to completing the questionnaire, while 2% returned from remote working to their normal workplace[14]. This suggests that a large proportion of the workforce of trading businesses remained on furlough or working remotely.

In the two weeks after initial restrictions were applied (16 March 2020) footfall in high streets and shopping centres declined below 20% of its level the same time last year[14]. On 15th June many types of non-essential shops and businesses were allowed to reopen in

England and footfall more than doubled from 14 June to 15 June 2020[14]. On 28 June, footfall in retail parks had increased to around 70% of its level the same time last year, while footfall in shopping centres was just under 50% and that in high streets was below 40% of its level in the same period last year[14]. The differing trend for retail parks is thought to represent the presence of essential shops in these locations. This is likely to have an impact in Sheffield which has Meadowhall Shopping Centre.

Moving forward

Between 19 June and 26 June, job adverts across all industries remained around half of their 2019 average nationally[13]. The full impact on employment and job losses is anticipated to be felt following the end of the CJRS in October 2020[25]. The CJRS has been criticised for failing to include conditions of job security or rights to workplace democracy[16].

The national BICS showed that of businesses who had not permanently stopped trading, 47% said they had less than six months or no cash reserves[14]. 67% of the accommodation and food service activities businesses who responded reported less than six months or no cash reserves[14]. This also applied to 58% of construction businesses[14]. This will potentially result in business closures over the coming 6-12 months given the ongoing restrictions in place meaning a return to business as usual is unlikely for most. We can see a cycle whereby workers are made redundant, meaning people have a lower income and thus they can spend less at local businesses which in turn will impact the ability for these businesses to remain open and continue to employ their staff[16]. The Office for Budget Responsibility estimates that 1.6 million more people will have been made redundant by the time the CJRS ends in October 2020[34].

The UK has entered a recession, with a drop in GDP by 20% in the last quarter[37]. The recovery is likely to be quicker than recessions in recent history, but with sectors recovering at different rates. It is possible that the recession will see some sectors and businesses flourish (e.g. supermarkets) while others struggle (e.g. cafes)[34]. Many businesses were working on tight margins before the pandemic and struggling for viability. These businesses have been surviving with CJRS, grants and Coronavirus Business Interruption Loan Scheme/bounce back loans. Many will have taken on debt to survive but will struggle to service this debt going forwards. Cash flow and servicing debt therefore become a key issue for businesses as Government support tapers off. There will be insolvency events with resultant job losses.

Conclusions

Before the Covid-19 pandemic there were stagnant earnings, 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 pandemic has exposed existing inequalities and further impacted these groups.

In Sheffield, 53,500 employments have been placed on furlough under the Coronavirus Job retention Scheme with the three most deprived constituencies having the most furloughed workers. 74% of self-employed people in Sheffield used the Self-Employment Income Support Scheme, with the four most deprived constituencies having claims of a value below the national average for the scheme. Some sectors have been disproportionately affected by the pandemic, including arts/entertainment, hospitality, construction work and retail.

Job losses are expected as the Coronavirus Job Retention Scheme ends in October 2020 and we can see a cycle whereby workers are made redundant, meaning people have a lower income and thus they can spend less at local businesses which in turn will impact the ability for these businesses to remain open and continue to employ their staff. Businesses are likely to be faced with cash flow issues and debt leading to insolvencies.

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 will be 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.

Stakeholder Mapping

High Interest	Low Level Interest
Elected Members City Growth Board Sheffield City Council Directors Employment and Skills Subgroup (ESSG) Youth Unemployment Prevention Group South Yorkshire Officer Group	Sheffield City Region, Mayor and Exec Local Enterprise Partnership Business network (Chamber of Commerce, Federation of Small Business, Sheffield Property Association) Sheffield Anchor Organisations (e.g. universities, hospital trust) Local Media
Sheffield City Partnership Pathways Programme	

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Chapter 4

Health Behaviours

Diet and weight management services

Summary of impacts:

Diet, obesity and Covid-19 risk

There is evidence that people who are obese have a higher risk of catching Covid-19 and a higher risk of being severely ill with it.

In a study of nearly 17,000 hospital patients with Covid-19 in the UK, those who were obese - with a body mass index (BMI) of more than 30 - had a 33% greater risk of dying than those who were not obese. A separate study of NHS electronic health records found a doubling of the risk of dying from Covid-19 among people who were obese. In addition to being a risk factor in its own right obesity is also linked to other health conditions such as heart disease and type 2 diabetes which in turn increase the risk of Covid-19 severity and death.

There is a strong relationship between deprivation and obesity nationally and this is also seen in Sheffield in both children and adults. Nationally higher than average rates of obesity are also seen in White British and Black ethnic groups; those with physical disabilities that cause mobility problems; those with learning disabilities; and those with severe mental illness (NICE, 2014)

Maintaining a healthy diet is part of supporting a strong immune system. Poor diet is also associated with obesity and health conditions such as heart disease and type 2 diabetes all of which increase the risk of worse Covid-19 outcomes. Healthy eating can be defined as consuming five or more portions of fruit and vegetables every day. In Sheffield only 25% of people aged 16+ eat healthily. This is significantly lower than the England value of 29%.

There is a strong relationship between eating healthily and deprivation, with the most deprived communities in the city able to eat the least healthily. The eleven areas in Sheffield which have the lowest percentage of healthy eating are all in the top 10% most deprived neighbourhoods in England. At the other end of the scale, six of the areas in Sheffield which had the highest percentage of adults eating healthily are in the least deprived 10% neighbourhoods nationally.

Supporting data on diet and obesity in Sheffield can be found here in the Joint Strategic Needs Assessment

Impact of lockdown on eating habits

Summary: Impacts on eating habits are polarised. Covid-19 has demonstrated just how vulnerable the food system is and the inequalities at play. We need to understand more

about how the impacts are distributed locally across sub-populations. It is likely that the negative impacts on diet will be experienced by those already disadvantaged and vice-versa and this may further increase health inequalities if nothing is done.

National data show an increase in food and drinks grocery sales post lockdown. However, some or all of the increases in household purchasing from food retailers will reflect a reduction in food and drink purchased and consumed from the eating out of the home sector (for example quick service restaurants, cafés and coffee shops) and do not necessarily mean more food and drink has been purchased overall. See https://analytics.phe.gov.uk/apps/Covid-19-indirect-effects/

Summary of negative impacts:

- National survey data and local data on food bank usage suggest food insecurity has increased. Nationally households with children eligible for free school meals, BAME communities, those shielding/self-isolating and households with a disabled adult were most likely to report being food insecure during lockdown. Older adults were least likely to report food insecurity, probably due to having fixed incomes from pensions and other benefits. Sustained periods of food insecurity have a negative health and wellbeing impact across the life course
- People from lower socioeconomic backgrounds have consistently come up against greater barriers in accessing healthy food and the impact of Covid-19 has exacerbated this gap.
- National surveys and local insights suggest many people are eating less healthily than usual. For example increased snacking and eating fewer fruit and vegetables
- Children not in school are not receiving school meals, for some this may continue until September. School meals are nutritionally balanced and varied and play an important role in encouraging healthy eating habits. We know little about what children are eating for lunch out of school.
- Whilst schools have been closed to the majority of children those who receive free school meals either received vouchers to spend in local shops or food parcels organised by schools. Where vouchers are being relied on there are issues where there are no participating shops in a family's local area or where participating shops are more expensive than other shops in the local area. The likely result of this is that children who normally receive free schools meals face the possibility of missing meals or consuming meals of lower overall nutritional quality, potentially negatively impacting dietary habits, future disease risk and educational attainment (Northumbria University). On the plus side for some families the £15 per week per child vouchers may have been a boost to the family budget, particularly if they were able to stretch the money further through their food choices
- National research and local insights suggest young people from lower income households are far more likely to eat less healthily due to a lack of routine, lack access to healthier food and drink options and are also less likely to have more home cooked meals while living in lockdown when compared to those from more financially stable backgrounds (Bite Back survey).

Summary of positive impacts:

- National surveys and local insights suggest many people are

    - cooking more
    - spending more time eating with family and friends
    - buying better quality food (as they are spending less on other discretionary items)
    - wasting less food
    - supporting local food businesses
    - buying fewer takeaways
- Although positive this is unlikely to be a universal experience in Sheffield.
- Many people indicated an intention to maintain better eating habits but it is unclear how this will play out as people return to work and school
- Media attention on the links between poor health, including obesity, on Covid-19 outcomes provides an opportunity for increased messaging around this and potentially a more interventionist approach both nationally and locally

Impact on local weight management services

Services are still available via the commissioned programme – Live Lighter. Delivery has switched from face to face groups to virtual sessions for the time being. Risk of this excluding some groups e.g. due to language barriers, digital exclusion but potential benefits including increased flexibility, reduced travel time/costs and reduced childcare barriers.

Current data suggests the switch to online programmes has not impacted on the gender or age profile of clients (predominantly working age females). However there is currently a lower ratio of service users from BAME groups than pre-Covid which may reflect language or other barriers (NB current numbers are relatively small and so this will need to be monitored over time and feedback sought from those who do not take up the digital offer. Family programmes had not yet recommenced at the time of writing). There is currently a higher proportion of service users from postcodes with above average deprivation compared to when services were delivered face to face – this is positive but requires ongoing monitoring and further investigation as digital exclusion may still be an issue for some).

Overview of impacts on sub-populations

Sub populations and impact	Description of impact
Disability *Negative*	Households with a disabled adult have been most likely to report being food insecure during lockdown. Initially this may have been due to difficulties accessing food for some who are shielding or who may have relied on online deliveries with slots no longer being available (Food Foundation, FSA Consumer Tracker). Some people with learning disabilities or mental health problems may struggle with the changes to food shopping brought about by social distancing, causing anxiety People with disabilities who are shielding or clinically vulnerable may have reduced informal support with preparing meals etc.

	There are currently some mitigations through mutual aid, community hubs and support teams and food projects People with physical disability that limits mobility, learning disability and severe mental illness are all more likely to be obese. Obesity increases the risk of catching Covid-19, of becoming severely ill from it and of dying from it. Annual health checks for adults with SMI are unlikely to have been taking place during lockdown so there may be missed opportunities to deliver health promoting advice and interventions to this group Sources: • Anecdotal – national evidence re supermarkets, feedback from MPs etc re constituents not being able to access food. Mostly at beginning of lockdown period • Food Foundation lockdown surveys (national) • Local and national obesity data and research on link between obesity and covid 19 outcomes Gaps: This is a diverse group and so the impacts and experiences are likely to be variable
Carers (including young carers) *Negative*	Unpaid carers are twice as likely as the general public to have relied on a food bank during the Covid-19 pandemic. Foodbank use was highest for carers age 17-30 Carers reported higher incidence of going hungry than general population. Younger adult carers were most likely to report that someone in their household had gone hungry in the past week. Female carers were more likely to report hunger than male carers At the start of lockdown there may have been difficulties accessing food due to lack of online delivery slots where carers were unable to leave the house for extended periods of time or were caring for an individual who was shielding. Sources: Survey of carers during April (full lockdown) Gaps: • Local data and insights • Ongoing data as lockdown eases • Data for young carers (under 18)
Gender reassignment *Neutral*	No anticipated impacts on diet resulting from Covid-19 No specific data found
Marriage & civil	No anticipated impacts on diet resulting from Covid-19

partnership *Neutral*	No specific data found
Pregnancy and maternity *Neutral*	At the start of lockdown there may have been difficulties accessing food for pregnant women who are shielding, due to lack of online delivery slots. The situation now seems to have improved. Also mitigated by mutual aid and community hubs. Most antenatal and postnatal appointments are taking place as usual and therefore routine health promotion advice should be received as usual. Group programmes such as Pregnancy Birth and Beyond have not been running and so some expectant parents may miss out on health promoting information and support. There are plans for this to recommence via zoom, need to consider digital inclusion. Sources: • Maternity services feedback • Anecdotal – national evidence re supermarkets, feedback from MPs etc. re constituents not being able to access food
Race *Negative*	National surveys suggest food insecurity has increased amongst BAME households (Food Foundation) Local feedback from food banks, food projects and CAB suggest those with no recourse to public funds e.g. EEA nationals and new arrivals may be particularly vulnerable to food insecurity. Black and White British ethnic groups have a higher prevalence of obesity. Obesity increases the risk of catching Covid-19, of becoming severely ill from it and of dying from it. Currently there is a lower ratio of BAME participants on online weight management programmes compared with when these were delivered face to face. This will need to be closely monitored as it may reflect a barrier to access. Sources: • Food Foundation lockdown surveys (national) • Food projects via Sheffield Together • Data from Live Lighter weight management service • Local and national obesity data and research on link between obesity and Covid-19 outcomes Gaps: Local data/Intelligence and data broken down into specific ethnicities
Religion and belief	Individuals following religious diets may have had difficulties accessing some foods at the start of lockdown when there was panic buying. Shopping restrictions may also have impacted during Ramadan. Also

Negative	there may be negative emotional wellbeing impacts of not being able to follow usual customs regarding shared meals and celebrations during Ramadan and Eid
Sex *Negative*	Men (67%) are more likely to be overweight or obese than women (61%). Obesity is linked to poorer Covid-19 outcomes. Men are underrepresented in local weight management services • Sources: Local and national obesity data and research on link between obesity and Covid-19 outcomes • Data from Live Lighter Weight management service
Sexual orientation *Neutral*	No anticipated impacts on diet resulting from Covid-19 No specific data found
0-5 years *Negative*	Health Visiting appointments are still being delivered although some take place over the telephone Start Well parenting programmes paused between March and August. Information available via Facebook and plan to resume via zoom from August Children who would have accessed nutritious meals and snacks at childcare providers may not receive this at home. Reports of lack of routine and structure leading to increased snacking. This alongside reduced physical activity may lead to weight gain Baby and toddler groups and some other family centre activities not currently running. SCC groups are an opportunity to promote public health messages and for staff to identify families who may benefit from additional support Food insecurity remains more of an issue for those in households with a child (FSA consumer tracker) Sources: • service feedback – Start Well, Live Lighter, 0-19 service • Hungry for Change survey Gaps: Understanding of food security impact for this age group
School years *Mostly negative* *Some positive*	Hungry For Change Survey conducted May-June 2020 with 1000 young people aged 14-19. Found a mix of positive and negatives. Those in higher income groups experienced more of the positives • Increase in snacking and inequalities within this. Young People from C2DE (lower income) groups are more likely to snack, less likely to eat fresh fruit and vegetables and more likely to feel they are eating unhealthily across the board when compared to those from ABC1 (higher income) groups. Cause was lack of structure to the days,

boredom and comfort eating.

- Reduced access to takeaways and cafes has restricted access to unhealthy food and drink but may have negative emotional consequences as it was connected to socialising and seeing friends.
- 32% reported eating more home cooked meals and 33% reporting that they ate more as a family through lockdown. However, those from ABC1 groups are much more likely to have tried home cooked meals than C2DE and are also much more likely to say they are eating more as a family through lockdown. This may be due in part to the increased number of key worker parents amongst C2DE households
- Young people from C2DE backgrounds, especially those from single parent households or with keyworker relatives, referenced how they are involved in preparing food to help out as opposed to simply for the enjoyment of it which was more likely in ABC1 groups
- over 50% of reporting increased consumption of water due to availability of tabs and lack of ability to get alternatives as purchasing is often done by someone else

(Bite Back and Guys and St Thomas, July 2020)

Feedback from local services – Live Lighter, SHINE, 0-19 service and Eat Smart, reinforce that the findings above are also reflective of families in Sheffield. For example increased snacking, reliance of many on cheap processed foods, lack of daily structure, lack of access to nutritious school meals.

"Lack of motivation from parents or lack of time trying to juggle work, home schooling, childcare etc. This then affects the child's activity levels, diet choices, maybe increased takeaways and tablet/Xbox time which in turn all effect weight. " Live Lighter service feedback

"Parents have reported their children are snacking more frequently due to boredom and easy access whilst at home, which in turn could have an impact on weight. " 0-19 service feedback

Younger age group reported it was more difficult to control eating during lockdown than in school as food was more easily available. The older group reported it was easier to control eating during lockdown with less 'temptations' than in school, no 'tuck shops' unhealthy breakfasts, junk foods including bacon and sausage sandwiches, pizzas, burgers, cookies and reported junk food to be cheaper than healthier foods. (SHINE programme evaluation July 2020)

Food insecurity remains more of an issue for younger age groups and those in households with a child (FSA consumer tracker)

Children on Free School Meals

- Those on FSM are more likely to be affected by food insecurity (Food Foundation surveys).
- 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.
- Those with no recourse to public funds e.g. EEA nationals and new arrivals may not be eligible for FSM. The LA can allow discretionary FSM in these cases but lack of clarity nationally impacts on the ability to maximise the reach of this
- Some vulnerable children are in school and can still access meals. A small number of schools are doing food parcels rather than vouchers. FSM vouchers have been extended to cover school holidays including over the summer which should help families financially. In Sheffield there is also "Healthy Holidays" a DFE funded programme to provide targeted additional healthy meals to families identified by schools as in greatest need

Northumbria University – Free School Meal Voucher Scheme: What are Children actually eating and drinking?

Survey of 57 9-12 year olds receiving FSM vouchers including use of food diaries. The preliminary findings show that

- Children are consuming significantly fewer portions of fruit following school closures; with an average intake of fruit across the three days, decreasing from just over 1 portion a day to an average of ½ a portion per day. 45% of children reported that, following school closures, they did not eat any fruit on any of the three days on which they completed the questionnaire. Children's mean vegetable intake dropped from just over 2 portions of vegetables per day (when attending school) to an average of approximately ½ a portion per day. In addition, 55% of children reported that they consumed no fresh vegetables on any of the three days for which they completed the questionnaire.
- Conversely, the number of sugar sweetened beverages children consumed increased four-fold following school closures, with an average consumption of 2 servings per day.
- Children's consumption of crisps, chocolates and sweets increased from an average of 1 portion (e.g. one bag of crisps, one bar of chocolate, one small bag of sweets) across three days to an average of 6 portions across three days.
- Prior to school closures, approximately 25% of children skipped at least one meal a day, with breakfast being the most frequently skipped meal. Following school closures, this percentage increased to 35% of children skipping one meal a day, with 10% skipping more than one meal per day. Families and children relied on snacks consisting of ultra-processed foods to ward off hunger.

	Sources: • Food Foundation national surveys • Hungry for Change survey • Northumbria University survey • 0-19 service feedback • Eat Smart service feedback • Live Lighter service • Healthy Holidays family interviews • School audits re FSM • SCC school food service Gaps: How impacts are distributed across the population

Working age adults
 	
Negative and positive
	Mixed and somewhat polarised impacts. Increased food insecurity and increased emotional eating vs increased cooking from scratch, shared meals etc.
	
	Covid-19 has changed how consumers access food. Restaurants, cafés and sandwich shops were closed from 23 March 2020 and restrictions have changed how and where people buy, cook and eat.
	
	A survey by British Nutrition Foundation found that 27% of respondents feel they have been eating less healthily during lockdown, 50% of people state their habits have not changed and 22% say they have been eating more healthily than usual. There was no breakdown of data for population sub-groups
	
	Positive
	Hubbub survey 2020
	• 44% of people are enjoying cooking more
	• 47% of people are enjoying spending more time eating with their family or housemates
	• Over a third of people see the lockdown as an opportunity to improve their cooking skills, rising to almost half amongst 16-24 year olds.
	• Over half of people are valuing food more with 48% saying they are throwing away less food
	• People are also making better use of their freezer, with 35% using it more and 29% freezing a wider variety of foods. Portion control is also a factor, with 27% now giving more accurate portion sizes and just over 1 in 4 (26%) are leaving less on the plate
	• Shopping habits have shifted -
	  • a quarter said they are buying better quality food as they are not going out or spending money on other things
	  • More than a third of people are supporting smaller/local businesses more than ever before
	  • 43% say they are buying fewer takeaways as they are worried

	about contamination. A further 42% say they are not buying takeaways because money is tight. • 29% said they were using their local corner shop/convenience store for the first time. • 89% of those who've made changes say they will continue to use at least one of the new shopping alternatives to supermarkets once the restrictions have ended. • No breakdown of data for population sub-groups FSA Consumer Food Tracker survey (2020) • People say they are wasting less food and eating together more often as a family, eating healthy meals more often • People are buying fewer takeaways overall when compared to before lockdown. The stated reasons for this include concerns around availability of open takeaways, food safety, food hygiene, financial reasons and increased cooking from home. However, younger people say they are buying more takeaways. Local feedback • There have been positive reports of people and families having more time to plan meals, cook from scratch and eat together. As lockdown eases it seems that many individuals are now starting to think about their health and lifestyle and make changes *"For many clients who have chosen to attend virtual sessions, weight loss seems to have happened more quickly and changes seem to have been made earlier. Staff wonder if this may be due to less distractions and less to do (for some of them) which has allowed them to focus and make time for their health. One client has stated that having something to focus on has been a massive benefit to her mental health and she has relished the structure that making positive lifestyle changes has given her."* Live Lighter service **Negative** Hubbub survey 2020 • 43% of people said that they are worried about the extra cost of providing food for their household • This rises to 59% of those aged 35-44 and 54% of those aged 25-34 • 36% reported comfort eating due to boredom and anxiety • 31% reported reduced fruit and veg consumption due to avoiding shops • No breakdown of data for population sub-groups FSA Consumer Food Tracker survey (2020) • People report eating snacks such as cakes, confectionary and savoury snacks more often.

	• Whilst the proportion of people concerned about food availability dropped from 31% in April to 21% in May, and concern around affordability dropped from 28% to 23% over the same time, these remain worries for a significant minority of the population. Food Foundation • 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. • The number of adults who are food insecure in the Britain is estimated to have quadrupled under the COVID-19 lockdown. Lack of food in shops explains about 40% of food insecurity experiences (affecting adults with disabilities and adults with children the most). • Poverty accounts for the remainder of those reporting food insecurity under Covid 19. The groups most affected include adults who are unemployed, adults with disabilities, adults with children, and Black and Ethnic Minority groups. In addition to poverty self-isolation and a lack of food in shops has layered on additional risk and dimension of food insecurity for these groups. Local feedback and data • Households with children have reported spending more on food due to increased snacking from children and being at home all the time • Emergency food projects data shows that w/c 13th April 1144 households received food from a food bank or similar operation. This increased to 2202 by w/c 8th June – an increase of 92%. Data prior to the pandemic are not available • There have been local anecdotal reports of lockdown weight gain and increased snacking due to new working patterns, pressures of home schooling, lack of routine etc. *"Weight has become less of a priority to a large number of clients. Added pressures such as new working patterns, new roles and home schooling have all contributed to a consensus of "I don't have time to think about this right now""* Live Lighter Service Reasons given for eating less healthily include boredom, stress and lack of motivation. 30 percent of people claim that not being able to go to the supermarket as often is making it difficult for them to eat healthily (British Nutrition Foundation). *"Emotional eating has become more of an issue and is discussed more regularly. Many clients and their families are stress eating due to the added pressures of Covid-19 or boredom eating due to having more free time/all day access to the fridge and cupboards. "* Live Lighter service

	Adults living alone may experience increased social isolation which is linked with malnutrition. There is a strong relationship between deprivation and obesity. Obesity increases the risk of catching Covid-19, of becoming severely ill from it and of dying from it. Sources: • Food Foundation national surveys • Hubbub • Food Standards Agency • British Nutrition Foundation • Anecdotal – e.g. Live Lighter, colleagues and peers • Local and national obesity data and research on link between obesity and Covid-19 outcomes • Local data on food bank use Gaps: How impacts are distributed across the population
Old age *Negative*	Older people may be less likely to experience a change in food security due to poverty as their incomes tend to be more stable Older people who are shielding or vulnerable may have experienced food insecurity as a result of not being able to go out to shop, lack of online delivery slots, digital exclusion. May also have reduced informal support with preparing meals etc. Mitigated to some extent by mutual aid, community hubs, community support teams Older people who might have accessed a lunch club or community meal may be negatively impacted as these are not currently running. Social isolation is linked to malnutrition Sources: Food Foundation national surveys. Issues raised by MPs and counsellors on behalf of constituents experiencing problems with food shopping – mostly earlier in lockdown
Those who are shielding/self-isolating *Negative*	May have experienced food insecurity as a result of not being able to go out to shop, lack of online delivery slots, digital exclusion. May also have reduced informal support with preparing meals etc. Food Foundation (2020): After accounting for background socio-economic factors, all adults who reported self-isolating, whether for 7-14 days or 12 weeks, are at heightened risk of going without food because they cannot go out and do not have other means of acquiring it. Adults who are less than 70 are at particularly heightened risk but the over 70s are also at higher risk compared to those who are not self-

	isolating. Adults who are under 70 and self-isolating and adults self-isolating for 7-14 days are also at heightened risk of food insecurity arising from a lack of money for food. Where those shielding have needed to switch to online food shopping this will limit the options of where to shop. Discounters tend not to offer deliveries and therefore food bills may have increased Mitigated to some extent by mutual aid, community hubs, community support teams Those who live alone are increased risk of social isolation which is linked to malnutrition Sources: • Food Foundation national surveys • Issues raised by MPs and counsellors on behalf of constituents experiencing problems with food shopping – mostly earlier in lockdown

Recommendations:

These draft recommendations will be reviewed at the Food and Obesity Board.

1. Implement the Food and Wellbeing Strategy with renewed focus on policy and environmental change (whole systems approach) such as restrictions on junk food advertising, increasing access to affordable fruit and vegetables and public sector food environments. Such actions can have an impact at population level and are most likely to narrow health inequalities but are difficult to implement without high level support across the whole system.

2. Ensure the voices of all communities are heard in the development of the food and wellbeing strategy and other related strategies and interventions. In particular this includes the BAME community, those experiencing socio-economic disadvantage and those living with disabilities. Ensure that local interventions and campaigns are relevant and resonate with all target populations to achieve sustainable behaviour change.

3. Accelerate efforts to develop culturally competent health promotion and disease prevention programmes. For diet and obesity these include weight management and services for the effective management of chronic conditions including diabetes and hypertension. Continue to monitor service data and service user feedback to ensure these are representative and accessible to all.

4. During lockdown there have been clear messages about the added risk obesity poses to those who contract Covid-19. The ongoing pandemic response provides an opportunity to enhance messaging around the connection between diet, healthy

weight and physical health. A national "Better Health" campaign related to obesity is due to launch and there are plans for increased NHS investment in weight management. Consideration should be given to how we can embed this locally alongside our existing services and initiatives.

5. The council and partners should support a collaborative approach to developing the local response to food security, working with the diverse range of food projects in the city and leading academics. This should follow the principles of "food ladders" (Blake, 2019) across provision. In doing this we will mitigate the effects of poverty on diet and in particular can increase access to affordable fruit and vegetables for those on lower incomes.

    - Severe insecurity = Emergency support e.g. food bank
    - Moderate insecurity = Budget stretching e.g. community meals, food clubs, surpluses
    - Secure = Commercial

6. Food insecurity is largely a result of poverty and therefore the above recommendations should be considered alongside the poverty HIA.

7. Evaluate the effectiveness of virtual weight management support and continue this option if results are promising. There is potential for this to improve the equity of service offer in the longer term if provided as an option alongside face to face support

Gaps: Reliance on national survey data that cannot be broken down into sub-populations. The Sheffield population questionnaire and ongoing gathering of softer intelligence will help develop a more fine grained picture but may still risk some sub-populations being missed

Contributors:

Jess Wilson (Health Improvement Principal – food and obesity)

Other contributors:

- Service providers: Live Lighter, Start Well, Eat Smart, 0-19 service
- Food banks and emergency food providers (via Together Sheffield network)
- Voluntary Action Sheffield and local VCF case studies
- National surveys and research (Hubbub, Food Foundation, FSA, Caring and Covid-19 etc)
- Food and obesity board members

Methods and Sources of Intelligence:

Data from providers on those accessing services
National survey data

Qualitative intelligence from local VCF and partner organisations

More detailed summary of evidence below

Covid 19 HIA Eating habits evidence sumn

Governance, Stakeholders and decision making

The findings of this HIA will be shared in draft form with the Food and Obesity Board and members will be invited to input. It is intended that this will be an ongoing/live piece of work with evidence and intelligence added as it becomes available. Recommendations will inform the Food and Wellbeing Strategy and any commissioning and actions arising from this.

Food security issues will also be shared with the Tackling Poverty Partnership, officers involved with the Early Help Strategy and those involved with inclusive economic recovery.

Physical Activity

Summary of impacts:
Emerging evidence suggests there have been two key phases to date affecting the physical activity sector: crisis response (P1) and gradual release (P2). National data would suggest that overall physical activity has declined across all groups. Individuals, especially in P1 were more sedentary. Some individuals/families were able to access online structured exercise sessions and had more time to take part, but this is a minority and more likely to be people from higher socio-economic backgrounds. Data from the University College London showed that one in four reported not exercising during the week and people with mental and physical health conditions were doing the least physical activity. Older adults were doing more gentle exercise like walking than other age groups but doing the least exercise at home or moderate/high intensity exercise outside the home. And people living alone and those with lower household income reported also engaging less in all kinds of physical activity. There is a well-established body of academic evidence to suggest that a reduction in physical activity will have a negative impact on people's health and wellbeing. There is emerging evidence that being physically fit, and of healthy weight may support people to withstand the physical and psychological trauma associated with the Covid-19 crisis. Sport England carried out a survey for the first 8 weeks of lock down, to understand people's access to physical activity and also their attitudes towards physical activity. The survey was conducted with 2000 adults aged 16+ from the period 3 April 2020 – 25 May 2020, they have now moved to monthly surveys and will make the next report available at the end of June. The overall findings from the report show that, on the whole activity levels held up relatively well throughout this 8 week period, with a third of adults doing 30 minutes or more of physical activity (at a level that raised their breathing rate) on five or more days a week. However, below the surface, we see familiar inequalities replicated, even exacerbated. The whole population has been affected, but not affected equally. The wider public health, social and economic impact of coronavirus is likely to have a greater negative impact on the capability, opportunity and motivation to be physically active for some groups over others. We see this reflected in people's behaviour. The demographic groups and audiences we were focusing on prior to the pandemic - such as women, people from lower socio-economic groups, older adults, people with a long term condition, illness or disability, and

people from some BAME communities - are still finding it harder to be active.

It is likely therefore that Covid-19 has exacerbated existing physical activity disparities. Covid-19 has led to an increase in anxiety generally, and anecdotally, people, without health conditions were more fearful of people out of their homes, especially in P1.

Data below from Sport England and the University College London, highlighting impacts at a sub-population level;

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Disability	Negative	n/a	Sport Eng	Local
Gender reassignment	No specific data	n/a	n/a	n/a
Marriage and civil partnership	No specific data	n/a	n/a	n/a
Pregnancy and maternity	No specific data	n/a	n/a	n/a
Race	Negative	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.	Sport England	Local
Religion and belief	No specific data			
Sex	Negative	Women are likely to be		

		disproportionately affected by fall in activity levels during lockdown (Sport England) The gender gap has widened for women and men during lockdown – at week 4, 36% of men were doing 5x 30 min, whereas 28% of women were doing the same levels of physical activity.		
Sexual orientation	No specific data			
0-5 years	Negative	Children of all ages and particularly those in more deprived settings, have on-the-whole decreased their physical activity levels.		
School years	Negative	Children of all ages and particularly those in more deprived settings, have on-the-whole decreased their physical activity levels. Most parents have reported their children were doing some activity with only 9% of adults said the children in their households were doing no physical activity and exercise on a typical day. But only 19% said they were meeting the Chief Medical Officer guidelines and doing an hour a day.		

		Furthermore, research by StreetGames with 200 young people from lower socio-economic groups found 68% of them were less active under lockdown.		
Working age adults	Varying dependent on population group	Dependent on sub-population; lower socio economic groups have been less active, some more affluent people have had opportunity to be more active		
Old age	Negative	Older people who have either been encouraged to stay at home (over 70s) or who are fearful to leave their homes will have reduced their activity levels both in terms of active minutes per day and in terms of the quality of that activity (i.e. likely to be low impact/not strength based). Early indications are for de-conditioning in the older population, increasing the risk of falls and the likelihood of serious impact of such falls. Physical activity is a key factor improving morbidity for long term conditions and it is likely that lower physical activity levels will exacerbate sleep loss, low mental health, weight gain,		

		strength, flexibility and pain. Weight gain/obesity is a confounding factor for a range of long-term health impacts as well as a compounding the possible poor outcomes associated with a Covid-19 diagnosis.		
Shielding/vulnerable	Negative	As above (70+ Adults) plus; 41% of people reported doing less activity than before lockdown and that those with a longstanding condition or illness were less likely to be regularly active than those with no longstanding condition or illness		
Others as appropriate; Mental Health Others as appropriate; Digitally excluded	Negative Negative	People with mental health issues and who may need more tailored support to be active will have reduced their physical activity levels Digitally excluded people have less access to ideas and resources for physical activity (ShipShape/Move More).		

Positive impacts highlighted within Sport England's research;

- At week 8 of the survey, 70% of people said that they had more time to be physically active
- On the whole there was enhanced recognition of the importance of physical activity on physical and mental health, some of which could be attributed to this being communicated within the governments guidance
- Significant increases were seen in the numbers of people walking, running and cycling
- At week 8 of the survey, more people reported an increase in their activity levels during lockdown than those reported that they were doing less

Provide an indication of which issues/impacts the task and finish group feel should be given highest priority when developing the response to this HIA

- We have yet to discuss this as a group of partners, therefore will complete this section when we have had the conversation

Recommendations:

The national profile of physical activity as a way to safeguard wellbeing has, arguably never had a higher profile, but the extent to which this is a message that is getting through to those most at risk of inactivity is uncertain.
Decline in physical activity has likely been brought about by a combination of factors including:

- restriction of movement, i.e. less incidental movement to work, around the work-place, school drop off, to shops etc.
- closure of leisure, health and fitness facilities.
- fear of leaving the house.

The National Centre for Sports and Exercise Medicine, has one of its bases in Sheffield and this is now housed within the Advanced Wellbeing Research Centre in Attercliffe. Sheffield has a whole systems approach to physical activity: *Move More,* which is Sheffield's Physical Activity Plan. There is a partners group and a coordination group with attendance by Local Authority, CCG, Sheffield Teaching Hospitals, Yorkshire Sport Foundation, Voluntary Action Sheffield, Sheffield International Venues, Primary Care clinical champions, Parks and Countryside, Learn Sheffield and School Sports Trust colleagues. There is a core active group, but the spread and reach of this group is unclear. There is an opportunity for this group to support an integrated response and influence policy across a number of sectors to ensure physical activity is a priority but visible senior support for this may be crucial to ensure it is supported.

The interconnections of this group meant that even when local authority colleagues were redeployed to support other council services during P1 there was still a core team sufficient to launch the Move More month and quickly mobilise a 'Stay Active At Home' booklet

https://www.movemoresheffield.com/active-at-home/booklet and distribute it via the VCS and Primary Care Networks/Pharmacies to people vulnerable in the city. Articles with the Sheffield Star have ensured a regular presence of practical physical activity solutions across the city print and digital media.

Sheffield is a Sport England Core City and as a result receives investment across a number of projects. Two of these are *This Girl Can* and *Empowering Communities*. These take a similar bottom up Asset Based Community Development approach and are delivered through the community sector. The work is aligned to the People Keeping Well Areas. These projects, along with the regular physical activity provision (chair aerobics, walking groups, cycling groups, local exercise classes etc.) were largely paused in P1.

Staff associated with delivering the physical activity projects in the VCS were redeployed to support the crisis community response. This Girl Can Southey, coordinated by SOAR, continued with a community development officer at 0.4 FTE supporting the initiation of a community forum and upskilling health trainers to include physical activity in their work with clients. ShipShape, Zest and Manor & Castle Development Trust, after a short pause have now recruited their officers and work is starting.

The likely scope and scale of these projects is not widespread but aimed at building and sustaining conditions for greater levels of physical activity by nurturing, connecting and harnessing community assets for physical activity. In conjunction with this, we are developing a community of learning to share lessons between the groups and wider into the voluntary and community sector. These sessions will also uncover system blockers that will be shared back to the Move More Coordination Group and Partners.

There is a real and immediate threat to the leisure sector, with the financial viability of reopening facilities. Staff have been furloughed but with the reductions to that scheme and no detail yet regarding the reopening of facilities, what shape that will take and whether customers will return, the sector face some significant challenges. This is a rapidly evolving situation, which will undoubtedly impact significantly impact on activity levels.

There are also a number of other initiatives (supporting grass roots sports clubs, supporting schools, active GP practices, active travel etc.) that we do not yet have sufficient detail about to report.

It is suggested that these initiatives combined would not provide sufficient support for physical activity across the city. There are cultural and structural reasons for inactivity, related to deprivation, which are beyond the scope of individual interventions. The principles behind a whole system approach is that every effort is made to align policy, practice and place-based working to promote physical activity and remove influences which inhibit it. Given the very real benefits physical activity offers both in health promotion and protection against the negative consequences of Covid-19 it would seem to be an important step to redouble efforts to ensure an integrated response.

As noted above, regular physical activity is associated with a wide range of positive benefits for mood, sleep, conditioning, healthy weight, reduced risk of chronic health conditions, and

better management of long-term health conditions. We have noticed in P1, that with few exceptions, attention has been diverted away from Physical Activity to respond to the crisis. Notable exceptions include the SOAR This Girl Can Southey, GP clinical champions, who have continued to promote physical activity to patients as something they can do to help protect themselves and safeguard the NHS and the work the Move More team have done to develop a distribute a hard copy brochure to vulnerable people at home. The feedback that has come back from these initiatives highlight that people are grateful to have something tangible and positive that they can work on.

This would suggest that this is a crucial time to refocus on a systems approach investment and engagement in physical activity including:

- Clear consistent public narrative.
- Changes to policy and practice in transport and urban street design.
- Build on Move More Active at Home initiatives to consistently promote the importance of, and practical support for, those who are vulnerable, older or shielding to increase their physical activity levels.
- Invest further in local evidence gathering potentially in collaboration with Sheffield Hallam University, Advanced Wellbeing Research Centre, National Centre for Sports and Exercise Medicine and the University of Sheffield.
- Co-design solutions with communities, to ensure local relevance and ownership and to recognise systemic/structural barriers to physical activity which may be tackled at a city level.
- Support the sport, leisure, health and fitness sector which may be facing a genuine fight for survival.
- Support Active Workplace initiatives across all anchor institutions.
- Review policy and practice across sectors to reconsider policies which are counter to physical activity.
- To consider priorities and target audiences, within the next phase of the Move More Plan 2021-2025/6, in light of the disproportionate impact of Covid-19 on certain sub-populations

As mentioned above, there is a central Move More team of partners who work together to deliver the outcomes as outlined within the Move More plan. There is further planned work to develop these recommendations and Move More's Covid-19 response and priorities, feeding into the next phase of the Move More plan. Therefore these recommendations are an indication at this stage but are likely to evolve after more involvement from partners.

Contributors:
Dr Katie Shearn – researcher at Sheffield Hallam (and evaluating a number of Move More programmes), has led on this response with input from Jo Pearce, Sheffield City Council and Dr Anna Lowe, Sheffield Hallam/National Centre programme lead We plan to consult with the wider Move More team of partners, on this work, particularly around the recommendations

Governance:
There will be a sign off process through the National Centre of Sport and Exercise Medicine Board, who will ultimately own the recommendations

Methods and Sources of Intelligence:
To inform the work so far, we have included findings which have been reported by community anchor organisation leads, Move More coordination group feedback, top line evaluation data from Sport England funded initiatives and extrapolated from national data sets, including Sport England and University College London. We do not have reliable Physical Activity data for Sheffield however we use the Move More index to understand as a place, how we are performing against other county/unitary authorities and core cities in relation to key outcome areas including; Active Environments, Active People and Families and Physical Activity as Medicine. This is to add further context, detail and local insight to Sport England's Active Lives Survey. The data was last reviewed for the Move More index in November 2019 and a review date has yet to be agreed. We have submitted a request via the HIA leads for support with this via the SCC PH Insight team but previously had been advised that they didn't have capacity for this. Sport Englands Active Lives survey, is the method we have available to understand physical activity levels at a national level and then in Sheffield. The last report was published in November 2019, prior to the Covid-19 outbreak which showed record activity levels (although stubborn inequalities remain). The next report will be available in November 2020 and will be important to understand the longer term impact of Covid-19 on physical activity levels. Sheffield Hallam University have just started a research project which will gather further qualitative data from across the multiple stakeholders involved in Move More. The first phase will be completed by October 2020 and the second phase by February 2021.

Tobacco

Summary of impacts:

We are not all in this together; some communities are being hit harder. Specifically those already living in disadvantage, those who have a disability, older people (over 50), men, black and ethnic minority communities, people with mental illness and those with underlying health conditions are more at risk of severe disease and death from Covid-19.

- All of these groups are more likely to be smokers and have a higher smoking prevalence than the general population. Furthermore Smokers are more likely to be on a low income, in non-secure work or unemployed and experience more financial hardship due to lockdown. 1 million smokers with mental health conditions live in poverty. Homeless people are a group of high prevalence smokers who are more likely to share cigarettes or roll-ups and smoke cigarette butts whom others have discarded. This increases the risks of transmission of the coronavirus and infection.

- Furthermore people who work in environments with higher risk of exposure to Covid-19, such as health and social care, and food retail, also have higher than average rates of smoking, and people from black and minority ethnic backgrounds are disproportionately likely to be working in these sectors.

- In a study published in the journal Addiction, University of Bristol researchers have found evidence for a causal link between prolonged experience of loneliness and smoking. There was evidence that being lonelier increases the likelihood of starting smoking, the number of cigarettes smoked per day and decreases the likelihood of successfully quitting.

- Smoking is the leading modifiable risk factor responsible for health inequalities, accounting for half the difference in life expectancy between the richest and poorest.

- Covid-19 has shone a light on existing health inequalities and exacerbated them. Levelling up and tackling smoking is part of the solution in reducing health inequalities but also in helping to build resilience in health systems and boost the local economy, essential as we head towards winter and the risk of co-circulation of Covid-19 and flu.

Public Health England guidance states that: On the available evidence, we advise:

- Smoking harms the immune system, making it harder to fight off infections, like coronavirus.

- If you smoke, you generally have an increased risk of contracting respiratory infection and of more severe symptoms once infected. Covid-19 symptoms may, therefore, be more severe if you smoke.

- Stopping smoking will bring immediate benefits to health, including if you have an existing smoking-related disease heart disease, diabetes, COPD and stroke, cancer. This is particularly important for both you and for our NHS at a time of intense pressure on the health service.

Positive impacts:

The Impact of lockdown/response to Covid-19 on smoking prevalence has been mixed with some very positive impacts at both at a national and local level. People have been very worried about their health and responsive to messages on quitting.

- A national survey from charity Action on Smoking and Health (Ash) identified that more than one million people have given up smoking since the Covid-19 pandemic hit. The survey found of those who had quit in the previous four months, 41% said it was in direct response to coronavirus. That may have been down to a range of factors including health concerns, access to tobacco while isolating or no longer smoking socially. Separately, University College London (UCL) found more people quit smoking in the year to June 2020 than in any year since its survey began in 2007.

- A contributor to this success is also likely due to national and local delivery of the QuitforCovid Campaign which is being further developed and rolled out to target high smoking prevalence groups.

- While thousands have heeded advice to quit during the Covid-19 pandemic, there is great variation by age, with younger smokers quitting at a much greater rate than older smokers. Around 400,000 people aged 16-29 have quit compared to 240,000 of those over 50. It remains to be seen whether this trend amongst younger smokers will continue beyond lockdown.

- Welcome news, smokers with Mental Health Conditions are as likely to quit as all smokes (25% vs 26%), more likely to use an e-cigarette and more likely to have quit during last 4 months according to data from the Covid-19 YouGov tracker. Covid-19 provides and addition incentive to quit.

Negative impacts:

The weekly YouGov Covid-19 survey shows that some smokers have increased the amount they smoke and the likelihood they will quit Covid-19 has decreased. In England in 2019 13.9% of the population smoked, equivalent to around 5.7 million adults so there is still much work to do. Sheffield current smoking prevalence is in line with the England average however prevalence varies significantly across the city and amongst various populations.

- Lockdown has also led to increases in second-hand smoke exposure for children spending more time at home. The YouGov Covid-19 tracker shows that people who live in households that include children are 50% more likely to report being exposed to second-hand smoke since lockdown compared to those without children (10%

compared with 6%).

- Parents who smoke are just as likely as other smokers to report making quit attempts and trying to reduce the amount they smoke since lockdown.

- This is an issue of equity. If you live in a high-rise block, taking your smoke outside is much harder than in a semi-detached with a garden. Must ensure parents get the right support to quit and to protect those around them from tobacco smoke at this time

Local Population positive impacts – QuitforCovid Campaign

- Smokefree Sheffield have delivered a comprehensive QuitforCovid campaign from March to July which has focused on the importance of quitting to be as healthy as possible right now at a time when we are all worried about our health. Getting behind the national campaign has included developing local social media messaging, direct e-mails to staff, news updates, press releases, blogs, text messages via GP practices, radio adverts (Hallam FM) and TV adverts as well as QuitforCovid stickers and leaflets being developed to be placed on food parcels and via Foodbanks as part of the city response.

- The campaign has seen significant engagement and success at a population level and has been hailed as best practice by UK leading charity Action on Smoking and Health. The campaign had reached over 480,000 people and had over 3,000 engagements, 4,403 people visited the Smokefree Sheffield website between April – June 2020 (641%⬆ on the previous year), 2,703 visited the QuitforCovid page and 1,941 visited the Support page (2,356%⬆ on the same time the previous year).

https://www.smokefreesheffield.org/news/sheffield-city-council-approach-tobacco-control-Covid-19/

Access to Stop Smoking Services – adults, children, pregnant women.
All face to face support and carbon monoxide monitoring was stopped and each service moved to supporting smokers via telephone and/or online via video conferencing and text. Smokers receive behavioural support for up to 12 weeks and medication.

However there have been issues in the city around unequal access to Nicotine Replacement Therapy during lockdown. The adult stop smoking service provides a NRT e-voucher and these are dispensed by pharmacy and either collected, posted or delivered. For pregnant women and mums who have just given birth the current route is to access a prescription via their GP and then to take this to the pharmacy to have the medication dispensed. There have been a number of issues with this route.

- Pregnant Women have been attending pharmacies multiple times (in one case, four times before receiving a prescription) therefore increasing exposure of vulnerable

woman to infection at the height of the pandemic.

- Increased anxiety for women about going out of the house to collect NRT, the increased episodes of attending pharmacy / GP surgery attendance adversely impacting on women's mental wellbeing and anxiety levels.

- Reduced capacity in pharmacy due to increased demand, negatively impacting on ability to source NRT, therefore reducing accessibility to NRT for pregnant women.

- Limited access to support network and isolation adversely affecting pregnant women's resilience levels, adversely affecting mental health and wellbeing.

Case study examples are available.

Problems with access to NRT were also apparent amongst mum's being supported by the Health Visiting Service. Either they could not access a script via the GP or pharmacy or were unable to at times to access repeat prescriptions – this impacted on relapse rates of Women within the service and wider family members not taking up the opportunity to quit.

Some Health Visitor staff report smoking has increased due to boredom, stress anxiety and less inclination to search out NRT. New mum's have kept away from GPs and stayed in to self-isolate and that means keeping away from pharmacies etc. E-cigarette uses were relying on post which is slow.

Stop smoking services adults local impacts

- During March 2020 as the lockdown measures were introduced due to the widespread transmission of coronavirus the service saw a 55% (85) increase in referrals than in the previous year. However April to June 2020 there has been a dip in referrals (133 less). The service is working to understand what factors underpin this. It is likely the closure of GP surgeries and the Moor market walk-in service as well as the halting of chronic disease reviews may have contributed to the reduction in referrals. These are key routes of referral.

- In terms of referrals into the service there has been no significant drop amongst any priority populations.

Covid-19 and Stop smoking in pregnancy service

As a precautionary measure, the government has classed pregnant women as a group at risk of severe illness with Covid-19. Pregnant women are therefore in the Shielded category.

The number of referrals to the midwifery stop smoking service has increased from 162 in the period 1st March – 31st May 2019, compared to 215 in the period 1st March – 31st May 2020 during lockdown which is extremely positive.

However data from 2020 shows the percentage of black and ethnic minority (BAME) women

engaging with the service has reduced between 1st March and 31st May in 2020 compared to the same period in 2019.

This is concerning as pregnant BAME women are eight times more likely to be admitted to hospital with Covid-19 symptoms. Anecdotal evidence from the local community is telling us that BAME populations are not accessing care/ services for fear of getting infected or going into hospital and not coming home.

Number of women quitting in lockdown similar to previous year. However a larger proportion of these were achieved in March during in the lockdown than the previous year 15 vs 8 (2019).

Missed opportunity to support more smokers to stop - halt of QUIT in hospitals

The halt of the implementation of South Yorkshire QUIT programme (the treatment of tobacco dependency in hospitals) due to Covid-19 via the ICS and Yorkshire Cancer Research, has led to significant challenge in terms of limited capacity to adequately identify and support the treatment needs of service users and patients in delivering brief advice on smoking at STHFT, SHC and SHSC. Some staff have also been re-deployed.

SHSC wards are supporting service users to swap their cigarettes for Nicotine Replacement Therapy (NRT) or e-cigarettes on admission and this has had a positive impact on the number of people switching. Free NRT (for up to 12 weeks during the Covid-19 outbreak) for staff- uptake been welcomed.

At STHFT patients who smoke are being offered smoking cessation support via telephone 10 of the 70 wards. Awaiting evaluation**.**

Given that smokers are 30% more likely to be hospitalized – a real opportunity to harness teachable moment has been missed for many smokers during the pandemic. This would have supported those who are more at risk from their underlying health condition and at more risk of developing severe symptoms from coronavirus to potentially improve health outcomes.

Covid-19 and impact on the Smokefree C&YP service

SmokefreeSchools programme stopped as this is no longer viable with schools being closed. Moved staff resource to support the wider community effort and response to Covid-19. This will initially cover six months (April to Oct) until schools reopen and are able to engage with the Smokefree schools programme. Service reviewing how they can flex to meet needs of C&YP in the longer term remotely.

Impacts: Schools, social workers and school nurses are the main source of referrals therefore referrals into the C&YP service they have almost completely ground to a halt. Email/telephone/fb/text support: Zest have set up a Smokefree Facebook page for the service (this is new since lockdown)

Many young people who use the service are not heavy smokers – they often report smoking on their way to and from school and were struggling to break the habit.

A few also reported they only smoked around friends in the evenings so due to the restrictions in place the service feeIs that most of the young people may now not be smoking as their behavioural habits will have been broken due to the restrictions.

In addition most of the young people being supported reported their parents did not know that they smoked so it's anticipated that lockdown has meant that they have not had access to cigarettes as easily.

SCC Trading Standards impact of Covid-19 on illicit tobacco sales
All staff are working from home routine visits to traders are cancelled/stopped. Staff have been re-deployed to work on Covid19 related enforcement issues with businesses

Covid-19 impacted on the ability of trading standards officers to progress prosecutions successfully, revocations of licenses due to courts been shut and licensing prioritising critical cases only. This is problematic as known illegal traders could operate without oversight and legal action. This had led to two cases having to be dropped due to time delay and others not being taken forward. Local intelligence has emerged on 'Fag Houses' in deprived communities.

This is important as poorer smokers are more likely to purchase illicit tobacco due to cheaper prices £4-50 to £6 per pack compared to £10 per pack as usual RRP. This also robs the NHS of much needed funds to treat tobacco related illnesses in tax duty not paid. This criminality in communities is linked to other crime such as gun, drugs and terrorism. This further blights more deprived communities and widening inequalities.

In each of the tobacco control services staff capacity due to home schooling, working from home has been limited at times due to the challenges this brings.

E-cigarettes

E-cigarette shops have been closed limiting access to the most popular nicotine product and quitting aid. We are yet to fully understand what impact this has had on prevalence of smoking amongst smokers and sub population groups. Online access was in place however anecdotally we have been made aware that people did not trust this route and it could be slow – risking them reverting back to smoking.

Recommendations:

Covid-19 has shone a light on existing health inequalities and exacerbated them. Levelling up and tackling smoking is part of the solution in reducing health inequalities but also in helping to build resilience in health systems and boost the local economy, essential as we head towards winter and the risk of co-circulation of Covid-19 and flu.

Priority should be given to population level interventions that can impact at scale across the

city. It continues to be vital to deliver a whole systems approach to tobacco control to effectively stop the inflow of children taking up smoking and supporting smokers to stop.

Specific priority actions for action include:

1) Review NRT provision in the city and access for all smokers and especially pregnant women, new mothers and those with mental health conditions. Consider direct supply for pregnant women (CCG and STH considering this approach). Work to reduce barriers and accessibility for those smokers who do not want to access support via the citywide stop smoking service.
2) People who smoke should be added to the Directed Enhanced Service (DES) specification for seasonal influenza and pneumococcal immunisation. Smoking is a modifiable risk factor, unlike most other risk factors for flu like age, or co-morbidities (many of which like COPD, cardiovascular disease or diabetes are caused or exacerbated by smoking).
3) Advocate for local and national smoking prevalence data to be collected routinely on BAME and other groups not currently in place such as LGBT groups, Disability where we know smoking prevalence is high. This will enable local review of trends in prevalence and specific focus on sub populations within the BAME communities. This should form part of the Local Tobacco Control Profiles.
4) It would also be helpful to have data on disease prevalence locally in terms of for example the proportion of smokers who have diabetes or heart disease by ethnicity. Trends in this profile would be very valuable for targeting interventions at a practice level.
5) Continue to review national and local evidence on sub populations impacts re: Covid19 and deliver targeted, tailored and culturally appropriate smoking cessation interventions for those high smoking prevalence groups especially BAME populations and smokers in routine and manual jobs who are more likely to be at increased exposure risk of infection, severe disease and death from Covid19.
6) Evaluate the effectiveness of telephone and online stop smoking support and continue this option if results are promising for adults, children and pregnant women. Potential to contribute to equity of service offer if an option alongside face to face (not instead of). Review access and uptake of support across all high risk groups.
7) Continue to deliver and build on the Sheffield Quit for Covid /Today is the Day campaign. The local successful outcomes and level of reach demonstrate the continued importance of promoting the #QuitForCovid message and communications campaigns as well as the ongoing investment in tobacco control communications and the increased partnership approach in getting messages out to ensure reach to smokers of all ages to make a change, but particularly those older smokers who might be more at risk. Smoking related illnesses which have been linked to worse outcomes from Covid-19 include COPD, diabetes, stroke and other heart conditions.
8) CO monitoring should be re-introduced as soon as the Covid-19 situation has resolved to a background risk.

9) Smokefree home interventions should be reinstated to reduce risks for children across the city in all settings including community and via Sheffield Children's Hospital. Behavioural support and access to alternative nicotine products (including NRT or e-cigarettes) should be part of this intervention offer to ensure success.
10) Accelerate the re-introduction of QUIT - the provision of tobacco dependence treatment to all hospital inpatients to ensure all opportunities to support smokers are harnessed.
11) Smoking is recorded on GP records so smokers can be identified, and should be advised to quit at every opportunity. GPs should be required to contact smokers on their lists (by text or letter) encourage them to have the flu vaccine and communicate to them the increased risk they have of contracting flu, the immediate benefits of quitting and the help available to increase their likelihood of success and reduce risk of severe symptoms from Covid-19 of they were to become infected.
12) Review SCC Trading Standards position re Covid-19 working practice and ability to reinstate work on illicit tobacco sales to prevent illegal activity and drive down smoking prevalence and achieve successful sanctions and license revocations.

Contributors:

Various Tobacco Control Board Members who make up Smokefree Sheffield including:

- Maggie Milne (MM), Service Manager – Yorkshire Smokefree Sheffield
- Moira Leahy (ML), Consultant Psychologist – SHSC NHS Foundation Trust
- Pete Stewart SHSC NHS Foundation Trust
- Helen Baston (HB), Consultant Midwife - STH Jessop Wing
- Nicola Pearson (NP) – Stop Smoking in Pregnancy Service Manager STHFT
- Pauline Williams (PW) – Sheffield Children's NHS Foundation Trust
- Rebecca Sobey and Fran Sheils - Health Visiting Service- Sheffield Children's NHS Foundation Trust
- Laura Whitfield (LW) Senior Health Coordinator – ZEST – Smokefree C&YP service
- Amanda Pickard, Health Improvement Practitioner SCC
- John Maher – SCC Trading Standards
- Helen Baxter (HBax), QUIT lead – STH
- Gary Barnfield (CCG)
- Jen Tully - DIVA Communications
- Natalie Ralph – DIVA Communications

Governance:

The recommendations will be owned, reviewed and monitored by the Sheffield Tobacco Control Board.

Methods and Sources of Intelligence:

Data sources:
Data from providers on those accessing services
National survey data
Qualitative intelligence from local VCF and partner organisations

Gaps: We need to understand more about how the impacts are distributed across sub-populations specifically BAME populations, LGBT, Mental Health and pregnant women, routine manual workers and Learning disabilities at a national and local level.

Need to understand impact of Covid-19 at population level to review if people were more likely to smoke more or less during lockdown. Whether or not this impacted on quit rates at a population level in Sheffield. Furthermore how these behaviours are now evolving as lockdown is eased i.e. Who has stopped and remain stopped, who has smoked more and has this level of consumption continued or subsided now?

We have quit data at the stop smoking service level for these subgroups but this only covers those who accesses support.

Furthermore:

- No national data yet on impacts on smoking during Pregnancy, routine and manual workers, unemployed or homeless in relation to impact of Covid19.
- Impacts of Covid-19 by those smokers who were Shielding or have an underlying health condition.
- Local data on loneliness and impact on smoking behaviour.
- Local population level questionnaire will help with some of these insights and case studies.

Business HIA - may provide local intelligence on impact of Covid-19 on smoking rates of those in low paid jobs and none secure work and environments with higher risk of exposure to COVID-19, such as health and social care, and food retail.

Alcohol Use

Summary of Theme:
This review considers the impact Covid-19 has had on alcohol use in Sheffield, understand factors leading to an increased use of alcohol understand how this may affect the health of the Sheffield population in the short, medium and long term and highlight changes to meet need. Evidence indicates that during Covid-19 sales of alcohol have increased by one third (34%) of the general population, of whom 7% report a significant increase in their weekly spend. Whilst pubs closed off licenses and supermarkets remained open; listed on the 'government's list of essential UK retailers'[5]. It is anticipated that the average weekly spend has increased to £12.19 given that the average weekly spend on alcohol pre Covid-19 was £9.10 per household[6]. This amount may seem low, however: • we know that 18% of the Sheffield population do not drink, therefore it is likely that the average spend for household that do consume alcohol is significantly higher than £12.19. • £12.19 would purchase nearly double the 14 units of alcohol a week; which is the current government guidelines[7] for healthy drinking. You can buy a cheap bottle of vodka which contains 27 units[8], 2.5 bottles of cheap wine which contain 25 units) or a crate of eighteen 330ml cans of lager/beer containing 30 units per week. Evidence indicates that there has being a significant increase in the number of people reporting an increase in their alcohol consumption during Covid-19. This ranges from 21%[9] (one in five) to a 29%[10] (one in three) of us drinking more. Research and qualitative feedback from agencies indicates drinking habits have changed – with those who drink; doing so more frequently, starting earlier in the day and drinking in larger quantities. These changes are against the national guidelines which recommend drink free days and no more than 3-4 units per day. Alcohol has become a new way to interact socially, deal with boredom, isolation and stress. Some people need prevention advice; and many but not all with respond to harm reduction messages without the need for professional help. But for some Covid-19 has had a deeper and more negative impact – particularly individuals who were already or who are newly affected by mental health, those who have had support networks and security removed

[5] https://whiasu.publichealthnetwork.cymru/files/1715/9430/8711/HIA_-_Rapid_Review_of_SAH_Policy_Main.pdf

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/expenditure/bulletins/familyspendingintheuk/april2018tomarch2019

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545911/GovResponse2.pdf

[8] https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/

[9] 21% https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings

[10] 29% https://www.kcl.ac.uk/news/nearly-a-third-of-uk-public-drinking-more-alcohol-than-usual-during-the-pandemic

(jobs, schools, community groups, keyworkers), those already drinking at increasing and higher risk levels and /or those who had previously being in alcohol treatment. These people need support, treatment and interventions.

Impact on Sheffield residents and their health

The health harms of alcohol consumption are well known. Indeed the NHS explain that the long term risks associated with drinking more than 14 units per week include '*cancers of the mouth, throat and breast, stroke, heart disease, liver disease, brain damage and damage to the nervous system.*

There's also evidence that regular drinking at high-risk levels can make your mental health worse and there are strong links with alcohol misuse and self-harming, including suicide[11]*'.*

Alcohol is well known to have a negative impact on people's ability to manage negative emotions and decreases self-control, thus making the risk of intentional and accidental suicide more likely.

The number of individuals affected by alcohol in Sheffield is significant. PHE (2019) estimates that in Sheffield 25.3% (CI -/+-95%) (one in four aged 18+ years or around 144,000 Sheffield residents) drink at levels higher than the recommended guidelines (14 units per week). Whilst an estimated 6,818 individuals drink dependently (over 50 units per week) and may benefit from alcohol treatment.

Adult alcohol treatment is commissioned by the DACT. A new substance misuse contract started with SHSC-FT on 1st April 2020. Service provision has being in accordance with Public Health England *Covid-19 guidance for commissioners and providers of services for people who use drugs or alcohol*[12]. Providing the most essential services; with a focus on remote working and remote contact via telephone and technology.

Young people's alcohol treatment is provided The Corner, CGL and commissioned by the Young People's Commissioner, SCC. During COVID-19 their service has offered remote access to treatment and support.

The Sheffield alcohol strategy[13] is in the last year of implementation.

In scope

Adults and young people under the age of 18 years old who consume more than 14 units of alcohol per week.

Out of scope

Individuals who are abstinent or who drink within the recommended 14 units government guidelines per week.

Illicit drug use only.

[11] https://www.nhs.uk/live-well/alcohol-support/

[12] https://www.gov.uk/government/publications/ https://www.gov.uk/government/publications/Covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol/Covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol/Covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol

[13] https://sheffielddact.org.uk/drugs-alcohol/resources/local-strategies/

Summary of impacts:

Covid-19 for many has been and remains a traumatic event. Professionals working in the field are associating responses similar to the likes of the trauma associated with the recession in 2008. For some individuals Covid-19 has brought a new trauma and / or brought previous traumatic events to the forefront. Services have responded by being flexible, changing delivery models and by being positive in their approach.

In the medium and long-term there will be a response required to address more people with long-term dependent/problematic use of alcohol; significant and long-term deterioration in physical and mental health, with possible fatal consequences for an increased number of people, not unlike what is being predicted for cancer patients.

Overall research indicates that changes in drinking habits are associated with significant changes that Covid-19 brought – there are links associated to how individuals respond to trauma and why individuals may have turned to alcohol. These include:-

- An increase in poor mental health (including a fear of Covid-19). The commissioned treatment services, SHSC FT have already observed a significant increase in the new people starting treatment with mental health conditions (44% compared to 33%). For those who were already in treatment there has being an increase in the number presenting in crisis, requiring a lot of support with allied agencies such as mental health services.
- Increased stress e.g.one in five (19%) drank alcohol as a way to handle stress or anxiety during lockdown and of those who drank more heavily during lockdown (nine plus units on each drinking day), 40% had drunk as a response to stress or anxiety[14].
- Financial difficulties – e.g. The centre of poverty found that in the first 3 months of Covid-19 3.1 million households were in serious financial difficulty[15]. Individuals were furloughed, with reduced income and the concern about future employment. The prospects of an impending recession, threat of increased unemployment and no prospect of furlough funding for future lockdowns will only exacerbate this stress for many households.
- Increased anxiety and distress in keyworkers from carrying out their duties at the time of a pandemic[16]. All workers working with alcohol service users have continued to work during Covid-19 and are keyworkers. All agencies have reported that employees have being affected by Covid-19 and also by the additional pressure of changes to working practice. Responding to their needs is also a priority.
- Parenting during lockdown. The innate fear of a child getting Covid-19, concerns for their child's education and the stress of working with children in the household. Parents of under-18s were more likely to say that they increased their alcohol use (30%) than non-parents (17%) and parents of adult children (11%)[17].
- An increase in people feeling isolated. All research indicates a significant increase

[14] https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond
[15] https://www.poverty.ac.uk/editorial/Covid-19-impact-uk-households
[16] https://whiasu.publichealthnetwork.cymru/en/news/health-impact-assessment-staying-home-and-social-distancing-policy-wales-response-Covid-19-pandemic-executive-summary/
[17] https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond

e.g. one in four (24%) had feelings of loneliness in the "previous two weeks" compared to one in ten people (10%) before lockdown[18] and 43% of people in the UK have felt more lonely than usual[19]. The treatment service report that those in treatment had higher degree of feeling of isolation, particularly among males. Many people have had their support (family, friends, keyworkers) removed during Covid-19.

- Bereavement and anxiety of the virus – e.g. particularly those who are socially isolating.
- Multiple and complex needs - Agency feedback indicates that more frequent telephone support is no replacement for weekly face to face key worker support.
- The economically poor - Not all service users have access to IT or can afford IT equipment or the cost of broadband. Whilst services have helped to provide laptops and telephones to those in recovery with donations from the public, SCC funding and private companies some have struggled to engage in this way.

Sub-population groups

Local treatment data is limited to a 3 month period and therefore it is too soon for any significant changes to be observed. It is anticipated these will become more apparent over the next six to 12 months. However local anecdotal information and national research provides some insight into individual who are more likely to be affected by alcohol misuse: -

- **Age** – difference observed, with one in three aged 54 years or younger reporting an increased compared with one in five aged 55+.
- **Employment** - Working people (33% compared to 20% of non-working people). However it will be interesting to see long term if this changes to those who are unemployment / out of work in the medium and long term.
- **People in 'socio-economic group'** ABC1 were more likely to says they had been drinking more than people in group C2DE (32% compared to 24%).
- **Previous service users** - 13%[20] of current and former drinkers said their typical number of units had increased during Covid-19. These are people are likely to return to treatment, require recovery interventions and or detoxification.
- The Portland group found that there appears to be a strong overlap with **those already drinking at increased or harmful levels[21] before Covid-19**. Agency information[22] indicates that these individuals may have been functioning, and had a social network and/or capital (i.e. job, family, community) but COVID-19 removed these and the drinking became a cause for concern.
- **Single households and those who are shielding due to physical health related conditions** – links with isolation, mental health; anxiety of Covid-19 and access to keyworkers.
- Anecdotal evidence of **deterioration in the presentation of both new clients** – in

[18] https://www.mentalhealth.org.uk/coronavirus/coping-with-loneliness
[19] https://www.kcl.ac.uk/news/nearly-a-third-of-uk-public-drinking-more-alcohol-than-usual-during-the-pandemic
[20] https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond
[21] https://www.portmangroup.org.uk/Covid-19/
[22][22] SASS / Project 6.

physical and mental health.

- **Perpetrators of domestic abuse** – Alcohol Concern found that 6%[23] of people reported that Covid-19 had created more tension in the household. Anecdotal feedback from domestic abuse services is that victims have reported alcohol use by the perpetrator during Covid-19, MARAC cases have involved alcohol misuse and a higher proportion of referrals for perpetrator support have had alcohol as a need.

Impact of access to alcohol treatment and support due to Covid-19 and priorities for consideration

Positive impact

- **The increase in use of technology to deliver support and treatment** - Contact remotely using telephone, Skype and other electronic methods appear to increased engagement and reduced the DNA rate with treatment and recovery services. E.g. in SHSC the DNA rate to telephone appointments for assessments has reduced to 10% compared with an average rate of 26% for the financial year 2019/20. Online groups have perhaps removed the anxiety of attending a group in person and made it easier to access logistically (no travel). There are organisation-level plans to conduct appointments through Attend Anywhere. Research by Humankind supports electronic methods as a successful way to deliver brief and extended brief interventions; however the caveat is that this is not for everyone and for some people face to face contact is essential. These individual seem to be the more chaotic and more complex individuals.
- **Community detoxification** has been limited however, when used this, has worked successfully. There is a real need for this to be reintroduced.
- **Specialist substance misuse outreach to those accommodated in hostels and hotels during Covid-19.** There are examples of individual who have never engaged with services before, now engaging with treatment. The repeated feedback is that these individuals need face to face contact, they need time with professionals and want to be heard. These individuals and struggle with electronic solutions.
- **Services and staff have become flexible.** Alongside new technological solutions new methods of providing face to face contact are taking place. This includes socially distanced walks and group sessions, meetings in gardens. Whilst this doesn't work for everyone, these have maintained some level of physical contact. Homeworking by employees; whilst having its own new complications has being welcomed by many.
- **Young people's services have maintained contact with 85% of their caseload**.
- **Sheffield City Council has launched a new comms alcohol campaign in July 2020, to raise alcohol awareness to the general public.** These new resources can be used in the short, medium and long term.

Negatives impacts

- **Delay in people presenting to commissioned treatment and A&E**. During Covid-19

[23] https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings

there has being a 27% reduction in new starts to alcohol treatment in the Yorkshire and Humber region (June PHE 2020), with a 33% reduction in Sheffield (SHSC). Referrals were down 60% in April and 40% in May; however activity has started to increase back to expected levels. Similar patterns were observed by The Corner. STH A&E data also shows similar trend, with the lowest activity in April. This has started to increase again, however June activity is still lower than that at the same time last year. There is a concern that those who present later than they would have done previously may be more complex; have more psychological needs and require more intense or longer interventions, which may further limit capacity and swift access to treatment.

- **Limited capacity in SHSC and SASS to take new referrals alongside existing service users.** SASS referrals were up from an average of 20 referrals per week to 100 in w/c 6th July 2020. Anecdotal feedback indicates that people who would not have ordinarily have been seen in treatment services are presenting due to the trauma of Covid-19.
- **Trauma informed care approaches citywide**. One third presenting at SASS require trauma informed care. Indications are there is a need for wider strategic and operational discussions between commissioned and non-commissioned services which includes a review of pathways and a wider discussion on trauma informed care.
- Those already in alcohol treatment have reported increased frustration with lockdown restrictions and distress and there have being more service users presenting in crisis. This has led to a greater need to link in with mental health services and used more professional time and capacity.
- **Limited access to inpatient detoxification beds** (these are on the mental health wards in Sheffield). The risk of Covid-19 stopped alcohol admissions. Often these beds are required for mental health patients and an increase in mental health conditions at this time has also restricted access for alcohol detoxification. There are examples where people have had to have detoxification via admission to the Sheffield Teaching Hospitals, rather than in the inpatient detoxification beds. Sheffield doesn't have its own inpatient facility, unlike other areas e.g. Doncaster and this concern has been raised once again.
- Our SCC safeguarding lead has indicated an increase in the number of safeguarding children referrals where alcohol is a concern. Data is required on this in order to understand the response required, however work is ongoing. SHSC will advise the Sheffield Safeguarding Hub and work with Children's Social Care social workers as part of the forthcoming Safe and Together model to inform work with children affected by parental alcohol misuse.
- **A reduction in the use of the citywide use of the alcohol screening tool**. Whilst use has been maintained from pre-Covid levels by SHSC (wards, liaison psychiatry, CMHTs) its use was down by GP surgeries and between April and June 2020 was used only by one GP practice. Pulse data found that there was a 27% decrease in GP appointments in April 2020, with many avoiding health services for fear of Covid-19; however Bradford GPs have observed an increase in the proportion of alcohol attendances. This data is unknown for Sheffield GP practices and requires further exploration. *There is need to promote health services, contact with GP practices by treatment services and increase the promotion of the alcohol screening tool in*

Sheffield.

- The full implementation of the new substance misuse contact has being on hold during COVID-19. There is a need to fully mobilise the new contract with SHSC (which includes a broader range of talking therapies, outreach, community interventions, technology solutions for access to the service and recovery interventions) – all areas of need to address isolation, mental health and long term recovery.
- The alcohol and complex needs social impact bond was on hold during Covid-19. The need to reduce the most frequent flyers to hospital admissions for alcohol misuse and the need for a service specific to those with multiple and complex need (e.g. alcohol, mental health, housing and drug misuse) remain until it is implemented.
- Workforce has being impacted by Covid-19. Both in terms of capacity (working limited hours due to childcare and / or social distancing and their own health needs) and their own mental health. Work place / employee wellbeing is crucial.
- Young people services have found that unlike adults, most of their young people have not responded to online technology and there is a preference for telephone contact or face to face.

While this report is not required to discuss drug treatment many of the agencies consulted work with individuals who misuse drugs or drugs and alcohol. Whilst opiate referrals have remained steady, non-opiate referrals initially reduced before returning similar to alcohol. Most of the same positive and negative factors have being also observed in those who misuse drugs and therefore learning taken from this exercise can also be implemented to drug treatment and support interventions.

Recommendations:

Priorities

1. Work towards fully mobilising the alcohol contract whilst addressing the learning from Covid-19; review the outreach offer, embrace the use of technology with cohorts where it has being successful and link in with partner agencies – alcohol and organisations and initiatives that remove isolation and improve wellbeing.

2. Promote the citywide use of the alcohol screening tool with statutory and third sector agencies.

3. Promote the introduction of the minimum unit pricing for alcohol - - by lobbying national government and locally in Sheffield.

4. Lobby national government for increased funding for those affected by alcohol related harm for treatment and recovery focused services.

5. Review the offer to individuals with dual diagnosis (mental health and alcohol) and have robust agency links with mental health services.

6. To continue to provide alcohol detoxification both in the community and inpatient

settings.

7. Promote alcohol safe drinking messages and treatment provision with the general public. Including linking in with the national obesity strategy and promote the calories in alcohol and counter the normalisation of alcohol use in society.

8. Review and refresh the alcohol strategy which ends in December 2020.

9. SCC to consider introducing an alcohol implementation group.

Contributors:

Task and Finish Group

The task group was led by Amy Buddery, Health Improvement Principal and lead for Substance misuse commissioning in SCC.

The accountable body will be the Drug and Alcohol Strategic Board who govern the implementation of the alcohol strategy.

Report

The author of the report is Louise Potter, SCC DACT, Commissioning Officer and lead for the consultation. Data contributors included James Newcomb, DACT information and Performance Analyst and Julia Cayless, Business and Information manager, SHSC

Consultation, written and verbal discussions with:-

- The management team at SHSC.
- Members of the Substance Misuse Operation Group – attendees: Tracey Ford from DACT, Leigh-Ann Farrar & Rodd Dutch, Lisa Pidd from START – SHSC. Mike Ng, from Project 6, Katie Ryan from Shelter, Jenny Robertson from The Corner, Jane Steel from Human Kind.
- Members of the Domestic and Sexual abuse provider consultation group.
- Mandy Craig, SCC safeguarding lead for substance misuse SCC.

Methods and Sources of Intelligence:

All sources of data are referenced. The main reports used are Alcohol Concern's research, PHE data and local SHSC data. Other sources of data that will be used in the report and on an ongoing basis include -

- A&E Alcohol related attendance data
- SHSC NHS FT substance misuse treatment data.
- PHE national substance misuse treatment dataset
- PHE Fingertips/PHOF/LAPE data.

Service user feedback and consultation is required as a matter of priority.

Breastfeeding

Summary of impacts:

It is too early to make clear comparisons between feeding pre and post COVID-19. However, recent data suggests that there has not been a detrimental effect on early feeding.

Breastfeeding Statistics (%)

2020	*intention*	*discharge*	*dropoff*
April	81.39	74.44	6.95
May	81.23	74.8	6.07
2019			
April	77.2	70	7.2
May	81.2	75.4	5.8

Anecdotal evidence suggests that the pandemic may have had a positive impact on breastfeeding. Firstly through increased awareness of the protective benefits of breastfeeding for babies. Secondly due to women spending more time at home during the lockdown period and therefore having more time to focus on feeding.

The Infant Feeding team (IFT) at Jessop Wing undertake regular audits of women's experiences. These telephone interviews took place at the end of May to coincide with hand over to the health visitor, around day 10 postnatally.

Some positive stories:
The Jessop Wing hospital and community midwives have been encouraging mothers to consider breastfeeding even if they hadn't previously thought about it before. Also, there has been more in the media about this too linked to Covid and benefits of breastfeeding.

Mother 1 - intended to formula feed and started doing this in hospital and was bottle feeding when she went home. Then her breasts felt full so she decided to put baby to the breast and her baby fed so she decided to breast and formula feed and is successfully mixed feeding.

Mother 2 - Started formula feeding then decided after 2 days to give breast feeding a try and was supported by her community midwife and is now mostly breastfeeding.

Mother 3 - Intention to mixed feed. She started giving formula milk from birth but then at 2 days decided to breast feed and with support from her midwife she is now exclusively breast feeding.

Negative

- Antenatal care sometimes felt rushed
- Antenatal appointments reduced
- Would have liked more preparation for breastfeeding antenatally

- Would have liked more support from professionals at home
- Offered video call but not comfortable to do this
- Would have liked their partner with them on the postnatal ward

The Infant Feeding Team asked additional questions, over and above the usual BFI audit requirements, to assess what women had heard or were worrying about during the pandemic. Concerns were mainly about what to expect and mis-information about being alone in labour. They were also asked to offer tips for other mothers coming through maternity care and recommended staying in contact with others such as NCT group, zoom, WhatsApp, Facebook, finding out as much as possible to be prepared and stay calm.

Summary of changes in service provision post-Covid:
From a maternity perspective, whilst x2 early antenatal contacts and x1 postnatal contact is by phone, the majority of care remains face to face. Midwives and support workers are able to continue to provide support on the wards, wearing PPE and accessing women without interrupting time with visitors.

The postnatal Rapid Access Clinic, for babies with feeding problems has continued and there has not been an increase in babies attending due to weight loss.

There has been some concern raised by women with babies who have a tongue tie that they have been unable to access treatment for this condition. This service is provided by SCH and is currently suspended. When SCH are able to offer appointments again mothers will be contacted to ascertain if a referral to the service is still required. In the meantime, feeding plans may need to continue for some time if, despite support, the baby does not learn how to breastfeed. Midwives are encouraging mums to do lots of skin to skin contact and laidback baby led attachment to give baby plenty of opportunity to learn how to breast fed and get the best attachment possible.

Parent education groups have also been suspended although an online offer is in development

The information below was put out on social media during Breastfeeding Celebration Week– (STH Face Book page) to inform mothers what support with breastfeeding is available.

- What support is there in Sheffield to help mothers to breast feed?

'During pregnancy, mothers can discuss their thoughts about feeding with their midwife during antenatal appointments, and once the baby is born mothers will continue to be supported at every step of the way. This will include supporting mother's to hold their baby in skin to skin contact which will trigger the baby's natural instincts to find the breast and have the first breast feed.

More mothers are now considering breastfeeding or giving the first few breast feeds to provide valuable protection and support for their baby's immune system. During the pandemic some mothers have chosen to give their breast milk in a bottle instead of formula

milk. Whatever your decision is, we will be there to support you.

Community midwives will contact mothers by telephone, and support mothers and babies face to face at Family Centres around the city and in the mothers' home. They give the same support as the maternity service has always provided, with the only difference being that they will be wearing protective clothing (PPE) when seeing women face to face. The community midwife will continue to support breastfeeding until transferring the mother and baby to the health visitor at around 10 days after the birth.

There is also on-going support from the Local Authority Infant Feeding Peer Supporters via telephone or video call and all mothers will be given the usual telephone numbers for emergencies or extra support for the duration of breastfeeding. Although breastfeeding groups are currently suspended across the city, mothers can access mother to mother support via the Breastfeeding in Sheffield website https://www.breastfeedinginsheffield.co.uk/ and Facebook groups https://en-gb.facebook.com/BreastfeedinginSheffield/ '

Groups most likely to be affected by changes in services:

- Mothers whose first language is not English
- Women who do not have access to on-line resources
- Women without a strong community network of family and friends
- Women from disadvantaged communities where breastfeeding is not prevalent and asking for or seeking skilled support is not the norm

Recommendations:

Breastfeeding in Sheffield is promoted via the Unicef Baby Friendly Initiative accreditation process. Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. Sheffield should continue to prioritise this work

Breastfeeding initiation and continuation is monitored through the Public Health Outcomes Framework. Rates should continue to be monitored both for the city overall and for sub-populations.

Contributors:

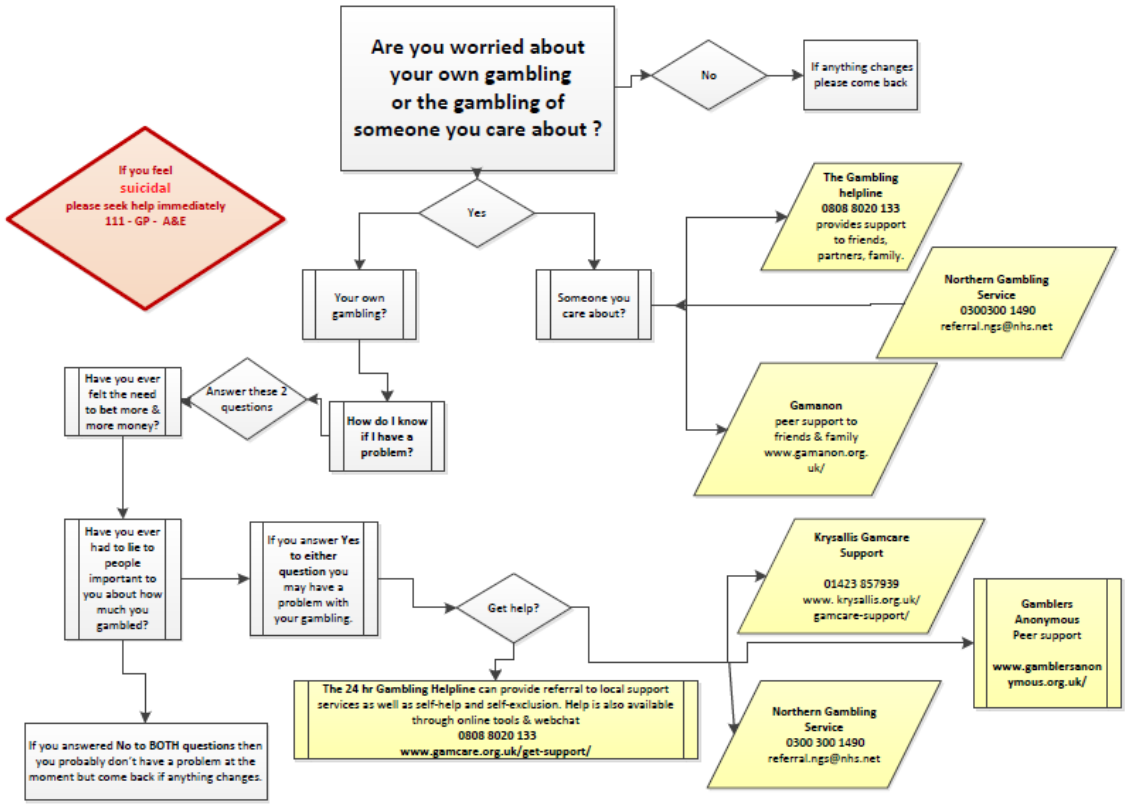
Helen Baston (Consultant Midwife Public Health) and maternity services colleagues
Infant Feeding Team (STH)
Community Infant Feeding Peer Support team
Debbie Hanson (SCC, Public Health)

Methods and Sources of Intelligence:
Data breastfeeding intention and on discharge Intelligence from service providers including case stories

Gambling

(Overlaps with Mental Wellbeing, Suicide and Poverty themes)

Summary of impacts:
The general definition of gambling is to stake or risk something of value on an event with an uncertain or chance outcome. The Gambling Act 2005 defines gambling more specifically as gaming, betting or participating in a lottery. For many people, gambling is a recreational activity. For some people however, gambling can lead to serious and significant problems including compromised, disrupted or damaged family, personal, societal or health outcomes. We estimate that as many as **8,300 adults** in Sheffield may be experiencing this type of problem gambling currently. For each person who gambles problematically an estimated 6-10 other people close to them may be affected such as partners, children, family, friends, colleagues. You may have a problem with gambling if you need to: (1) bet more and more money and/or (2) lie to people important to them about betting (Lie Bet Screening Tool). Gambling Disorder is a recognised mental health condition and people who experience these problems are entitled to receive help through the NHS rather than try to overcome them on their own https://www.sheffieldmentalhealth.co.uk/search/gambling . Some people who have difficulties with gambling may also need support with other addictions and mental health conditions. It is important to recognise that people with a Gambling Disorder may have problems with money and debt but their main problem is psychological – trying to help sort out money without addressing the underlying compulsion to gamble may not help long-term and may make the situation worse. The flowchart below can help you find support if you are affected by your own or someone else's gambling.



There are some groups who are considered more vulnerable to problem gambling and this is shown visually in this diagram below from Geofutures (2015) research. However, some stakeholders dispute this approach towards individual vulnerability and placing responsibility for gambling-related harm on the person and instead describe gambling as an intrinsically harmful product.

Vulnerable Groups (Geofutures, 2015)

Key: Supported by evidence | Emerging evidence | No/conflicting evidence

Demographic	Socio-economic	Poor judgement/ impairment	Other
Youth	Unemployment	Low educational attainment	Poor mental health
Older people	Low income	Low IQ	SMS/alcohol
Women	Deprived	Under influence of drugs/alcohol	Problem gamblers
Ethnic groups	Financial difficulties/debt	Learning disability	
	Homeless	Personal traits	
	Migrants		
	Prisoners/probation		

Like other addictions, it can be difficult for people who have problems with gambling to ask for, accept and engage with help due to shame and stigma. Those in treatment are often the most severely affected by problem gambling where a financial or mental health crisis has brought them to seek help. Although services are open to all there are more male treatment seekers and therefore treatment services and mutual aid predominantly support male gamblers. Male and female gamblers use online support forums and mutual aid and evidence suggests that there are more women accessing help in this way. Gambling is an illicit activity in some cultures and faiths so it may be more difficult for people from such communities to seek help. It is estimated that around a third of people get better without formal treatment or mutual aid: this could mean a return to recreational levels of gambling rather than being able to stop gambling. There are many routes out of problem gambling, however those who follow abstinence based routes tend to have more lasting recoveries.

There is more detailed information about problem gambling and gambling related harms in Sheffield's JSNA chapter here: https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=427a39b0fca04e9a9a1fdfe558071110

In March 2020, as the UK entered lockdown, Sheffield City Council provided input into Toni Williams, Consultant in Health and Wellbeing, Public Health England health impact assessment into gambling during lockdown. This health impact assessment predicted and anticipated likely problems with gambling behaviours and changes to support services. This is shown in the table below:

Impact	**Potential action**
While overall gambling levels initially dropped with the closure of all land-based gambling venues and the cancellation of sport and racing, there is evidence that play is increasing on some online products such as casino games. Some individuals, especially those with existing gambling problems, may be vulnerable to increased harm while spending more time at home during lockdown. Operators have been warned to be particularly responsible on monitoring play and intervening to prevent harm, and on advertising. The National Problem Gambling Clinic is reallocating resource to more acute mental health issues yet continues to maintain a reduced service offer. (Please note, Sheffield residents also have access to the Northern Gambling Service an NHS Clinic based in Leeds	The National Problem Gambling Helpline is still open to provide information and support, as well as some online treatment and support series. Those requiring support should call the helpline for further information about the best source of support for them. (Please note, Sheffield residents also have access to the Northern Gambling Service an NHS Clinic based in Leeds https://www.sheffieldmentalhealth.co.uk/support/northern-gambling-service/) Those requiring support with problem gambling are still able to access GAMSTOP, a free service that enables individuals to put controls in place to help restrict online gambling activities. Many banks also continue to offer gambling transaction blocking tools.

https://www.sheffieldmentalhealth.co.uk/support/northern-gambling-service/) Gambleaware commissioned treatment providers are having to adjust to online support services only.	Gam-anon meetings have moved online and there is an online meeting nightly (except Saturday night) from 19:00-21:00. Concerns about the behaviour of an operator can be logged with the Gambling Commission by phone or email and with local Responsible Authorities Some organisations such as The Gordon Moody Association (who offer residential care) has switched to proactively contacting ex residents remotely to offer support.

The All Party Parliamentary Group on Gambling Related Harm (http://www.grh-appg.com/) made the following appeal to the gambling industry in an effort to limit gambling-related harms potentially being exacerbated by the crisis:

Our asks of the gambling industry in light of the Covid-19 crisis:

1. Commit to implement deposit limits for the duration of the crisis.
2. Implement a £2 stake per spin limit on slot content online to reduce the harm that this highly dangerous content can have.
3. End VIP accounts, which encourage high levels of expenditure.
4. End *all* gambling advertising and sign up offers for bonuses.
5. Make data available to ensure independent research can be undertaken to assess the scale of harm being caused by the industry and the need for further harm prevention measures

As the UK eases and exits lockdown, information has been released by specialist gambling organisations on the impacts of lockdown. These confirm that switching to online use or resuming online use, and spending more time and money gambling were impacts of lockdown. There has been a spotlight on regulation of the industry during this period to protect consumers and particular concern about young people's gaming where this mimics gambling (e.g. lootboxes). The following organisations have produced specific reports on impacts of Covid-19 and lockdown on gambling:

- **The Royal Society for Public Health Gambling Health Alliance** survey revealed that two in five (40%) respondents who engaged in gambling activity or have done in the past had seen an increase in advertising for online gambling sites on social media while under lockdown.

- **The Gambling Commission** has monitored the impact of Covid-19 on gambling and its data from April/May 2020 shows:
  a. Overall, fewer consumers are gambling as shops and events closed during lockdown

b. Lockdown prompted some people, who were gambling already, to try new products

c. Overall, gamblers claim to be playing products at the same rate or less. However, a majority of those who have participated in three or more gambling activities in the last four weeks claim to be spending more time or money on at least one product.

This is reflected in growth in the average number of bets per customer on some products, particularly real event betting through May

d. And we have seen a slight decrease in the number of sessions over an hour (but an increase in overall sessions – people are gambling in more frequent shorter bursts)

- **Gambleware** submitted evidence on gambling to the Department of Culture, Media and Sport (DCMS) on impacts of Covid-19 on DCMS sectors which included:

- evidence from online search trends showing increased interest in online gambling during this period (+193% growth in the 2 weeks post lockdown);
- Gamcare also reported a rise in people calling to lift self-exclusion through GAMSTOP at the start of lockdown
- As part of Wave 5 of the ongoing Safer Gambling Campaign (Bet Regret) Tracking study, conducted by Ipsos Mori 2-11 April, targeted at male sports bettors aged 16-44 yrs old, a number of questions were included on the impact of COVID-19. Key findings included:

  1. Betting still prevalent during lockdown - a fifth of the Campaign Audience have recently
  betted on eSports or Virtual Sports.

  2. Majority are betting less, but those who are betting more are more likely to be high risk gamblers.

  3. Risky betting (as self-reported) has not increased, but there has been a rise in betting
  when bored and on unknown sports.

- Gambleaware's submission to the DCMS Select Committee included international data from Gordon Moody Association Gambling Therapy website. Common threads were:

- Uncertainty about the future leading to increase in gambling
- Removal of support structures that enabled people to cope (and gamble)
- Difficulty in accessing support services that controlled peoples gambling habits due to close proximity of partners
- Gambling through boredom under lockdown leading to an increase in recreational gamblers
- No access to normal stream of finances therefore turning to alternative sources leading to possible debt
- Gambling on obscure sports/activities due to cessation of major sports
- Turning to online gambling due to ease of access.

- Gambleaware's submission to the DCMS Select Committee included data from Gamban blocking software:
- Gamban has experienced an increase of approximately 30% in activations (new registrations) by people wishing to install software to block access to gambling sites on their computers and mobile devices since lockdown (comparing April 2020 with March 2019).
- There has also been a marked increase in early uninstallation requests

- Public Health England's Wider Impacts of Covid-19 on Health (WICH) tool has been updated to include Gambling: https://analytics.phe.gov.uk/apps/Covid-19-indirect-effects/

It contains the following categories:
- Gambling status
- Gambling activity
- Gambling activity over time
- Change in gambling frequency
- Gambling frequency
- For some categories the data can be broken down by sex (male/female) and age group.

- **Gambling status** – there were slight increases in both male and female respondents reporting no gambling activity during lockdown compared with before lockdown

- **Gambling activity** – there were slight decreases on numbers of respondents participating in all types of gambling activity during lockdown compared to before lockdown. This included lotteries, games and machines, and betting.

- **Gambling activity over time** – there has been a reduction in all gambling activity during lockdown compared to before lockdown during every month for which data was collected (May-August). However, July and August show the highest levels of gambling activity of all the months suggesting that the relaxation of lockdown is beginning to have an impact.

- **Change in gambling frequency** – gambling frequency has changed (decreased) in every age group from 18-24 to 75+ and both men and women report less gambling.

- **Gambling frequency** – when gambling frequency in terms of how many days a week is examined, this has mostly stayed the same or slightly increased during lockdown. The exception is monthly

As lockdown eases betting shops are being re-opened and football matches, horse and greyhound racing are being resumed. Those who made a switch to online and other sports betting during this period may revert to their sports betting of choice or they may continue to use a range of gambling products. There is a tendency for those with more severe problems to gamble across a range of different products.

As we exit lockdown, longer term impacts are likely to be :

- **A legacy of debt** from people who gambled more and are now facing end of furlough or other economic impacts such as withdrawal of credit;

- **An increase in Mental health problems and addictions** there is predicted to be an increase in mental health problems following the SARS-Cov-2 epidemic. As gambling is highly comorbid with other addictions (alcohol, drugs, tobacco) and with mental health difficulties there may be an increase in people needing support around gambling.

- **Suicide** There may be increased gambling related suicides as mental health crisis/financial crisis are predictors of gambling-related suicide.

- **Online gambling market share increases** as many switched to online gambling during lockdown or lifted online exclusions. This may have ongoing impacts in terms of time/money spent as there is no "pause" point in online gambling unlike event-based or in-store (non-remote) where the end of the event or closure of the shop can signal to stop gambling. This may also impact on Local Authority revenues through licensing non-remote shops, tracks and casinos.

- **Hidden harm/intergenerational/ACE** impacts for children who will have been exposed to household addictions including gambling will also be ongoing (ACE). This may increase the likelihood of young people developing their own addictions and harmful coping behaviours as well as being harmful in terms of potential financial problems and lack of parental attention.

- **Affected others** there are 6-10 people affected for each problem gambler. These people may experience additional stress and need support for their own mental health, and may experience financial and other impacts.

- **Gaming** there may have been impacts on young people of increased screen time and spend gaming during lockdown due to school closures. The similarities between gaming with lootboxes and gambling received attention from the House of Lords during lockdown (https://committees.parliament.uk/committee/406/gambling-industry-committee/news/147122/time-to-act-to-reduce-gamblingrelated-harm-says-lords-report/)with the government launching a review. Most children will have been out of school from March-September 2020 and may have had increased screen time and higher exposure to promoted content and advertising for gaming/gambling through social media. They may need help re-setting to less screen time and a healthier relationship with in-game risk taking behaviour and games of chance. Some experts are concerned that gaming behaviours may socialise children to gambling and for some children compulsive gaming causes problems in its' own right.

These impacts will be unequally experienced. Problem gambling has higher prevalence amongst younger people and young men in particular. These groups may find it more difficult to ask for and accept help. Therefore it is particularly important to proactively identify and offer help in a range of settings where young men socialise and spend time and

in ways that young men find acceptable. There are strong links between this theme and suicide prevention in terms of the cohort and in terms of the known but currently poorly understood links between gambling and suicide.

Priorities to address Covid-19 impacts on gambling behaviour going forward could include:

- Helping people re-set behaviours to more normal recreational use, using time/money limits
- Helping people re-establish exclusion from sites, exclusion through banks, blocks on adverts
- Helping people recognise if their gambling has changed and/or become a problem during lockdown
- Helping professionals to recognise and respond to harmful gambling
- Helping people access treatment services and mutual aid
- Helping people sustain or re-establish recovery routines
- Helping affected others access help and support
- Helping children and parents address screen time and gaming and re-set boundaries and healthy behaviours
- Helping parents understand the impact on children of gambling and gaming
- Giving gambling parity with other addictions – there has been a strong focus on drinking and smoking behaviours during lockdown but gambling has not had the same focus as it does not have the same strategy or funding as other addictions
- Recognising the (known but poorly understood) links between gambling and suicide and responding immediately and appropriately to disclosures of problem gambling

Recommendations:

There is currently no SCC Strategy for problem gambling and no formal funding. This workstream is supported by a small officer matrix team of Magdalena Boo, Public Health (1 day a week) and Julie Hague, Safeguarding and Licensing (part-time). Sue Finnigan leads on e-safety and works with children and schools on gaming and gambling amongst other e-safety issues. This area of work does not have parity with other addictions in terms of strategy, funding, or officer time.

This area of work has some support from Public Health England as a programme of work but does not have parity with other addictions such as tobacco, alcohol and drugs in terms of programme support.

There is a Yorkshire & Humber Association of Directors of Public Health Working Group on Problem Gambling which supports development of this work across the region by sharing good practice between authorities. There are opportunities to bid for funding through the Gambling Commission for the Yorkshire and Humber region to support this activity and these are being explored with Leeds City Council. However, bidding for funding will take the already limited capacity away from current work on gambling. Greater Manchester Combined Authority has recently received an award of funding to support work across their city region against shared strategic priorities.

There is a Sheffield Problem Gambling Stakeholder Group convened by SCC but this has not been convened during lockdown – e-mail contact has been maintained. The workplan of Sheffield Problem Gambling Stakeholder Group has been to increase the capacity of all organisations to identify, treat/refer to treatment problem gamblers. Problem Gambling is an issue with high stigma, where the trigger to ask for help is often a financial or mental health crisis Therefore, a focus has been on training debt including arrears, addictions, mental health organisations to recognise and identify problem gambling and offer support. This awareness raising is annually refreshed through a targeted training offer to the adult and children's workforce. Mental Health Directory pages maintained through Sheffield Flourish have been kept updated with problem gambling sources of support and information.

Formal Gambling Treatment Services in Sheffield are funded by Gambleaware and provided through Gamcare (Krysallis). Gambleaware and the NHS fund the Northern Gambling Service in Leeds which can be accessed by Sheffield residents. There are mutual aid services in Sheffield through GA (Gamblers Anonymous) and SmartRecovery. Sheffield City Council and Clinical Commissioning Group do not commission or grant fund any gambling specific services for our residents.

It will be important in recovery from Covid-19 that organisations dealing with mental health and debt impacts have an awareness to screen for problem gambling. There are tools available to help identify and refer to treatment. It is crucially important that we are alert to the known but poorly understood links between gambling and suicide and particularly act to protect young men who are most at risk.

Internal to SCC: Workplace guidance is in consultation with staff Trade Unions – this will bring gambling into parity with other addictions in terms of workplace help. For SCC staff information is now available on the wellbeing pages on sources of help. Training has been offered to TU and HR reps through the Gambleaware Calderdale Citizens' Advice offer. Toolbox talks are being made available online and are particularly targeted towards male staff in routine and manual roles that may not otherwise access written policies and guidance, and apprentices. These workplace resources have been offered to VCF and SME businesses in Sheffield through SOHAS and VAS for those who wish to adopt the workplace guidance.

Contributors:
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Methods and Sources of Intelligence:
SCC Office of the Director of Public Health, Joint Strategic Needs Assessment on Problem Gambling PHE currently does not produce data on gambling through fingertips but is currently analysing treatment data for the North East Region and PHE nationally has commissioned an evidence review which is due to report shortly. Royal Society of Public Health Gambling Health Alliance: https://www.rsph.org.uk/our-work/alliances/the-gambling-health-alliance.html The GHA launched a "Survey to understand the impact of the coronavirus outbreak (COVID-19) on those vulnerable to gambling related harm". The results have not yet been published. Gambling Commission https://www.gamblingcommission.gov.uk/news-action-and-statistics/news/2020/Data-shows-the-impact-of-Covid-19-on-gambling-behaviour-in-May-2020.aspx https://www.gamblingcommission.gov.uk/news-action-and-statistics/Statistics-and-research/Covid-19-research/Covid-19-updated-July-2020/Covid-19-and-its-impact-on-gambling-%E2%80%93-what-we-know-so-far-July-2020.aspx Gambleaware evidence to DCMS select committee on Covid-19 and gambling: https://about.gambleaware.org/news/dcms-select-committee-call-for-evidence-into-the-impact-of-Covid-19/ Retrospectively it should be possible to gather: **Gambleaware treatment data** Gambleaware reported to the DCMS Select Committee Call for Evidence into the impact of Covid-19 "*A Treatment Needs survey was carried out by YouGov in October 2019. An adapted version of this survey went into the field in the week commencing 25 May 2020. This will provide a 'before and after lockdown' analysis of gambling behaviour, harm and demand for treatment and support*". Gamcare treatment data Northern Gambling Service treatment data Flourish Mental Health Directory hits for gambling pages Consumer Data Research Centre

Governance:
Sheffield City Council's work on problem gambling currently sits under The Fairness Commission Steering Group (Adele Robinson) under the "fair money" workstream.

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)

Contributors:
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Methods and Sources of Intelligence:
The information in this report has been provided by members of the new education and Skills Directorate in Sheffield City Council. A wide range of supporting statistical data is available via PAS (Performance and Analysis Service) and this could be made available on request if it were deemed necessary. The information would be drawn down from reports taken from Capita ONE which is the city-wide school information management system.

Chapter 6

Income and Poverty

Introduction

This impact assessment is related to poverty and income. In Sheffield, we have adopted the Joseph Rowntree Foundation definition of poverty as 'when a person's resources are well below their minimum needs, including the need to take part in society'. However, we also recognise the stark inequalities we face within Sheffield, as across the UK, and the profoundly negative impact which this has on all Sheffielders and all aspects of city life. The recent publication of the Marmot Review: 10 Years On, reminds us that poverty and health inequality are inextricably linked and that over the last decade inequalities have widened overall. The crisis created by COVID-19 has brought these links into sharp focus.

Our Tackling Poverty Strategy (2015-18), and more recently the Sheffield Tackling Poverty Framework (2020-2030), sets out a detailed evidence base about the everyday realities for the people living in poverty in Sheffield, but we know that the impacts go well beyond this, with national and international research demonstrating that inequality has negative implications for everyone in society, and this has been especially evident in recent months.

Based on this established evidence base and our observations about the key impacts arising during the current crisis, as well as taking account of the issues covered across the other RHIA theme areas, this discussion broadly covers:

1. Universal Credit and Welfare
2. Provision of food and basic needs
3. Digital Inclusion
4. Inequality of impacts

And the specific issues identified within this are:

1. Financial insecurity & its impacts
2. Access to services
3. People who are disproportionately disadvantaged

Summary of impacts

Note: there is further detail provided in Appendix 2 to support this summary of impacts.

1 **Financial insecurity is more widespread and more severe since the beginning of the pandemic**, and although many will be currently taking a breath having endured the initial crisis, we expect people's financial situation to get increasingly worse as recession hits. 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 (Health Foundation).

1.1 The number of Universal Credit (UC) claimants has risen dramatically in the city, roughly doubling to 44,000 at the end of June. As the Job Retention Scheme (JRS) comes to an end, and many people are made redundant, there is expected to be a second large spike in UC applications. UC levels are significantly lower than most JRS levels. This is likely to cause issues for households whose UC income falls short of their expenditure. Although UC has allowed many people during the crisis to access some financial support at a speed that the legacy system would not have been able to manage, there are issues with the system, including the 5-week wait, that have had a negative impact on claimants.

1.2 There has been a significant rise in people who have been without money or food since the crisis hit. Whilst this is now starting to level off, we expect that emergency food will continue to be needed. Demands on food banks increased four-fold during the initial crisis, with one in 150 households accessing food support in April, while donations dried up and some came close to running out food as supermarkets ran short. The sustainability of the network was in question (VAS: 2020). Between the middle of April and the middle of June, then number of households supported with food parcels rose from 1144 to 2202 - a rise of just over 92% (see appendix 2 for notes on this data).

1.3 **People did not access other benefits/financial support during the initial crisis**: there was a significant reduction in some types of advice that people sought during lockdown. Most notably, people enquiring about, and applying for, disability benefits reduced substantially since lockdown, although this is rising again. This will be partly because of people 'hunkering down' and not wanting to put pressure on essential services, though may also be due to barriers accessing services. Citizens Advice expect a 30% increase in demand for their services as lockdown eases more. Similarly, we have not seen the increase in Council Tax Support claimants that we would have expected, suggesting that people are not claiming the support they are eligible for (although the Benefits Service is taking steps to increase the number of people on CTS).

1.4 There has been a lot of protection since the crisis started for people in debt or arrears, which is very good news. However, these protections ended 23 August 2020 and many people who are being financially impacted by the lockdown and recession are seeing their debt grow. We know that rent arrears are rising – for example, the number of Council tenants who owe £1000 or more on rent in June 2020 has increased by a third compared to June 2019. Once arrears are at 8 weeks, a very easy situation for people to have found themselves in since the pandemic started, judges have no discretion if a landlord applies for eviction: they have to allow it. Council tenants and the majority of housing association tenants are able to access support in this situation. Some tenants in private-rented accommodation may be able to access similar support and understanding from their landlords, but many more will find them unable or unwilling to help, leading to eviction and homelessness.

1.5 **Vulnerability to crime and exploitation:** whilst overall crime levels reduced during lockdown, scams preying on people's fears during the pandemic have been widely reported in the press (UK Finance) and as the economic impacts take hold in

communities, exploitation through organised criminal activity is likely to rise. We know anecdotally that one result of the DWP (rightly) rushing through the huge number of UC applications, taking a flexible approach to identity checks and being unable to see people in person led to a large number of fraudulent claims for UC which are now being investigated. We do not yet know the numbers, but it is likely that a proportion of these will be due to people being exploited rather than willingly carrying out fraud.

2 Increased issues with accessing services and support

2.1 **Digital exclusion**: Lockdown has made access to the internet (both devices and Wi-Fi/data) and digital skills/confidence vitally important, but many vulnerable people are excluded from this. There are positive stories of lockdown encouraging people with access but little previous confidence to engage with digital in order to participate in groups and activities they can no longer attend in person. However, there are too many people who do not have the money, device and/or skills to get online. This is impacting severely on their ability to access services, education, training, jobs and social contact.

2.2 **Lack of face to face support**: whilst organisations in the city have done a remarkable job of providing support remotely, there will be many people - particularly those who are more vulnerable and chaotic - for whom remote support isn't enough and who are facing difficulties they were managing to overcome before the pandemic.

2.3 **Rapid move toward a cashless economy** in order to reduce the risk of infection. An unintended consequence of this is that it presents barriers to those who only use cash, particularly those for whom using debit or credit cards is problematic, such as some people with learning disabilities. This also exacerbates the 'poverty premium' that people on low incomes were already facing.

2.4 Language and other barriers. Further detail below.

3 People in particular groups are being disproportionately impacted by the crisis. The pandemic is increasing inequality: people who were already disadvantaged are getting more so. All the groups listed below have been impacted negatively.

3.1 **Poorer people and those who live in deprived communities are more vulnerable to Covid-19 and to the impacts of lockdown**. The age-adjusted death rate in the most deprived tenth of areas is double that of the least deprived areas and this is born out at a local level (see Health Foundation: 2020). These groups are more likely: to be in jobs that expose them to the virus; to be in insecure jobs that have been affected by lockdown; to have underlying health conditions that make Covid-19 more serious; to live in overcrowded housing; and struggle to access support and information.

3.2 **Private-rented tenants are more likely to be particularly hard hit** as protection from debt/arrears action comes to an end: they are less likely to get financial/practical support from their landlords and are in less secure tenancies compared to Council/housing association tenants. Poor housing conditions are more prevalent in private-rented housing than in social-rented or owner-occupied housing. In addition people from BAME communities are disproportionately likely to live in private-rented housing, which compounds the issues they are already facing as a result of the pandemic.

3.3 **People with disabilities**: applications for disability benefits are likely to have decreased during the crisis given the substantial decrease in calls to Citizens Advice Sheffield for support with disability benefits. Whilst this has started to increase again recently, there will be a lasting impact on people's financial situations. Disabilities can make accessing services, including benefit advice much more difficult, particularly during lockdown. The Citizens Advice Deaf Advice Service have told us about the additional barriers their clients face. There is a strong link between mental health and financial wellbeing and both have been negatively impacted by the crisis.

3.4 **Age:** Whilst Covid-19 itself has a larger health impact on older people, the demographic facing the most significant financial impact will be younger working-age adults. (IFS study and local CItA data). Citizens Advice has helped a higher proportion of under-35s than before the crisis; likely to be linked to loss of jobs in hospitality and retail. Local DWP are seeing a lot of 18-24 year olds coming on to benefits. Workshop participants have noted that - although they have over-70s who need support - family and community support networks are often in place to help them. They are finding more younger people struggling and needing their support.

3.5 **Sex**: Similarly, whilst Covid-19 is slightly more likely to be serious in men, women are disproportionately negatively affected by the overall crisis (women are predominantly carers of children, in low paid work and/or reliant on welfare benefits) and it is likely that gender inequality will become greater (IFS, ONS).

3.6 **Black and minority ethnic communities** have been particularly hard hit by the virus itself as well as the impacts of lockdown; 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; there are a lot of self-employed people in BAME communities (35% of social enterprise in Sheffield is run by the BAME community) and - although central government has made funding available for those in self-employment - they didn't announce it until some time into lockdown and they have made the application process increasingly complicated which in turn increases the barriers for those whose business structures may be less formal (FaithStar). Citizens Advice Sheffield stats show that the pandemic is having a disproportionate impact on incomes of BAME communities. 40% of the people they have helped over the last few months describe themselves as from BAME communities.

3.7 **Refugees** are more likely to be digitally and financially excluded. The cost of phones/laptops is a barrier, as is the lack of Wi-Fi in asylum housing (Health Watch, via CCG Covid Community Impact Log)

3.8 **People with language barriers** are less able to access services remotely, even if they have the digital access;

3.9 **People without recourse to public funds:** we have heard from Citizens Advice Sheffield of people who have been just managing to get by before, working long hours, who have been plunged into financial crisis by lockdown and without access to the financial support that others in society are eligible for. Visas are a major source of financial hardship: they need to be applied for regularly and cost more than £2000 per family member. If legal assistance is needed to challenge a visa decision it is virtually impossible to afford solicitors.

3.10 **Some people will be moving into poverty who weren't there before.** We think that

some of the new UC cohort are people without experience of the benefits system (local DWP anecdotal evidence; lower than expected numbers of SCC tenants as a proportion of the new Sheffield UC claimants). As the recession hits, there are likely to be more of these people. People currently on the Job Retention Scheme who are made redundant when it ends will have to apply for UC, levels of which are significantly lower than JRS.

3.11 **People who are shielding/medically ultra-vulnerable**: Those people who have been shielding who have been reliant on government food parcels – may now be able to go to the shops but remain in poverty and may not be able to afford all the outgoings they suddenly need to find. Other support that has been in place for those people such as sick pay is being removed, which will cause concern and may force people back to work in unsafe circumstances.

3.12 **Children (0-5 years and school age)**: Families who previously relied on free school meals have struggled during lockdown: although vouchers have been made available to most families in the city there have been administrative complications with issuing them and spending them. Families who were already financially on the edge have not had the cushion to be able to cope with this. Sheffield Young Carers Project told us that children who might previously have been digitally connected have now been cut off because their parents can't afford the internet.

3.13 **Marriage and civil partnership:** single people aged under 25, or under 35 in private-rented accommodation, were already facing disproportionate risk of poverty because the levels of government benefits are lower for them. This is likely to have been exacerbated by the pandemic and lockdown.

3.14 **Religion and belief:** much emergency food support in the city during the crisis has been associated with religious institutions, including churches and mosques and - although the support is usually open to people of any or no religion. Ramadan taken place during lockdown and FaithStar provided food support to both front line workers and vulnerable people during that time. We have not been able to compile evidence of how religion and belief has impacted on poverty and income during the crisis.

3.15 **Sexual orientation and gender reassignment:** Social isolation and lack of employment, income or savings may mean that many LGBT+ people have had little option but to move back in with parents or family who may be LGBTphobic or otherwise unaccepting of their identity. This is particularly true of younger LGBT people (LGBT Foundation and SayIT via CCG Covid Community Impact Log).

Recommendations:

1. **Ensure a collective, city-wide approach to developing responses:** for this to be an effective process we need to consider how we will work with stakeholders and communities to take this forward on an ongoing basis, not just during the first 'intelligence gathering' stage. I.e. thinking beyond our own decision-making processes and service design, seeking new opportunities for ongoing dialogue and collective responses/action.

   For example, we need to:

   - Involve stakeholders and where possible the wider community in developing next steps. Especially those groups who have contributed to the assessment.
   - Consider how we involve these groups in designing our policy and practical responses.
   - Work with SCC, stakeholders and partners together (for example, through the Poverty, Social Exclusion & Fairness Partnership, Making Sheffield Fairer Campaign Group, UC Partnership, Supporting Vulnerable People's Group and other forums as they arise) to develop bold and impact-focused ambitions for the city.

2. **Build on and nurture good partnership working on the ground:** learn from the strong joint working between organisations and sectors that has helped us support people through this crisis and seek out further opportunities to support this.

   For example:

   - Citizens Advice Sheffield have used its strong links with food banks to act as a referrer for people who are in contact with DWP or SCC. We might want to consider how, in a future where front line services start to exist but in a more limited 'Covid-secure' way, we can make the most of co-locating services or providing e.g. video booths to enable people to access different services without having to move to a new building.
   - We should recognise that people in poverty / with complex lives need support they can trust. Supporting the diversity of VCF organisations in the city helps with that and our multi-sector responses should be recognised as best practice.

3. **Focus on some quick wins in key areas:** this should be informed by the processes of developing collective responses as outlined above, but may include the following areas which have already been identified:

   - Prioritise making digital access available to disadvantaged people and communities in the city (including devices, internet and skills/confidence): digital exclusion is compounding poverty and inequality more than ever before as a result of the pandemic;
   - Explore how we can 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. Getting support to people early stops them from going into crisis; explore introducing 'financial healthchecks' for households in response to the crisis. This would need appropriate funding.

4. **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.

   For example, we should:

   - Ensure that we are disseminating the insights we have gathered more widely to community groups, partners and others who may find it useful to inform what they are doing (beyond HWBB, SCC and SCPB).
   - Expect and plan for poverty to increase and therefore demand for services/support to grow over the next few month/years, despite the fact that the initial crisis has eased somewhat at the moment;
   - Work with partners to 'horizon scan' and ensure that we inform our next steps and conversations at all levels with a strong understanding of future anticipated impacts where possible.

5. **Seek to influence high-level strategic conversations about recovery and next steps for the city:** the current crisis has illuminated the impacts of poverty and inequality in our city and made the wider implications of these issues (for everyone's health, the city's economy and wider city life) more clear than ever. It has also necessitated new types of collective action and responses to these issues We need to harness the energy, action and focus which has come out of this.

   For example, we should:

   - Consider how we deepen our understanding of the relationship between poverty and inequality at a local level and identify how we can further respond to Marmot's latest recommendations as we develop our actions and responses, both short and longer-term.
   - Focus on capturing good practice and learning from the crisis to help us further long-term ambitions to address structural inequalities and eradicate poverty.
   - Use the insights generated by the crisis to bring discussions about poverty and inequality into new spheres and a wider range of policy areas. For example, we should be articulating these impacts to city leaders and decision-makers across the board to influence city and city-region conversations around what our economic recovery should look like. We should also be feeding this work into the strategic discussions about the future of locality working in the city, and how embedding positive relationships with communities can and should help us to address poverty (and the impacts of poverty) as part of that.

Contributors:

Key Stakeholders

- SCC colleagues (services supporting vulnerable people and community leads), public and voluntary sector partners.
- The existing Supporting Vulnerable People Group (SVP Group) will capture many of the relevant stakeholders, as well as the UC Partnership and Community Hubs meetings.
- The People Keeping Well networks have provided useful contacts/insight.
- The Local Community Response Team leads and their teams on the ground.
- Sheffield City Partnership (SCPB) - relevant conversations are also happening with these networks as part of the SCPB community impact work and Board members have had an interest.

Consider: How do we go beyond existing networks? How do we ensure the perspectives/voices of vulnerable people are captured within the proposed methodologies (stakeholder engagement & survey). Also, how are community groups involved in 'sense checking' the methods being used? E.g. helping to shape the questions we are asking, how this is being facilitated and approaches to data collection?

We have not established a specific task and finish group because we believe that the networks and groups that already exist were the right people to contribute to this theme, particularly as there are strong links to other themes. See below for further details.

The stakeholder organisations include (but are not limited to): VAS, Citizens Advice Sheffield, Shelter, ACP, CCG, SY Police, DWP, housing associations, MCDT, SOAR, Zest, food banks, Disability Sheffield, SAYiT, ShipShape, Firvale Community Hub, Good Things Foundation; Sheffield Carers Centre, and smaller community organisations/networks.

Governance:

Informal partnerships and stakeholder engagement - as outlined above, this report has been developed in partnership with relevant stakeholders, and both the content and recommendations are informed by this collaborative approach. Within this process, we have regularly shared notes and summaries of the inputs we have collected with partners and asked for ongoing comments and contributions.

In this way, 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.

Formal partnership and council structures - the formal routes through which we disseminate our findings will be partly focused on influencing strategic decision-makers. In addition to the engagement with the Health & Wellbeing Board through the wider process, we will also be presenting our assessment to the SCPB (as well as feeding into specific SCPB work around impact, which will be published over the summer) and we hope that both of these bodies will formally endorse our recommendations.

However, we are also seeking out ways to shape the development of short and medium-term local responses to poverty and inequality, and we will be using this impact assessment to facilitate a conversation with members of the Poverty, Social Exclusion & Fairness Partnership and the Making Sheffield Fairer Campaign Group, which will inform the next steps and actions to be taken forward by those partnerships. As part of the Sheffield Tackling Poverty Framework (2020-2030), which was approved by Cabinet in March 2020, an explicit commitment was made to work with the aforementioned groups to a produce a city-owned and flexible Tackling Poverty Action Plan to develop our next steps for the short, medium and longer-term. It has been agreed with the Cabinet member that this should now partly focus on how we are explicitly responding to the impacts of the current crisis on levels of poverty and on those who live in poverty, and so this impact assessment will form part of the evidence base for an initial plan to address that. There will also be an internal SCC working group, made-up of members and officers, which will also use this assessment to feed into the 'Action Plan' and to inform next steps in terms of policy development and allocation of resources.

Methods and Sources of Intelligence:

Methods

Our role as set out is primarily to consider the stakeholder engagement elements of this, capturing relevant data (qualitative and quantitative) from our partners (internal and external). Although we should consider wider reach and voice where possible within this process (see above).

Using our existing networks we have:

- Started with an initial review of the evidence - we had already collected a good deal of qualitative (including anecdotal) data and some quantitative data as part of our ongoing conversations with the SVP group and as part of the SCPB work. We used this to share a high level overview of the issues covered and identify gaps.
- Shared the review and hosted several workshops with SVP group, and other identified stakeholders (in some cases jointly with other themes) to gather evidence to fill the 'gaps' and identify further work needed.

Sources of information

- Quantitative sources of information has come from Citizens Advice, DWP and the UC

impact tracker compiled by SCC, food banks and other data as relevant, including national data from IFS and Health Foundation.

- Qualitative (including anecdotal) data has come from the groups listed above, along with further sessions with stakeholders as appropriate.

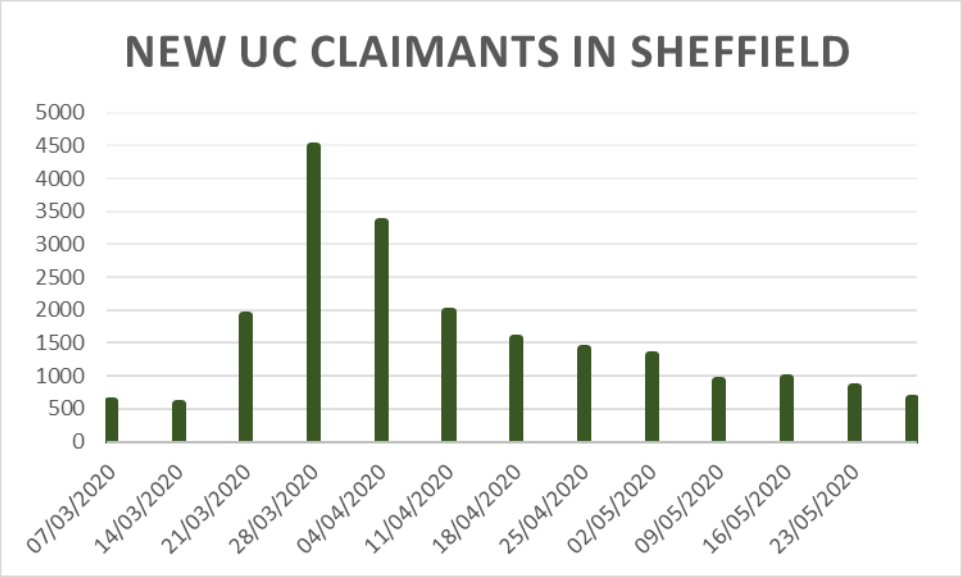
Appendix 1: List of Sources:

Sheffield Joint Strategic Needs Assessment
Health Foundation (2020) Inequalities and Deaths involving Covid-19
Health Foundation (2020) Living in poverty was bad for your health long before Covid-19
https://www.health.org.uk/publications/long-reads/living-in-poverty-was-bad-for-your-health-long-before-COVID-19
Institute for Fiscal Studies (2020) Covid-19: the impacts of the pandemic on inequality (https://www.ifs.org.uk/inequality/Covid-19-impacts/)
ONS (https://www.ons.gov.uk/)
Sheffield City Council (May 2020) 'Covid 19: Sheffield's Response & Recovery', Report to Cabinet
Sheffield City Partnership Discussions (June 2020)
Voluntary Action Sheffield (2020) The Voluntary & Community Sector's Initial Response to the Covid-19 Pandemic
Vulnerable People Workshop notes (included as appendix 3)
Shelter RIA response
Citizens Advice Sheffield: How we have helped people 1st April-30th June 2020
Mortgage Solutions: https://www.mortgagesolutions.co.uk/news/2020/06/19/one-in-six-uk-mortgages-on-payment-holiday-uk-finance/
COVID-19 and Food – A FPH position paper. 15 June 2020
Sheffield CCG Covid Community Impact Log
Economics Affairs Committee (2020) The Economics of Universal Credit – https://committees.parliament.uk/work/31/the-economics-of-universal-credit/publications/
UK Finance (2020) UK Finance reveals ten Covid-19 scams the public should be on high alert for – https://www.ukfinance.org.uk/Covid-19-press-releases/uk-finance-reveals-ten-Covid-19-scams-the-public-should-be-on-high-alert-for

Appendix 2: Further data/information to support summary of impacts

Universal Credit and other benefits (further details to support 1.1 in impacts summary)

Universal Credit (UC) provides financial support for those not in work or on a low income. It was gradually being introduced to Sheffield before the pandemic. The chart below shows the number of Universal Credit claimants in Sheffield from the beginning of March to the end of May, demonstrating the huge spike in claims as the country locked down and people lost jobs, had hours reduced, self-employed people lost business etc, leading them to apply for UC.



The number of Sheffield claimants on UC in July is roughly double the number before the pandemic (there are now approximately 44,000 UC claimants - information from local DWP Partnership team). Although the rate of new claims has fallen since the first spike, it is expected that the end of the Job Retention Scheme and continuing redundancies will lead to another increase in UC claims.

In many ways, the existence of Universal Credit during the crisis has been a success story, because the legacy system would never have been able to cope with the sudden increase in claims. The digital system meant that people could claim online and the DWP moved as many staff as they could onto claim processing and relaxed their identification procedures in order to reduce delays in payments. Locally the Sheffield DWP Partnership team has worked closely with agencies in the city to help the most vulnerable people get the money they needed, even in the midst of strict lockdown.

However, there have been issues with UC which will have negatively impacted on claimants' financial positions. This includes the inbuilt 5-week wait for payments (made longer in many cases because of the huge spike in claims), the fact that some people will be worse off on UC than on legacy benefits but are not allowed to move back, and existing challenges with the way UC is applied for and managed that can make it harder for those who are already disadvantaged. The cross-party Economic Affairs Committee has concluded that UC needs an £8m overhaul to make it able to properly support all its claimants, particularly the most vulnerable.

The Government increased the basic weekly rate for people claiming Working Tax Credit (WTC) and Universal Credit but did not put in place a corresponding increase for those claiming Employment Support Allowance (ESA), Job Seekers Allowance (JSA) and Income Support (IS). There is a concern that the government will follow through with the intention of reducing the basic rates of UC and WTC after a year. Even if they don't do this there remains the concern that they will just continue with the two tier system (Shelter RIA response).

As expected, the numbers of Council tenants on UC increased during the pandemic, but instead of having around 25% of the city's new claims, we only had around 10%. This shows many other people around the city (i.e. not council tenants), potentially new to the benefits system and maybe out of work for the first time, claiming UC.

Average monthly number of new UC claims from SCC tenants prior to March was 368 (previous 4 months) whilst March and April showed an average of 697. The number of new claims in May and June have dropped, as lots of people have been more stable, i.e. have kept their jobs, already claimed UC etc, and these numbers averaged 207/month.

Rise in people who have no money or food (further details to support 1.2 in impacts summary)

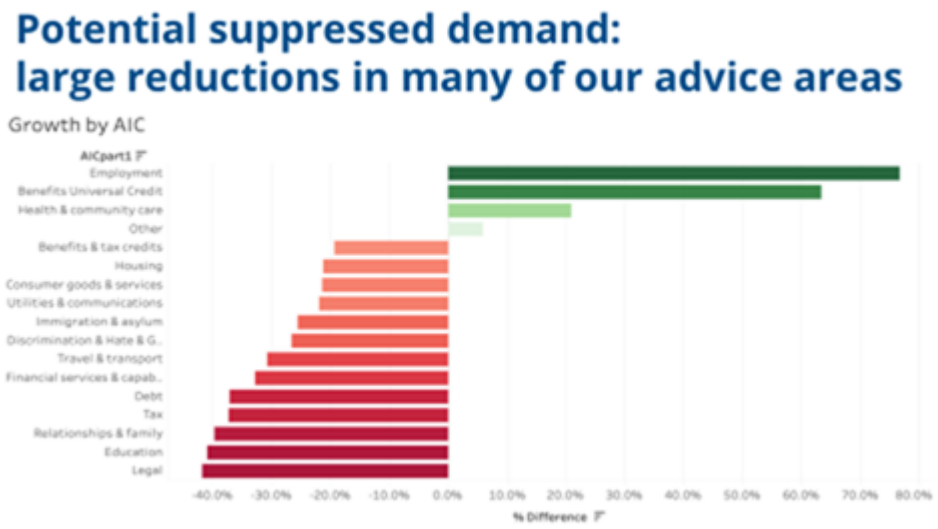
- Thousands of people across the city have received essential support. One in every 150 households has been helped with food, feeding over 3,000 people each week. From the start of lockdown to the end of April, Citizens Advice Sheffield handled an average of 120 calls daily through their Adviceline, and supported 2964 individuals with nearly 8000 issues.
- Foodbanks continued to play a crucial role. Demand has grown exponentially and the pressure is considerable and sustained. Foodbanks are clear that they remain the last resort for people who cannot afford food i.e. people who are vulnerable. Those who can pay need to be referred to the Community Hubs, NHS Volunteers, mutual aid etc. SCC, VAS and the sector have been working together to help with co-ordination of the foodbank infrastructure since the onset of the crisis. There are currently 27 foodbank sites for which we have data. Across these 27 sites the total number of people fed in the week commencing 20th April was 3587. This was a 14% increase from the previous week. The total number of households served was 1598, a 9% increase on the previous week. The ratio of households in Sheffield supported was 1 in 144. These figures are based on data which has been collected by those who are supporting the foodbank network and has come directly from foodbanks themselves. Bringing foodbanks together in a trusted network proved powerful. The network worked closely with the City Council, which bought food in bulk, which was then available to food banks at no cost. Without this joint effort the picture would likely have been very different. A collective approach to food was also important for the hubs - one of the significant challenges faced early on was how to manage financial transactions securely for both volunteer and client. Sharing options for how to buy food for people at home is an example of the importance of hubs working together, maximising capacity to be working with people needing support. (VAS COVID-19 VCS report)
- 19 organisations provided emergency food parcels for 15,319 households in total. During the week commencing 13th April 1144 households were supported when compared with 2202 during w/c June 8th, an increase of just over 92% (it should be noted that an organisation started to share data with us between this time frame). Between the same period a total of 35,437 individuals were provided with an emergency food parcel from these organisations. During the week commencing 13th April 2779 people received a parcel, by the w/c 8th of June this had increased by 82.8% to 5080. When analysing this data, it is important to note that these

households and individuals are not unique. We do not know the amount of times each household/individual has been provided with a parcel. We also do not have a centralised database which records the underlying causes of why people accessed support although food providers have highlighted issues including benefit delays, low income, debt and unemployment.

- The level of people needing support could be far higher than the data suggests. The Food Foundation has recently reported (May 2020) that 4.9 million adults (9%) living in the UK are still experiencing food insecurity. Of those 24% tried to access support and received it, 16% tried to get help but were unsuccessful and 52% of people did not try to get help as they didn't know where to ask for support, they didn't want to ask or they felt too ashamed to ask. This Food Foundation report shows that the potential levels of 'hidden' food insecurity and poverty could be extremely high.
- "There is a risk that existing health inequalities will grow as the outbreak continues over time. Many more individuals and households have become reliant on food banks and wider community support. The Trussell Trust reported an 81% increase in emergency food parcels during the last two weeks of March 2020 compared to the same period in 2019 including a 122% rise in parcels for children. YouGov polling commissioned by the Food Foundation and the Food, Farming and Countryside Commission estimated that 4.9 million people in the UK, including 1.7 million children (12% of all children) experienced food insecurity in May 2020, a 250% increase over pre-Covid-19 levels. Polling data showed that compared with the average, a 150% higher risk of food insecurity was seen in households headed by a black, Asian or minority ethnic (BAME) adult or with children eligible for free school meals, individuals with disabilities, and households who were self-isolating".
  COVID-19 and Food – A FPH position paper
  Version 1.0 FINAL Dated: 15 June 2020

People not accessing other benefits/financial support (further details to support 1.3 in impacts summary)

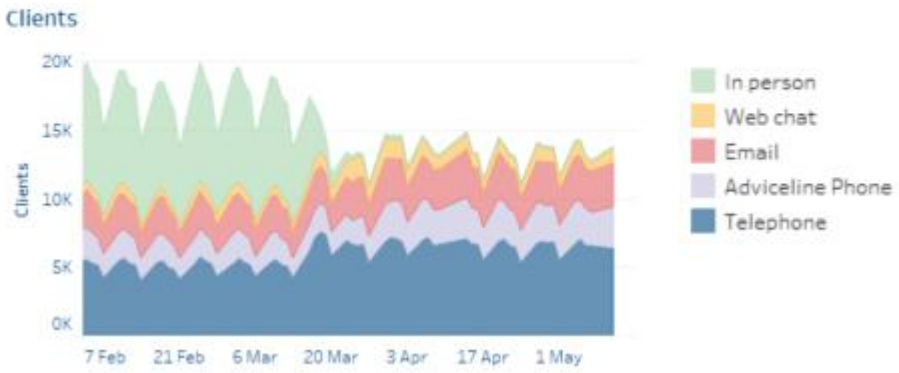
Chart from national Citizens Advice indicating how certain enquiry types have gone down (and therefore how they expect them to rise again):



National Citizens Advice data showing drop off in clients seen since lockdown, though the local picture is a bit different (see next chart).

Clients

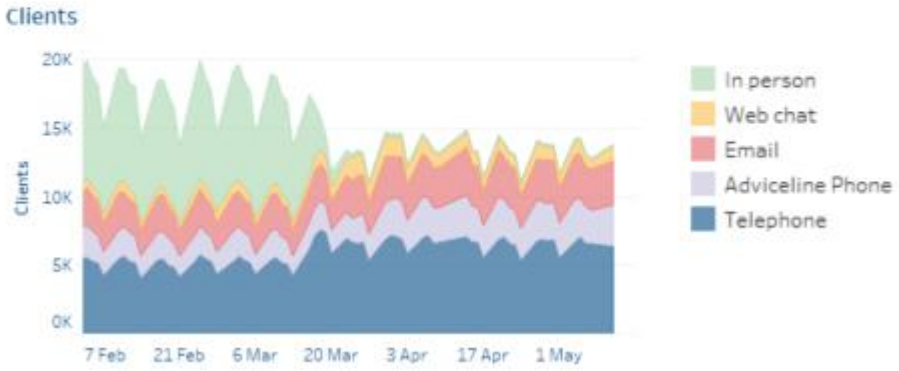
Last 5 days	24-28 Feb	Change
52,387	77,504	-32%



Local Citizens Advice data – showing channel. They appear to be reaching more people than the national picture, but there will be people who are not seeking support because they need/want it face to face:

Clients

Last 5 days	24-28 Feb	Change
52,387	77,504	-32%



Increased debt/arrears (further details to support 1.4 in impacts summary)

Although enquiries to Citizens Advice about debt issues have gone down during the crisis (Citizens Advice Sheffield 2020), debt itself has almost certainly increased. Government measures have stopped creditors/landlords from taking recovery action until 24 August 2020, meaning that people are less likely to address the rising debt/arrears until it is urgent. We know from Shelter and other local support organisations report that there is increasing anxiety amongst the people they support around the coming deadlines for recovery action starting again.

Since March 2020 when lockdown commenced, SCC's tenants rent arrears have increased steeply. In March 20, as the country moved into lockdown, arrears increased by £460k, which was due to Covid. Since then the average monthly increase we have forecast/seen is approximately £495k.

Total additional arrears due to Covid at end of 20/21 are estimated to be £5.1m, we expect impacts to continue for months/years after, as many of these arrears will take years to recover, if at all. Any local lockdown or measures introduced in the Sheffield City Region will cause a greater impact than that highlighted above.

Increase in number of tenants in arrears compared to 12 months ago is shown here:

City Wide	Apr-19	May-19	Jun-19		Apr-20	May-20	Jun-20
No of Tenants owing £30.01 & over	35.30%	37.7%	37.2%		36.4%	38.1%	39.2%
No of Tenants owing £1000 & plus	5.50%	5.7%	6.1%		7.6%	8.5%	8.9%

Council tenants who are in arrears are encouraged to contact us so we can help them gain control of their finances, including helping them to apply for any benefits they are eligible for, and referring to debt advice or providing hardship support where necessary. Most social landlords in the city provide similar support to their tenants and most have, like the council, been proactively contacting their tenants regularly to offer support. There are, however, significant concerns for private-rented tenants in the city, many of whom will have found themselves in similar financial difficulties and are far less likely to be able to turn to their landlord for support and understanding.

The crisis has not just affected renters' ability to pay their housing costs. A sixth of all mortgages in the UK were on a payment deferral in June 2020 (Mortgage Solutions website). Although these are often called 'mortgage holidays', they in fact usually lead to higher payments when the period comes to an end, which puts more pressure on mortgage-holders if they have not yet been able to get back on their feet.

Impact of the lack of face-to-face support (further details to support 2.2 in impacts summary)

Even where people have support provided remotely, there will be those whose lives are so complex and chaotic that remote support just isn't enough.

Case Study provided by Shelter:
Shelter provides the Homelessness Prevention and Resettlement Service on behalf of the LA, which supports households to effectively resettle out of homelessness and prevent homelessness, through intensive, holistic support, to help a household feel stable and secure. It is available to singles and families, in any tenure, and has a specialism in working

with children and families, with DA and in addressing multiple and complex needs. We also have a service focused on people affected by drug and alcohol use, who need support to maintain independent living and engage in recovery services. We have continued to support over 400 households intensively through the lockdown via these services, using phone and digital means primarily, with risk managed socially distanced face to face work where it has been impossible to engage or meet a household's needs in another way and where absolutely necessary. Many of those we support are experiencing increased vulnerability at this time – social isolation, loneliness, fear, worsening mental health, physical health deterioration, family stress and pressure, lack of ability to meet the needs of children, digital exclusion and inability to engage with services through the routes currently available. Some of our clients are unable to follow the lockdown rules, often resulting in neighbour tensions, police attention and ASB. This is one example of the how this situation has affected a household we have been working with for a while and where, pre-Covid, we were making progress in helping the family get some stability:

B is a very vulnerable client - isolated, scared of her 'community' and struggling with independent living. She is a single parent to 4 children. She does not read or write.
She has previously experienced domestic abuse from partners and also family.
She and her children have moved several times, have been homeless and in temporary accommodation before. She has been in her current tenancy since 2019, when we started to work with her – and this is the first housing stability her children have had.

Things had been going well at this property relatively speaking, compared to prior tenancies, before lockdown. She had maintained that tenancy until lockdown, was engaging with our support worker. It was often difficult to get hold of her – but she would sporadically engage, and we were able to work alongside school to support her. Key to engagement was building a relationship, being consistent and reliable and taking very pragmatic action to support her.

Since lockdown it has been almost impossible to support her. The services that she needs can't be in place at the moment. She is often difficult to contact – she has a long history of poor engagement with services and does not do well with phone contact. She had built up a relationship with the Shelter worker. Before lockdown, we would 'pop round', and on those occasions undertake as much work in that session as possible – taking action immediately, and being extremely proactive, getting quicks wins to encourage engagement. She came on our trips and activities – brilliant for her and the kids. This motivated her and gave her breathing space. So much of this has stopped during lockdown.

It is only possible to phone her and she doesn't always answer, or loses or sells phones. We have bought her new phones and dropped them round and provided food parcels for the family, but that doesn't offer the ability to properly engage with her. School also would regularly see her and the children and also pop round to the house if they hadn't seen them for a bit. That has not been possible either.

She is unable to enforce her own boundaries within the family, when she is engaging and we are in regular contact we might be able to provide her with support and advocacy to help her with this. If her family have decided that they are going to her house to sit on her front,

or go into her house – she will have very little agency or ability to prevent that, even less so without regular support from agencies.

ASB was taking place before lockdown, however due to lockdown regulations – the nature and frequency of the ASB around her property has escalated very quickly, and this has resulted in a closure order being put on the tenancy – and because she has breached that regularly during lockdown, things have escalated. She is being evicted. We are trying to stop this, but it may not be possible.

We have worked so hard with B to keep her in this property, which is the first bit of stability for her younger boys. They were attending school regularly and we had managed to build a positive relationship with her and the school, which was difficult as she was so wary. The prospect that this could all be lost and they will end up back in homeless temporary accommodation away from these support systems, with the need to start all over again is tragic. Her vulnerability and risk factors will increase as will those of the children.

Reduction in shops/services accepting cash (further details to support 2.3 in impacts summary)

Case studies:

- A man supported by our Central Local Community Response Team has Asperger's Syndrome and mental health issues and has had regular contact with his mental health nurse throughout lockdown. He uses cash specifically to help him manage his mental health and avoid spending money he does not have. During lockdown he was diagnosed with macular degeneration and wanted to buy a bigger television. He found this very difficult as very few stores were taking cash. In one store (part of a national chain) he was given the television, handed over cash and was then told by the manager they could not accept cash and had to physically hand the television back, despite having put cash on the desk. He felt humiliated and angry. He also had similar issues trying to replace a lost mobile phone - his primary means of communication with the outside world - and found that no major suppliers in the city centre would accept cash.
- A lady with learning difficulties who lives independently (the daughter of one of the VCS people who joined one of our workshops). She uses cash in order to help her understand how much to spend but - with shops only accepting cards - she applied for a credit card and then almost immediately overspent on it and got into difficulty with debt.

Poverty disproportionate affects different groups (further details to support 3.1-3.12 in impacts summary)

"Disabled young people, young carers and care leavers moving into adulthood face additional barriers that have a significant impact on their future life chances and risk of poverty. Disabled young people are half as likely to be in paid work as non-disabled peers, and disabled children growing up in poverty generally achieve adult goals of employment, economic independence, personal autonomy and independent housing to a lesser degree and later than non-disabled adults. Families, schools and other agencies may treat some

disabled young people as children longer because of their physical needs and perceived vulnerability. They can be particularly vulnerable to poverty at this time. Of the 9 million young people aged 14–24 in the UK, 2.7 million (30%) are living in relative income poverty. This is higher than any other age group and it is in this age group, too, that the poverty rate has grown the most over the last decade. They are also at higher risk of tipping into more extreme forms of poverty: young men under 25 are the group most likely to be destitute in the UK today. Of the 9 million young people, 2.6 million live independently rather than with their parents or other family, and 370 000 young people are parents themselves, 95% of whom live away from their parents and over half (54%) are in poverty."
https://www.jrf.org.uk/report/we-can-solve-poverty-uk

Appendix 3: Case studies on community support

Case study from Firvale Community Hub : The impact of Covid-19: Client Z in her own words

"I live alone, so when I started to get a cough and a fever I didn't know how to get essential supplies because I'm not vulnerable and couldn't get government help. I was also worried in case something happened to me while I was by myself.

I phoned Firvale Community Hub to find out what I could do. Obviously I didn't want to go out to shops myself as I didn't want to risk infecting others, and I don't have internet so I couldn't order food. I was running out!

The volunteer really helped. She helped me order food from a local shop on the phone, picked it up for me and dropped it off at my door. She also phoned me to check I was OK every day. Luckily I have now made a full recovery. I don't know how I would have coped without the volunteer. It helped to keep me going."

Case Study: Manor and Castle Development Trust

We have supported the people we were working with throughout the pandemic, offering on line groups, 121 conversations by zoom or telephone, socially distanced chats on door steps and daily telephone calls with people who we have concerns about in terms of their mental health.

From a community perspective we have seen the amazing response of the community:

- Mutual Aid groups offering neighbourly support, swapping and sharing resources, a friendly person to talk to.
- Groups providing food parcels and meals to people shielding , self isolating and those who have been financially challenged.
- Voluntary and Community groups working together to make sure those needing support actually received what was needed.

What the pandemic has highlighted though is the already existing structural inequalities in our communities and indeed made the gap wider. Work in communities will need to continue to address mental health issues, digital exclusion, financial and social exclusion of

those with fewer resources including children and young people. The impact of the recession is guaranteed to hit those already facing inequalities and disadvantages fastest and hardest but as a city we need to recognise, acknowledge and have confidence in communities they can and will play a key role in finding solutions to the challenges.

Case Study: Pitsmoor Adventure Playground

- *partnered with Burngreave Foodbank, enabling them to move to a delivery service*
- *co-ordinated print and delivery of 5000 leaflets with details of local support across Burngreave*
- *referred more than 30 households in for food parcels*
- *provided emergency food to about 10 households who were waiting for food parcels*
- *Somali engagement worker has supported approx 30 families with advice on benefits, foodbank referrals*
- *Delivered more than 100 playpacks to local families*
- *Supported the BAMER COVID-19 group with food purchasing and regular donations through the Fareshare scheme*

Appendix 4: Summary of Sheffield City Partnership Board Discussion (June: 2020)

Chapter 7

Loneliness and Social Isolation

Introduction

It is clear through listening to narratives of people told by staff and understanding experiences, lockdown has either exacerbated or created more people who are lonely and / or socially isolated.

We have also heard that many people are experiencing loneliness feelings even though they are connecting with friends and family (telephone / zoom). Therefore, we can only surmise that these feelings derive from something more fundamental which is *lack of face to face contact* with people.

I have been struck by two comments heard, these typify that this is a unique time and traditional solutions to L&SI may not mitigate the impacts:

- *I have a friend who has been doing these amazing gigs online, there are more than 75 people dialled in, but it made me feel more isolated / sad because we weren't together*
- Connecting with people in a face to face process (rather than video / digital) is a protective factor

Leaving lockdown: this report has been finalised as lockdown eases, shielding has been paused and people are returning to leisure and recreational activity. Therefore it might be easy to assume that the loneliness that people did feel during the crisis has dissipated, Unfortunately the 'new normal , social distancing and wearing face covering' now brings different challenges that reinforce isolation and loneliness:

- People do not feel comfortable or confident about going to public places or meeting other people
- Public transport is key for older people to getting out and there is a great reticence to using public transport
- Activities and building are not necessarily reopening or going back to what they were
- Many activities are still on line and digital exclusion remains a large barrier

Scope: The scope of this theme is ALL people, children and families of Sheffield immaterial of age or community and the impact of loneliness / social isolation on their health during the covid pandemic

Our approach:

- Desk exercise of the research into
    - loneliness & social isolation (L&SI) and the impacts of reduced social contact

- emerging national thoughts and evidence of the impact of covid on existing and developing L&SI
- Narratives and experiences of people in Sheffield – told through
  - People directly
  - Professionals and volunteers who support people
  - Professionals also contributed their own personal and family experiences

Definition: Public Health England define loneliness and social isolation as:

- social isolation as an absence of social interactions, social support structures and engagement with wider community activities or structures
- loneliness as an individual's personal, subjective sense of lacking connection and contact with social interactions to the extent that they are wanted or needed

We know that anyone of any age or community can experience social isolation and loneliness. Particular individuals or groups may be more vulnerable than others, depending on factors like physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life-stage.

Facts and figures: The Wellbeing and Loneliness - Community Life Survey 2019/20 was published 14Jul2020 which gives a national baseline of wellbeing and loneliness pre covid:

- Average scores for life satisfaction and happiness have remained stable since 2013/14 but the average score for anxiety has increased from 3.5 to 3.7 since 2018/19
- 6% of respondents said they felt lonely often/always
- Loneliness is higher for women, 16-24 year olds and those with a long term limiting illness or disability

Throughout covid the ONS published national data: coronavirus and the social impacts on Great Britain: 19 June 2020 the Indicators of concern, well-being and loneliness

- Almost two-thirds of adults (64%) said they were very or somewhat worried about the effect that the coronavirus (COVID-19) was having on their life now.
- This has decreased when compared with last week (68%) after remaining stable over the previous three weeks.
- Almost half of adults (48%) said their well-being was affected by the COVID-19 pandemic in the past seven days, an increase from 42% last week.
- The proportion of those aged 70 years and over who reported their well-being had been affected (34%) continued to be lower than the general population, however, for those with an underlying health condition it was higher at 60% – an increase from 56% last week.
- The most common issues affecting well-being continue to be feeling worried about the future and feeling stressed or anxious (62%), followed by feeling bored (57%).

Through the weeks of lockdown, of the four measures of personal well-being, falling anxiety

levels have seen the largest change over the period, falling again this week to an average score of 3.8 out of 10. As a point of reference, the average anxiety rating of people in the UK in Quarter 4 (Oct to Dec) 2019 (pre-COVID-19) was 2.97, although it should be noted that these figures come from different surveys. An analysis focused on personal and economic well-being throughout the lockdown period, and the impact of the COVID-19 pandemic on people and households in Great Britain is available in *Personal and economic well-being in Great Britain: June 2020*

Recommendations:

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

We cannot go back to the 'old' Sheffield – people were lonely and lacked social connections before covid – WE WANT the NEW Sheffield to be a compassionate city, where support is 'trauma informed' and people and communities actively help each other (which will lead to reducing loneliness and isolation)

Many people in Sheffield give of something to their community regularly, whether that is knocking on the neighbour, picking up rubbish or volunteering at a library. This can be quantified by the estimated to be £287m per annum economic contribution by volunteers to the City.

BUT we also know that in Sheffield, even before covid, many people lack the 'agency or activation' (lack confidence, motivation and have anxiety) to connect or know how to share of the 'talents and gifts'. We have heard from the narrative that many people are uncertain about going out and re-connecting with family and friends. Some people will need help to understand and support to leave the house.

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

   Rationale: Loneliness is a contributor to poor physical and mental ill health. Some activities / buildings will never reopen and / or it will be a long time before

community activities will be properly open. Therefore many people will remain isolated in their own home becoming more socially disconnected.

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 coivd safe face to face) – a reason to get together with meaning and purpose to people eg knitting, sporting memories

    Rationale: Hillary Cotton (Radical Help) advocates building relationships and people to come together for a reason or interest rather than people being a recipient of a 'service'
        - *peer to peer – buddies – people helping each other, people feel valued and they also have something to contribute. Long standing evidence describes the impact of peer support is more powerful than that 'structured' support.*
        - *New and reopening activities will need more and new volunteers as some volunteers will not return volunteering.*
        - *Resilient communities that are thriving, have many social activities and informal support networks*

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

    Rationale: we need to capitalise on the already self started non service approaches and enable them to flourish along with making sure they don't put people at risk (sharing information about vulnerable people inappropriately)

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**

    Rationale: evidence from children who have long periods of cancer treatment and have been separated from their family struggle to connect with people into their adulthood

    Rationale: people who are lonely; die younger, receive formal services earlier and for longer
3. **Help people and families manage the risk of covid so that they are not too frightened to re-engage in their life**

    Rationale: older people who may live alone are also at greater risk of covid are anxious about leaving home and this is compounding their loneliness and social isolation

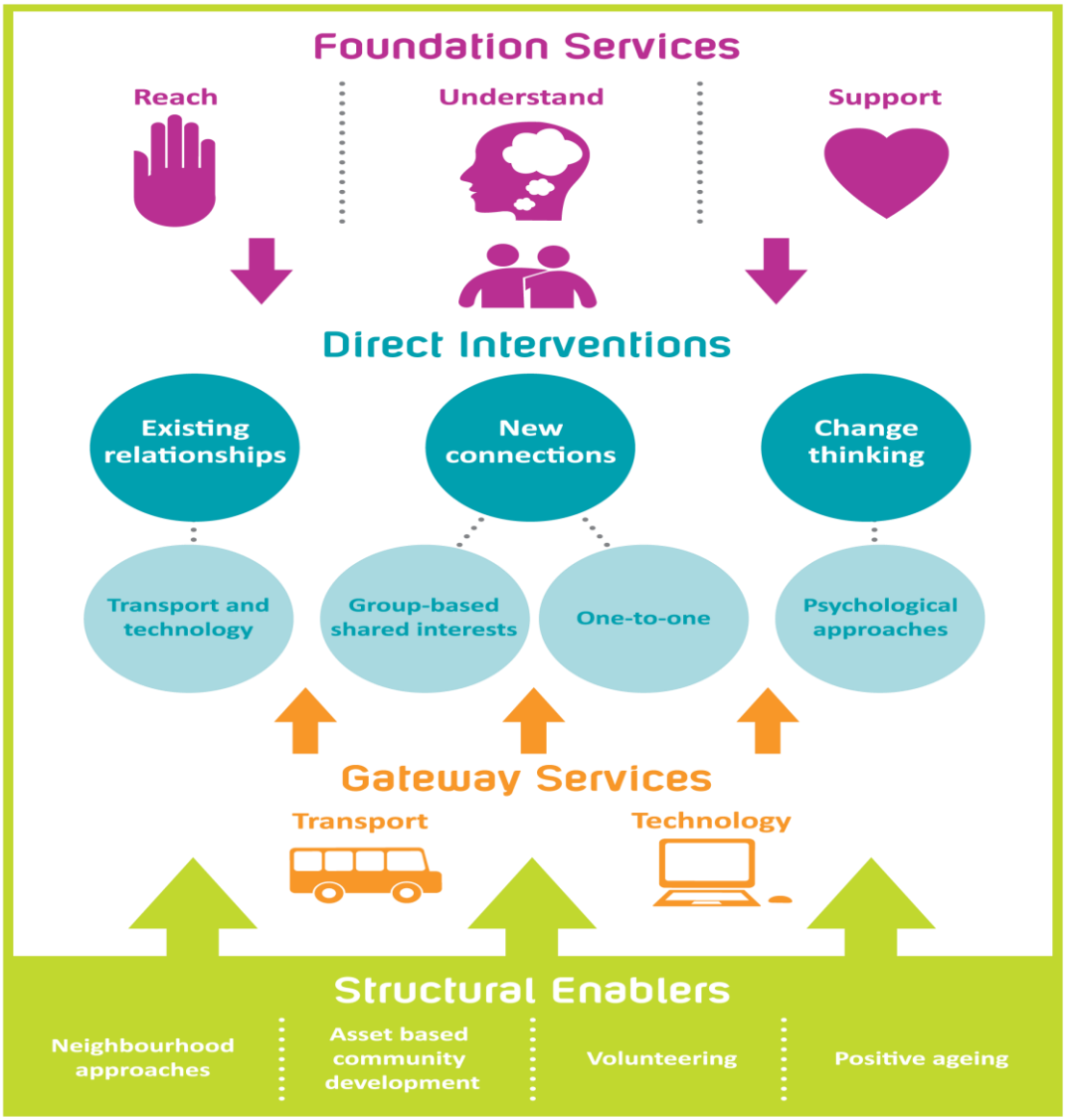
4. **Reduce digital exclusion**

   Rationale: if you are digitally excluded (lack kit, wifi / credit, skills or the understanding what a device does) you cannot mitigate some of the lack of face to face contact
5. **Support small community and volunteer led building and activities to reopen or start activities in a sustainable and covid safe way**

   Rationale: smaller and volunteer led organisations may not have the capacity or skills to assess guidance, make or afford the changes required for covid safe opening. These community venues and volunteer led activities are the life blood of many communities and peoples social interactions
6. **Support people to develop the tools to manage living by themselves (needs to connect to the work of the mental wellbeing HIA)**

   Rationale: social distancing and possible return to lockdown will be here for some time and we need to equip people with the skills to manage their social and emotional wellbeing whilst being alone for periods of time

The following diagram comes from the Campaign to End Loneliness and although is not covid specific, it describes what is needed to *end loneliness'*



What have we heard from people of Sheffield:
The following is a range of narratives, experiences and stories from professionals and volunteers working across statutory and VCF sector. These narratives are primarily about the people they are supporting, however, some are personal reflections and the experiences of family and friends. What is evident from gathering this data is that there is no typical profile of someone who has been affected by social isolation and loneliness during the COVID-19 pandemic and this has been an unprecedented challenging time for the people of Sheffield. A number of key themes have been identified from these narratives:

- Lack of face to face contact with family, friends, community activities/services. Phone calls and Zoom cannot replace face to face contact and interactions.
- It is now emerging that people are now anxious about life after lockdown, increased levels of fear and anxiety about leaving the house and the future.
- Increased levels of loneliness and social isolation since the COVID-19 pandemic due lockdown, shielding and social distancing.
- Digital exclusion / digital skills limit the ability to connect with family and friends and join in social activities
- The profound effect of bereavement on individuals and families during COVID-19.
- How can services and activities safely resume post lockdown/ COVID 19?

However, it is also important to recognise that the some people also acknowledged unexpected positive benefits of lockdown:

- Lockdown for some allowed people to forge lasting friendships with neighbours and community members.
- Neighbourly and community support was overwhelming. People have talked about a sense of community spirit. People are looking out for each other, helping with shopping etc.
- It was reported they had more time to focus on their own health and well-being.
- Increased digital skills and increased online connectivity, catching up with people some had lost contact with.
- Regular check in phone calls and Zoom activities were greatly appreciated "*Value enormously what we are doing to remain in contact and support, built up by trust and our outreach work*"
- Some people had support from a range of different services
- Staff reported that organisations have worked hard to ensure supervision / peer support continued
- Young carers reported they have more time with family, less time travelling to college, checking in more with other family members and friends, been good to have time to process - and time to do breathing/meditation
- People are now in engaging with services that they had resisted in the past.
- One service reported an uptake new mum's breastfeeding.

Cohort specific narratives: This table highlights many overlapping themes:

Older People	• Older people are more likely to be living alone and therefore had no Face to Face contact with family (to protect the older person) or friends (vulnerable too). • Age UK Sheffield have reported an increase in volunteer befriending by 22% during the coronavirus outbreak • People have lost of social and physical contact/connections with families, services and community activities • Digital Exclusion – lack of kit and/or lack of Digital Skills or do not have the 'motivation / activation' to use kit • BAME older people where English is not first language struggle to engage with zoom activities • BAME people living in busy houses have reported feeling

	lonely because they have not been able to see friends or have down time because they are supporting other people in the home • Some people who were digitally included also stated they were profoundly lonely due to living alone • Government messaging confusing and lacked clarity and didn't know what they could do or assess or understand the risk to them or their family • Some are very concerned, as no idea the end point or will life ever be normal again • The lack of daily structure/ motivation – diet, daily exercise and functional mobility has been affected • Concern about losing independence and being reliant on other people (maybe strangers) for practical tasks such as shopping • Reported increase in mental health issues and anxiety • Fear of leaving the house/ loss in confidence - Will activities reopen? Will older people attend? - Is public transport a safe way to travel? - Loss of functional mobility
Bereavement during lockdown (may or may not be covid related)	• Guilt of not being able to provide the right funeral or being able to grieve properly • Distress at not being able to hug or comfort family and friends at church / graveside • *Case study: We heard that one lady went home after her husband's funeral, by herself – with her meal from church on a plate, just sat and cried for an hour, she just never expected it to be this way* • *Case study: Another lady wished that she would not wake up in the morning* • One bereavement service seen 3 fold increase in calls from people over 55
Carers	• *Case study: Lockdown has made her feel more isolated as the hobbies that used to take her out of the house are not happening at the moment so all her usual distractions are gone and she is noticing how much of an impact caring for her husband is having. She talked of feeling she is grieving for the time they have had in the past and what is unlikely to happen in the future. Zoom sessions are not the same.* • *Case study: 3 months of not seeing friends is a very lonely place and made me realise how small my world is* • Support/day services closed at the start or before lockdown, they are now starting to reopen not all people will return to activities and therefore carers will not get the same breaks o Less people can use organised transport, people do not want to use public transport

	○ Activities might not be able to give the support to people who need a bit more help ○ Some people attending activities do not understand social distancing and extra hygiene requirement • The carer / family may choose not to use a care home for a break and could also have reduced domiciliary care due to COVID-19 risks and are completing all tasks alone • Caring can be lonely, as the carer making all decisions on their own with no face to face contact with family / peers / professionals
Young Carers	• No other social outlet or peer support as schools and activities closed – it placed a strain on relationships • School and activities is a way that young carers get a break from family life. It can feel like a constant rollercoaster and no break from family, it's hard not having different people to be around. • *All in the same storm but not in the same boat.* • *Case study Mum's peer support and activities have stopped and now she is a bit down about it all, she is spending more time in bed which then means she gets achy, so me and Dad have to lift her more, which causes us pain – so it's becoming more tiring for us. And this creates a cycle because her pain means she wants to stay in bed– but staying in bed makes pain worse and then she is in a low mood*
People with Dementia and their carers	• *Case study: a person whose spouse has early onset dementia, she was working whilst her husband was at day care. She has now had to take the step for him to move into a residential home as his dementia has deteriorated significantly and she is exhausted.* • Carers struggling because they are at home alone with the person with dementia • The person with dementia may not remember or understand about covid or the different way of living • Cannot go to the park and have not got outdoor space. • We do not walk past our daughter's house because they don't understand why we can't go in. We tried to go to wave through the window, feeling frustrated. • Feeling isolated and 'lost' due to so many changes with what they did and can't do now • Used to get respite through family member, friends and seeing a neighbour but cannot do this now • Family members also shielding and not visiting. Self-isolating and protecting others • Feeling challenge 'when it will all end'? 'When will we go back to normal'? • Missing routines "it's like we are living in a bubble!"

	• Wondering what the new 'normal' will look like! Frightened • Losing the social links and contact with others, like the Dementia Café and 'On the plot' Dementia Activity at the Allotment • The person with Dementia is sleeping more • The person with Dementia has a down turn noticeable already in their condition 'worsening' • Lack of digital skills and kit • Anxieties about going out, which adds to isolation and nervousness that will impact on wellbeing and mental health, not only now but as a reality post Covid – 19.
Homeless people	• a lot of the people support have many different barriers eg poverty / under managed mental health issues, BAME / substance misuse etc • absence of casual / routine interactions - I think the absence of small daily contacts (conversation with the person behind the counter in the local shop, staff in coffee shop knowing what you order when you walk in, etc) can hurt people who either can't spend or whose appearance makes shop staff nervous when they walk in. • Related to that point is the importance of places where everyone is "entitled" to be. There are our projects & similar, but also places like the library. A couple of our guests have been very severely impacted by the closure of the library as a safe place to go and sit. I wonder about the impact of loss of the library's IT access. Again. A lot of our guests are very regular users and probably have no IT at home. • Our evidence from Walk & Talk is that there are people in the city centre who are lonely and isolated and we have had positive feedback as to the benefits of short chats. I think one lesson is there is a place for that engagement that goes out to people - out in public places
Migrants/Asylum Seekers	• Major issue for people is with digital exclusion/ data / connectivity • Increase in number of people seeking emotional support due to cut off from own social connections, some have had no contact with anyone but support phone calls focusing on well –being chats, encouraging clients to go out and exercise and general well- being advice • Fears to go outside as reported BAME group more at risk to COVID -19 • Language barriers a challenge on the calls furthering the feeling of isolation and loneliness • high levels of frustration as their immigration cases are not advancing due to COVID – 19 • *Case study family living in a flat with no garden, feel isolated*

	as they have no friends or family locally and school is the only social connection. Parent has struggled with physical and emotional health. Two socially distant meetings from Services have helped
Disabled people	• Some Specialist Service have been quiet because become don't want to 'bother' services at the moment • Workers have seen some clients go into serious decline, people have had services reduced , day activities and visits out have stopped, furthermore reduced support in the home and therefore no longer having any contact • Difficulties with accessibility and using IT equipment due to impairments • People with sensory impairments being unable to access public and outdoor space safely, thus remaining more isolated than they would be usually – and not able to participate as things 'open up', as they feel it is not safe – e.g., for Blind or Deaf people to be able to socially distance effectively is hard. • Disabled people rely more heavily on public transport and they are becoming more isolated through not feeling they can use it safely • There has been an increased number of people supported by services dying and this has been hard for staff particularly working from home alone • It has been challenging for staff, working from home without the immediate peer support of an office
People in social housing	• We know that people's lives are on hold to a large extent, and are unable to access therapies, community activity or rehousing - issues such as confidence, and some physical health problems and money/debt issues are being stored up too. • Quite a few clients have had their housing move put on hold which has caused them considerable anxiety and stress in what is already a difficult situation. • We are dealing with people with mental health problems • There are those few people who have a learning disability and who can't keep in touch by phone and are not able to adjust to distanced contact. They have very little support therefore. • A small number of people are having great difficulty coping without face to face contact. Their mental health issues have been exacerbated hugely. A small number have started self-harming again. Mental Health services are not responding as they would have done. • Some community responses have been wonderful. (volunteers, food banks etc).
Parents and new Parents	• Parents have shared have missed the peer support at school pick up / drop off e.g. seeing people at the gate of the school

	and the support that this brings. • Single-parents no longer having that information wider network of support that they have had when not in lock down. • Developing and identifying your 'social bubble' is creating lots of stress as to who picks who for families and the tension that this brings. • Cross generational loss – those grandparents that have been supporting parents and the pressures this places on parents. • Where English is not first speaking language and the delivery of service to support over zoom is difficult • Parents with children who have additional needs have not being able to access respite in some instances *Emerging concerns and issues of professionals:* • Missing or late diagnosis of perinatal issues • Parental mental Health as well as Children and Young People's mental health • Delay in diagnosis for ASD and then delay in the support that is available afterwards • Bringing back ground rules and household management moving forwards. Transition back into education after such a long time off. *New Parents* • The lack of support for pregnant women during the lockdown with health appointments and general access to support and advice being reduced • All the plans, hopes and thoughts about becoming a parent is not the reality - completely not what new mums / parents expected. • At home and not going out and not building a network • No support from family / parents, not having grandparents meet new babies • Concerned about attachment and bonding over the short and longer term • A positive is that, with more people working from home, some fathers have spent more time with their new baby
Lunch Clubs	• Members are keen to resume lunch clubs because this is one of their only social events of the week • Some Lunch Club volunteers are calling members and sending out activity packs • Digital exclusion, kit and skills for some older members is an issue • Reopening is huge concern due to the nature of the club its self, transport, post Covid-19 safety measures, volunteers and cash flow.

VCF/Other organisations/ Groups in Sheffield	• Physical activity is not only important for physical wellbeing but also mental wellbeing. The closing of local activity groups (e.g. Health walks) has left a lot of people without the emotional support they need to stay active and also reduced their social contacts • Reported increase in isolation and loneliness especially among people who are shielding • Reported increase in younger people and families seeking support due to being newly unemployed • People describe a preference for face to face connections • Seen increase in addictions or relapse or self-harming due to loneliness and feeling frustrated with situation • People behaving out of character – anti- social behaviour • New pressure to provide more meals per day due to schools closed • Financial worries • Phone calls greatly appreciated but not the same as face to face interactions and activities • People fear of resuming to normal life, bus travel etc. • Organisations feeling overwhelming responsibility to get 'reopening right' fears of infection resurgence with customers • Green spaces becoming busier, harder to social distance, more rubbish and toilets closed • People living alone have reported deterioration in their mental health due to isolation. This also includes self-reported lack of motivation and engagement • People have had their housing move put on hold which has caused them considerable anxiety and stress in what is already a difficult situation. It is not clear when they will be able to move • Volunteers appear to be highly concentrated in the SW of the city, which might mean that people from lower socio-economic backgrounds also find it more difficult to be matched to a volunteer befriender
Workforce / Staff / professionals	• Home working is very isolating when working and supporting people – there is the lack of immediate peer support or checking other colleagues opinions • Calls can be over an hour to support people who are anxious / low – some clients have not spoken to other people in weeks • Juggling family life, home schooling and work • Missing work colleagues and sounding board • Staff who are still visiting families and seeing people are reporting that visits are getting longer – because the person is not seeing other people / family

How has Covid affected services aiming to reduce isolation?

- e.g. lunch clubs and social cafes not running. What is knock on of this – do they all plan to resume as lockdown eases, will people be confident to attend, what can we do to encourage this etc

COVID-19 has had a dramatic impact on support services that help those who are potentially at highest risk of being isolated or lonely. It is too early to understand fully the longer term impact. The list below describes some key issues and the section below explores the Lunch Club in more detail:

- many services closed before lockdown was fully instigated
- community activities are either run by or supported by a huge army of volunteers – many who are in vulnerable categories also
- activities and sessions are delivered out of buildings that are owned by other people . Reopening and making the building covid safe might be prohibitively expensive. Or all the facilities such as kitchen, toilets and sharing food cannot be done in a safe way.
- sessions might only be available for a reduced number of people.
- People who were previously independent and used public transport to get to services may not want to travel on the bus / tram now
- Some volunteer led activities may choose not reopen

Lunch clubs

An example of this is the 48 lunch clubs that Sheffield City Council grant funds. These clubs have tried to adapt their support where possible, including: weekly or fortnightly calls, delivering cards/flowers on birthdays, weekly fish and chip runs and monthly delivery of activity packs and newsletters. An example of this is Parson Cross Forum who are doing Zoom sessions for various social activities but digital inclusion is a barrier for many, either because they don't know how to use technology or don't want to.

Whilst adaptations have been made, social contact is still limited or different than pre-COVID-19. Lunch clubs are not currently running which is concerning as these clubs are specifically aimed at older people to help combat isolation and loneliness. Obviously, the reduction in social activities will further exacerbate the feelings of isolation and loneliness brought about due to lockdown restrictions. This is especially true for those who have additional social restrictions due to being clinically extremely vulnerable.

Black, Asian and minority ethnic (BAME groups that meet up via lunch clubs are also at risk of being increasingly isolated, with some attendees being unable to speak fluent English. This can be a social barrier and it is why activities like the Chinese Healthy Eating Lunch Club are so important. Attendees feel a sense of community and belonging. COVID-19 restrictions will cause additional isolation for groups who are already at risk of being marginalised due to language barriers. A large proportion of those attending the lunch clubs are over 80-years-old.

The majority of lunch club attendees are desperate to go back to clubs again; however, there remain a number of logistical problems that will need to be resolved before clubs can once again open. These include:

Community transport – many attendees rely on community transport. Community transport was struggling with capacity before the pandemic, so if social distancing measures are put in place, it will be difficult to get all the attendees back to lunch clubs.

Safety – many attendees need help when getting out of community transport or when going to the toilet or their seat. Volunteers and attendees will want to know measures have been put in place to make these kinds of contacts safe. This could require more volunteers to be present, however lunch clubs are running with the minimum number possible so would need to plan to recruit more volunteers. If there is close contact then there is also the need to consider personal protective equipment, which could complicate things further logistically speaking. Safety is important due to the age/health of those attending, the majority of which are in the clinically vulnerable or extremely vulnerable groups for COVID-19.

Premises – many of the venues are cramped so wouldn't lend themselves to social distancing. Plus, current guidance suggests restrictions on how many people from different households can meet both indoors and outside.

Organisers' skillset – whilst lunch clubs are funded by the Council they are organised and run by volunteers. These volunteers can themselves be elderly. The logistics of trying to run a lunch club during a pandemic are very different to the logistics that were required during pre-COVID-19 times. It is not easy for some of the lunch clubs to adapt, as the volunteers who run them are not always digitally included and don't have the skills to create things like activity packs. Some volunteers are also clinically vulnerable or extremely vulnerable, meaning they're just trying to adapt to their own circumstances. They are not necessarily thinking about planning COVID-19 lunch clubs that are 'safe' in accordance with Government guidance.

Attendees are 'fed up' and want to return to their lunch clubs. However, 75% of lunch clubs that have been consulted so far say they don't intend to open before next year. This means people at high risk of being lonely or socially isolated, will continue to be so even after lockdown eases.

Next steps

Things being considered at the moment are:

- Continuing activity packs
- Creating advice on how to re-open lunch clubs including risk assessments.
- Digital inclusion.
- More Zoom meetings.

1. Impacts on different groups of people
Disability
Negative
Disabled people In May 2020, just over 7 in 10 disabled adults (73.6%) reported they were "very worried" or "somewhat worried" about the effect that the coronavirus (COVID-19) was having on their life (69.1% for non-disabled adults); this represents a decrease compared with April 2020, when nearly 9 in 10 (86.3%) disabled adults reported this. Concerns about well-being tended to be most frequent among those with mental health and socio-behavioural-related impairments, whereas concerns about access to essentials tended to be most frequent among those with hearing- or dexterity-related impairments. Disabled adults more frequently reported their well-being had been affected through feeling lonely in the last seven days (48.7%) in May 2020 compared with April 2020 (30.3%); disabled adults were more likely to report this concern than non-disabled adults (29.4%) in May 2020. (**ONS May2020**) **Impact on L & SI on Mental Health** Loneliness and social isolation can be the catalyst for many mental health problems, including acute stress disorders, irritability, insomnia, emotional distress, mood disorders, including depressive symptoms, fear and panic, anxiety, frustration and boredom, loneliness, self-harm, suicide, substance abuse (Holmes, 2020; Donovan, 2020; Brooks, 2020; Desclaux, 2017). People with severe mental illness are already likely to be affected by social isolation and other social issues compounding their vulnerability such as homelessness, loneliness and poorer physical health (Usher, 2020).
Gender reassignment
• Gap in national data • We did not hear from anyone locally
Marriage and civil partnership
Negative
Speculation from legal professionals is that divorce rates will increase due to underlying relationship tensions coming to the surface because of lockdown(s). This could have an impact on how lonely or isolated people feel although there didn't appear to be any research specific to this theme to cite.
Pregnancy and maternity
Negative
Pregnant women (and new mothers) may be more at risk from the potential dis- benefits of social distancing (for example loneliness, reduced access to services and information, reduced physical activity and access to a balanced diet /healthy food, peer support, increased instances of domestic abuse during pregnancy and beyond).

Pregnant women have been told to self- isolate and may delay seeking help from maternity services when they should not delay.

Race

Negative

COVID-19 will likely exacerbate isolation and loneliness in black, Asian and minority ethnic groups. According to British Red Cross research, BAME groups are at a higher risk of being isolated/lonely.

The research shows that people from BAME backgrounds are more at risk of experiencing certain factors that cause loneliness and can often face greater barriers to accessing support.

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

Sixty-seven per cent of respondents who felt they didn't belong in their community said they were always or often lonely, compared to just 16 per cent who felt they did belong.

Discrimination, bullying and disrespect increases loneliness - racism, discrimination and xenophobia are all additional triggers of loneliness that have all too often been overlooked. Almost half of people (49 per cent) who have experienced discrimination at work or in their local neighborhood reported being always or often lonely, compared to just over a quarter (28 per cent) of people who hadn't.
Just 31 per cent of Black African respondents had not experienced any type of discrimination, compared to 74 per cent of White British respondents.

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, with almost 60 per cent of all survey respondents admitting they didn't feel confident talking about loneliness, and a third more saying they'd never admit to feeling lonely. Worrying about what people would think was higher for some minority ethnic groups.

Religion and belief

Negative

Places of worship were closed during lockdown, so for some, not being able to socialise or talk with people will have led to them feeling more isolated/lonely. Some services have been online but not everyone is able to access them due to digital exclusion. There doesn't seem to be specific research on religion/isolation and loneliness

Sex
Negative
Spantig explains that the new research showed that the biggest strain placed on the mental wellbeing of women in lockdown was feeling isolated and lonely. “Before this study everyone thought it would be related to economic factors because we see that women need to work more at home, and they take more responsibility in terms of household work, but actually the largest factor contributing to the gender gap was loneliness,”. The research revealed that more than a third of British women have been experiencing loneliness in lockdown, with 34% saying they ‘sometimes’ feel lonely and 11% saying they ‘often’ feel lonely. The number of men struggling with feelings of loneliness in lockdown is considerably lower: 23% said they ‘sometimes’ felt lonely and only 6% said they ‘often’ do. “Those who had more close friends before the lockdown were also more likely to report loneliness after the onset of the lockdown” Spantig explains that, while there’s likely to be “several factors” at play here, this difference in the levels of loneliness between men and women can be primarily explained by the differences in their friendship groups pre-lockdown. “What we looked into a bit more was the role of friendship groups,” she explains. “So those who had more close friends before the lockdown were also more likely to report loneliness after the onset of the lockdown. And we also see this pattern where women are more likely to report greater numbers of friends.” The research, which was based on online interviews from the UK Household Longitudinal Study (a project which has allowed social scientists to track the mental states of the nation during lockdown), also revealed that the number of women experiencing at least one severe underlying mental health problem has risen 16% in lockdown (from 11% to 27%), compared to an 11% rise in men (from 7% to 18%).
Sexual orientation
Negative
Loneliness has become an epidemic during lockdown, especially for young people: Before lockdown 21% of LGBTQ+ people said they experienced loneliness “very often” or “every day”. During lockdown this more than doubles to 56%. Epidemic of loneliness among young people: more than two in three (67%) of under 18 LGBTQ+ people felt lonely "very often" or "every day" during lockdown. LGBTQ+ people are already at higher risk of mental health problems, and our findings show that lockdown has exacerbated the existing epidemic of poor mental health. There have been dramatic increases in the severity of depression, anxiety, and loneliness, and many more people reporting their general mental health declining. This is extremely worrying and may have long-term consequences for particularly at-risk groups.

"I'm currently on lockdown with my family and I'm not out to them. it would be fine if I could talk to my friends but I can't so I'm feeling lonely and isolated. I'm not worried for my personal safety as I don't believe my family would be homophobic if I came out but I'm not ready to do that so it's difficult to hide it from them." Amy, 20

There has been an explosion in loneliness. Before lockdown 21% of LGBTQ+ people said they experienced loneliness "very often" or "every day". During lockdown this more than doubles to 56%.
It's clear that young people have borne the brunt of the epidemic in loneliness produced by lockdown.

Loneliness more than doubled in under 18s who reported staggering levels of "very often" or "every day" loneliness during lockdown (28% before / 67% during). Ages 35-44 started and ended at lower levels (14% before / 39% during).

Lesbians and bisexual people reported bigger increases in "very often" or "every day" loneliness than gay men (bisexual 23% before / 61% after, lesbian 24% before / 61% during, gay 15% before, 43% during).

Trans and gender diverse people reported a bigger increase than cis people: (trans and g/d 23% before / 66% during, ciis 20% before / 51% during).

South Asian people reported the biggest increase in "very often" or "every day" loneliness (almost three fold), though all ethnicities reported large increases: (South Asian 23% before / 61% during, Black 20% before / 53% during, white 21% before / 56% during).

0-5 years
Negative
Coronavirus isolation is hard on all of us because as social beings we miss being with other people. But in some ways, children suffer from lockdown much more than adults. Children are still learning how to regulate their emotions. That makes it more difficult for kids to cope with the feelings of loneliness that come from being away from their friends. Spending time with peers is also crucial to child development, as socialising with others their age is how children learn social norms. School, friendships, peer activities, and achieving age-appropriate milestones are the work of childhood. All of these activities affect child development in a variety of ways. When a child is isolated from friends, whether by childhood illness, or a pandemic, the usual social rhythms of childhood are interrupted, affecting a child's social development. Survivors of childhood cancer, for example, report having fewer friends and more difficulties forming close friendships than their healthy peers. The isolation and social distancing that come with COVID-19 interfere with a child's social life and social development in much the same way.

School years
Negative
See the impact for 0-5.
Working age adults
Negative
Working-age adults living alone, and those in "bad" or "very bad" health, in rented accommodation or who were single, or divorced, separated or a former or separated civil partner were at greater risk of chronic and lockdown loneliness Great Britain, 3 April to 3 May 2020 (ONS)
Old age
Negative
Older people Older people can be more vulnerable to being lonely (and living alone) with declining social circles, deteriorating health, death of partners and friends (Victor, 2012). And certain sub-populations such as older people within the gay, lesbian and bisexual community and immigrants are even more vulnerable (American Psychological Society, 2020). Considered alongside the current Covid-19 social restrictions, the impact of disrupted social care services, the ageist discourse, and devaluing of older people contributing to feelings of worthlessness, of being a burden, older people are particularly vulnerable (Brooke, 2020). Self-isolation will disproportionately affect older people whose only social contact is out of the home, such as shopping, day-care and community centres and places of worship. Those who do not have close family or friends, and rely on the support of voluntary services or social care, who are already lonely, isolated, or secluded, face further barriers to contact (Armitage, 2020). ***People in institutional settings*** Older people in residential care homes are at risk of becoming more socially isolated due to visiting restrictions. Generally people living in institutional settings - care and residential homes, assisted living facilities, prisons and jails - are already cut off from many parts of society and further susceptible to loneliness and isolation (The Hill, 2020). One of the immediate issues around social isolation is the reduction in physical activity and greater sedentary time, which can impact on mobility and contribute to increased risk of frailty, ill-health and poor wellbeing, particularly for older people (CEBM, 2020; Schrempft, 2019; BGS, 2019). An ONS analysis (2018) highlighted three profiles of people at particular risk from loneliness: Widowed older homeowners living alone with long-term health conditions.

Shielding/vulnerable
Negative
Local information The voluntary, community and faith sector has commented that they have seen an increase in isolation and loneliness especially amongst the shielded group

Significant impacts – general
A major adverse consequence of the Covid-19 pandemic is likely to be increased social isolation and loneliness. Both of these can have a detrimental effect on health and wellbeing under normal circumstances. This risk is greater for some people than others, and as is often the case, it's those who are already vulnerable are at greatest risk. A general population survey (Ipsos MORI, 2020) revealed widespread concerns about the effects of social isolation and distancing, including increased anxiety, depression, stress, and other negative feelings (Holmes, 2020). Social isolation and loneliness are risk factors for poor mental and physical health (Santini, 2020). A study (Steptoe, 2013) highlights isolation as one of the main risk factors that worsen pre-existing conditions, comparable to smoking. Meta-analysis research has found that feeling lonely, being physically isolated or living alone were each associated with a risk of early death (Holt-Lunstad, 2015) One study (2018) pointed to poor habits developing due to loneliness and social isolation, with people overeating, smoking or using alcohol and drugs more when lonely and isolated. Prior to Covid-19 this was acknowledged in health and social care policies and campaigns. The Campaign to End Loneliness created a network of national, regional and local organisations to work together to ensure that loneliness of older people remains a public health priority (Brooke, 2020) **Impact of L & SI on Physical Health** - In meta-analyses, is associated with a 50% increased risk of developing dementia, around 30% increased risk of incident coronary artery disease or stroke, and a 26% increased risk of all-cause mortality (Donovan, 2020; Armitage, 2020). - One of the immediate issues around social isolation is the reduction in physical activity and greater sedentary time, which can impact on mobility and contribute to increased risk of frailty, ill-health and poor wellbeing, particularly for older people (CEBM, 2020; Schrempft, 2019; BGS, 2019). **Impact on L & SI on Mental Health** - Loneliness and social isolation can be the catalyst for many mental health problems,

including acute stress disorders, irritability, insomnia, emotional distress, mood disorders, including depressive symptoms, fear and panic, anxiety, frustration and boredom, loneliness, self-harm, suicide, substance abuse (Holmes, 2020; Donovan, 2020; Brooks, 2020; Desclaux, 2017).

- People with severe mental illness are already likely to be affected by social isolation and other social issues compounding their vulnerability such as homelessness, loneliness and poorer physical health (Usher, 2020).

The impact of people being in quarantine

The longer a person is confined to quarantine, the poorer the mental health outcomes. Symptoms of posttraumatic stress disorder, avoidance behaviour and anger may be seen (Brooke, 2020). The mental health impacts often continue beyond the quarantine period.

However, it is also important to remember that the health effects of loneliness are measured over a long period of time. While we don't know the exact mechanisms that influence the negative health impacts (such as risk of stroke, heart disease or increased risk of early mortality) it is not likely that a short period of loneliness will have a serious impact on our health.

We can surmise the impact of L & SI during covid for many of Sheffield will have some impact on our health but it is unclear if the L & SI will be prolonged and therefore if there will be the health impacts as described above

In the short term, the raised cortisol levels that result from loneliness will have some impact on our health through the stress levels we experience and have an impact on our sleep.

Population groups are differentially affected by L & SI

Social isolation and loneliness can affect all members of society, including families and younger people, so there is no typical profile of someone at risk (NHS Health Scotland, 2018).

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.

An ONS analysis (2018) highlighted three profiles of people at particular risk from loneliness:

- Widowed older homeowners living alone with long-term health conditions
- Unmarried, middle-agers with long-term health conditions
- Younger renters with little trust and sense of belonging to their area.

Which issues/impacts are highest priority

Clinically Extremely Vulnerable – 'shielding'

35% of CEV individuals report their mental health and well-being as worsening during the coronavirus (COVID-19) pandemic; 29% of CEV people report it becoming slightly worse and 6% report their mental health becoming much worse. Of CEV people aged under 50 years and aged between 50 and 59 years, almost half report worsening mental health (46% and 45% respectively) compared with 26% and 23% of those aged between 70 and 74 years and

aged over 75 years respectively. More females reported a worsening of mental health (40%) compared with males (28%). (**ONS 2020**)

Older people
Older people can be more vulnerable to being lonely (and living alone) with declining social circles, deteriorating health, death of partners and friends (Victor, 2012). And certain sub-populations such as older people within the gay, lesbian and bisexual community and immigrants are even more vulnerable (American Psychological Society, 2020).

Considered alongside the current Covid-19 social restrictions, the impact of disrupted social care services, the ageist discourse, and devaluing of older people contributing to feelings of worthlessness, of being a burden, older people are particularly vulnerable (Brooke, 2020).

Self-isolation will disproportionately affect older people whose only social contact is out of the home, such as shopping, daycare and community centres and places of worship. Those who do not have close family or friends, and rely on the support of voluntary services or social care, who are already lonely, isolated, or secluded, face further barriers to contact (Armitage, 2020).

People in institutional settings
Older people in residential care homes are at risk of becoming more socially isolated due to visiting restrictions. Generally people living in institutional settings - care and residential homes, assisted living facilities, prisons and jails - are already cut off from many parts of society and further susceptible to loneliness and isolation (The Hill, 2020).

People with disabilities
In May 2020, just over 7 in 10 disabled adults (73.6%) reported they were "very worried" or "somewhat worried" about the effect that the coronavirus (COVID-19) was having on their life (69.1% for non-disabled adults); this represents a decrease compared with April 2020, when nearly 9 in 10 (86.3%) disabled adults reported this.
Concerns about well-being tended to be most frequent among those with mental health and socio-behavioural-related impairments, whereas concerns about access to essentials tended to be most frequent among those with hearing- or dexterity-related impairments.

Disabled adults more frequently reported their well-being had been affected through feeling lonely in the last seven days (48.7%) in May 2020 compared with April 2020 (30.3%); disabled adults were more likely to report this concern than non-disabled adults (29.4%) in May 2020. (**ONS May2020**)

Rural areas
Rural areas, already facing barriers to countering social isolation and loneliness, including transportation, and limited internet and mobile access, are likely to struggle further with older populations and spread health and care resources (The Hill, 2020).

What does the literature say about solutions to loneliness and social isolation?

A review of the existing literature suggests the following recommendations:

Findings from an Italian survey (Barasi, 2020) suggests support designed to reduce the boredom of long term social isolation and increase the attractiveness of following public health recommendations. The paper highlights the need for interventions that make isolation more desirable, such as virtual social interactions, online social reading activities, classes, exercise routines.

Brooks (2020) suggests the experience should be made as tolerable as possible for people in the short term by:

- explaining what is happening, why and how long it will continue
- providing meaningful activities for them to do while in quarantine
- providing clear communication
- ensuring basic supplies (such as food, water, and medical supplies) are available
- reinforcing the sense of altruism that people should be feeling

Holmes (2020) identifies short and long term interventions:

Immediate interventions - determine the best ways of signposting and delivering mental health services for vulnerable groups, including online clinics and community support. Find evidence-based interventions that can be rapidly scaled up. Identify gaps requiring bespoke remotely delivered interventions.

Long term interventions - from the gaps identified, design bespoke approaches for population-level interventions targeted at the prevention and treatment of mental health symptoms (e.g. anxiety) and at boosting coping and resilience (e.g. exercise). Develop innovative interventions from experimental and social sciences (e.g. for loneliness consider befriending) that can help mental health; assess the effectiveness of arts-based and life-skills based interventions and other generative activities including exercise outdoors.

Supporting people to manage at home for periods on their own:

- Having a structure to the day and starting the day with something 'to get you going' – getting up/going to bed at a similar time each day
- Thinking in the short-term (today, this week, this month) rather than the longer-term
- Strategies for staying in the moment include mindfulness and breathing techniques
- Reminding yourself to try and focus on the positive – what do you have that's important to you and that you want to keep doing?
- Planning something every day to look forward to (eg phone call, watching a film, meal prep),
- Stepping out into the garden if you have one or finding a window with a view to take in the 'outside world' and appreciate the nature around you
- Talking about your worries – the stigma of loneliness may be reduced at the moment given the extreme circumstances and it may be easier for people to talk about how they're feeling. People need reassurance. People with pre-existing mental health

problems will be at particular risk
- Activities within the home that distract you – keep 'doing something'
- Activities with more 'purpose' – reading, any interests you have

Governance:

- The approach we have taken is:
    - Commissioning undertook desk based research – colleagues and partners have also contributed by sending useful reports
    - Listened to peoples experiences either from themselves or via colleagues through 4 mini workshops, attending team meetings or activity sessions: Cares Centre, Young Carers Service including the YC Action Group – run by YC, Parson Cross Forum Dementia Café, Church of God of Prophecy – Duke St, SACMHA, Western Park Charity, SCCCCs, Parenting, MAST, Early Years and Family Centres, Disability Sheffield team meeting, Age UK, CAB – Advocacy Hub, SOAR, SYHA, Darnall Wellbeing Team Meeting, City of Sanctuary Partnership, Great Places, Shelter, Stocksbridge Leisure Centre, Love Sheffield
- We have widely circulated the report to ensure there is agreement for the recommendations
- This report will contribute to:
    - Overlapping rapid impact assessments
    - the work the Sheffield City Partnership Board
    - recovery planning process
    - Early Help action plan and Strategy
    - Business case for Resilient Communities

2. Methods and Sources of Intelligence:

- All evidence for the desk based review has been cited throughout the report
- The ONS have published national data about peoples' wellbeing, loneliness and anxiety during covid / lockdown. Although this data is not at a local level, the narratives we have heard substantiate the national finding.

Chapter 8

Domestic and Sexual Abuse

Summary of impacts:

'This pandemic creates a paradox as regards staying safe at home and it is one to which we should all pay attention. Governments across the globe have called upon us all to play our individual part in tackling COVID-19 by staying at home, but a critical mindfulness of what this means for many women and children is also important.'[24]

Domestic Abuse is a particular concern during the COVID 19 pandemic because of :

- 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

The pandemic has highlighted the importance of understanding the dynamics of coercive control when responding to domestic abuse. The public narrative around Domestic Abuse has tended to be associated with physical manifestations e.g. black eyes and bruises, and while physical violence is of course harmful and can lead to serious harm or loss of life (and it is likely the rate of domestic homicides will have increased during lockdown), the daily reality of living with domestic abuse is likely to be the experience of coercive control. This is abuse that removes the victim's/ survivor's 'space for action'[25] through the micromanagement of everyday life and which creates a state of hypervigilance that is described as 'walking on eggshells'. This liberty crime[26] 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.

Coercive Control became a specific offence in 2015 (Section 76 of the Serious Crime and Victims Act) and is a key feature of the form of domestic abuse that Johnson[27] called 'intimate partner terrorism' – the most dangerous form of domestic abuse. It is defined as follows:

- Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim
- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for

[24] The pandemic paradox: The consequences of COVID-19 on domestic violence Caroline Bradbury-Jones RN, PhD Louise Isham PhD
[25] Liz Kelly, 2003
[26] Evan Stark, 2009
[27] A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence Michael P Johnson July 2008

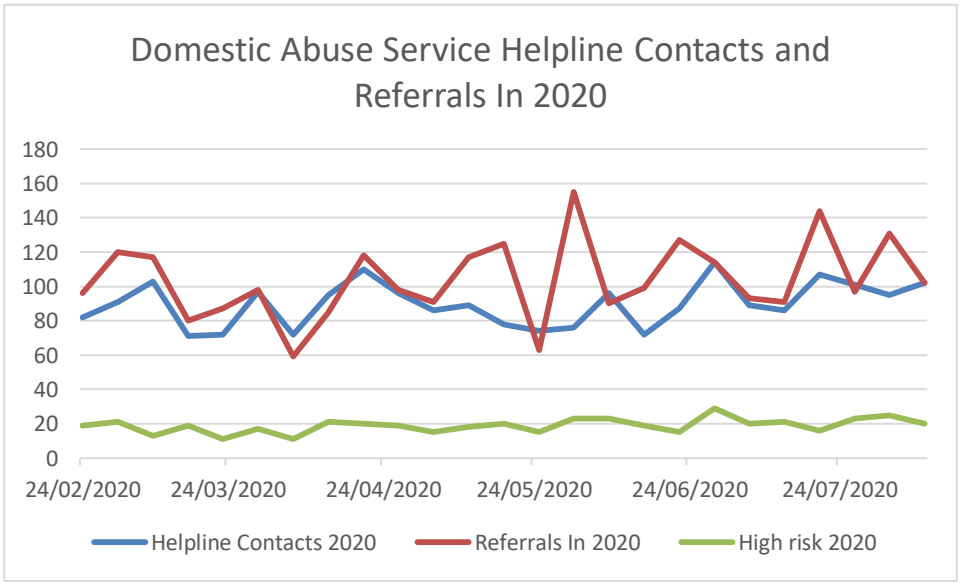
independence, resistance and escape and regulating their everyday behaviour

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. Referrals to Sheffield community support service IDAS where the victim/survivor is vulnerable as a result of isolation have increased from <1% of referrals last year to 3% during lockdown.

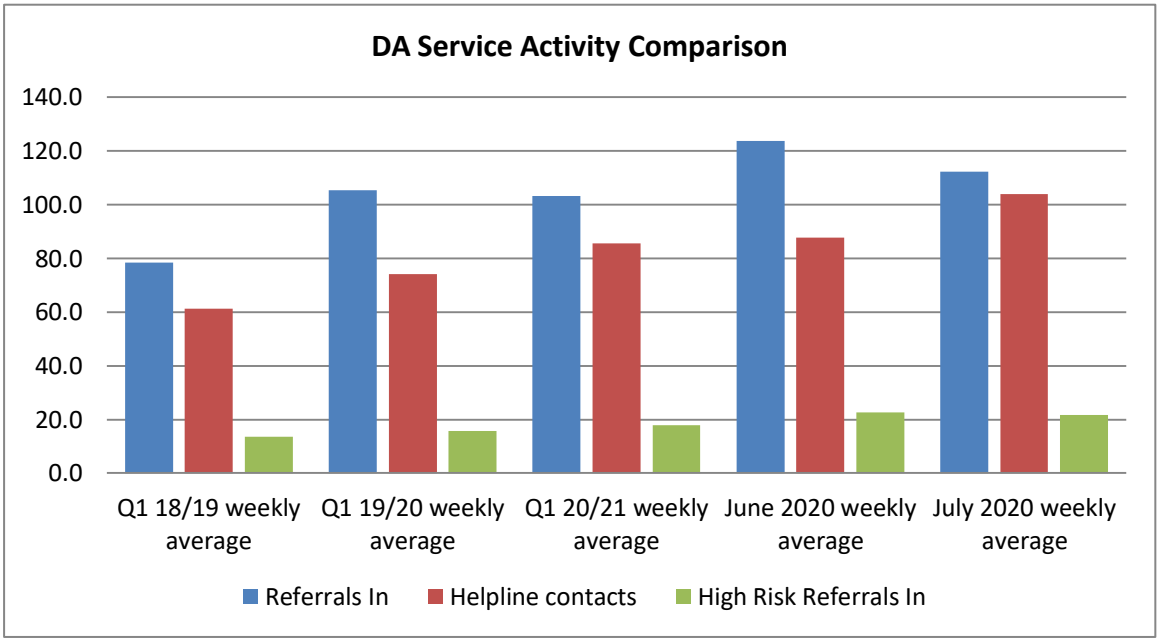
To summarise the impact of coercive control in the pandemic: people who were isolated because of domestic abuse already are likely to be more so during a lockdown. They are less visible to services and less able to seek help. Victims/survivors of sexual abuse are also less likely to report. And people who were most vulnerable already would have felt this impact most keenly e.g. people that have been shielding on health grounds at risk of domestic or sexual abuse. Services contacting shielding people need to be confident to respond to disclosures and aware of domestic and sexual abuse pathways.

Conversely, for those that were not living with an abuser during lockdown some agencies have reported that victims/survivors have been able to use lockdown as an excuse to end the relationship and stop further contact with the perpetrator.

Initially the lockdown meant a reduction in referrals for support locally – both to domestic and sexual abuse services. The chart below illustrates weekly monitoring of the calls and referrals to the community based domestic abuse support service IDAS illustrating the dip in referrals in March as lockdown started:



In June, however, when compared with the quarter 1 average in the last three years, referrals, helpline calls and numbers of high risk cases all showed an increase, as they did in July but not quite to the same extent:



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 with referrals to IDAS since February 2020 now averaging 104 a week – up 11% from last year. 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, 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. Risk to family members as a result of threats to infect is a concern felt keenly by children in particular. Also at MARAC several perpetrators were reported to have been reported to be flagrantly ignoring shielding and distancing by visiting other people, deliberately raising the risks to partners/victims. Fears about COVID causing barriers to accessing support have been reported by survivors to services. One woman said she was scared to leave and come to the refuge because she thought there would be lots of people sharing rooms, she was happy when she arrived and found she had the option to self-isolate. Another survivor reported that when she had the symptoms of Coronavirus prior to coming to refuge - she wasn't allowed to self-isolate. The perpetrator (father of their child) moved their 12 year old son into the same room as her so he would catch it too. Another 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. In another case a woman with three children said her abusive husband kept bringing

lots of men to her house for gaming and she had to sit with them with her children in the same room, and was frightened they would get COVID. She rang the refuge and they supported her to leave.

The high number of high risk cases has meant that extra day long MARAC meetings have had to be scheduled during July and August. With regard to Police referrals the BBC has reported that: 'Figures show there were 8,517 domestic abuse incidents reported in April to the North, West and South Yorkshire police forces compared to 7,693 for the same period last year. In addition, more than 2,500 domestic abuse arrests were made in the same month - nearly a third more than the previous April. In South Yorkshire, the number of domestic abuse arrests in April rose by 50% compared to the same month in 2019. Supt Shelley Hemsley, the force's lead for domestic abuse, said measures had been brought in during the lockdown to make it easier for people to report domestic abuse. She said there had been 250 contacts made to police via an online reporting method as opposed to having to use the telephone, which could be harder for victims.'[28]

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%. At the same time criminal trials have mostly been suspended which will leave those that do wish to pursue a conviction waiting a long time before they get to court – prolonging stress and anxiety. The National Domestic Abuse Helpline has reported a large rise in contacts since lockdown - 40,000 calls and contacts during the first three months of lockdown. In June, calls and contacts were nearly 80% higher than usual[29]. This large increase is likely to be due to its national prominence. Unfortunately we are unable to see evidence of these referrals filtering through to a local level – 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.

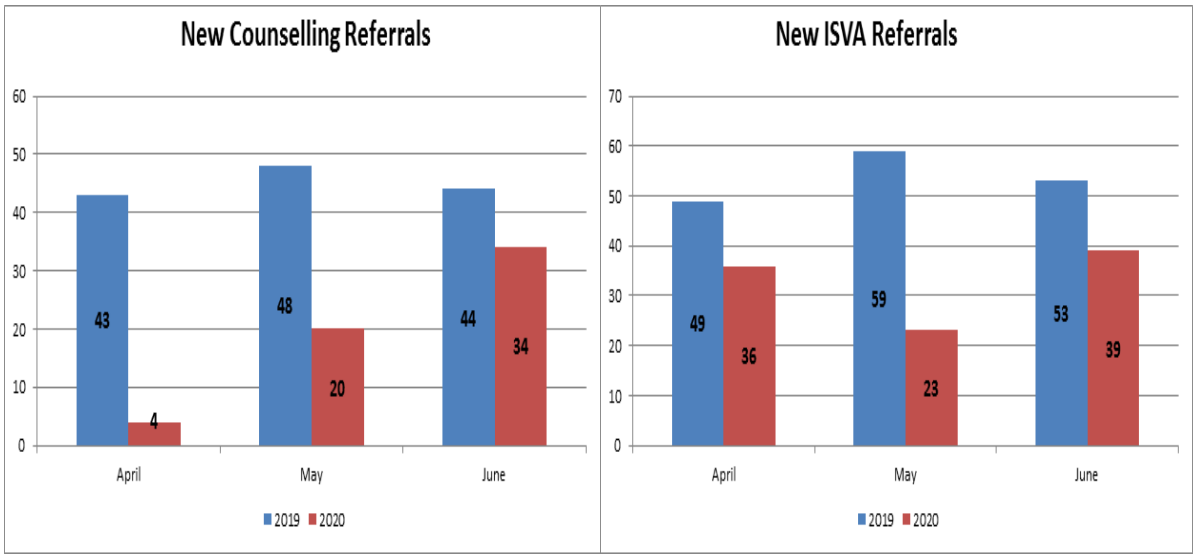
Other local third sector support services have also reported a rise in referrals e.g. Ashiana and Roshni – both specialising in support for BAME women, Shelter – who work with domestic abuse survivors through their homelessness prevention and resettlement support service, and the Together Women Project 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. And this is in contrast to the fall in homeless presentations overall during lockdown: Sheffield City Council's Housing Solutions has seen

[28] https://www.bbc.co.uk/news/uk-england-53493263
[29] https://www.bbc.co.uk/news/uk-53498675

between 75-85% fewer presentations per month. 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. There were also 251 more contacts of a domestic abuse nature in the period March – May 2020 than there were in the same period in 2019.

Sexual abuse services have seen a similar pattern with regard to referrals since lockdown. Sheffield Rape and Sexual Abuse Centre saw referrals for both its counselling service and to its 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 as the graphs below illustrate:



The dip is much clearer in relation to counselling referrals indicating that 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. However where the perpetrator is an acquaintance, friend or in a small number of cases a stranger then lockdown is likely to have impacted by reducing the capacity to seek support rather than exacerbating the abuse itself. Exceptions to this will be where victims were locked down with their abusers but no intimate relationship existed e.g. in houses of multiple occupancy or where the sexual abuse was perpetrated by a carer.

Therapeutic services such as counselling and therapy services initially faced significant barriers to resuming their offer of support during lockdown and as lockdown eased. Services such as SRASAC immediately began telephone check ins with counselling clients but were

concerned about resuming in depth counselling sessions with people impacted by trauma by phone rather than face to face. However Rape Crisis England have since developed an online secure counselling room service that SRASAC are now using to offer to those clients who wish to / are able to use this method of online support – see section on digital exclusion. Victims / survivors of domestic and sexual abuse are all recovering from trauma, both recent and often historic – especially in the case of adult survivors of child sexual abuse. 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.

The Mental Health and Learning Disabilities Improvement Board for the city agreed a paper in September 2019 that highlighted issues with lack of capacity and unclear local pathways in relation to therapeutic support for survivors of domestic and /or sexual abuse and which recommended the establishment of a task and finish group to consider these issues – unfortunately this has not yet been set up. Members of the Domestic Abuse Service User Reference Group were keen to point out that lockdown will have had an additional significant impact on the mental health of victims / survivors, many of whose mental health would already have been impacted by their experience of abuse. IDAS also report that access to mental health services has become more difficult during the pandemic. Recent research (as yet unpublished) by the Transforming health and social care in Kent and Medway partnership highlights the link between suicide and domestic abuse e.g. finding that over 60% of high risk victims had felt suicidal and / or attempted suicide, and that out of 93 Domestic Homicide Reviews published in England and Wales since 2016, over a quarter (26%) contained a suicide; either that of the victim or perpetrator (murder/suicide).

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

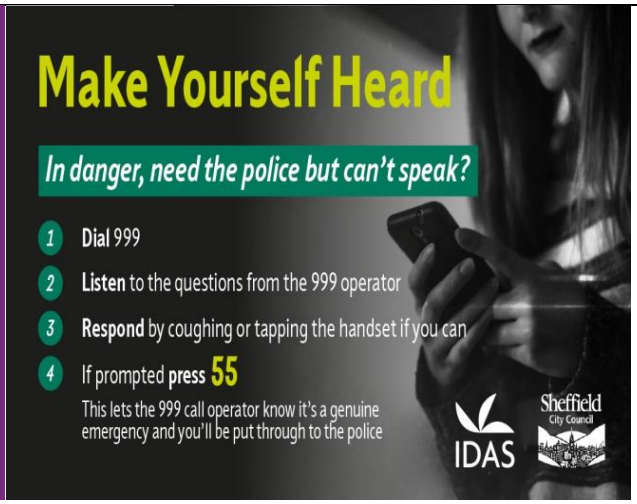
Refuge spaces and move on accommodation, including the additional temporary dispersed capacity commissioned locally and then expanded as part of the CV19 response, are mostly full up. This is because tenancy quittings reduced dramatically and the Choice Based Lettings system was paused (in line with government guidance) and remains suspended at time of writing although there are plans to reintroduce it in the autumn. Only people assessed as in critical need are being offered tenancies and viewing of properties is not currently allowed although steps are being taken to address this issue, meaning that move on refuges and other supported or temporary accommodation is very slow. This means that 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 stay with or return to abusers. Housing providers / support organisations have also seen large rises in demand. For example, Guinness Trust in Sheffield have reported a 20% rise in domestic abuse cases. Combined with the rise in homelessness presentations due to domestic abuse

this situation has meant that agencies have had to accommodate women and children in B and Bs (which are often not suitable environments for traumatised individuals and vulnerable children) and hotels.

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. The Council has made PPE available to refuge staff and St Luke's Hospice were commissioned to provide training via zoom on using PPE safely. Space in refuge buildings was adapted to ensure socially distanced face to face contact e.g using the lounges as a keywork rooms and using the outside spaces more. The play leaders at the refuges made video contact with every child every day and supplied materials (arts/crafts/bake a cake/dance off/making rainbows) to enjoy in their own flat with their mum. Face to face (socially distanced and family specific) play sessions resumed from the 1st June 2020 - encouraging mums to 'play' with their children and using the outside space no matter what the weather. Sheffield Women's Aid have ensured regular food bank and Food Pharmacy deliveries for residents. Work has also been ongoing to put in measures for testing and tracing in accommodation provision like refuges and upgraded business continuity plans will be an expected outcome in case of further outbreaks.

Alongside the online reporting form developed by SYP, agencies such as 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 e.g. £485,000 came to specialist domestic and sexual abuse organisations in South Yorkshire form the Ministry of Justice via the Office of the Police and Crime Commissioner a large proportion of which came to those working in Sheffield. Charities such as Women's Aid have also managed to secure funding from businesses such as John Lewis to enable purchase of equipment for residents. Information about local services was sent to Pharmacies participating in the national Safe Spaces scheme providing an option for victims/survivors needing to seek help who could not use the phone or internet to do so. Members of the Sheffield Domestic Abuse Service User Reference Group felt that this sort of initiative should be encouraged and expanded.



Digital exclusion is a key concern raised by local support providers - 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. This links to coercive control and isolation – 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. There is also likely to be pressure due to children being at home who may not be able to access lessons, support, or entertainment either or there may be competing demands in a household. There is also a limit to the size of groups that can be conducted via online platforms. Some agencies, voluntary and statutory, are providing equipment to vulnerable families they are working with thanks to additional funding. These issues also apply to children and young people being supported by local services such as Haven (the local specialist service supporting children and young people affected by domestic abuse) who have found that some of those that they are working with:

- Lack the ability to maintain safe space/contact (e.g. the perpetrator may be present and entering in support can provide extra pressure, worry and risk for the young person as the perpetrator may think they are sharing details of the abuse)
- A lack of private space means that young people do not feel able to communicate.
- Young people often do not have access to technology and borrowing phones etc. from carers can be problematic. Support can be disrupted with the notifications/messages etc. and sometimes carers are reluctant to give up their phone for an hour or just don't have the data to spare.
- Or in some cases the relationship wasn't built with the practitioner prior to lockdown and this can impact on the young person's ability to engage remotely
- The young person had additional issues which impacted on their ability to communicate (prior to lockdown) e.g. anxiety, emotional regulation, able to 'be still' and this was even more problematic when communicating online.

Poverty

Poverty as a result of domestic or sexual abuse has always been an issue due to having to leave your home or job or support networks to escape it, but also due to national /

structural issues such as benefit caps imposed in recent years. Shelter have reported that during the pandemic there have been problems in relation to housing benefit for example, where this is set at a level that precludes access to private rented accommodation or results in growing arrears. According to the Sheffield Star[30] 'Department for Work and Pensions figures show 866 households had their benefits capped in Sheffield in May. This was a rise of 61% on the number capped in February, when there were 537 families who had either their housing benefit or Universal Credit payment reduced.'

Children

The NSPCC have seen an increase in the number of people contacting the NSPCC helpline about domestic abuse, rising from an average of around 140 contacts a week earlier this year to an average of around 185 contacts a week since the government's stay at home guidance was issued.[31]The themes the NSPCC have identified from these contacts are:

- lockdown bringing domestic abuse into sharp focus
- making it harder for children and young people to speak out
- making it more difficult to leave
- parental drinking during lockdown has increased
- abusive parents have been exploiting fears about the coronavirus
- young people are worried about other family members.

A common view among the public and professionals is that children are affected by domestic abuse if they have 'witnessed' it however increasing understanding of coercive control has enabled us to improve our awareness of the long lasting harmful impact of living with an abuser has on children whether they are directly physically harmed or not. As Dr Emma Katz asserts: 'Perpetrators'/fathers' coercive control places children in isolated, disempowering and constrained worlds which can hamper children's resilience and healthy development and contribute to emotional and behavioural problems…Children may be harmed by non-physical abusive behaviours inherent to coercive control-based domestic violence, including continual monitoring, isolation and verbal/emotional/psychological and financial abuses'.[32]

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.). Haven have been funded by SCC during lockdown to increase their capacity so that they can work with more vulnerable children impacted by Domestic Abuse. 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. For some families, the impact of home schooling and home working will have been significant, especially if this is impacting on a perpetrators mental health and increasing substance misuse and anger issues within the home. Operation Encompass, the sharing of information

[30] Sheffield Star 21/08/2020

[31] https://learning.nspcc.org.uk/research-resources/2020/coronavirus-insight-briefing-domestic-abuse

[32]https://www.researchgate.net/publication/281633706_Beyond_the_Physical_Incident_Model_How_Children_Living_with_Domestic_Violence_are_Harmed_By_and_Resist_Regimes_of_Coercive_Control

about police call outs re. domestic abuse with relevant schools, was initially paused at the start of lockdown but has been re-offered in a revised form to schools for safe operation while most children have been at home, with extra resources provided to support safe contact with victims.

Haven have reported that lockdown has had a significant impact on their clients: 'Many of the CYP we support have some level of mental distress, many issues relate to anxiety and CYP have struggled to maintain attendance at school – we will need to work with teachers to recognise the impact of abuse and how they can adopt a more trauma informed approach in managing behaviours that could be masking the inability to managing emotions, disassociation etc. Additional support will be needed for CYP to help them cope in returning to schools that are likely to feel unfamiliar and unsafe.' Women's Aid reported issues as formal contact arrangements via Social Care were stopped. This meant one of their residents didn't see her child at all during lockdown. Although social care supported video contact - this didn't work as the child was 1 years old. Her solicitors and the Court couldn't help. Mum was really struggling with this (contact went from 3 x a week to nothing) and self-medicated using drugs and alcohol after being 'dry and stable' for months. A member of the Domestic and Sexual Abuse service user group also said that contact with her child's father through remote means was impossible due to the child's age.

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)'[33]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. The model responds to domestic abuse by removing victim blaming and instead placing a specific focus on the perpetrator's behaviours. Safe and Together is specifically designed to focus on promoting the best interests of children focusing on safety, permanency, recovery from trauma and well-being. 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. Setting high standards for fathers helps children because it guarantees a more comprehensive assessment of risk, safety and protective factors and increases the effectiveness of the system in engaging men to become better fathers. It is intended that the programme will be rolled out across the city by trainers from the Strengthening Families specialist domestic abuse team working with social care in the council and trainers from IDAS.

Members of the Domestic and Sexual Abuse Service User Reference Group felt that the

[33] Emma Katz ibid

Family Courts process was even more difficult than usual during COVID e.g. re. making contact with court staff or sorting our problems such as ensuring Courts were not sending documents to the wrong solicitor.

Young People

Haven has outlined some of the harmful impacts of the lockdown on the young people they support as follows**:**

- Young people are experiencing greater degrees of isolation and are being forced to spend more time in the home environment, with none or little respite – for many children and young people this is not a safe place to be.
- For some children and young people contact they were having with non-abusing parents has been stopped
- Some children and young people are breaching 'lockdown' requirements that is bringing them in contact with the police and in conflict with communities
- Children and young people are engaging in 'risky' behaviour, becoming vulnerable to exploitation both criminal and sexual[34]
- 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.[35]

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. Data from IDAS shows an increase in referrals in quarter 1 2020 compared to last year of those aged 16 and 17 from 1.5% to 1.8%, aged 18 from 1.3% to 1.7% and 19 from 2% of all referrals to 2.6%. These numbers are still low e.g. 26 16/17 year olds during lockdown

Older people

Referrals of those aged 65+ to IDAS increased during quarter one to 4.1% compared to 3.5% of all referrals last year. 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

[34] A finding echoed by NSPCC https://learning.nspcc.org.uk/media/2246/isolated-and-struggling-social-isolation-risk-child-maltreatment-lockdown-and-beyond.pdf

[35] NSPCC ibid

at home if they are a partner / spouse. It is important to remember that older people are not all heterosexual. Stonewall's most recent report[36] into the topic showed that lesbian, gay and bi people over 55 are more likely to be single and live alone, and less likely to have children or regularly see family members than straight people. If LGBT+ older people are living with an abuser then getting help may be even more difficult than for their heterosexual peers. 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. A finding of a local case review was that agencies sometimes do not recognise this form of abuse as domestic abuse and risk assessments and referrals are sometimes not undertaken, this rise in referrals during lockdown emphasises the need agencies to be alert to adult family violence as a form of domestic abuse.

Gender

Women generally are more likely to be affected by domestic abuse and more likely to experience repeated or severe domestic abuse. The evidence for this is outlined in Sheffield's Domestic and Sexual Abuse Strategy. The gender split of referrals has stayed the same as last year during the lockdown period e.g. around 89% female 11% male. There are a small number of people this year (and last) who are non-binary, or who prefer to self-describe their gender and a small number who disclosed their gender is now different to that which was assigned to them at birth. 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 and it is intended to review the effectiveness of this offer in the autumn and make a case for longer term investment.

The South Yorkshire voluntary perpetrator programme Inspire to Change has seen a rise in engagement during lockdown. Of the referrals they received during the quarter 210 were males and 75 were females however the provider (South Yorkshire Community Rehabilitation Company) has expressed a view that a proportion of the referrals of women were inappropriate as they are women who are the primary victim in the situation but who have retaliated or 'used violent resistance'[37] against the primary perpetrator.

Pregnant women

The proportion of pregnant women referred to IDAS declined during the lockdown period from 13.8% last year to 11.5%. 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 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 Teaching Hospitals NHS Foundation Trust has reported that the rapid introduction of telemedicine into the abortion service has helped the majority of women experiencing domestic abuse (but not all women) access care. Women can now self-refer to abortion services if required so they do not need to see GP or sexual health services.

[36] https://www.stonewall.org.uk/resources/lesbian-gay-and-bisexual-people-later-life-2011
[37] Johnson 2008 ibid

Sexual orientation
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. Manchester's LGBT Foundation has conducted surveys during COVID and found that 8% of respondents did not feel safe where they were currently staying. This included 9% of BAME LGBT people, 15% of disabled LGBT people, 17% of trans people and 17% of non-binary people. The LGBT Foundation's Domestic Abuse programme had seen a 38% increase in number of people referred for domestic abuse support again indicating that there is more work to be done in Sheffield in relation to engaging marginalised communities in domestic abuse support.

Black, Asian and Minority Ethnic people
In 2019/20 34.4% of IDAS service users were BAME. In Q1 of 20/21 the proportion is 27.4%. The most significant reductions were in relation to people identifying as: Arabic (8.3% to 4.6%), Asian other (i.e. not Bangladeshi, Pakistani, Indian or Chinese: down from 5.7% to 5%) and Black other (i.e. not African or Caribbean down from 4.7% to 3.9%). The pandemic and lockdown have potentially increased barriers to accessing support amongst the BAME community. Specialist agencies have reported that some BAME women are likely to more be more isolated and have less access to usual supportive agencies and / or technology to help them access support. Some of the problem will be in relation to language barriers. The majority of social media messages have been in English however at the time of writing a card translated into community languages is being printed for distribution via food banks and other community outreach provision. Shelter have reported that people without regularised immigration status fleeing domestic abuse are also experiencing problems accessing emergency accommodation. And the higher level of incidence of COVID 19 in the BAME community has also raised issues – a local health trust reported a recent case involving a BAME staff member where the risk of isolation and coercive control by their family members was heightened as they argued that the victim/survivor should not leave the household to go to work for fear of them being exposed to COVID in the community or workplace and potentially bringing the virus back to the home. Local specialist services – Ashiana and Roshni have reported a rise in referrals and while their overall referral levels are low compared with IDAS this may indicate that more could be done to work jointly with BAME specialist organisations to safeguard and support victims/survivors. The proportion of people referred to IDAS who described themselves as being at risk due to forms of abuse more prevalent in certain cultures (i.e. Forced Marriage, so called 'Honour' Based Abuse and Female Genital Mutilation) has not changed over lockdown. Some victims/survivors with no recourse to public funds have faced additional barriers to access support: one survivor was trafficked into the country as a child. As well as experiencing domestic abuse she had been sex working to support her children and maintain her privately rented flat. During lockdown she stopped working and sought help from school who helped her access a refuge. Another woman with one child said her husband told her she wasn't allowed to leave because the government won't allow it due to COVID, she would have her child removed and she would be arrested. The woman was from Iran, English was her second language, so she believed

him. Children's Social Care got involved and she was then supported to leave.

Religion and Belief
There appears to have been little if any change in the proportions of people who declared their religion or belief, or that they had none, during the pandemic.

Marital Status
A higher proportion of IDAS clients were married in quarter 1 compared to last year, up to 14.7% from 12%. However the biggest change was in terms of those stating they were single at the time of receiving the service – up from 20% last year to 27% during the lockdown. However a proportion of the perpetrators in these cases must be a family member rather than an ex-partner as the number of perpetrators that were described as 'current partners' has increased during lockdown (28.5% to 32.7%) while the proportion of perpetrators that are ex-partners has decreased (from 40.2% to 37.6%). This may highlight the negative impact that lockdown has had on some couples, and the reduction in ex-partner domestic abuse could mean that lockdown has led to less contact with people outside the home.

Working age people
During lockdown, employees that are experiencing domestic abuse may be more at risk due to isolation and the abuser using lockdown to control them further. It is therefore important to check in with them regularly and:
• if staff are home based – managers should ensure that information about online support is shared and that this includes technology security tips, such as how to hide or clear your browsing history, without arousing suspicion;
• Managers should have regular; structured 1-2-1s/contact with all team members, including those who are subject to sickness leave or furloughed;
• Managers should help support staff wellbeing by sensitively asking how they feel about the changes to their working environment and what support they have at home;
• Managers should ensure they have sufficient time with staff and undertake 1-2-1s via video calls to check in.

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.

Disability
National evidence[38] tells us that disabled people are at higher risk of serious harm due to domestic abuse in non-lockdown circumstances. During Q1 2020/21 41.7% of IDAS service users are recorded as having a disability – however around 20% of clients were not asked / the data is not recorded. This is in comparison to 24.5% of service users during 2019/20. This may be a positive change in the rate of accessing support for people with disabilities due to new remote routes in / increased promotion of alternative methods to access support. 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 particular issues during lockdown e.g.

[38] https://safelives.org.uk/sites/default/files/resources/Disabled%20Survivors%20Too%20CORRECTED.pdf

people with hearing difficulties will face further barriers when support is offered by phone or zoom unless they have specialist equipment. People with care and support needs will however still have been getting visits if health or social care agencies were providing their care.

Carers can be at risk of domestic abuse themselves. Sheffield has undertaken domestic homicide and serious case reviews where the victim has been a carer. Again increased isolation during lockdown is likely to have exacerbated abusive behaviour. Social care has reported a higher level of care arrangements breaking down in relation to people living with dementia during the lockdown period. Some of these circumstances will have involved abusive behaviour.

Substance misuse

Substance misuse does not cause domestic abuse but it can be a trigger and can increase the frequency or severity of abuse. Deteriorating mental health, fear and anxiety about the virus and reduced access to or reluctance to engage with assessment , support, treatment for substance misuse during COVID may be impacting on both the victims/survivors and perpetrators and subsequently on any children present. Alcohol Concern found that 6%[39] of people reported that COVID-19 had created more tension in the household. MARAC cases are showing high levels of substance misuse as additional factors / needs during COVID. 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. A single woman who was living on the streets and a drug user, told services she was scared because she found it impossible to socially distance, but after coming to refuge and developing symptoms of COVID she was able to isolate and recover. Sheffield Women's Aid supported her by picking up her script and bought her shopping in and accessed food bank donations (her benefits were not in payment at the time). She said if she was still on the streets, ill and being abused, she believes she would be dead now.

Perpetrators

The voluntary perpetrator programme Inspire to Change has seen increased issues for their clients with regard to substance misuse during the pandemic – e.g. large rises in referrals relating to alcohol especially during the bank holiday periods of lockdown. They have also seen a large rise in referrals generally – mostly due to changes in police practice - this time last year Inspire to Change received approximately 121 referrals, by mid-July this year they had already received 576[40]. Structured group programmes are not going ahead as yet and clients are reported to be missing the peer contact which leads to more effective rehabilitation. However they are still running drop-in groups over the phone once per month. The service has posted lots of digital content and videos via its YouTube channel, and uptake has been positive, and the people attending have said it has been useful. Engagement has increased as a result of the change in offer – many clients have preferred telephone assessments to attending a building for their initial contact with the service. This

[39] https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings
[40] Reported at July 13th Domestic and Sexual Abuse Provider Consultation Group

has meant an increase in successful completions from 26 in the whole of 2019/20 to 18 in quarter one. However the service was designed as a primarily group provision and therefore capacity is extremely stretched with most interventions now being one to one, and no COVID related government funds being made available to perpetrator focussed services.

Recommendations:

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. Several of these themes are already captured in Sheffield's Domestic and Sexual Abuse Strategy 2018-22 which we will continue to implement. In addition, we must:

Invest in services for all those impacted by domestic abuse – victims / survivors, children and perpetrators, and increase capacity where needed to ensure needs are met

- Continue to commission good quality victim / survivor support services that have enough capacity to respond to the need in the city. IDAS is receiving an average of 104 referrals a week since lockdown, 19% of which are high risk. The capacity of the service is not enough to fully meet the needs of these victims/survivors many of whom have complex needs due to their experience of trauma, and support them to recover from the impact of abuse.
- Work to ensure that commissioned services meet the needs of all sections of the population, particularly BAME victims / survivors encouraging partnerships and joint working where expertise is needed.
- Increase the capacity of specialist therapeutic support for victims/survivors of domestic and sexual abuse and review and rationalise pathways to and from mental health services.
- Ensure commissioned services are trained in suicide prevention.
- Invest in voluntary support for perpetrators. During COVID it has been proven that greater engagement is possible if the offer is right. We must put efforts into behaviour change to stop people ruining the lives of others, and usually their own lives, as a result of using abuse in relationships and in their parenting. Professionals must be trained to understand how to talk about domestic abuse with perpetrators in order to protect children and victims / survivors – the Safe and Together model must be rolled out and embedded in practice. This will also promote better understanding of the impact of abuse on children and the need for trauma informed responses to victims/survivors of all ages.
- Continue to promote awareness of services and how to access support, building on all that has been done during the pandemic including continuing to identify safe spaces where people can ask for support e.g. working with local businesses.

Including finding ways to promote support messages discreetly and via languages other than English.

- Promote digital inclusion including in safe spaces – libraries, children's centres, schools etc. Find ways of offering group work support to people who are digitally excluded. This could be through considering mixed methods of delivery i.e. delivering a physical group with a very small number of people in a social distanced space with others connected in via Zoom on a screen. This would mean the needs of those who really need to be seen face to face and those that need to isolate or simply cannot get into buildings would be met. Or if this is too difficult for group cohesion, begin offering small face to face groups alongside virtual groups for those that prefer them or can safely access them.

Ensure there is adequate provision of good quality, safe, appropriate emergency accommodation with specialist support

- Maintain and grow the new dispersed safe accommodation offer (currently funded by an MHCLG grant) as this has proved vital when refuge provision filled up, it also means families with children are less likely to be placed in unsuitable B and B accommodation. Promote the offer of safe accommodation to men and the LGBT community as this was the gap it was set up to fill prior to lockdown.
- Consider providing more emergency safe accommodation for families with specialist support which can be accessed in an emergency that can flex and grow in times of emergency and / or consider remodelling existing provision.
- Ensure better joined up working between support providers and housing so that move on is more streamlined from supported housing into sustainable tenancies. This means finding a way to enable viewings (virtually or in person) for direct lets.

Improve responses from agencies and employers

- Ensure organisations have effective domestic abuse policies covering both clients and staff and include responding to victims/survivors but also perpetrators.
- Encourage attitudinal change in relation to domestic abuse. Safe and Together will move the focus for agencies from 'why doesn't the victim leave' to why doesn't the perpetrator stop'. A greater understanding of coercive control and its impacts is still needed. This training should be mandatory for key professionals e.g. health, criminal justice agencies, voluntary sector providers, housing and social care.
- Encourage all professionals and organisations to continue to work toward becoming trauma-informed, to an approved standard.
  - To complete a mapping exercise of trauma informed training across the borough
  - To agree and adopt a set of trauma informed principles and standards

  Partners should self- assess against the agreed trauma informed principles and standard
- Improve multi agency information sharing and creative joint working to increase engagement in support e.g. so that agencies co-ordinate appointments to enable attempts to engage victims when perpetrators are seeing agencies such as Probation or by working with universal services such as health and education.

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

- Encourage attitudinal change in relation to domestic abuse in terms of the general public. Attitudinal change and awareness of the issues could also be championed by key city leaders in order to provoke debate and discussion among the public.
- Positively promote the importance of healthy respectful and nurturing relationships throughout the life course –as children, parents, in couples, as neighbours, as friends, as carers and as colleagues. We should commit to making a statement about the importance of relationships as Rochdale has done in it's Relationships Manifesto. This is being explored as a result of the work to connect and clarify the differences between responding to parental conflict and domestic abuse, and has been discussed with partners in SCC and public health with an initial agreement to explore further.
- Roll out high quality Relationship and Sex Education in our educational settings. A recent article in the Lancet emphasised the importance of comprehensive sex education in combatting 'gender based violence': 'GBV is a multifaceted issue, but the failure to implement comprehensive sexuality education (CSE) internationally puts all people at increased risk of violence. CSE includes developmentally and culturally relevant, science-based, medically accurate information on a wide range of topics, including human development, gender identity, sexual behaviours, communication skills, empathy, and mutual respect. CSE teaches the skills needed to develop healthy relationships and to prevent and not perpetrate violence.'[41]
- Support the roll out of bystander projects such as the Glasgow model Mentors in Violence Prevention which builds the skills of young people to challenge their peers around bullying, harassment and controlling relationships. This is part of the Violence Reduction Unit strategy which aims to 'end domestic abuse'.

Work with organisations such as the Local Government Association to raise national issues

- Work with partners to pressure national government to ensure housing benefit is set at a level that helps secure access to private rentals and prevents growing arrears as a result of the pandemic. The benefit cap must be lifted to ensure people receive the uplift in housing benefit and can flee domestic abuse to new tenancies they can afford.

Contributors:

- Sheffield Domestic Abuse Service User Reference Group (facilitated by Sheffield Domestic Abuse Coordination Team Sheffield City Council)
- IDAS (DA helpline and IDVAs)
- Young Women's Housing project
- Haven (children and domestic abuse service)
- SAYiT (currently delivering an LGBT+ domestic abuse project)
- Sheffield Rape and Sexual Abuse Centre
- Sheffield Women's Aid

[41] Comprehensive sexuality education to address gender-based violence, the Lancet Vol 396 July 18, 2020

- Roshni
- Ashiana
- Vida Sheffield (therapeutic services)
- Shelter
- Together Women Project
- Strengthening Families Domestic Abuse Team (SCC)
- Guinness Partnership
- South Yorkshire Housing Association
- Office of the Police and Crime Commissioner
- South Yorkshire Police
- Sheffield Teaching Hospitals Foundation Trust
- Sheffield City Council Housing Services
- Sheffield Safeguarding Hub
- Sheffield City Council Housing Independence Service
- Sheffield Clinical Commissioning Group
- Head of Commissioning Vulnerable People – Sheffield City Council
- Sheffield Probation Service
- Sheffield Health and Social Care Trust
- Sheffield Children's NHS Foundation Trust.
- South Yorkshire Community Rehabilitation Company

Methods and Sources of Intelligence:

Performance monitoring information relating to contracts commissioned by the Council has been used alongside information provided by Housing Solutions, the Sheffield Safeguarding Hub and South Yorkshire Police.

A provider meeting was held on 15th June and a further meeting with a wider group of invitees was held on the 13th July. The RHIA and its recommendations was also discussed at the Domestic and Sexual Abuse Strategic Board on the 2nd July and the Domestic and Sexual Abuse Joint Commissioning Group on 13th August. Emails asking for contributions were sent to a large group of contacts from agencies ranging from statutory to voluntary sectors. Providers were also asked to consult with service users e.g. service user voices were provided by Sheffield Women's Aid. Sheffield Domestic Abuse Service User Reference Group were also consulted on the draft report in August.

Where policy or research has been used it has been indicated in references.

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

Summary of Data Showing How COVID-19 affected Access to Primary and Secondary Care
Data was collected anonymously from SystmOne representing approximately 75% of the practices in Sheffield with thanks to the Medicines Optimisation Team. Also, secondary Care activity data was supplied by the Intelligence Team. None of the data has been analysed for statistical significance and any comparisons are descriptive in nature. The key areas that have been looked at is the effect on age, ethnic origin, and deprivation (to follow) on access to primary and secondary care.

Effect of Age
Overall face to face (F2F) consultations were down 54.4%, telephone consultations, were up 94.8% and all referrals to another service were down by 62.9%, the graph (link) shows that for patients over 80 there appears to be a smaller decrease in F2F consultations, a smaller increase in telephone consultations and variable change in referrals with small numbers on those above 100. This may be due to older patients preferring face to face consultations rather than the telephone or driven by clinical need.

Effect of Ethnicity
Ethnicity is recorded for most patients in primary care although not all patients, for example for face to face consultations April and May 2020, 8.7% did not have an ethnicity recorded. The date we have looked at concentrates on when ethnicity is recorded although it is acknowledged that this could be improved.

Data from primary care looking at the top 10 largest recorded ethnic groups only, shows that some ethnic backgrounds appear to have greater reductions in face to face referrals that others e.g. (XaJR3) Pakistani or British Pakistani - ethnic category 2001 census -61% vs an average reduction of 54.4%. The changes in terms of access to telephone consultations was variable across ethnic categories, with (XaJR3) Pakistani or British Pakistani - ethnic category 2001 census, having the greatest reduction in overall consultations at 25.9% vs 21% average.

Referrals were also down more for some ethnic groups that the average (XaJR3) Pakistani or British Pakistani - ethnic category 2001 census at -68.8% and (XaJR7) African - ethnic category 2001 census -76.6% vs that average decrease in referrals of -63%.

In terms of actual secondary care activity, this is far less clear particularly with respect to coding of patients as patients with no code make up the second biggest category.

SECONDARY (HOSPITAL) CARE SERVICES
Some patients with protected characteristics were facing barriers to accessing healthcare pre COVID. In some cases this will have worsened, for others the changes forced on the NHS as a result of the pandemic will have opened up an improved patient experience and better access to healthcare e.g., telephone and virtual clinics for those people for whom travelling to site can be a real barrier to accessing healthcare.

Secondary care has seen reductions in referrals and reduced A&E attendances. Some of this will reflect a reduction in trauma due to a more sedentary lifestyle in lockdown, as well as people's perspective temporarily altering in respect of 'quality of life' medicine. It also

reflects people's fear of accessing healthcare due to the perceived threat of catching COVID and people's inability to access their GP for full examinations that might have resulted in earlier and incidental diagnosis of health needs.

Hospitals therefore face 4 key challenges during COVID:

- The cessation of routine healthcare resulting in a backlog of patients, whose timescales for receipt of care are likely to be delayed.

- The capacity to provide on-going clinical review and monitoring of these patients whose care is delayed to manage the risk from deterioration

- The challenge of providing socially distanced and COVID 'secondary spike' reactive services of sufficient capacity to clear backlogs and provide access for newly diagnosed patients

- The likely unknown number of people within the city who are either unknowingly unwell and deteriorating or knowing well and reluctant to access care due to COVID concerns and will present late and more acutely unwell requiring a more rapid access to Secondary care.

The solutions for some of these problems are clearer than others, some are established and others embryonic, some are provider specific and others city wide.

On-Going Service Changes

We have identified Secondary care service changes implemented in response to the pandemic that providers and commissioners agree must be here to stay. All will benefit from wider system support to ensure equity of access for all individuals, including those with protected characteristics.

Some of these are new concepts or technologies and offer an opportunity to agree a Sheffield system- wide and/or an ICS level solution:

1. Telephone appointments
2. Video appointments
3. Secondary care triage of referrals (meaning patients may not be seen as expected)
4. Community based diagnostics
5. Community based clinical services
6. Impact on patient transport services
7. Advice and guidance provision
8. Rapid Access Clinics

The following section indicates developments which have been implemented in response to the pandemic. Individual impact severity is indicated where known (see Recommendation 1)

Individual Developments and Impacted Groups

In each case below a colour-key has been allocated against each of the protected characteristics group (plus other groups identified as significant) based on the following:

	Red - greatest impact
	Amber - some impact
	Blank - no perceived impact

Development 1: **Extensive use of virtual appointments (telephone & video)**
Key Impact Area(s): **Secondary Care**
Primary Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

Whilst GPs have undertaken telephone contact with patients for some time the approach has been less widely used by hospitals where a more traditional face-to-face approach has been the default position in many cases.

In response to the pandemic clinicians in both secondary and primary care have adjusted quickly to the new or increased use of telephone and video technology to engage virtually with patients.

The virtual approach has been used for appointments themselves and also to enable additional information to be gathered directly from the patient in order to support referral triage and care provision. SCHFT clinicians have, for example, undertaken the information gathering element of the normal face-to-face appointment via telephone prior to the patient attending hospital in order to shorten the time required to be present in the hospital.

User Feedback:
Anecdotal feedback from hospital clinicians and service managers has highlighted that non-face-to-face patient contact can be a very effective way of engaging with their patients.

Sheffield Children's Foundation Trust has undertaken an extensive patient and staff survey of non-face-to-face appointments over the covid period, it's findings are available here: https://view.pagetiger.com/a-whole-new-world/2020

Long Term Conditions (LTC): Use of Apps has been identified as an effective tool to support patients with long-term conditions and more specifically those who utilise programmes based on activation levels, e.g. MYCOPD. Patient Activated Measure (PAM) levels can be used to stratify the population to identify those who would benefit from access to App technology.

Positives: (Secondary Care)

- Safer during pandemic due to lack of face-to-face interaction with others
- Safer during pandemic due to removal of need to visit physical clinical services
- Patients relaxed in home environment
- Family and carer support present on a larger scale
- No additional stress of travel to hospital and difficulty in parking (often sighted as a key concern for patients)
- Huge reduction in DNA/WNB rate compared with face-to-face hospital based appointments
- Effective use of Consultant time
- Supports remote working for secondary care clinicians
- Supports remote working for primary care clinicians
- Less time sat in waiting rooms
- Less attendance on site reducing the risk incidental acquired health issues – coughs colds flu, etc.
- Quieter hospital site allowing more efficient working and potentially different use of space in medium term.
- Less city wide traffic and pollution reduction
- More late take up of clinic slots as appointments can be added to daily routine

Positives: (Primary Care)

- Improves ability to triage and manage patient care
- Enables remote ward rounds in aligned Care Homes
- Positive anecdotal patient feedback
- Patient feel they have greater choice over their care
- Less time sat in waiting rooms
- Less attendance on site reducing the risk incidental acquired health issues – coughs colds flu, etc.
- Less city wide traffic and pollution reduction

Negatives:

- Not an option for some patients or carers
- Language can be a barrier particularly where no easy route to access interpreter services
- Some patients do not have access to suitable technology for video calling
- Some patients do not have access to a telephone
- Patient may not have credit on phones to enable calls to be made
- Privacy issues for patients if limited personal space in own home
- Domestic impacts, e.g. coercive control can potentially be applied for patients restricted to home
- Unable to view the patient 'in the round' for a more comprehensive physical assessment.
- Reduces the opportunity from incidental findings from examinations of convenience e.g., will

further examine as the patient is there but would not necessarily have been essential.
- Primary Care provision is reliant on good wifi and suitable equipment within the GP practice

Mitigation
- See Recommendation 1) page 4. Establish an infrastructure of community locations with support for patients to use technology e.g. libraries and GP surgery's etc.,

Virtual Appointments – Patient Experience Feedback

Advice for Providers:
HealthWatch England have put together tips on how to get the most out of the virtual health and care appointments both for patients and health and care professionals:
- Provide a precise time window for appointments.
- Check that the person is in a confidential and safe place to have the phone or video call.
- Understand the person's level of confidence using technology and give people a choice of how to communicate.
- Proactively check what the patient needs, clarify what is happening next and who is responsible for the next stages of care.
- Slow down the pace of the consultation, demonstrate active listening.
- Use the chat function in video calls to make the appointment more interactive, share links to information or summarise next steps.
- Don't ask people to provide information you already have access to.
- Give guidance about how the appointment will work, offer demonstrations, provide an opportunity for a test run/provide some training.
- Seek feedback about peoples' experiences and use this to improve the service.

Summary of patient experiences collected via the COVID-19 Insights Log Operated by NHS SCCG.

Patient Reported Experience of Telephone Appointments

Affected Group	Key Issues reported
People with disabilities and impairment	Deaf community have difficulty communicating with mask wearers and telephone consultations. People with LD, may not have capacity to understand and telephone consultations may be unsuitable. More difficult to provide advocacy support at medical appointments when carried out remotely.
People from BAMER communities	Limited access to technology for health advice and support, limited access to interpreters for tel. consultations. Cultural appropriateness and challenges through language. People from the Roma Refugee communities won't pick up the phone if don't recognise number, so communication from a trusted source is important
People with poor digital literacy	Poor digital literacy and lack of access to IT is leaving people isolated.

Patient Reported Experience of Video Appointments

Affected Group	Key Issues reported
People with disabilities and impairment	Deaf community have difficulty communicating with mask wearers and telephone consultations. People with LD, may not have capacity to understand and telephone consultations may be unsuitable. More difficult to provide advocacy support at medical appointments when carried out remotely.
People from BAMER communities	Limited access to technology for health advice and support, limited access to interpreters for tel. consultations
People with poor digital literacy	Poor digital literacy and digital poverty - lack of access to IT is leaving people isolated.

Digital Exclusion:
The Office of National Statistics (ONS) produced a paper in March 2019 entitled 'Exploring the UK's digital divide' which reviewed the scale of digital exclusion in the UK; those who aren't currently using the internet, how digital skills vary for different groups of the population and some of the barriers to digital inclusion. Embedded below the document considers:

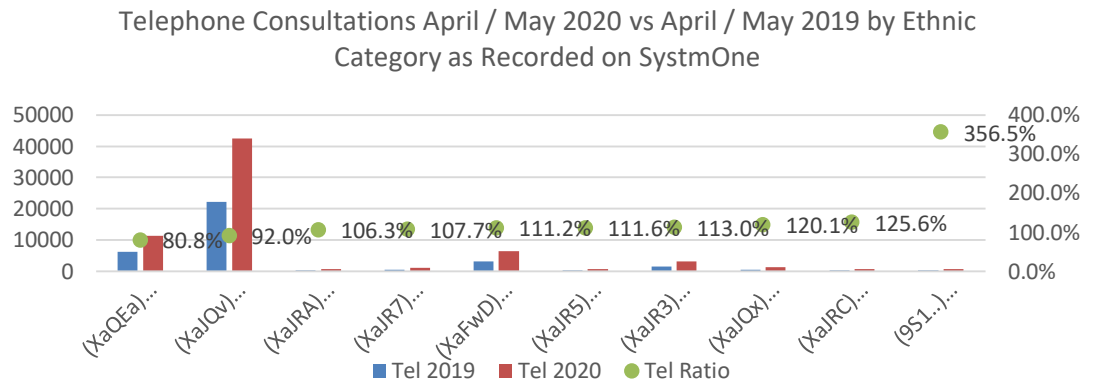
- The scale of digital exclusion in the UK
- What is the pattern of digital exclusion across the UK?
- How does internet usage and digital exclusion vary for men and women?
- How does digital exclusion vary with age?
- What is the pattern of internet usage among disabled people?
- How does internet usage vary for different ethnic groups?
- What other patterns are there in internet usage?
- What are the barriers to digital inclusion?

Full document embedded here:

RHIA Exploring the UK s digital divide.pdf

The above paper indicates the following reasons for not having access to internet services from home. The developments across lifestyles implemented as a result of the pandemic are likely to have shed new light on the top reason of 'no need, not useful' and affected a change in attitude across elements of the population. This should be built on upon going forward.

Primary Care – Comparison of telephone consultations 2019/2020 (COVID-19 Period)



Mitigations:

1. Engage with, invest and implement the local, regional (ICS) and national actions to support widespread digital inclusion activities (including telephone access).
2. Provision of 'safe place' locations for patients to undertake virtual consultations
3. Provision of easy access technology and support, e.g. virtual consultation rooms within GP practices to enable secondary care consultations to take place.
4. Staff available able to support patient in 2) above, e.g. language support, clinician explanations/question preparation, etc.
5. Technology provision in mobile support units, e.g., homeless support units
6. Develop and implement a programme of access to technology to support children, parents and carers to access technology to support their health and social care needs. Combine with education and other relevant areas as locally determined.

Development 2: **Electronic prescriptions and FIT notes**
Medicine reviews by Clinical Pharmacist

Key Impact Area(s): **Primary Care**

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

Activity: June 2020 recorded 89% of all items in Sheffield were via electronic prescription.

Positives:

- Easy and efficient method allows patients to take ownership of their prescription needs
- Reduces number of physical visits to practices
- Efficiencies for GP practices

Negatives:

- Appropriate technology required to access online services (see development 1 above)
- Requires increased access to clinical pharmacist to support
- Potentially misses other issues that could be identified during a face-to-face visit

Mitigations:

- Electronic repeat dispensing
- Access to the manned Prescription Order Line (POL) but does require telephone access/use

Development 3: **Increased use of social media to communicate and engage**
Key Impact Area(s): **Secondary Care**
Primary Care
Community Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

The Healthcare Information Management Systems Society (HIMSS)[42] says that social media platforms lend themselves well to reminding patients to contact their providers with questions through various kinds of posts.

"Although social media is not the most appropriate platform for direct patient-physician communication, it can be used to remind patients to ask questions," HIMSS explains in an information brief. "Social media can also direct patients to the appropriate secure communication

[42] The Healthcare Information and Management Systems Society (HIMSS) is an American not-for-profit organisation dedicated to improving health care in quality, safety, cost-effectiveness and access through the best use of information technology and management systems.

channels, such as their patient portals."

With such an easy-to-access forum, HIMMS recognises that some questions are going to pop up on Twitter or Facebook; in these instances, the organisation says social media managers should be in charge of redirecting the questions, or having standard answers on hand for general questions (i.e. "how do I make an appointment?").

"When patients use social media to ask health questions, a smart social media strategy would be to put a 'no wrong door' policy in effect," HIMSS states. "The social media manager can answer general health questions or direct patients to secure channels for addressing more personal health information."

Positives

- Primary care note patients feel more informed of their care options when communicated to this way

Negatives

- Primary Care note can result in negative patient feedback if communications are managed badly
- Restrictions for some in the ability to access social media

Development 4: **Increase informal telephone advice, guidance and reassurance to patients**
Key Impact Area(s): **Secondary Care**

Implementation of informal advice and guidance and telephone reassurance services in the form of patient helplines manned by specialist nurses.

Negatives:

- Relies on access to, and ability to use, telephone
- Requires robust interpreter access to allow equity of use

Mitigations:

- Support to understand guidance received via the advice line could be provided as part of a GP practice response to provision of suitable IT to enable patients to access video or telephone appointments in place of hospital face-to-face (see recommendations).

Development 5: **Patient Activation Measures (PAM)**
Key Impact Area(s): **Secondary Care**
Primary Care
Community Care

Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions. Use of the measure for LTC patients.

Sheffield CCG Is a national Mentor site for PAM with a plethora of information, learning and

development opportunities for staff to access and understand, how understanding an individuals' knowledge, skills and confidence can support a person centered conversation .

PAM can be used as an outcome measure; to tailor a conversation; to stratify/segment a population.

See infographic:

PAM Inforgraphic FinalShiftsIllustrationI

Development 6: **Support patient self-management**
Key Impact Area(s): **Secondary Care**
Primary Care
Community Care

Many people's knowledge, skills and confidence to self-manage their individual health condition may have deteriorated over lockdown and may result in increased use of resources. Need to re instate SSM Programmes. Stratification of population (using PAM) to ensure most appropriate provision according to their level of activation. Utilisation of wider MDT to support none medical interventions (e.g. Social Prescribing e.g. in Pulmonary Rehab) in readiness of clinical interventions. Creative utilisation of Personal Health Budgets (PHBs) to support self-management approaches (See Hackney – utilisation of PHBs to purchase mobile phones for non 117 Clients).

Programme of work in operation across the ACP to provide skills and awareness of person centred approaches to bands 2-4 (and their equivalents in social care) ICS programme in operation – Person Centred approaches to EOL care

Professional bodies, such as the Tissue Viability Society, have responded to the pandemic by publishing extensive patient self-care resources available at: https://tvs.org.uk/self-care/

An example for patient self-wound care is embedded below:

TVS-SHARED-CARE-FOR-WOUNDS.pdf

Development 7: **Referral Triage within Secondary Care**
Key Impact Area(s): **Secondary Care**
Primary Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	

Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

Previously the majority of patients referred to hospital by a GP were seen on a face-to-face basis. During the pandemic hospital clinicians have undertaken a triage approach whereby they review the referral and aim to provide advice on treatment and care back to the GP when patient does not need secondary care. Advice can also take the form of direct information back to the patient in order to enable them to self-manage their condition where appropriate to do so. For example, GP referrals to skin (dermatology and plastics) have been followed up by STHFT with a telephone call directly to the patient asking them to email in a photograph of their skin which can often enable triage to take place.

Positives:

- Patients receive their care in the most appropriate setting
- Supports more timely access to appropriate services
- Increased patient awareness of self-care techniques
- Whole pathway approach and blurring of traditional clinical divides
- Education and upskilling of primary care clinicians
- Increased awareness of skills in primary care
- Appropriate and effective use of secondary care resources
- Appropriate and effective use of primary care resources

Negatives:

- Patient may consider they have received lessened care if an appointment is not required.
- Some patients may struggle with their own self-care and need additional support. Initiatives such as PAM (see above) can support here.
- May be considered to be a shift in healthcare activity which is not appropriately funded.

Patient Feedback - Experience of Secondary Care Triage of Referrals

Affected Group	Key Issues reported
People affected by Cancer	Delayed or changes to treatment is causing heightened anxiety and may affect outcomes.  Lancet Cancer Care COVID.pdf
People with disabilities	Some medical appointments are being delayed.

Development 8: Pre-appointment triage (GP)
Key Impact Area(s): Primary Care

In April 2020 NHS England issued a blueprint for the implementation of patient triage in primary care. Whilst the full guidance is embedded below the following key messages were issued:

Key messages

- All practices should move to a total triage model as rapidly as possible to protect patients and staff from avoidable risks of infection.
- Practices should manage patients remotely (online, phone, video) and any pre-booked appointments should be converted to remote appointments unless face-to-face contact is absolutely clinically necessary.
- Turn off online pre-bookable appointments and, instead, triage all demand.
- Encourage use of other online patient-facing services, e.g. repeat prescription ordering and patient access to medical records.
- Appointments made available to NHS 111 for direct booking should be set up as remote appointments.
- NHS England and NHS Improvement are working with local commissioners on implementation resources and capacity to help practices deliver the changes required for a successful total triage model.

Full document embedded here:

NHSE Primary Care-Total-triage-blu

Positives/Negatives: (see secondary care triage above)

Development 9: **GPs seek consultant advice and guidance before making a referral**
Key Impact Area(s): **Secondary Care**
Primary Care

GPs in Sheffield have long-standing access via telephone and email to contact consultants at our main hospitals in order to ask advice and guidance regarding individual patients. However this has never been a formal agreement nor specifically commissioned. The model so far utilised in the city has been one of optional GP peer review of routine referrals in a range of specialties.

Secondary care referral triage has expanded during the pandemic and has highlighted the need to support the provision of high quality, auditable consultant advice and guidance provision in order to maintain patient care in the appropriate setting.

Positives:

- Education/upskilling and knowledge sharing two-way between primary and secondary care
- Care provided in the right clinical setting at the right time/care closer to home
- Patients receive care from their GP who is often well-known to them
- Less demand on stretched secondary care resources
- Moves the system toward joint patient care and shared population health responsibilities

Negatives:

- Some patients may not feel they have had the appropriate level of care if they are not seen by a specialist. This may affect some groups more than others.
- Advice may not be from named Consultant (patient choice implication)

Mitigations:

- Use of technology to enable virtual MDT working which includes the patient would reassure patients by allowing them to be part of the primary and secondary discussion at the same time.
- Specialist opinion combined with GP's personal knowledge would provide a patient-centred treatment/care plan to be agreed with the patient being supported to be an engaged stakeholder in their own care.
- Clearly identify the education and upskilling that has been developed and how this has positively impacted on local patient care.

Development 10: Services/diagnostics moved into the community setting
Key Impact Area(s): Secondary Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

Hospitals have had to take innovative approaches to service provision; this has been particularly evident in Sheffield with regard to services which previously operated on a drop-in basis such as ECGs and phlebotomy.

In order to respond to continued physical distancing requirements services will continue to be provided outside the hospital with consideration being made to expanding the range of services made available to local patients.

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.

Positives:

- Service available closer to home for many

- Facilitates closer community engagement for the hospital
- Releases additional estate space for priority group use in hospital
- Can facilitate joint secondary to primary care working enabling more holistic view of the patient.
- Patients can receive care faster as multiple sites offers increased capacity to see patient backlogs
- Flexibility of service provision in the right location to reflect patient demand e.g. evening services
- With the right year round compatible estate can move from drive through to quick stop testing , injections, height and weight for pre-op etc.

Negatives:

- Workforce skilled in supporting patients may not be adequate cover additional community sites
- Some patients will require support adjusting to the change service location
- Off sets the environmental impact of some of the virtual work.
- Makes a one stop shop appointment into drive through plus a call (notwithstanding for some this is still more convenient
- Access to people without cars – locations have to be Public Transport Friendly

Mitigating Actions for protected groups:

- Pre-attendance support to be offered to patient groups, including trauma and LD, to provide assurances over service location changes.
- Targeted communications with population groups to implement services in community locations which address specific requirements, e.g., language, religious considerations.

Development 11: **Increase in Prevention, admission avoidance and rapid access**
Key Impact Area(s): **Secondary Care**
Primary Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

For example, long-term conditions, gathering of biometrics for Diabetes patients. Based on the covid-response model of phlebotomy services operating on a drive-through basis at The Arena in Sheffield a similar community based one-stop-shop model would allow for the collection of patient biometrics to enable virtual consultations to be held with the patient by both GPs and hospital

clinicians.

The 'one-stop' approach would expand to include patient-self-care, prevention education and support from third sector organisations/mental health wherever deemed suitable.

Positives:

- Prioritisation of patients to be seen for further care including by ethnicity, multi-morbidity.
- Patients seen on this basis can have they full care needs assessed and suitable treatment offered combined with self-care education and support.
- One-stop approach enables further services to be made available, e.g. access to technology resources, voluntary sector support groups, etc.
- Enables the patient to access the support they need or be referred onto appropriate agencies in a more timely and effective way.
- Health messages will be shared in a non-threatening relaxed environment making the most of every contact to influence changes in behaviour.

Negatives:

- As per above development 1

Development 12: **Rates of 'hear and treat' increased**
Key Impact Area(s): **Yorkshire Ambulance Service**

Refer to above development 1) regarding issues for patients in use of video or telephone technology.

Development 13: **Rates of 'see and treat' increased**
Key Impact Area(s): **Yorkshire Ambulance Service**

Ambulance services have limited flexibility. Single-sex crews may, for example, have an impact in terms of patients and vulnerable groups potentially being unwilling to share all symptoms and therefore possibly not referred to the optimum service.

Mitigations:

- 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 (e.g. arranging telephone translators for non-English speakers/carers.

Development 14: **Implementation of 'drive through' phlebotomy service**
Key Impact Area(s): **Secondary Care**
Primary Care
Community Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender		Homeless		Hard to Reach		Migrant	

Reassigned						Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

Positives:

- Improved service delivery speed
- Patients better able to integrate care into their lifestyles
- No long waits due to over-running appointments
- No parking issues as there are at the hospital
- Positive anecdotal service user feedback
- More efficient use of healthcare resources

Development 15: **Managing fear of the virus**
Key Impact Area(s): **Secondary Care**
Primary Care

Patients have been reluctant to access primary, community and secondary care health services due to fear of infection, regardless of safety measures being in place. Whilst potentially affecting all patients, particular measures can be implemented to support those in the protected populations.

Impact:

- Potential deterioration in long term conditions (LTCs)
- Potential increase in multi-morbidity and incidence (eg. Type2 diabetes)
- Potential increase in condition severity and complexity
- Potential failure to identify early cancers
- Potential reluctance to accept ambulance transfer to secondary care (post 999 call)

Mitigations:

1. Engagement with population support groups, voluntary sector and community leaders to design and deliver targeted verbal and written communications.
2. Combine clinics and service to provide 'one-stop-shop' approach, e.g. Diabetes patient check-ups (bloods, podiatry, medication reviews, etc.

Development 16: **Staff utilising Personal Protective Equipment (inc. face coverings)**
Key Impact Area(s): **Secondary Care – Elective**
Secondary Care – Urgent
Yorkshire Ambulance Services
Primary Care
Community Care

Disability		Religion & Belief		Age		Race	
Sex		Sexual Orientation		Marital/Civil Partnership		Pregnancy	
Gender Reassigned		Homeless		Hard to Reach		Migrant Community	
Living in Poverty		Mental Health		Domestic Violence		Trauma Affected	
Carers		Other Vulnerable Groups					

Negative:

- A Health & Safety Executive note in their May 2020 paper[43] that PPE can heighten patients' fears of isolation and patients being cared for by healthcare staff in PPE can feel vulnerable and afraid. If you haven't previously met the patient, PPE can also pose a significant challenge to building rapport. The quality of patient experience with staff wearing PPE can be affected by:
- the inability to engage in usual nonverbal social behaviours, such as handshakes/fist bumps, leaning in, and facial cues.
- the sense of disconnect and distraction created by the PPE and difficulty hearing what the patient or clinician is saying due to reduced speech clarity. This, combined with the loss of lip reading and visual cues, can make communication between staff and patients extremely difficult.

These barriers compound the existing obstacles to interpersonal interactions, such as cultural and language differences between patients and staff. Despite some barriers, demonstrating empathy is possible while wearing PPE.

Mitigations:

- Deaf transparent masks, but we also need awareness and advocacy from healthcare staff, and a commitment to ensuring that patients with hearing loss are no longer overlooked, but are fully involved and supported in decisions about their care. https://www.rcplondon.ac.uk/news/read-my-lips-downside-ppe-and-how-you-can-improve-communication
- HSE Communications Report embedded here:

[43] HSE: https://www.hse.ie/eng/about/our-health-service/healthcare-communication/nhcp-communication-skills-for-staff-wearing-personal-protective-equipment-ppe.pdf

nhcp-communication-skills-for-staff-wearin

Development 17: Targeted Health Messages and Referrals
Key Impact Area(s): All

Directing of patients to the correct services with more targeted health messages for specific conditions.

Positives:

- Personalised patient care
- Patients feel more connected to their care
- Improved awareness of self-care options
- Opportunities to ensure patients are referred to most suitable service.

Negatives:

- Must be well planned to avoided missed conditions or inappropriate referrals
- Requires clear pathways to ensure there are no referral delays

Long-term Conditions

In response to COVID-19 a non-peer reviewed paper 'Supporting people with long-term conditions (LTCs) during national emergencies' was published in March 2020. Produced on behalf of the Oxford COVID-19 Evidence Service Team[44] the paper identified the following indirect drivers of suboptimal care for LTC patients

- Diversion of health care resources
- Interruption to routine care
- Interruption to medication supply
- Increased stress
- Changes in food supply
- Changes in activity levels
- Disruptions in transport

The verdict of the paper was that disruption of care, diversion of healthcare resources, and interruptions to medical supplies can all impact patients with long term conditions (LTCs) during national emergencies. Some LTCs may be further exacerbated by increased stress and changes in diet and activity patterns. The data does not rule out any LTCs as not being at risk of neglect, but particularly highlights cardiovascular disease, diabetes, older people and people in deprived areas as being at increased risk. Suggestions for mitigation strategies can be grouped into planning and responses phases, and broadly focus on collaboration, communication, and continuity planning.

[44] Centre for Evidence-Based Medicine, Nuffield Department of Primary Care Health Sciences University of Oxford

Further information is available in the full paper:
https://www.cebm.net/Covid-19/supporting-people-with-long-term-conditions-ltcs-during-national-emergencies/

LTC: Diabetes

Consequence (direct or indirect) of Covid	Implication for Elective Care	Implication for Unplanned Care
Disruption of planned annual review of patients in PC	Treatment targets (BP, Cholesterol, HbA1c, BMI, eye screening) not collected at scheduled anniversaries.	Increase in diabetes NELs due to deterioration in control and developing complications e.g. stroke, MI, feet ulcers, hypos etc.
Prioritisation of patients to be seen	Prioritisation (by ethnicity, (multi) morbidity) using latest readings on pt record. Use Q Risk3 to identify pts, or PRIMIS grasp (writing pt search)	
Gathering of patient biometrics	Suggestion to 'upscale' the Arena operation to be able to gather all required biometrics to allow virtual patient consultation with PC/SC. Can the Arena operation be replicated for other parts of the city? *NB this could be utilised to gather biometrics for other LTCs, not just diabetes.* Take to CCG Gold and STHFT Silver command structures	
Deterioration of Diabetes control	Many pts' control will have deteriorated over lockdown	Increase in diabetes NELs due to deterioration in control and developing complications e.g. stroke, MI, feet ulcers, hypos etc.
Increase in Diabetes related complications	As elements of condition requiring outpatient care increase, how to manage these pt contacts safely in PC (and community) as well as SC. There will be pt reluctance to attend f2f appointments	Increase in diabetes NELs due to deterioration in control and developing complications e.g. stroke, MI, feet ulcers, hypos etc.
Increase in pre-diabetes	Almost nonexistent referrals from PC to the NDPP – how to re-start; Less opportunistic finding in PC Unknown no of pts tipping in to Type 2 diabetes over lockdown period	Increase in NELs due to pts developing Type 2 diabetes with no awareness.
Remote patient appointments where possible	Virtual consultations already widespread as response to Covid 19.	

	Needs to be expanded; Will tech be resourced/standardised or will practices choose what they use and pay for. Zoom/Teams will need to be paid for after free periods withdrawn.	
Management of face to face patient appointments	For patients that do have to be seen, how will this be managed	
Delivery of patient structured education	Virtual structured education being made available (Children and young people with T1DM – Digibete; Adults with T1DM – Diabetes MyWay; Adults with T2DM – Healthy Living). Resourced by NHSE for first 12 months. Will create potential cost pressure after 'free' period	
Delivery of practitioner education	Some foot training already available online from STHFT, need to expand	
Advice & Guidance service (CASES)	Initial discussions with STHFT in May 20	
Increase in inequality in most at risk communities		Increase in diabetes NELs due to deterioration in control and developing complications e.g. stroke, MI, feet ulcers, hypos etc.
Housebound patients	Community/practice nursing to visit housebound patients to gather biometrics and adjust treatments accordingly. Challenges of f2f contact, adequate PPE required.	Increase in diabetes NELs due to deterioration in control and developing complications e.g. stroke, MI, feet ulcers, hypos etc.
Care homes	Ensure Care homes DES includes management & treatment of pts with diabetes	Increase in diabetes NELs due to deterioration in control and developing complications e.g. stroke, MI, feet ulcers, hypos etc. and potential lack of understanding from care home staff, possibly greater in residential homes?
Mental health of pts with diabetes may have deteriorated during crisis	Promote/refer pts to IAPT virtual offer	Increase in diabetes NELs due to deterioration in control and developing complications

Management and reporting of national programmes	Has stopped during crisis but will be re-instated in Autumn 20.	

LTC: Respiratory

Consequence (direct or indirect) of COVID-19	Implication for Elective Care	Implication for Unplanned Care
Significant increase in patients with lung scarring (due to covid)	• Potential increase in need for pulmonary rehab • Need alternative delivery models (not face to face)	• Potential increase in respiratory NEL admissions. • Additional breathless patients – increasing demand on mental health services and urgent care services.
Deterioration in existing respiratory patients due to self-isolating	• Reduced lung capacity • Needing more encouragement to increase exercise levels. • Annual LTC reviews not happening/not as effective via phone/video exacerbating this deterioration. • Longer term deterioration which cannot be reversed.	• Increased risk of NEL. • Potential increase in frailty and likelihood of admission.
Lack of COPD diagnosis due to lack of spirometry testing / lack of tool to measure deterioration.		• Potential increase in patients attending urgent care services as condition not diagnosed/managed appropriately.
Reduction in attendance for Flu/Pneumonia vaccines	• Self-isolating patients may delay obtaining vaccines. • Carers may also delay/avoid attending for vaccination.	• Potential increased in NEL.
Increased need for MH services	• Patients with newly diagnosed lung issues (post covid) may need psychological support. • COPD patients may have increased anxiety leading to NEL due to breathlessness and lack of exercise.	

•**Healthcare access** has changed rapidly and dramatically; as it is restored, a very nuanced public health message will need to be found to encourage people who need healthcare to come forward in the midst of infection precautions. North Yorkshire and York RHIA

Cancer Services

Sheffield has a population of around 590,000 people. There were around 1940 people recorded in 2018 as newly diagnosed with breast, prostate or colorectal cancer in the city. Around 3.3% of the city's population, 17,700 people are living with a cancer diagnosis.

The Joint Strategic Needs Assessment highlighted inequalities that exist for people affected by cancer in the city. People living in areas of deprivation and from certain BAME communities are more likely to have worse cancer outcomes than white people living in more affluent areas in the city. The incidence of cancer is also significantly higher in the older population. It is estimated that two thirds of cancer diagnosis occurs in those aged 65 and over and one third in people 75 and over.

Cancer pathways across all tumour sites within STH have been impacted by Covid and this impact may further exacerbate these inequalities.

To protect people affected by cancer from the risk of contracting Covid, site plans have been developed for each tumour site within STH, to detail service changes that were necessary to minimise risk. These plans confirmed pathway changes to triage, diagnostics, MDTs and treatment, which enabled the effective risk stratification of patients to ensure those with highest priority were seen first.

Within primary care, we know that people have been reluctant to contact their GP's during lockdown due to fear of Covid and this will result in delays for some people in getting a cancer diagnosis and access to timely treatment.

Two Week Wait Referrals-

Evidence gathered from SystmOne, covering 75% of GP practise, shows that referrals from Primary Care were down by 62.9% during April and May 2020 vrs same period the previous year. We can assume that most of these referrals would be 2WW's. By looking at the ethnic categories recorded on the system it would appear that referrals were down more for some ethnic groups than others, with the Pakistani or British Pakistani ethnic category down by 68.8% and African ethnic category down by 76.6%, compared to the average decrease in referrals of 63%.

Waiting times

The volume of people waiting longer for a diagnosis of cancer within STH has increased. Despite a reduction in demand during the initial phase of the pandemic, diagnostic and treatment pathways were disrupted to a significant extent, such that demand continues to outpace available capacity. This had led to an increase in the backlog (patients waiting over 62 days on an open cancer pathway.

Appendix 2 illustrates the volumes of patients waiting across tumour pathways in STH.

Diagnosis and Treatment

All patients on cancer pathways are being managed in-line with national best practice clinical guidance concerning the prioritisation of care within the COVID-19 related resource limitations of the current system. Guidance has resulted in risk stratification of patients to timed delay profiles based on clinical risk. All pathway changes are aligned with ICS partners and they continue to be reviewed and revised where necessary to ensure patients are receiving optimum care. In addition STHFT continue to share data to support modelling an ICS approach to service recovery that will ensure equitable provision of care to patients on cancer pathways.

Providers across South Yorkshire and Bassetlaw have been working together across the system and through an elective and diagnostic hub, have coordinated all access to care and ensured oversight of capacity, enabling access to independent sector diagnostic and treatment resources where it has been appropriate. The Cancer Alliance is working with ICS workstreams such as Elective and Diagnostics as well as local providers towards the formation of a single queue for patients to ensure equity of access for those patients with clinical priority to both diagnostics and treatment from across the system.

A SYB modelling tool has been developed which; coupled with the intelligence obtained through utilisation of the West Yorkshire modelling tool, will provide greater insight re: demand and capacity. These tools will enable a more detailed understanding of how unseen referral backlogs, existing secondary care backlogs and new activity will translate in to diagnostic and treatment demand. This should inform effective recovery/resetting plans – both at place and as a system.

All pathways are being regularly reviewed so clinicians can ensure the most clinically urgent are seen first. Regular reviews, either by appointment (face-to-face or non-face-to-face) or by MDT review of results/healthcare records, are ensuring that risk stratification is agile and if necessary upgraded to ensure that the clinical priority reflects the ‘live’ state for patients

Existing patients are being supported by Clinicians to consider benefits and risks of treatments during Covid.

STH continue to ensure that there are appropriate mechanisms in place to support STHFT clinical teams in continuing to deliver cancer care in a safe and effective manner, in-line with new and emerging guidance and that patient safety and experience remains a priority. Whilst 62 day and 104 day backlogs have grown significantly STH are confident that, as a result of risk stratification, patients are being treated/managed appropriately based on robust clinical criteria.

Most tumour sites have continued to see patients face to face with social distancing in place, as well as using non-face to face consultations, where possible. No Endoscopies have been taking place during lockdown and patients at high risk have been referred for CT scans instead. Although surgical treatments have been greatly reduced, priority surgery has continued. Radiotherapy Treatment and Systematic Anti-Cancer Therapy has continued but with modifications. The consequences of these changes may not become evident for some time

Patient Follow-Ups
Non face to face patient follow up has continued with patients and many have fed back that they were glad not to have had to come to hospital again. Some however have fed back that they would have preferred a face to face meeting.

Screening and Early diagnosis
The breast screening, cervical screening and bowel cancer screening programmes recommended by the UK national screening committee are commissioned nationally by NHS England and NHS Improvement. At the start of the Coronavirus Pandemic, there was no national decision made to suspend screening programmes, however following individual trust risk assessments (capacity e.g. environment and staff redeployment and the risk to patients in relation to Coronavirus e.g. potential exposure), decisions were made locally to prioritise resources to support the Covid-19 response.

The screening services in Sheffield and across the region are working hard to ensure that patients get their screening as quickly as possible. Routine cervical screening invitations are now almost back up to normal service level and routine breast screening invitations have re-started. In terms of bowel screening we are currently prioritising appointments for people that need follow up tests following their bowel cancer screening result, including telephone appointments with a specialist screening practitioner (SSP) where appropriate.

Support Services
Cancer support services have continued to support patients remotely through lockdown using telephones and technology. Services report that patients and carers are presenting with increased anxiety, psychological distress and sense of isolation. Their concerns are notably amplified by self- isolation; in particular those with a poor prognosis and concerns around increased risk from lockdown measures being eased.

Services have seen a significant increase in the number of carers accessing support; approx. 2/3 of people accessing therapy have been carers.

Patient Experience-
Patients (and carers) have talked about lockdown in terms of “losing precious time” - not being able to make the most of their life if illness is life limiting.

Some patients have reported that they are struggling with caring responsibilities and working remotely from home causing anxiety – managing time and expectations of the workplace.

Concerns and frustrations have been reported from carers where treatment is being stopped completely for patients with incurable but treatable cancer. There is a sense of injustice and unfairness that life is being shortened for their loved one.

Other specific themes which have been commonly raised with support services are; Feeling there is a new level of “unknowns” to deal with on top of existing health related unknowns which causes increased anxiety.

Constant reminders of mortality in the media triggering and increases fears around own mortality “there is always talk of death”.

Unable to access services/ activities which support clients to manage their well-being in normal day to day life– accessing complimentary therapies, evening classes, holidays, meeting friends for coffee etc.

Feeling overwhelmed by change & lack of structure to day/week etc

The technology for a small number of clients has raised stress levels. However, for some this has increased accessibility (notably, those with children and one patient with Agoraphobia

Th**e main themes of concerns that Sheffield CNS teams within STH have reported are:**

- Delays/changes/unavailability of treatment options/surgery/clinical trials and the effects/risks associated with this
- Fear of attending for OPA/Scans/GP surgery during the pandemic and concerns about how safe it is to do so/not feeling able to readily access aftercare from Primary Care during or following treatment
- Uncertainty as to whether the patient’s cancer diagnosis/treatment places them in the vulnerable/high risk category and queries around how strictly they have to follow shielding advice.
- Queries from patients who have received the shielding letter who don’t feel that they fall in to the vulnerable/high risk category/Not being able to make the most of their time due to shielding/isolating. Feeling isolated from family and friends due to shielding/lock down
- Anxieties around not being able to bring relatives to hospital appointments or the prospect of not being able to have visitors if they need an inpatient stay. General increased levels of anxiety and low mood associated with the uncertainty of the COVID19 situation and feelings of vulnerability and isolation.
- General calls following telephone consultations to ask questions/clarification.
- Reporting COVID symptoms and feeling anxious/ asking for advice about what they should do.
- One team reported delays in the processing of DS1500 applications.
- Concerns that staff cannot support patients effectively due to wearing PPE or through non-face to face contact.

Summary of concerns raised by people affected by Cancer in South Yorkshire, Bassetlaw & North Derbyshire during the COVID pandemic - May 2020

Summary of Cancer patient concerns duri

Local Cancer Service Data

The paper embedded below provides an update on the management and delivery of cancer pathways at STHFT as well as current performance metrics relating to Cancer Waiting Times (CWT) performance in the context of the global novel coronavirus (COVID-19) pandemic.

Cancer Data WTPOG - CWT Report Sectior

Predicted estimate of excess deaths in cancer patients related to the Covid-19 emergency. Data from England, Northern Ireland and US.

https://www.researchgate.net/publication/340984562_Estimating_excess_mortality_in_people_with_cancer_and_multimorbidity_in_the_COVID-19_emergency

Chapter 9b

Access to Social Care and Support Services

Summary of Theme:

1. **Theme summary and scope:**

1.1 In the context of this RHIA the theme Access to Care and Support includes provision, access, delivery and management of health and social care, whether formally or informally, that is intended to meet the care and support needs of people at home or in residential care.

1.2 Included in the cohort of people affected are older people, people with a learning disability, autistic people, people with a physical disability, and people with a sensory disability.

1.3 On a broad level care and support can be categorised by the services people access, by the settings within which care is provided, and by functions supported. The main strands of service provision are:

- **Care Homes** – care commissioned predominantly from independent providers and delivered in community based care homes and nursing homes.
- **Domiciliary Care** – care commissioned from independent providers delivering services in people's own homes.
- **Day Services** – activity centred care support provided by a mixed market of independent and statutory providers.
- **Hospital Service** - including Community Intermediate Care Services and Somewhere Else to Assess [S2A] placements, which form part of a pathway alongside the Council run Short Term Intervention Team with home centred provision including re-ablement.
- **Supported Living** – community services and accommodation provided to people to promote and facilitate more independent living.
- **Respite Services**– care and support provided primarily on a temporary basis in a residential setting to people who live at home with a carer(s) to afford the carer(s) the benefit of a longer break from their responsibilities.
- **Direct Payments** – funding which allows individuals with care and support needs to commission their own care and support that best meets their needs.
- **Carer Support** – support available to carers who themselves have needs as a consequence of the caring role that they perform.

1.4 Throughout the provision of the above services the following elements must be maintained:

- **Deprivation of Liberty Safeguards** - making sure that where people with care and support needs who do not have capacity only have restrictions placed on their liberty within the terms of the legislation, regardless of their place of residence. Any

actions taken must be demonstrably in the best interests of the interest wherever they are deprived of their liberty.

- **Assessing planning managing and reviewing care and support** – this must include assessing mental capacity alongside physical needs.
- **Safeguarding** – protecting people who are vulnerable and ensuring that their care and support needs are met in line with the requirements of The Care Act 2014.
- **Information and Advice** – providing wrap around support options to individuals and their carers with the aim to avoiding negative impact on their own wellbeing and personal circumstances.
- **Transition from childhood to adulthood** – The pathways and services offered by the Health and Social Care system are different for adults and children. The legislation requires Commissioners ensure that the services commissioned support the transition into adulthood and adult services.
- **Engagement and involvement** – 'Co-production' of services is key to ensuring the system delivers quality, person centred services which meet the needs of the individuals while functioning as a service at scale capable of delivering for the whole population.
- **Advocacy** – some people with care and support needs may require an advocate. The absence of an advocate in these circumstances can have a detrimental effect on their outcomes and overall wellbeing. Commissioners must ensure advocates are engaged and available wherever they are requested.
- **Functioning Multi Agency Partnerships** – care and support functions at its best when provided within a comprehensive multi-agency environment. This requires clear co-ordinated communication between a number of agencies and effective liaison with all stakeholders.

2. Out of scope of this RHIA

2.1 **Mental Health Services** – care and support for people with a Primary Mental Health diagnosis is commissioned outside of the services identified above

2.2 **Acute and Community Children's Services** – The focus of this paper is adults as defined by individual pathways. Work continues to improve pathways from childhood to adulthood in the context of care and support. This work is a priority for the Commissioning organisations through the development of an 'All Age' approach to people with lifelong needs and disabilities.

2.3 **Commissioning of Care and Support** – The Covid-19 pandemic has been destabilising to the Care Home and Home Care market in Sheffield. In the short to medium term support is being provided to ensure the sector is stable pending a full review of the longer term requirements and sustainability required. This will be linked into overall strategic analysis of the Adult Social Care provided by SCC.

Summary of impacts:

3. Impact overview

3.1 The pandemic emergency has changed things.

- Hospital discharge pathways have changed in line with government issued guidance which has impact the flow of activity into and around the sector.
- Individual and their families have changed their behaviour due to lockdown, working from home and due to the media coverage of outbreaks within the sector. The overall demand for adult social care services has been volatile during this period and demand remains difficult to forecast.
- Social distancing has impacted upon the preventive work commissioned and required a change to how conversations are held with individuals and their carers.
- Carer support through respite and day care provision has been suspended during lockdown which has placed strain on carers and their mental health.
- The capacity for crisis support has been reduced but the services continued to support individuals, carers, families and providers when required.
- The commissioning and funding of hospital discharges and step up care has changed in line with national guidance during the pandemic.
- Staff across all partners have adapted to new ways of working and training to enable remote working to limit numbers entering building and movement between sites.

3.2 And is not yet over– there are challenges still to come

- Resumption of acute services such as elective surgery, the phased easing of lockdown measures including individual support networks or bubbles returning to work, as well as winter pressures make future demand uncertain.
- Allowing for social distancing within prevention services, crisis response and face to face care assessments make service delivery and decision making more complex.
- The changes to funding regimes and the reinstatement of the means testing for packaging commissioned during the pandemic will take effect from 1st September.
- The sustainability of the Care Home and Home Care market once the support for reduced activity and void capacity is removed.
- Conflicting information around vaccinations, and the possibility that test, track and isolate may be around for the next 2 years complicate planning.

4. Impact key data

4.1 The following data is taken from the SCC Adult Social Care system and is provided as a representation of the impact of the pandemic on the Home Care and Care Home market.

- As at the 26/07/20 the number of people receiving Adult Social Care services had decreased by 3% or 220 packages when compared with the week before the pandemic.
- This was felt disproportionately within residential care where there was a decrease of 140 people, or 10%.

- Ongoing Nursing Care package decreased by 24% in the same period.
- The impact was felt during the first 8 weeks of the pandemic with residential packages remaining at this lower level in the following weeks.
- The packages commissioned directly by SCCG increased as discharges with Covid-19 required additional short term support with their health during this period.
- There have been 74 care homes with confirmed or suspected Covid-19 outbreaks. There were deaths in 53 of these homes as a result of these outbreaks.
- Home Care packages have not seen the equivalent reduction as Care Homes have been treated as shielded sites with a reduction in new admissions and additional step up care has been commissioned to maintain individuals at home, at times with more support from their families during lockdown.
- New privately funded Care Home packages reduced during this period as families chose to lockdown to support and care for relatives while they were working from home.
- Social distancing has impacted on the ability of staff to review existing packages and converse with families and carers around changing needs.
- Although critical work continued to help keep people out of hospital and facilitate those being discharged, the number of people either awaiting support from the Equipment and Adaptations (E&A) team or currently within the E&A assessment process increased to 2,288 by the end of July.

5. Trends

5.1 Face to face contact with people who have care and support needs have been replaced with telephone and on line contact wherever possible during the pandemic. Assessing planning, managing and reviewing people's care and support, including mental capacity, has continued using remote technology, although at a reduced capacity. At this time the reviews are being undertaken on a prioritisation basis to minimise the risk of individuals with changing needs continuing to receive inappropriate care packages.

5.2 The main focus during this period has been to undertake wellbeing calls and checks to people who are identified as potentially vulnerable, either by local or government information. These included 1,141 people on the Government Shielding List who were classed as 'Extremely Vulnerable' and had self-referred via the government website, stating their basic care needs were not being met by personal support. This has meant a shift in emphasis to telephone contact and the mitigation of risk to individuals rather than routine reviews of existing support. These conversations may include giving information or advice, general help with medication/food, referrals to E&A, Carers Centre, VAS, signposting to other agencies, and details of the Council's advice line if they need support in future. As a consequence some people will be having more contact with us than previously, others less.

5.3 In accordance with the national guidance the initial focus of the system partners was to expedite hospital discharges to prepare for the anticipated upsurge in hospital admissions due to Covid-19. This was effectively managed and has created an example of partnership working and a template for future processes as we move towards the pressures of Autumn and Winter.

5.4 In the short to medium term there is expected to be a reduction in demand for formal care and support within a residential setting. The longer term requirements are being assessed to understand the markets ability to self-sustain the changes in demand.

6. Demographics Impact

6.1 The nature of the care home and home care market is that a high proportion of the service users are white, older females who identify as Christians. For example within the residential care market the demographic is recorded as 58% female, 60% are older adults (65+), 84% are White, and 36% belong to a denomination of Christianity . Females tend to outlive their male partners with two thirds, (5,400 in Sheffield in July), of people who identify as care givers being recorded as a female relative. The BAME community are less likely to access support from statutory organisations and therefore less likely to appear within the collected statistics and therefore have not felt the impact of changes to the Care Home and Home Care Market proportionately during the pandemic.

6.2 While there has been wide spread media reporting around the negative impacts of the lockdown for older people and the effects on their mental health there have also been reports by some of the older population that they have been more at ease in their own environment while supported by their families during lockdown. For example, someone with autism may feel more at ease in this environment that previously or an older person who was living alone with support visits may have benefited from 24 hour support from a family member.

6.3 Self-neglect is a major issue for Adult Social Care that predates Covid-19 but has been impacted by the lockdown as regular face to face contact has not been possible. This is a particular issue where people have capacity to make choices about their own lifestyles and are less intervention from statutory services. The reviews of vulnerable people and in particular the delivery of food parcels has enabled a dialogue to be maintained with this hard to reach demographic which has reported a positive response during difficult circumstances.

7. Major identifiable impacts and mitigations to date

7.1 Care Homes - The pandemic and specifically the rate infection in shared housing settings such as Care Home has had a devastating effect on people living in Care Homes.

The Commissioners are working in conjunction with STHFT and PHE to analyse information, establish the sequence and spread pattern of Covid-19 infections and deaths in care settings to learn from the pandemic and roll out training where possible around the themes identified. This analysis will be completed by the end of August 2020.

An increase in the mortality rate, particularly amongst older people in residential settings, has contributed to significantly reduced occupancy rates across the Care Home sector creating voids within most sites within Sheffield.

Those living within residential facilities have experienced less freedom of movement and

reduced ability to receive visitors than other members of the population throughout the lockdown and easement. This has been particularly felt by those with dementia, who often have less understanding of what is happening and are unable to practice social distancing or isolation during outbreaks.

As a Health and Social Care system a wrap-around support structure has continuing to provide help to residential and nursing care providers to enable them to meet the needs of their residents and their families during this difficult time.

While Home First wherever possible is still the focus of commissioner discharge planning, where appropriate individuals will continue to be admitted to care homes where that is the safest option for that person.

The Health and Social Care partners have built upon existing strong working relationships to create a significant package of support for the city's care homes, which will continue to evolve as the needs during the pandemic change. This includes;

- Funding support for additional Covid 19 costs incurred – managed by SCC and facilitated through a Google Form co-ordinated by SCC.
- Support with infection prevention and control – central allocations of funding alongside training and PPE. Specialist advice from STHFT and SCCG where required.
- Enhanced clinical support including EOL support provided by specialist staff from St Luke's Hospice.
- Rapid response elements for care homes that start to struggle, including providing trained Council staff – newly recruited, volunteers or redeployed existing staff.
- Prioritised Covid 19 testing through the Sheffield service (in addition to national scheme)
- Tablets with SIM cards to enable people in care homes to connect with their family and friends
- Regular calls to check in with Manager in the homes and network Zoom calls for Owners and Managers to connect with other Providers and provide a support network.
- A single point of contact monitored inbox for all enquiries from or about Providers, and dedicated web page with the latest information.
- Regular updates about national and local guidance
- Additional social work support

Adult Social Care teams continue to make contact with those people they know to be most at risk regardless of their usual place of residence, including residents of Care Homes. Where appropriate feedback is also being collated from families, carers and advocates, as well as staff working in a home. The intelligence gained through these conversations will be supplemented by a programme of virtual inspections conducted remotely throughout the Care Home sector in Sheffield to ensure quality standards are being maintained while few statutory services are making on site visits.

7.2 Domiciliary Care - Care in people's own homes has broadly continued as normal. Providers have felt increased pressure, including from higher staff absence due to illness, shielding and the requirement for isolation periods. In some cases people have been

reluctant to allow carers into their homes because of the risk of infection which has led to risk assessed changes to the previous packages of care. This, combined with the increased availability of family to provide support and people temporarily moving in with family members has relieved some of the pressure. In the first two of weeks lockdown (23/03 - 05/04) 15% of Home Care services were ended due to 'family and friends providing services'. The case notes around almost all of these cases show that the risk of infection to this vulnerable cohort of the population, who were advised to shield, was a big driver behind packages being stood down with informal support family replacing carers being commissioned. Over two thirds of people who cancelled their home care services in the first two weeks of lockdown for this reason still have no active services. This will be monitored as individuals are no longer able to work from home or end their furlough.

Despite this change to provision, other cancellations were relatively small in number, less than 1% of all people with Home Care ended their packages compared to 3% pre Covid 19 in a similar period.

We have worked closely with Home Care Providers to ensure stability in this part of the sector, including a block payment approach. We are deploying newly recruited Council staff to support home care as and when required.

7.3 Day Services - Independent day services have closed their buildings based activities in accordance with government guidelines. However, they have continued to offer alternative activities ranging from music, drama, exercise classes and bake offs via Zoom to the delivery of activity packs and regular contact via phone/Zoom for people using services and family carers. As restrictions are being lifted, services are being encouraged to plan activities outside on a 1:1 basis with robust risk assessments in place. All day services have continued to be paid based on February delivery and have received additional financial support and advice to modify facilities to meet infection control requirements.

Council Day Activities have also closed but contact has been maintained on a RAG rated risk basis, with those classified as Red being prioritised. Staff are being advised around changes to guidance, and linked into partner organisations for support as required. No issues have been raised for review during lockdown.

Any members of staff who were unable to continue to work during this time were redeployed into the STIT service or Supported Living schemes.

Closure of day services means that the structured activities built into care and support plans have ceased being delivered at day services centres. People with Learning Disabilities will have been disproportionately affected by this; 67% of people with day services in their support plan have a primary support reason of Learning Disability Support. The approach to how care and support needs are met has had to be rethought and in many cases alternative or more individually tailored support has been introduced. For example, there has been positive feedback from adults with Autism that this method of delivering services led to reduced social anxiety. This break in service is being taken as an opportunity to reassess longer term plans for individuals rather than reinstating previous services.

7.4 Hospital discharges - Discharges from hospital have been lower than would have normally been the case due to hospitals standing down elective care. Despite the impact of sickness, isolation and shielding upon the Council's Short Term Intervention Team (STIT) service the ability to recruit and utilise volunteers and redeployed staff has enabled the team to support the flow of people out of hospital.

Delayed transfers of care (DTOCs) were lower during the peak of the pandemic due to a co-ordinated system response from all partners including VCS organisations.

7.5 Supported Living - Supported Living has continued to operate, albeit in slightly different ways. Opportunities for leaving the properties have been reduced in line with lockdown legislation, and other elements of individuals' packages have had to be adapted to compensate. Framework, non-framework and in-house Providers have organised activities for people to replace day services which have been appraised with positive feedback.

Community outreach support for people who live in their own tenancy or the family home rather than supported accommodation has been flexible to meet their needs. For example, making contact throughout the week rather than for allocated block hours.

Payments have been made on commissioned hours as a block payment to provide stability during the pandemic.

The majority of people in Supported Living have a primary service requirement of LD support (88%) and are white (93%), male (56%) and over 65 years of age (78%).

7.6 Respite Services – Wherever possible respite care has been maintained but inevitably there have been individuals who have not been able to take their planned breaks during this time. Out of 6 providers, 2 have continued to provide a full service and 2 have offered a reduced service. Cancellations have been high. Providers have been funded by a block payment during this period to manage any impact of void costs on their facility.

There have been 26 adults who have Rolling Respite at Warminster as part of their support plan which have not been able to be supported. These individuals are all working age adults with Learning Disabilities. The staff have been redeployed where not required within this service to other carer roles within SCC services.

Three quarters of adults with LD respite packages in their support plan also attend day services – therefore these individuals and their carers are most likely to have been impacted by these specific service changes.

7.7 Direct Payments - For those who arrange their own care through direct payments (DPs) or through the use of a personal health budge the implications are by nature more varied. Social care teams have contacted everyone in receipt of a direct payment to discuss their situation, to devise contingency plans and ascertain their overall well-being is being maintained.

We have issued responses to frequently asked questions to everyone receiving direct

payments and ensured fast track emergency funding is available if people need to arrange alternative support.

In addition to this, 547 one-off Covid-19 Additional DPs were been made to recipients of DPs for Home Support (424) and Supported Living (123), as part of a 5% temporary increase to support providers during the initial 12 weeks of the pandemic where required.

We have worked closely with Disability Sheffield to utilise their expertise with personal assistance to understand how to changes can be made at pace to meet needs, advise around Covid 19 testing, and co-ordinate distribution of PPE. At least 30% of people with DPs to fund PAs have Physical Disabilities and at least a further 33% have Learning Disabilities. This means over 63% of people with PAs have some form of disability compared to 29% of all other social care users. All people with DPs for PAs were contacted to check if they had a contingency plan in place should their PAs were unable to support them as a result of shielding or self-isolating. In addition, an emergency PA Register for PAs to join to offer cover to people who have PAs shielding or self-isolating has been created. A programme is underway to co-produce, with people who use or could benefit from Direct Payments, improvements to the existing practice and processes in this area.

A higher proportion of DPs are made to adults from Asian (8%) and Black or Black British (8%) ethnicities than might be expected given the proportion people of these ethnicities who receive social care services (3% and 4% respectively). This is particularly true for adults with DPs for Home Support (who received Covid-19 Additional Payments to support providers) and those with PAs. Despite this, White people still account for the highest proportion of DP recipients.

Ethnicity breakdown of DP recipients:

Ethnicity	People with DPs for Home Support	People with DPs for PAs	People with DPs	People with ASC services
Asian	10%	12%	8%	3%
Black or Black British	11%	12%	8%	4%
Mixed/Multiple Heritage	2%	3%	2%	1%
Not Held	5%	6%	5%	7%
Other Ethnic Group	2%	3%	2%	1%
White	71%	65%	76%	84%

There are also a high proportion of people (8%) who receive DPs whose first language is not English, compared to 4% across all social care services. The first language of 13% of those who receive DPs for Home Support is not English and the first language of 15% of those who have PAs is not English. For DP recipients, the most common non-English first language is Somali, followed by Urdu, Panjabi and Arabic.

Also notable is the high proportion of Muslims with DPs; 9% of DP recipients are Muslim, compared to 3% of people who receive any type of social care service. 16% of DP recipients with PAs are Muslim and 12% of DP recipients with Home Support are Muslim.

Religion of DP recipients:

Religion	People with DPs for Home Support	People with DPs for PAs	People with DPs	People with ASC services
Atheist	2%	1%	1%	1%
Buddhist	0%	0%	0%	0%
Catholic	2%	2%	2%	3%
Christian	5%	9%	8%	8%
Church Of England	20%	14%	15%	25%
Hindu	0%	0%	0%	0%
Jewish	0%	0%	0%	0%
Muslim	**12%**	**16%**	**10%**	**4%**
Not Recorded	52%	53%	61%	52%
Other religion	5%	4%	3%	8%
Sikh	0%	0%	0%	0 %

It is thought all of these factors are linked – many framework providers for Home Care do not have the appropriate skillset to accommodate different language needs or the cultural understanding required by these sub populations, therefore these people receive DPs to commission appropriate support.

7.8 Carer Support - Sheffield Carers Centre reported that carers were initially feeling that we were all in this together rather than feeling isolated and felt a bigger sense of community. Some were reluctant to accept support in their homes as they protected their loved ones from the virus.

However, as time has gone on there is more of a feeling of carer stress and as others are stepping back out into the world they are not. The Carers Centre has contacted carers to give telephone support and worked with social care teams when the need has arisen. Individual case records show emergency support has been arranged quickly where risk of carer breakdown has arisen. Continuing to reach out to carers to identify and address support needs remains a key priority.

The Carers Centre also provided a list of 181 carers identified as particularly vulnerable to the impact of Covid-19 where additional support was offered or given.

7.9 Income and Payments - When government benefits increase in April we normally adjust our charging arrangements to reflect the changes. This has not been undertaken and has been delayed until the pandemic has been eased further.

With regards to Financial assessments and billing 'Light touch' assessments have been undertaken during the pandemic. There is an inbuilt delay on sending invoices for payment to people for February and March due to staff adapting to changes in staff working arrangements and lack of clarity within national guidance.

7.10 Deprivation of Liberty Safeguards -The ceasing of face to face contacts has reduced the capacity to meet the demand. Whilst a smaller scale service has continued to operate

and undertake Best Interest Assessments remotely the number of DoLs granted in April 2020 was 47 (compared to 158 in March), this number has remained low in May and June.

As restrictions on access into care homes begin to ease we are able to resume face to face communications but only in Covid secure areas.

7.11 Safeguarding – Our responsibilities for Safeguarding adults have not changed through the Coronavirus Act. The overall numbers of safeguarding concerns received were below average around the time of the Covid-19 peak. Levels of concerns received fluctuate week on week but are broadly comparable with the same period last year.

Safeguarding remains a primary concern. In care homes we have introduced virtual inspections to compensate for the lack of direct access and stressed to all providers their continuing responsibilities in relation to Safeguarding.

7.12 Information and Advice - 'First Contact' the initial point of contact for people requiring information or support has continued to operate as normal throughout the pandemic. The uptake of the phone based service has been minimal with most contact being through the single point of contact email address and via frequently asked questions on the website.

7.13 Engagement and involvement – All meeting have now restarted through the use of virtual technology. These are working well and are well attended. The main challenge in relation to engagement and involvement is to broaden and deepen the range of people who can meaningfully engage with us and maintain this contact going forward.

7.14 Advocacy – The reduction for advocacy referrals mirrors the decrease of overall demand for Social Care. Access to Advocacy has always been challenging and this has been compounded during the pandemic by illness and isolating staff. We work closely with the Advocacy service and have continued to meet with them to discuss issues regarding practice and referrals.

7.15 Functioning Multi Agency Partnerships – The strong partnership working underway pre Covid 19 has allowed for quick mobilisation of service and a co-ordinated response. Communications are functioning effectively and IT has created opportunities to meet virtually to maintain working relationships.

7.16 Equipment & Adaptations - The number of requests for support from the Equipment and Adaptations (E&A) team were low at the start of the pandemic. Following the peak in April and May the number of requests has been rising again with more complex equipment being issued and installed to meet the complex needs of the individuals being maintained at home. Critical work to keep people out of hospital and facilitate those being discharged has continued, with staff resources concentrated on this cohort and discharges and step up support prioritised. The E&A assessment process had increased to 2,288 by the end of July compared to preCovid19.

The need to limit visits has led to the team exploring other options for future cross service working, such as an 'OT in your pocket' concept' where officers can have a senior OT on

zoom for advice whilst in a person's home.

Roughly two-thirds of people either on the E&A waiting list or within the assessment process are older adults. 62% are Female – which is slightly higher than the proportion of females receiving social care services at 58%. 62% are White, which is lower than the proportion of White people receiving social care services of 84%.

8. Experience of People Receiving Care

Our VCS partners including HealthWatch and Disability Sheffield have been providing the council and health partners with invaluable feedback from people receiving care. We use this insight to improve our response. Themes identified include:

- Consistency of clear information – Many sources of information across government, health and social care with rapidly changing advice being issued at different stages of the pandemic.

- Care homes – A variety of concerns, including around communication with people in residential care and uncertainty around how homes are managing while visiting was suspended. Some positive stories about using technology to connect to loved ones and organising socially distanced visits through windows.

- Carers - Lack of respite care increasing pressure on families and informal carers

- People with learning disabilities – Particular concerns that people with learning disabilities can find it hard to understand the lockdown rules and restrictions. This has meant some people are going back to their normal lifestyles, which may be unsafe for them at present.

- Social interaction - Worries about lack of social support (family/friends, support groups) becoming more detrimental the longer that lockdown continues. Digital options aren't suitable for all, either because people do not feel comfortable using them, or lack the money/skills to access IT.

- Statutory Services – Both positive and negative experiences of services including staff going above and beyond the call of duty on occasion, but also instances of slow responses and the impact of reduced levels of service where it has been required to scale back provision.

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Disability	Positive and Negative (varies within sub population, individual experiences different)	**LD:** Changes to Day Service delivery method where possible e.g. through Zoom, some creative support arrangements e.g. not traditional 9am-3pm timings.	Positive feedback from people receiving services, e.g. some adults with autism reported reduced social anxiety when interacting via technology, some found sessions easier to attend	
		LD: Service types which often appear on support plans for people with LDs more likely to have significant changes or suspensions than other service types e.g. Day Services, Rolling Respite – people may have more than one of these service types on their plan so changes have a greater impact on them	Mix of specific service types on support plans, e.g. three quarters of people with LD Rolling Respite in their support plan also attend Day Services	
		LD & PD: potential negative impact as a result of PAs being unable to provide support due to shielding, self-isolation or illness. This was mitigated through work with Disability Sheffield and contact with people to check contingency plans.	Work with Disability Sheffield – emergency PA register created. All those with DPs for PAs contacted directly to ensure they had a contingency plan for if PAs unable to provide support. At least 63% of people with PAs have a Physical or Learning Disability.	Disability may not be recorded on Liquid Logic if it is not a person's primary support reason therefore data may be understated for this cohort of the population.

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
		Dementia: Impact of service changes in Care Homes, e.g. less freedom of movement, visiting restrictions and use of PPE, particularly felt by people with Dementia	People with Dementia often have less understanding of the situation and the changes to their life and community.	Dementia needs may be addressed within an overall support package therefore not captured within data as a specific reason for care needs
Gender reassignment	No data			Data not captured within current data sets.
Marriage and civil partnership	Insufficient data within records			Not recorded for 60% of adults accessing support
Pregnancy and maternity	No data			Data not captured within current data sets.

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Race	Neutral	White people account for the majority of people receiving social care support therefore any impacts of service changes will affect White people in greater numbers. This does not always mean these impacts will be felt more greatly by people of this ethnicity. For example, mitigation such as provision of financial support to ensure Provider sustainability is designed to alleviate any impact felt by all service users. This mitigation was also of benefit to Asian and Black and Black British people who are more likely to rely on DPs than other types of support, as DPs allow more freedom to purchase support specific to any language or cultural needs which framework providers may not be able to accommodate.	84% of people receiving social care services are White. Asian and Black/Black British people account for 8% and 8% of those receiving DPs, respectively. This compares to 3% and 4% of those receiving any type of social care service.	

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Religion and belief	Limited Data Captured	The high number of cases where this information is not held makes it difficult to assess impact on people of different religions. The biggest religious group among people with social care services is Christianity which is driven by the demographic of the majority of users. This varies slightly across different service types where there are a slightly higher proportion of Christians in care homes than the proportion of Christians receiving any social care services. In the case of DPs, there are a higher proportion of Muslims receiving DPs when compared to the proportion of Muslims receiving other forms of social care service.	36% of people with social care support are recorded as belonging to a denomination of Christianity 38% of people in care homes are recorded as being Christian (54% no religion is recorded) 9% of DP recipients are Muslim, compared to 3% of people who receive any type of social care service.	Data has not been captured recorded for 52% of adults with social care.

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Sex	Positive and Negative (linked to other sub populations)	The majority of people receiving social care services are female therefore the impacts of service changes will generally affect women in greater numbers. The exact impacts vary across different service types and settings. For example, a higher proportion of care home residents are female. A high proportion of people with a primary service reason of Learning Disability Support are male, so they would have experienced a higher impact from the changes to day services and respite provision.	58% of people receiving social care services are female. 62% of care home residents are female. 61% of people with a primary support reason of LD are male.	
Sexual orientation	Insufficient data within records.			Information is not captured for 69% of adults using social care services.
0-5 years		Out of Scope		
School years		Out of Scope		

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Working age adults (18-64)	Positive and negative (variable across sub population)	There is a significant crossover between the impacts on this sub population and impacts on those with Disabilities. Positives and negatives feedback has been received for those previously accessing Day Services as discussed within the Disability section. Neutral for those with PAs as per mitigation discussed in Disability section.	48% of working age adults accessing social care services have a primary support reason of LD support, a further 27% have some form of Physical Disability.	

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Old age (65+)	Negative impacts mitigated where possible	**People in Care Homes:** visiting restrictions meaning contact between residents and family and friends more limited – mitigated through use of technology	As part of a package of support for care homes, tablets with SIM cards were provided to enable people in care homes to connect with their family and friends	
		Wellbeing reviews introduced for care home residents to discuss people's experiences of care homes during the lockdown. Opportunity to share best practice across homes and contribute to improved quality of wellbeing.	Review visits have been introduced where safe and managed at 28 care homes since the start of July.	
		People receiving Home Care: some people cancelled their care due to fear of Covid 19 and a perceived increased risk from having carers in their homes.	'Family and friends providing services' accounted for 15% of cancellations in the first two weeks of lockdown with case notes show the risk of infection was a factor in almost all of these cancellations.	
		People waiting for Equipment and Adaptations: ability to carry out assessments has been limited. A single visit is now being prioritised to minimise contact which has reduced the number that can be seen each day. Prioritisation has been to those being discharged or avoiding a hospital admission.	Use of remote technology to undertake house reviews with OTs. A number of individuals reporting that their non-urgent support being added to a waiting has now deteriorated to the point where they would be reclassified as urgent due to Covid delays.	

Sub populations	Impact (positive, negative or neutral) or no data	Description of impact (including variation within populations)	Sources of evidence	Gaps in intelligence
Shielding/ vulnerable	Positive	Phone calls to people on government shielding list and had self-referred are now accessed and having their needs met. Some were not known to Adult Social Care so may not have contacted us otherwise.	1,141 people contacted - 932 had no active social care involvement and at least 377 people were not previously known to statutory services. Feedback has been that the unconditional offer of basic support such as a food parcel prompted a dialogue that otherwise may not have occurred with these individuals.	
Carers	Negative impact has been mitigated through increased contact and support from other wrap around services.	The reduction in respite placements has increased the pressure on families and friends to support individuals who would previously have relied upon statutory services. This has changed the family/friend dynamic which previously existed, increased stress levels and raised the potential risk of carer breakdown. The Carers Centre has contacted carers to give telephone support and advice. Where the risk of carer breakdown has intensified, social workers have acted quickly to put emergency measures in place.	The number of reported interventions required has been in line with preCovid19 figures. Individual case records show emergency support has been arranged quickly in cases where risk of carer breakdown has intensified 181 carers identified by the Carers Centre as at increased risk due to Covid-19 were contacted by social care locality teams to advice and offer support when required.	Many carers are not recorded within systems and any informal arrangements which were stepped up during Covid19 would not be within any data set.

9. Recommendations

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.

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.

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.

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

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

9.6 Create additional resilience within services in preparation for the anticipated upsurge in Covid-19 cases through Autumn and into Winter. Specifically 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.

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.

Contributors:

- Adult Social Care Leadership Team
- Heads of Service
- Team Managers
- CHC and Independent Sector Cell – including SCC, SCCG, STHFT, St Luke's Hospice, PCS.
- With additional input on the impact of Covid-19 on Adult Social Care in Sheffield - from external VCF stakeholders, including Healthwatch, Disability Sheffield, Carers Centre, and Sheffield Age UK

Governance:

The sign off route for the recommendations will be through

- Adult Social Care Leadership Team
- People Portfolio Leadership Team
- Executive Management Team
- Representatives of Independent Sector Cell
- Executive Management Group (SCC and SCCG Executives)

Recommendations will be owned by Director of Adult Health and Social Care and the Director of Commissioning, Business Strategy accountable to Executive Director for People portfolio and the Joint Commissioning Committee via Executive Management Group.

Methods and Sources of Intelligence:

Data Sources:

- Liquid Logic – the Adult Social Care Case management system
- SCC, 'People We Support Data Hub – Person Dashboard'
- Central Government Daily 'Extremely Vulnerable Self Referrals' Lists (https://www.gov.uk/coronavirus-extremely-vulnerable)
- NHS Sheffield CCG 'Confirmed Case Numbers in Care Homes' spreadsheet (31/07 version)
- NHSE Care Home Capacity Tracker
- SCC Vulnerable People List – compiled from a mix of SCC sources (ASC, Housing, Council Tax, Assisted Bin Collection and Electoral Register), central government lists (Shielding List and Daily Extremely Vulnerable Self Referrals) and external partners (including the Carers Centre, Age UK, Reach, Darnall Well Being and others)
- NHS Sheffield CCG, 'DTOC DASHBOARD 14.07.20'

Gaps in Intelligence:

- **Disability:** Only 1% of people currently receiving Adult Social Care services are recorded as having a disability (88 people) – this is separate to when someone has a PSR of LD or Sensory Support. Dementia is not systematically recorded on Liquid Logic.
- **Gender Reassignment:** Data not captured.
- **Marriage and civil partnership:** not recorded for 60% of people with services
- **Pregnancy and maternity:** Data not captured.
- **Religion:** not recorded for 52% of adults accessing adult social care services.
- **Sexual Orientation:** not recorded or still to be obtained for 69% of people with current packages

Chapter 10

Housing and Homelessness

Introduction:

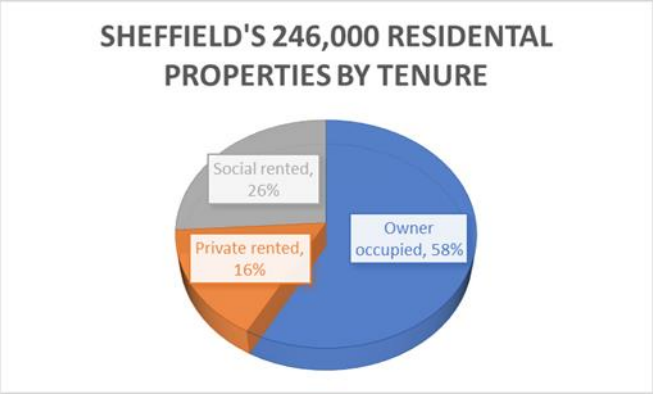
This document aims to summarise impacts of COVID-19 on housing in Sheffield from a health perspective.

The document explores all tenures of housing but acknowledges that as it was compiled from within housing in Sheffield City Council and via our partners, concentrates on council tenants, houses of multiple occupancy, social landlord tenants, homeless and people at risk of homelessness, and private rented tenants. Owner-occupiers are also covered in some areas and will indeed have their own issues – it is assumed that outside of potentially losing their property due to financial and economic impacts that these issues will manifest in areas captured within other RHIAs.

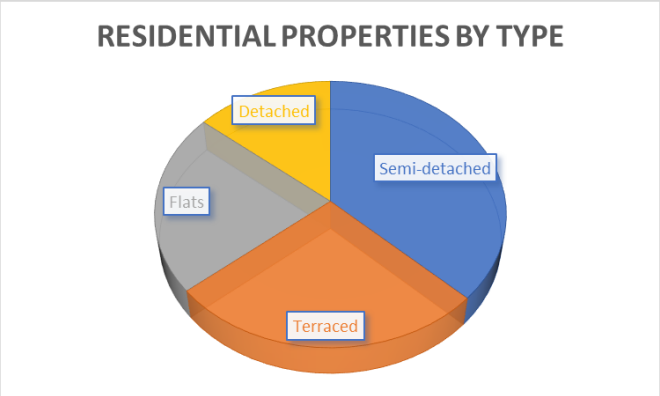
Due to the nature of housing and its key role on the individual to sustain relationships, health and security, and to enable growth, there are many touchpoints with other Rapid Health Impact Assessments. Once a housing perspective has been brought to this theme then a 'hand-off' is made to the relevant RHIA.

Housing makeup of the city

There are 246,123 residential properties in the city (data from January 2019)



The main tenure in Sheffield is owner occupation (58% of stock), but this level is lower than nationally. The city's private rented sector is growing and is 16% of the city stock. The majority of houses in the city are semi-detached (37%) and terrace houses (27%) with two (27%) or three (45%) bedrooms.



A fifth of properties are flats, with the majority in the city centre and a large proportion of these are student accommodation.

Council Housing

The Decent Homes programme started in Sheffield in 2004 and aimed to bring all social housing up to a decent standard by the end of the 2013/14 financial year, resulting in 39,000 Council homes being improved. This requirement was brought in nationally, but the Council Housing Service adopted a higher standard, ensuring that tenants' homes are free from damp, have modern facilities and have an efficient heating system and insulation. By the end of 2013/14 the decency rate was 94% amongst council properties.

As a result of ongoing Council investment the average Reduced Data Standard Assessment Procedure (RdSAP) rating of council owned housing has improved from a score of 59 in 2001 to 71 in 2017 which is well above the national average of 60.

The council housing system does not specifically record health needs of individual tenants but disabilities are recorded where declared. Three in ten council tenants report that they have a disability, with mobility issues being the largest by number. When viewing age statistics of eligible council tenants (starting at 16) these are normally distributed around the midpoint of 51-60 years of age. Further statistics on council tenants are available in Appendix A.

Housing and the economy

Quarter 2 2020 GDP is now 22% below Quarter 4 (Oct to Dec) 2019, which is more than three times greater than the total fall during the next largest period of recession, which occurred during the global economic downturn of 2008 to 2009.

A large number of construction businesses reported no turnover in April 2020 (43%), May 2020 (31%) and June 2020 (17%) which will have down-the line move-on implications for all housing tenures, however the ONS reports in July 2020 that of the active construction businesses emerging from lockdown, the majority reported accelerated programmes.

Private rented accommodation

Because many people experienced a drop or loss of income, where a tenant is struggling to pay their rent landlords have been encouraged to take a pragmatic approach and come to agreement with their tenants regarding late or deferred rent payments.

To reduce the risk of people losing their home over the period, the government brought in emergency legislation to prevent private tenants from being evicted if they are unable to pay their rent and to delay possession proceedings.

The notice period for termination of a tenancy by service of a section 21 notice has been extended to 3 months. Under emergency legislation this change will remain in effect until 30th September 2020.

Court action on housing possession proceedings has been suspended for a 90 day period from 27th March 2020. During this period claim seeking possession following termination of a tenancy will not be heard.

Landlords were made aware that eviction by any means other than through a court order is illegal and that Sheffield City Council would not hesitate to prosecute landlords who attempt to evict or harass tenants illegally.

Owner-occupiers and the purchase of property

On 17 March, the government announced that homeowners who are up to date with their payments can apply from a three-month payment holiday on their mortgage. A day later, this policy was extended to buy-to-let mortgages. On 2 June, the FCA confirmed mortgage holidays will be available to the end of October 20. This means those who haven't already applied for a mortgage holiday now have until 31 October 20 to do so, and those who already have a three month mortgage holiday can get it extended for a further three months if required. So far, payment holidays have been granted on 1.9 million mortgages across the UK. A decision was also made by government to temporarily cut stamp duty. These factors will impact on the Sheffield housing market and potentially drive an increased demand on private rented and social housing in the city.

Inability to pay rent or mortgage

A separate Income and Poverty Rapid Health Impact Assessment has been prepared alongside this document. Housing and related expenditure (e.g. fuel bills) are key outgoings for most households.
Citizen's Advice Bureau Sheffield noted that there has been an overall upward trend in their housing enquiries compared to Quarter 1 last year. Looking deeper into the figures, it is suggested that this is largely driven by increased enquiries from private sector tenants. A surge in enquiries relating to rent arrears has not yet been reflected, however this is expected to be a temporary until the moratorium on repossession action and the furlough scheme comes to an end and enforcement action recommences. Citizen's Advice are also anticipating that people will be faced with a number of conflicting repayment demands in relation to priority debts (e.g rent and council tax) and credit debts.

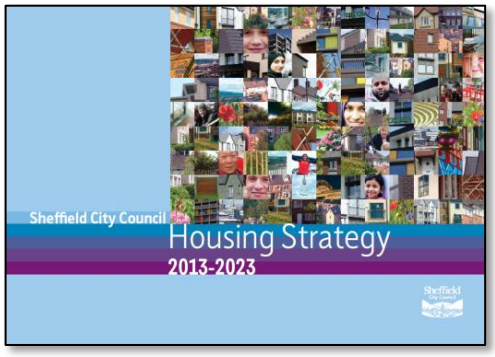
> *"We are also starting to see the impact of an increasing number of job losses and the subsequent sudden and devastating impact of loss of income (with an increase of over 60% against our normal levels in employment related enquiries). Some people have felt unable to address their everyday issues at a time of national emergency—a similar albeit on a smaller scale to why people have not been dealing with symptoms of serious*

illnesses." Frances Potter, CAB

Helen Anderson from Sheffield Citizens Advice (CAB) states that commonly recurring themes that CAB have seen in housing cases over the period of the pandemic have mainly been difficulties in paying rent as a result of furlough/redundancy, which in turn leads to an increased risk of eviction going forward. CAB have also noticed that some of their clients are struggling in being able to comply with the requirements of their tenancy (mainly paying their rent) as a result of a change of circumstances caused by the pandemic. This is likely to continue to worsen over the coming months given the turbulent employment situation the country is facing.

Strategies and Policies

There are a number of people-focussed strategies and policies in operation across the council. These align with or contribute to the overall Housing Strategy which is in operation until 2023.



The Sheffield City Council Housing Strategy itself has a number of ambitious objectives, including safe and healthy homes and ensuring good access to healthcare, education and employment. As a direct result of COVID-19 we may need to review our ambitions and prioritise accordingly in the immediate and longer-term future.

The Sheffield Accountable Care Partnership's (ACP) *Shaping Sheffield Plan 2019-2024* is rooted within the Sheffield Health and Well-Being Strategy and develops a set of ambitions for a healthier city that will make a difference both in the short and long term. The Plan calls for "[…] strong, mature relationships with providers […] to achieve high quality outcomes for our population."

Strong connections and networks have been forged during this period and meaningful partnership working is becoming business as usual for many housing services.

Overcrowding

Nationally, overcrowding has increased in both the rented sector and the social housing sector, and is at highest rate it has ever been in the social rented sector. In 2018-19, 8% of social renters lived in overcrowded accommodation, up from 5% in 1998-99. Over the same period, the proportion of private renters living in overcrowded accommodation increased from 3% to 6%. An overcrowded environment exacerbates issues around undertaking education, training and employment and social activities from home.

In Sheffield, during the full year of 2019/20, 129 overcrowding priority cases were awarded for social housing. However, no overcrowding priority cases have been awarded at all during the pandemic (period from 1st March – 14 August 2020). This is not necessarily a true reflection, and will have been disrupted by the implementation of social distancing measures culminating in officers working from home with the associated issues (such as lack of access to IT and systems). However, these comparisons raise concerns that opportunities to resolve cases will have been missed due to decisions to scale back priority work, and health issues stemming from overcrowding stored for future whilst worsening over time.

Overcrowding and health impacts on children

Bad housing affects children's ability to learn at school and study at home. Homeless children are two to three times more likely to be absent from school than other children due to the disruption caused by moving into and between temporary accommodation. Children in unfit and overcrowded homes miss school more frequently due to illnesses and infections.

Overcrowding is linked to delayed cognitive development, and homelessness to delayed development in communication skills. Homeless children are more likely to have behavioural problems such as aggression, hyperactivity and impulsivity, factors that compromise academic achievement and relationships with peers and teachers. It is unsurprising that homeless children have lower levels of academic achievement that cannot be explained by differences in their levels of ability.

Children in overcrowded housing are up to 10 times more likely to contract meningitis and there is a direct link between childhood tuberculosis and overcrowding. Children living in overcrowded and unfit conditions are more likely to experience respiratory problems such as coughing and asthmatic wheezing. For many children this means losing sleep, restricted physical activity, and missing school. Overcrowded conditions have been linked to slow growth in childhood, which is associated with an increased risk of coronary heart disease in later life. Overcrowded housing conditions during childhood certainly appear to have a long term impact on health. Growing up in overcrowded conditions has been linked to respiratory problems in adulthood. One in four people who had lived in overcrowded housing at the age of seven suffered from a respiratory disease at the age of 23. By the age of 33 the risk of respiratory disease among those who had experienced overcrowding throughout childhood had increased to one in three.

Young people

A consideration for young people is potential conflict during this period, with University students returning home and the associated requirement for their own space, and those in HMOs returning home during the pandemic. Tensions were also expected due to some younger peoples' unwillingness to engage with all social distancing and lockdown processes.

Roundabout is South Yorkshire's local youth housing charity providing shelter, support and life skills to young people aged 16-24 who are homeless or at risk of homelessness. Roundabout in Sheffield report that there has been no overall increase in requirements for mediation services during this period - which is not reflected in the national picture: the nationwide National Forum hosted by Homeless Link reports that its members such as London and Bristol are experiencing increased demand for these services.

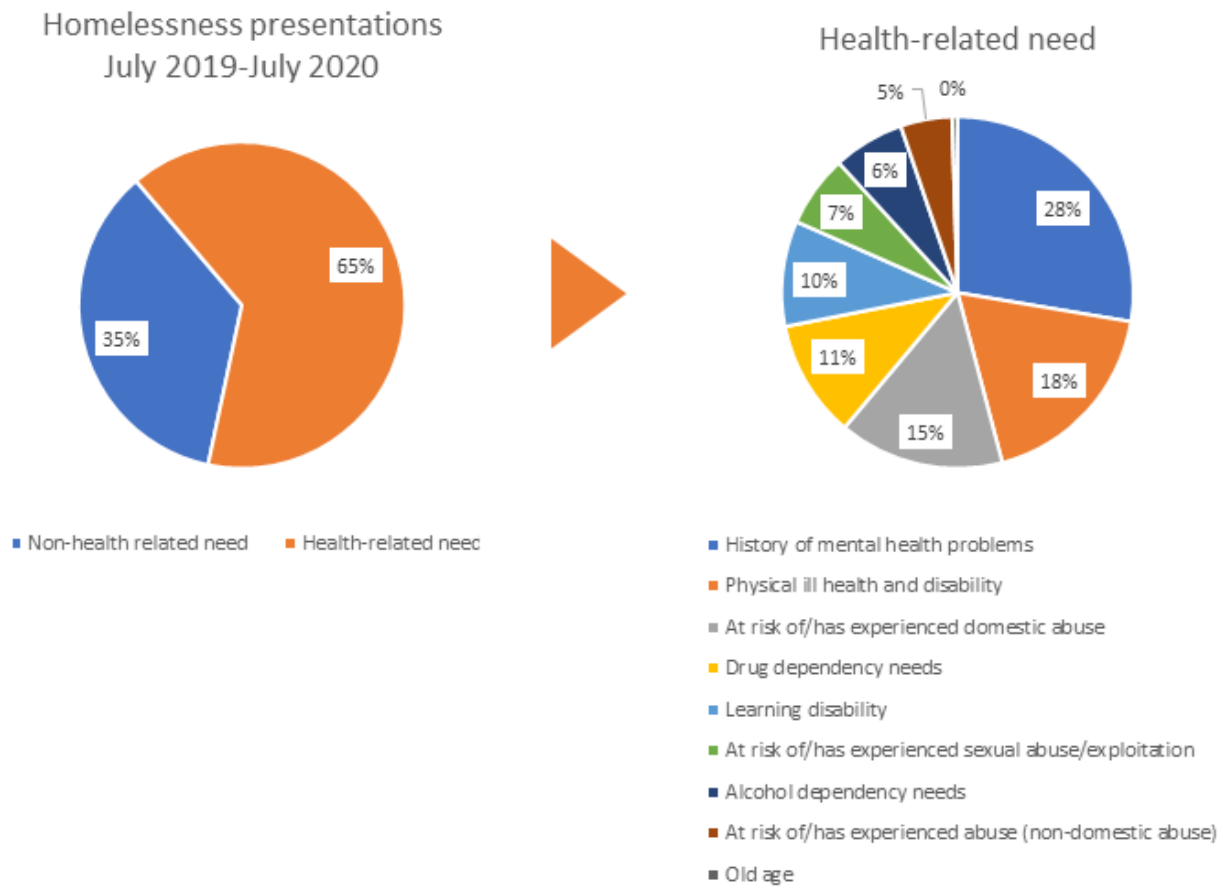
Ben Keegan, Chief Executive of Roundabout, considers there may be a disconnect between the national and Sheffield picture due to local baseline knowledge of the services on offer. A consideration is effective advertising on social media – as young people move on to newer platforms it can be difficult for an established organisation to catch up to the trend. Ben's feeling is that there will be a spike in demand for the service for young people once momentum rebuilds.
The current move-on plan for Roundabout is to reopen a physical location in the city centre in September 2020.

Access to equipment and space for education
Home-schooling and suitability of homes is a key issue – most children were not in school during this period and so availability of space to study, whether this was quiet and away from distractions of other family members e.g. cooking or watching television, and access to Wi-Fi/internet, and a desk and chair would impact on concentration and work output and have a direct effect on disengagement.

Nationally the government brought together a list of online educational resources to support children's education at home while they may not be attending their normal education setting. Subject specific resources in English, maths, science, PE, wellbeing and special educational needs and disability (SEND) were available free of charge.

In Sheffield, any care leaver or child of school age who was open to social care or the Multi Agency Support Team had an assessment by their keyworker to determine their IT need and were allocated either a laptop/ Wifi router or both as relevant.

Homelessness
Health aims are critical to the success of any individual's long-term plan and this cohort is no different. In the last year, **65%** of all 3,300 homelessness applications were identified as having one or more health needs (source: HSP system July 2019 to July 2020)



Support need	2019	2020	Change
Access to education, employment or training	159	113	-46
Alcohol dependency needs	120	130	10
At risk of/has experienced abuse (non-domestic abuse)	107	98	-9
At risk of/has experienced domestic abuse	305	320	15
At risk of/has experienced sexual abuse/exploitation	150	115	-35
Care leaver aged 18-20 years	18	14	-4
Care leaver aged 21+ years	93	33	-60
Drug dependency needs	202	230	28
Former asylum seeker	116	30	-86
History of mental health problems	594	582	-12
History of repeat homelessness	259	197	-62
History of rough sleeping	186	176	-10
Learning disability	218	208	-10
Offending history	329	333	4
Old age	7	5	-2
Physical ill health and disability	392	344	-48
Served in HM Forces	21	13	-8
Young parent requiring support to manage independently	19	14	-5
Young person aged 18-25 years requiring support to manage inde	89	57	-32
No support needs	1	16	15
Young person aged 16-17 years	19	26	7
Blank	180	67	-113
Totals	**3,584**	**3,121**	

The above table shows two comparable periods, March 23 until August 17, in both 2019 and 2020 to display changes in identification of needs at presentation during COVID-19. 1,100 presentations were made in the 2019 period, meaning that for each presentation, 3 needs were identified. 875 presentations were made in the 2020 period, resulting in an average of 3.5 needs per presentation.

There is a slight increase in some drug/alcohol dependency needs identified, and an increase in Domestic Abuse cases which is consistent with the separate DA Impact Assessment.

As a local authority, we are aware that there is another cohort which could potentially come to light as a result of the pandemic: 'sofa-surfers' and those asked to move on from their current situation. Potentially these would present less complex needs due to their circumstances but will still require assistance to source accommodation.

Inability to move from difficult living situations

Introduction

> *Things have not been so good with people being unable to move as fast as usual into more suited temporary or permanent accommodation. We feel this could have been handled better. – Nada Mortin (Earl Marshall Guest House)*

Suspension of Choice Based Lettings

Sheffield City Council uses a Choice Based Lettings (CBL) system for the management of social housing across the city. CBL enables customers to bid on the council property, pre-assessed private rented properties or housing association accommodation they want. The majority of lets through CBL are priority-based with other properties being let as a result of waiting time on the Property Shop register.

Before the COVID-19 period, CBL was by far the primary method of letting properties via Sheffield City Council. During early lockdown, the decision was made to suspend CBL in line with Government guidance on moving house.

From March 2019 to July 2019 (the comparable period from last year), 1340 Sheffield City Council property lets were made. For the same period in 2020, 41 lets were made. A similar reduction in lets will be observed for our Housing Association partners using our system. The lack of lets during this period has had knock-on effects both for customers, Sheffield City Council and external partners and these are explored in this section.

The consequences of CBL not operating will have 'ripple effects' throughout the housing sector in Sheffield and will include but are not limited to:

- Customers awarded a priority but unable to move to suitable accommodation
- Customers with waiting time built up cannot move to general needs accommodation from living with friends/family, potentially adding to 'overcrowding' impacts
- Significant rent loss on vacant properties we are unable to re-let, resulting in financial impacts to the Housing Revenue Account and therefore impacts to the 30-year viability of the Account without taking remedial action i.e. impact on capital and revenue projects and programmes

- Potential moves to unsuitable or unaffordable accommodation as a last resort

We will work with services within housing to monitor impacts and to implement strategic initiatives to mitigate them wherever possible. We are already identifying areas where a 'backlog' may surface.

From a Health & Housing/Equipment & Adaptations viewpoint, due to CBL being frozen there is a backlog of 150 service users on a Band B mobility priority built up over the past 6 months. The health impacts (as well as a lack of mental stimulation and limited care/support visits) are likely to have a negative bearing on the health of this cohort going forward.

The Local Assistance Scheme provides Sheffield Independence Grants to support independent living, and Sheffield Crisis Grants to help Sheffield residents in crisis situations who aren't receiving help. During the 4 month period of April to July 2019, the LAS received 97 applications for Rent in Advance of which 23 (24%) were awarded. During the 4 month period of April to July 2020, the LAS received 69 applications for Rent in Advance of which 12 (17%) were awarded. So despite Covid-19, the number of applications for RIA has actually decreased by 29% in comparison to the same period last year.

> *We think possible reasons for this trend include the Government's temporary ban on evictions and the suspension of CBL, as most of our Rent In Advance payments are made to Housing Associations who have also not been moving people. – Local Assistance Scheme*

As with other areas where a decrease in service requirement has been identified, time will tell if as we move to 'the new normal' the requirement is still there but has been delayed in surfacing due to the pandemic.

> *The suspension of CBL, as well as the not knowing when/how things will resume very much impacted on our clients' mental health, and we as staff have struggled to help them manage this additional uncertainty. – Snowdrop Project*

It is a priority at the time of this report's publication to resume CBL activities using available resources. This activity will require innovation as usual physical contact points will not be available to our customers. A positive is that the bidding process for most of our customers is 100% online, and for a small number of customers telephone support and bids can be placed on their behalf. As a service we are exploring the opportunity to provide virtual tours of advertised properties – a benefit which will go beyond this period as there is a potential to reduce the time consuming accompanied views process.

Not only will the innovations we explore and implement contribute to ramping up the CBL service, they will also protect the service for impacts of a potential second wave.

Move-on from Emergency Accommodation

CBL and planned hostel leaving were stopped, which means Framework reported their clients remaining in hostels (similar to NHS delayed discharge) because required move-on is not available. This has a knock-on impact on getting non-accommodated rough sleepers appropriate supported accommodation.

Providers and support services attend the weekly Adults with Multiple Complex Needs Panel meeting to look at moving clients on from temporary accommodation into more permanent housing. This involves multiple officers, as well as speaking to the client to try and get the best outcome for them.

> *Further work needs to be done around getting wrap-around support in place for these clients prior to move-on to prevent the tenancy from failing, but this is new to everyone and not been done before. This may be where we need to get health services more involved where possible, ideally in the tenancies and going directly to the client. – Framework (partner provider)*

Direct Lets

An option available to the Housing Solutions Team during this period is to 'direct let' properties, bypassing the CBL system altogether. This was the only option to let an emergency, temporary or general needs property. The process to direct let and the eligibility were rapidly developed in these unprecedented circumstances. Social distancing and lockdown created issues around accompanied viewing of properties and this did have some negative impacts on customers, who knew where the property was but had limited chance to view inside.

> *"How do they expect me to commit to a property I have not seen?" – Direct lets client*

As mentioned earlier we are exploring methods of providing virtual property tours.

Shared living arrangements (e.g. hostels)

Shared living accommodation settings such as hostels have presented their own challenges over this period. Reports to our Steering Groups show that our partners have been managing their spaces well for this vulnerable cohort.

> *We put safety measures in place: markings on the floor, wiping surfaces continuously, encouraging people to clean communal facilities, self-distancing, using face masks, signage. With regards to using communal showers and toilets, we have sufficient facilities to accommodate up to 40 people and are licensed for 33. During this period the number of residents has not exceeded 24 (usually around 20-21).*
>
> *We have also implemented a rigorous cleaning regime by cleaning communal facilities every 2 hours between hours of 7am and 10pm. All guests have access to cleaning products. We have suspended use of cookers but have put in more microwaves, thus reducing time when people need to be in close proximity.*
>
> *In the first couple of months we had a lot of people arriving, then moving on, with every new arrival presented a potential risk for COVID-19 spread. We were lucky that up to present no one was taken ill or tested positive for the virus. Over the past month or so, we have had very few residents moving in or out, which is great from a COVID-19 spread limitation point of view.*
>
> *Our greatest problem was for people to observe self-distancing rules […] people wish to spend time together - not locked within their four walls. Residents who are on drugs will make friends with others who have the same addiction, as with people who drink will soon find a drink buddy and the majority of residents smoke. We operate "no visiting*

other residents' rooms at all times" rule and we are very strict on this, however people then gather outside the building which is better than in the rooms. Nada Mortin – Earl Marshall Guest House

Domestic Abuse

DA is covered in more detail in the Domestic and Sexual abuse Rapid Health Impact Assessment. Relevant extracts are below.

Data for Sheffield from SYP shows that reports of Domestic Abuse rose 9% in the 8 weeks from 15th March. The National Domestic Abuse Helpline has reported a large rise in contacts since lockdown - in June, calls and contacts were nearly 80% higher than usual[45]. 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.

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. And this is in contrast to the fall in homeless presentations overall during lockdown: Housing Solutions has seen between 75-85% fewer presentations per month. Domestic abuse cases rose from being 22% of Sheffield Safeguarding Hub contacts in February to 29% in May. There were also 251 more contacts of a domestic abuse nature in the period March – May 2020 than there were in the same period in 2019.

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. This is because the choice based lettings system was paused and remains suspended at time of writing. Only people assessed as in critical need are being offered tenancies and viewing of properties is not currently allowed although steps are being taken to address this issue. This means 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. Housing providers / support organisations have also seen large rises in demand. For example, Guinness Trust report a 20% rise in domestic abuse cases. Combined with the rise in homelessness presentations due to domestic abuse this situation has meant that agencies have had to accommodate women and children in Bed and Breakfast accommodation (which are often not suitable environments for traumatised individuals and vulnerable children) and hotels.

Rough Sleepers

On the 26th March 2020 Luke Hall, Housing Minister wrote to Local Authorities setting out the Government's requirements for all rough sleepers to be offered accommodation and for this and the support needed to be co-ordinated by a local cell group. The "COVID-19 and Rough Sleepers Project" was Sheffield's co-ordinated response to this task. For the purposes of the Covid-19 pandemic response rough sleepers were defined as anyone who was sleeping rough for any length of time (from a single night). This cohort included people coming directly from

[45] https://www.bbc.co.uk/news/uk-53498675

the streets, people previously housed in shared night shelters and people who have become vulnerable to rough sleeping during the pandemic (MHCLG definition, March 2020). There was a significant increase in rough sleepers identified during this period perhaps due to hidden homeless becoming visible.

The sudden and dramatic changes of lockdown were considered by many stakeholders to have provided a unique opportunity. Stakeholders described how this unusual situation enabled some entrenched rough sleepers to address underlying problems without outside distractions. The addressing of basic needs such as housing, food, and healthcare on site allowed many rough sleepers the stability to consider their other needs. The closure of most services and the city centre for some people removed the need - or the draw - to leave accommodation (although this was not the case for everyone in this cohort). The bringing together of this cohort indoors was described in some ways as offering a semi-captive audience for interventions. The "hub" approach of all provision on site was described as working well for some rough sleepers. Another reason why rough sleepers may have responded differently and engaged with services is that services delivered interventions in new and different ways due to Covid-19. The additional government funding for rough sleepers during this period was considered to be extremely helpful. The opportunities provided by lockdown appeared to stakeholders to provide opportunities for rough sleepers who had previously struggled to engage with or refused services to receive support.

> *"One of the biggest opportunities from the pandemic is the ability to capture rough sleepers that have not previously wanted contact with the Council, or have negative attitudes towards the city's response to rough sleeping and work with them." – partner provider*

> *"By acting quickly and effectively to get people off the streets, the Government and organisations are restoring faith in those who may not have felt that they received enough support previously. This is a good opportunity to get those who are homeless and rough sleeping to engage and understand what support is available to them, which is why, it is extremely important that when this is all over that people are not just expected to go back to their old lifestyles living on the streets (even if they have declined support before) and that this opportunity remains open for them". – partner provider*

> *The multidisciplinary response with Devonshire Green, HAST etc. bringing support all together has been a good resolution for many issues. The funding from MHCLG has promoted a strong multi-agency response, and as services I feel we should capitalise on this success and build into the future of health & homeless services. – Tim Kendall, National Clinical Director for Mental Health*

Partnership working with Rough Sleepers

The Cell Group and Steering Groups

A local homeless cell has been convened (led by SCC) and meets weekly – moving shortly to fortnightly. On this group are representatives from Housing, Social Care, Public Health, Police and the NHS. A joint action plan was established and is being implemented.

A number of subgroups support the action plan, focusing on health, community safety, operational, and housing options. The Cell reports into the wider Covid-19 response and the chair has a weekly meeting with MHCLG specialists to advise on actions. Colleagues within the Cell Group have ensured that there is a city wide response to the pandemic and have worked together to create a good network of agencies across all sectors ensuring the city has a single multiagency response. Members from the Cell Group agreed to continue with multiagency approach going forward to reduce rough sleeping in Sheffield.

The group asked a number of people who experience rough sleeping how they feel about Sheffield's response and what we should be doing to help them move on and meet their needs. A full report detailing responses from this co-productive survey will be available at the end of August 2020. Some initial quotes are below.

> *Respect is massive, whilst being here. The owners have treated me like a human being, not just another rough sleeper, there are no labels here. – Customer currently in emergency accommodation (hotel)*

> *I would like to go back to work, but there is not much out there, I don't know how to use the internet or how to go about looking for jobs though. – Customer currently in emergency accommodation*

> *Having a worker who can coordinate my support, I have a lot of support and appointments at the moment, sometimes I cannot keep up. – Customer currently in emergency accommodation*

The Devonshire Green Clinic

A major success story during this period has been the Devonshire Green Clinic, a regular clinic hosting 5 remote clinics per week, with capacity for 10 or 12 patients per surgery.
As at end June 2020 there were 90 homeless people (86 males, 4 females), ages 19 - 62yrs, housed in hotels and temporary accommodation across the city, 21 of whom were registered with Devonshire Green (23%).

The pilot launched more smoothly with organisations that already had strong links with Devonshire Green such as the Salvation Army, who also have a private room with a video link for clients to use. Other providers had difficulties with sourcing the IT or a private room that clients could access, or thought the clinic was a one-off. Even more challenging logistically-speaking with the hotels, which lacked any staff nominated to oversee the service or prompt clients to engage.

It was generally felt to be preferable to register patients locally if possible to improve access and reduce their travel, especially if symptomatic as could not travel on the bus and Devonshire Green could not realistically visit the hotels as too far out.

There has been a significant uptake in Hepatitis C screening in the hostels/hotels, with more people accessing testing and treatment as a result of going in with the HAST team and using the rapport and trust developed by the workers to develop a rapport of their own with clients. There are now plans to add TB screening to these services.

During the clinics where callback lists are fewer the GPs have been using the time pro-actively review the notes of the Devonshire Green-registered patients at each accommodation site, for example of the 19 sets of notes reviewed for one provider there were 3 asthma reviews due, 1 smear, numerous medications reviews and reauthorisations and an important blood result to be communicated.

Patients who were on the verge of running out of crucial medications such as antidepressants and mood stabilisers had their prescriptions reissued to avoid the inevitable crisis that would ensue when they ran out, someone who hadn't requested their anti-epileptics for 2 months was contacted and reviewed over the phone and restarted on their medications. Contact was made with the vulnerabilities midwifery team regarding a pregnant patient who had been assaulted to double-check that she was on their radar and that the recent assault was known to them.
There have of course been challenges for the clinic during this period – especially the IT systems: Both from GP-end (i.e. how to look after patients not registered with Devonshire Green when can't access or write in their notes) and for the patients & providers where many don't have their own mobiles or cannot afford to have airtime/data and the accommodation does not have the facilities to allow residents to use e.g. offices kept locked and not for resident-access.

> *this pilot means that patients don't have to travel to the surgery or be there at a certain time, attending an appointment that potentially clashes with other things that they might prioritise above their health (such as getting their breakfast, collecting benefit money, meeting with their drug/alcohol or housing worker) and often lead them to DNA their GP appointment anyway. – Dr Louise Millington, Devonshire Green Clinic*

Housing First
Before COVID-19, funding was initially planned to be used for the 'Safe Space', a 22-bed drop-in hub based at the Archer Project in the city centre. Since lockdown made this arrangement untenable, another model was quickly developed and is on track to be launched in Q3 2020.

A Sheffield Housing First – type model will use a person-centred, trauma informed and strengths-based approach to enable some of the most complex rough sleepers to build on and use their own positives to sustain a tenancy.

A 'scaffold' of support will be wrapped around the tenancy to create a bespoke network, and the aim is for this support to have the time and space to really make a difference to the individuals health and wellbeing, as well as obtaining all the tools they need to sustain a tenancy and to sustain a quality of life:

We are also co-authoring a paper with the NHS to pilot a completely new way of measuring outcomes for the service user, based on their own aspirations and strengths, while evidencing achievement of personal, organizational and strategic objectives.

The Housing First – type model will require solid partnership relationships across the city and we feel that there is no better time to introduce this.

What did we respond well to and where is there still work to do?

Worked well	**Work still to do / address**
"Housing Solutions officers much improved during the COVID-19 pandemic, as they all answer their mobile phones - in the past landlines would often go unanswered." - Partner	Support agencies are waiting for the restart of CBL as bed spaces are routinely unavailable and hostels are struggling to move people on, causing a "bottle-neck" effect.
"From our point of view, SCC Housing services have done a very good job. They have an excellent team with good leadership, and every single officer knows what she/he is doing." - Partner	Lack of internet access in temporary accommodation, particularly for accessing virtual surgeries, consultations and support groups.
Framework have been specifically praised by various organisations external to SCC as playing a pivotal role in finding accommodation and support for rough sleepers.	Enabling regular communication with client and Housing Solutions as to the status of their homeless case.
The Multiple Complex Needs Panel is using a person-centred approach to identify suitable accommodation pathways.	Officers with limited IT and systems access in the field and at home.
Rapidity of developing the Housing First Model as a suitable accommodation and support package for a small number of the most complex-needs and vulnerable cohort.	"A general attitude/expectation from within SCC's homeless department that our external staff will pick this additional support work up." - Partner
The Street Outreach nurse offers face-to-	Issues around Page Hall / Pitsmoor area

face support to clients in their accommodation. This support is around physical health, mental health and substance misuse and alcohol.	mainly due to rubbish, the state of the streets and noise pollution. These all have significant impact on people's mental health.
The co-production survey as co-ordinated by Tracey Ford of DACT will enable future services to be built around the needs and expectations of our customers, and enable members of the cohort to have a voice in further conversations via partnership meetings.	Disrepair issues have been exacerbated, due to the suspension of repairs and a lack of access to outdoor space causing nowhere else to go during lockdown.
	Lack of day centres during COVID-19.

Mental Health

Mental Health and Addictions have separate assessments but as with all major topics, viewed through a housing lens these issues have their own unique impacts.

Figures from Mind show that nationally nearly four in five (79 per cent) of people with mental health problems said a housing situation has made their mental health worse or caused a mental health problem. More than two in three (69 per cent) of the people Mind surveyed said they had issues with the quality of their housing such as damp, mould, overcrowding and unstable tenancies. One in four tenants with mental health problems are behind on paying rent and at risk of losing their home.

> *"My flat is more than just a flat. When you say 'where you live' it's not just four walls and a telly, you've got neighbours, and you've got shops, a community. Everyone knew me and knew what happened and it all helped manage my mental health and come to terms with what happened." – Mind survey respondent (outside of Sheffield)*

Figures from online survey by Mind. Total number of respondents who said they had mental health problems was 1,780. Of those 1,410 said that their housing situation had made their mental health worse and 1,221 said that they experienced at least one issue with the quality of their housing.

The Health & Housing service (helping households requiring equipment and adaptations) reports that lockdown has had a massive impact on mental and physical health deterioration as service users are sitting tight, frightened to/not wanting to come out for physical activity, as well as an inability to attend medical appointments due to cancellations. These issues are being stored for the future in part due to this.

Recognising the mental health impacts of social isolation, the Community Response teams (for all tenures) and the Housing Plus teams (for council housing) have been performing regular wellbeing calls and/or befriending calls for those who were identified, contacted and asked for this to continue (covered in another section).

> *This tenant has autism, is supported by Shelter and housed in a block. They can hear main door to flats banging/slamming shut in early hours of the morning, 2am and 3am, when the client is in bed trying to sleep. They have also noticed lots of those small silver gas canisters (that can be inhaled) strewn around outside and in the communal areas of*

the block of flats. The rubbish chute continues to be an issue, with tenants not disposing of rubbish correctly and the area left littered and unclean. The tenant would usually cycle for a few hours per day, but has not wanted to leave the property due to the virus. These housing issues are causing them to feel unsafe, anxious and unsettled. – Housing Officer

There is anecdotal evidence that housing rough sleepers in hotels as emergency accommodation has had positive effects on mental health and addiction. A co-production survey is currently being carried out to have meaningful conversations with the rough sleeping cohort about their experiences of this period and the full results will be available in September 2020. Qualitative results so far have indicated that individuals have benefited from the hotel environment and "being treated like a normal person". Once the survey is completed further case studies around individuals reducing their drug dependency and an overall increase in take-up of Hepatitis C vaccinations will be available.

Green space

During this period we know that some residents of Sheffield have had nowhere to 'escape' to, either because of lack of nearby amenities, self-isolating or electing to stay indoors. Inability to administer self-wellbeing has an impact on physical and mental health.

Sheffield has more trees per person than any city in Europe, outnumbering people 4 to 1. It has over 170 woodlands covering 28.27 km2 (6985 acres), 78 public parks covering 18.30 km2 (4,522 acres) and 10 public gardens.

Ruth Bell from SCC Parks & Countryside states that the department have become aware of extremely heavy and increased use of parks throughout lockdown, with associated issues (ASB, littering and lack of social distancing) noted in a number of parks. Playgrounds were closed throughout lockdown period (as per government guidance), but continued use has been noted in all areas of the city.

According to the "Improving Access to greenspace" published by PHE March 2020, in Sheffield for every £1 spent on maintaining green space, there is a benefit in £34 in health costs saved, with local residents being the primary beneficiaries. The report, published prior to the pandemic, states "greener neighbourhoods benefit everyone, but appear to disproportionately benefit disadvantaged groups".

Housing of Multiple Occupancy (HMO)

Once national guidance had been issued, a series of documents, posters and leaflets were sent out to all 2,000 landlords and tenanted registered HMOs properties in the city. The pack consisted of a poster to display indicating the World Health Organisation's guidance on hand hygiene and washing, a landlord-specific guide covering reducing the risk of infection, termination of tenancies and non-payment of rent, repairs and maintenance, safety and cleaning; a public heath poster covering best practice in shared accommodation settings and a tenant-specific guide covering topics such as self-isolation and the use of shared spaces.

An important consideration over this period has been the safety and wellbeing of staff working with HMOs. Although physical inspections were suspended before lockdown, the intention is to resume this as soon as possible and due to the nature of HMOs the officer inspecting is at

increased risk due to the occupiers not being from a single household and neither the officer nor the occupiers aware if anyone is asymptomatic.

Social distancing within HMOs is a risk with the shared house forming a cohesive group. If an occupier tests positive for Covid this puts the entire premises into lockdown and the risk of this not happening must be taken into consideration.

Ongoing engagement with HMO officers could also provide a risk as it is expected that more opposition will be faced to cross the threshold, potentially bringing in an outside source of Covid-19. New occupants may be more apprehensive around starting their tenancy if they are concerned about the cleanliness.

Initial inspections before licence is issued were stopped close to the beginning of lockdown as the tenants would not allow access in many cases. It is the team's intention to resume inspections as quickly as possible however access granting will continue to be an issue. A script has been drafted for assessing the properties over the phone, in preparation for a potential second wave. This is a last resort but would help to get through the backlog of properties.

Housing Solutions have access to a small number of HMOs and these properties can be used to discharge homelessness duty. The team currently have four HMOs varying in size (4+bed), however from the commencement of lockdown have struggled to fill them as individuals have declined for a variety of personal reasons (health conditions, age (too old for shared), want own accommodation, don't wish to share with unknown individuals, access to children etc.). The team have carried out accompanied viewings and rehoused individuals into the rooms and looked at compatibility of households/ landlords requirements where possible to minimise risk. Notes are kept reflecting applicants health conditions and if they are displaying or had Covid-19 symptoms.

Customer engagement during COVID-19

Housing Plus – Services to General Needs Tenants
During the period, the seven neighbourhood areas teams identified the most potentially vulnerable tenants and contacted them first. These tenants numbered over 20,000.

A substantial number of tenants requested regular contact which constituted a weekly befriending phone call with the aim to reduce social isolation.

Business as usual for neighbourhood teams became phone-only, therefore visits became calls. When needed, a neighbourhood officer contacted the tenant by phone to conduct an annual visit and dealt with any issues as identified.

Where tenants were not contactable, further efforts were made to ensure their wellbeing was confirmed.

A summary of outreach activities is available in Appendix B.

Community Response
At the start of lockdown the new Community Response team was formed. The team comprises

of officers and managers from throughout Sheffield City Council, with many members of the team coming from housing backgrounds.

The team's responsibilities were to ensure that the most vulnerable residents of Sheffield maintained their wellbeing regardless of tenure and this was achieved through:

- Wellbeing phone calls (council tenants were contacted by Housing Officers as above)
- Prescription collection and delivery
- Food delivery

Partnership working through the Community Response and Neighbourhood Teams ensured that even the most hard-to-reach residents were eventually contacted and offered support.

A bespoke offer

Services around housing and health must be suitable for the individual customer to maximise engagement and ensure sustainability of health and housing goals.

Internet access is now a barrier to accessing health given that many GPs are moving online, as well as telephone, which can also be a barrier. The CBL system as mentioned above is accessed online, as are many local and national government services.

English as a second language is a barrier to many of our most vulnerable service users, particularly as announcements are made on local news programmes and social media.

> *"The message isn't getting through [to some people with limited English]" – partner*

In the era of the Black Lives Matter movement, and unsettling news reports that the BAME community is disproportionately affected by COVID-19, it is important to identify needs associated with BAME tenants and residents. At the last census, 19% of Sheffield's population was BAME, but in the last year 47% of homelessness presentations came from the BAME community. 20% of council tenants are from the BAME community. In order to capture housing and homelessness needs of the BAME community, a BAME Reference Group was established in July 2020 and is gathering members from across housing and health. The group will agree a set of actions to ensure that our services now and in the future support BAME people.

We have also identified a long-standing issue regarding declaration of gender identity and sexuality within housing. Our profile data on our customers is almost non-existent and is certainly not representative of Sheffield's population. One key factor about gender and sexuality is that if assumptions are made or questions are not asked then services can be delivered in an inappropriate way, sometimes resulting in potentially harmful outcomes. An exciting piece of work is coming out of these discussions: SCC is a partner working on a SAYiT project to produce an interactive video showing the implications to a service user and an organisation if meaningful and respectful questions are not asked at the start of a service user's journey.

A person-centred approach

A rapid change to the way services are delivered can lead to looking at customer engagement in a new light. Dr. Louise Millington comments on the effectiveness of a person-centered

approach using an example in a hotel setting:

> *At the start of the [Devonshire Green] pilot we were advised that the service would run more smoothly at certain hotels where staff were present but as the pilot has progressed we have been surprised to hear greater praise for the hotel without daily staff which only has a security guard. The RSI (Rough Sleeper Initiative) team provided him with a phone for clients to use and in-reach teams reported back to us that this security guard is really great and caring, he knows the clients well now, knows if someone is looking off or unwell and tries to help and support them, encourages them to seek help themselves, prompts and reminds them re meetings/visits eg from HAST etc.*

Recommendations:

Recommended mitigations to action immediately

- Reinstate Choice Based Lettings and associated functions (e.g. repairs) as soon as possible
- Review and modify communications strategies so that they identify and use the most suitable methods for service users, partners and staff going forward

Next Steps

True partnership working

It is evident from this document that existing partnerships have been strengthened over this period and there is more to do to ensure longevity of these relationships:

- Where projects and programmes will require partnership working, to bring in partners and service users at the offset and engage and credit them as co-authors of mandate documents
- Build in high-functioning steering groups and other meetings which have been established as a result of COVID-19 into existing governance structures, and disestablish structures that are not compatible with ways of working in 'the new normal'.
- Regardless of physical location, continue to push for innovative IT solutions so that the infrastructure becomes an active yet seamless participant of the meeting rather than a barrier to it. Essentially making the system the 'surface of the meeting table' rather than a 'locked door to a meeting room'.
- Explore possibilities of providing multiagency hub-based support services for rough sleepers.
- Capture and celebrate the many positive partnership outcomes that have surfaced in what otherwise has been an incredibly challenging environment.

Person-centred approach

- There is already recognition throughout the housing sector that a one-size fits all approach is impractical and sometimes harmful to the individual – but sometimes it can be just one characteristic of an individual that laser-focusses support workers into one area. The approach going forward must be to truly understand this individual and their personal strengths and aspirations before helping them on a

housing and health journey.

- Recruitment and training for support staff to be refocussed less on skills that can be taught or learned and more on qualities such as empathy and active listening.
- To provide a truly person-centred approach, a flexible set of options must be available to the individual.

A complimentary suite of housing options

- Furnish individuals at the start of their new housing journey with all available options and the benefits and drawbacks of each.
- Provide tools so that individuals can check affordability and eligibility of different housing options.
- Ensure that individuals are well aware of good quality private sector housing in the city.
- Develop Choice Based Lettings so that it is compatible with the 'new normal' i.e. virtual house tours.
- Identify gaps in our housing offer and develop services with our service users and partners to fill them.
- Engage and learn from the general needs Housing Plus and older people's OPIL experts when developing complimentary services.
- Ensure all parts of the 'housing system' are aware of the opportunities and services available in the city. This includes the financial, health and EET offer.

Ensure service users are at the centre of service development

- Expand upon co-production survey and engage service users in regular forums to discuss developments in service delivery.
- Continue to expand social media presence for council housing tenants – this has developed exponentially over the COVID-19 period.
- Give the opportunity to service users to be co-authors rather than distant stakeholders in the initial stages of service development.

Contributors:

The task and finish group comprised of:

- Harry Plant, Business Change Manager (Housing and Neighbourhoods), SCC
- Zoe Young, Housing Options and Advice Service Manager, SCC
- Klaudia Ksciuczyk, Business Change Manager (Housing and Neighbourhoods), SCC
- Steer: Suzanne Allen, Head of Service (Citywide Housing Services), SCC
- Editing: Dan Parry-King, Service Manager (Strategic Change Programme), SCC

Contributions have been made from other SCC teams (Strategic Change Programme, Housing Solutions, Neighbourhood Teams, Private Sector Housing, Housing Strategy and Policy) and from partners who are members of:

- COVID-19 Cell Group
- Homelessness Prevention Strategy Steering Group
- Addressing Health and Care Needs Steering Group

Governance:

During its creation the proposed contents of this document were presented to the Sheffield Homelessness Prevention Strategy Steering Group, COVID-19 Cell Group and the Addressing Health Needs Steering Group for comment and steer.

The final version will be circulated to the above Steering Groups and to the Sheffield Homelessness Prevention Strategy Forum, a large city-wide network of individuals and organisations involved with the homelessness cohort.

We will also seek opportunities to share this document with the Sheffield Accountable Care Partnership.

The completed document is proposed to be presented to the Housing Leadership Team for further circulation and sign-off and who will assign development tasks as appropriate to each meeting or subgroup or retain the action to move forward.

The 'completed document' as seen here will form the foundation of a living document, being revisited and added to by Steering Groups and reference groups throughout housing and homelessness.

Methods and Sources of Intelligence:

This document has been formed using data and case studies supplied by Sheffield City Council Housing and Neighbourhood Service, partners and service users.

Sources used in this document

- Housing statistics by tenure:

Health and Housing in Sheffield (Housing Strategy and Policy team, January 2019):
Economic data**:**
https://www.ons.gov.uk/economy/grossdomesticproductgdp/articles/coronavirusandtheimpactonoutputintheukeconomy/june2020

https://www.which.co.uk/

- Government data:

https://www.gov.uk/coronavirus/

- Sheffield Accountable Care Partnership Strategy:

https://www.sheffieldacp.org.uk/

- Children and Health data:

Brittan N, Davies JMC and Colley JRT, Early respiratory experience and subsequent cough and peak expiratory flow rate in 36-year-old men and women, British Medical Journal, 294, 1317-20, 1987
Marsh A, Gordon D, Pantazis C and Heslop P, Home Sweet Home? The impact of poor housing on health, Policy Press, 1999.
Chance of a lifetime The impact of bad housing on children's lives (Shelter 2006) ISBN 1 903595

- Letting data:

SCC Abritas system

- Tenant profile data:

SCC OHMS system

- Mind research:

https://www.mind.org.uk/news-campaigns/news/four-in-five-people-with-mental-health-problems-say-their-housing-has-made-their-mental-health-worse/

- Partner research:

Partner survey (COVID-19), Executive Summary – Magdalena Boo, SCC

- Service user research (rough sleepers):

Co-production survey, initial findings – Tracey Ford, SCC

Appendix A – Profile of Sheffield City Council Tenants

Tenant Profile - Statistics

City

Religion		
Buddhist	116	0%
Budhist	1	0%
Christian	19,346	43%
Hindu	19	0%
Jewish	27	0%
Muslim	3,107	7%
Sikh	11	0%
No Religion	12,357	27%
Other	947	2%
Blank / Not avail.	5,211	12%
Prefer not to say	3,953	9%
Total	**45,095**	

Gender text		
M	19,647	44%
F	25,303	56%
Blank / Not avail.	145	0%
Total	**45,095**	

Sexuality		
BS	171	0%
GA	205	0%
HS	29,431	65%
LE	130	0%
PNTS	8,981	20%
Blank / Not avail.	6,177	14%
Total	**45,095**	

Ethnicity		
Arabian backgrounc	437	1%
Bangladeshi	127	0%
Blank	-	0%
Caribbean	686	2%
Chinese	84	0%
Indian	46	0%
Mixed - Asian/Whit	160	0%
Mixed - B/W African	141	0%
Mixed - B/W Caribbe	519	1%
Pakistani	765	2%
Somali	728	2%
Traveller	33	0%
White British	35,094	78%
White Irish	231	1%
Yemeni	590	1%
Other Asian backgrc	517	1%
Other B. African bac	1,486	3%
Other Black backgro	346	1%
Other ethnic group	712	2%
Other mixed backgrc	181	0%
Other White backgrc	983	2%
Prefer not to say	619	1%
Blank / Not avail.	610	1%
Total	**45,095**	

Age		
Aged 0-16	141	0%
Aged 17-20	156	0%
Aged 21-30	4,589	10%
Aged 31-40	7,431	16%
Aged 41-50	7,679	17%
Aged 51-60	8,057	18%
Aged 61-70	6,580	15%
Aged 71-80	6,112	14%
Aged 81-90	3,506	8%
Aged 91-100	824	2%
Aged 101-110	20	0%
Blank / Error	-	0%
Total	**45,095**	

DisabilityYN		
Y	13,590	30%
N	29,004	64%
U	-	0%
Blank / Not avail.	2,501	6%
Total	**45,095**	

Disability text		
Hearing	617	1%
Hearing / Sight	97	0%
Mobility	6,161	14%
Mobility / Hearing	617	1%
Mobility / Sight	319	1%
Sight	307	1%
Other	4,623	10%
Prefer not to say	297	1%
Blank / Not avail.	32,057	71%
Total	**45,095**	

Appendix B – Neighbourhood Team activity as at mid June 2020

	Firth Park	North	City & West	East	South & South West	Burngreave & Shiregreen	South East
Total on vulnerable list	4153	2918	3044	3508	3610	1520	2994
Number of letters sent	1496	809	759	932	710	0	442
Total successfully contacted as at 19/6/20	3610	2424	1027	2643	3520	1157	2885
No of contacts as at 19/6/20 - (still working through, and trying to contact)	507	494	340	0	90	420	109
No of shielding calls made	614	456	198	1297	540	379	614
No requiring weekly befriending call as at 19/6/20	108	68	45	1	8	174	20
Referred to CRT for safe and well check as at 19/6/20	36	17	50	154	18	57	109

Chapter 11

End of Life

Introduction

The purpose of this paper is to detail the intelligence (both quantitative and qualitative) surrounding End of Life Care (EOLC) during the pandemic across the Sheffield system and make recommendations particularly with regard to the Key Lines of Enquiry set by the Health and Wellbeing Board.

The paper focuses on each area of Sheffield's EOLC system. Although elements of engagement have been carried out across the partners, it should be noted that engagement requires further work, to ensure that this paper will remain reflective of opinions as Sheffield moves into the next phase and whilst the pandemic is still present.

In response to the Covid19 pandemic, the Health and Wellbeing board suggested that the following Key Lines of Enquiry were considered to assess a number of areas within the Sheffield Health and Wellbeing system. These are;

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?

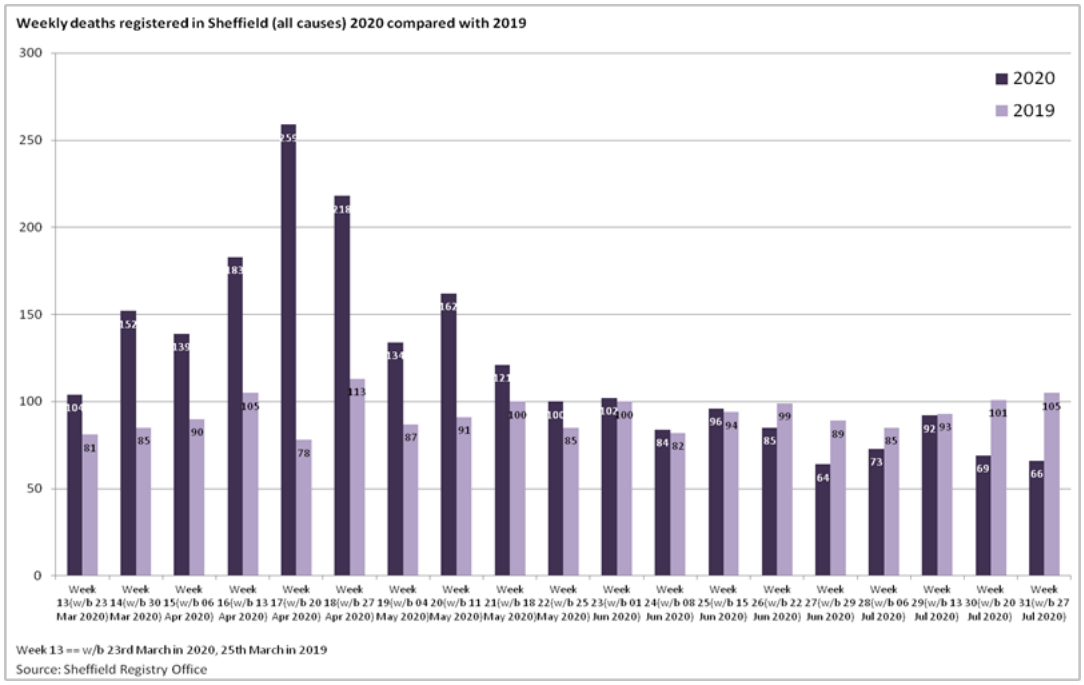
vii. What local, community-level intelligence do we have to substantiate our findings?

viii. How can we use this information to ensure negative impacts are mitigated in our future decision-making?

End of Life Data in Sheffield

End of Life care is defined by NHS England as *care provided in the 'last year of life'*. As Covid-19 emerged as a pandemic, it became a significant cause of Excess Death in the UK, peaking in April 2020 and continuing until June 2020. This in turn increased the need for high quality, rapid, responsive, personalised and compassionate end of life across the city.

The diagram below provides the weekly deaths registered in Sheffield (all causes) in 2020 in comparison to 2019.



Historically end of life care in Sheffield has taken place predominantly in the following settings;

- Hospital setting (51%)
- Individual's own home (22%)
- Care Homes as usual place of residence (22%)
- Hospice (5%)

(End of life Intelligence network 2019/20 based on 2018 data)

Whilst national statistics provide a crude basis for comparison; it is well understood locally that this historical national data does not provide a contemporary picture that wholly reflects the nuanced picture of mortality and end of life care in Sheffield and thus such comparison has not been made here.

Prior to the onset of the Covid-19 pandemic development of local intelligence systems was being undertaken in order to accurately describe the patterns of death and need at the end of life in Sheffield. The short term response to the pandemic has caused that to development to be paused but has enabled access to a different range of more up to date data that describes a changed pattern of deaths.

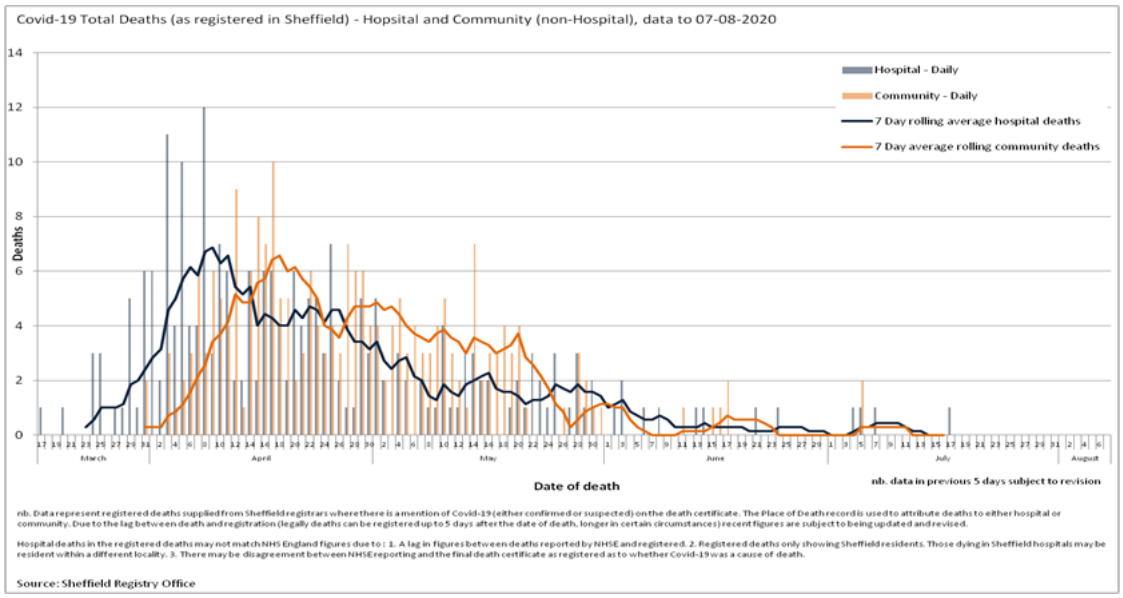
The focus on the impact of deaths from Covid-19 has enabled mortality data related to this novel virus to be explored in the absence of a more comprehensive set of data that would enable us to draw a broader set of conclusions on its impact on end of life care during this period.

The Office for National Statistics Death Registration data reported that in Sheffield up to the 14th August, there were a total of 3795 deaths from 'All Causes.' From this a total of 570 (15%) deaths were associated with Covid-19. These are broken down further;

- 1539 (41%) of deaths from all causes took place in a hospital setting, 270 (7%) were associated with Covid-19.
- 1042 (27%) of deaths from all causes took place in a care home setting, 281 (7%) were associated with Covid-19.
- 957 (25%) of deaths from all causes took place in patient's own homes, 15 (1%) were associated with Covid-19

Local data also identifies 183 (5%) of patients dying from all causes, doing so in Specialist Palliative, In-Patient Care settings in Hospice or Hospital over the same period.

The more up to date data below indicates that the pattern of Covid-19 deaths to date differs significantly from the usual pattern of deaths with an overall change in the balance of hospital versus community based deaths, with most of the deaths during the peak mortality period occurring in care homes as the usual place of residence.



With Covid-19 deaths contributing up to 31% of deaths during the period March 2020 to May 2020, the impact of Covid-19 on organisational and system-wide approaches to the end of life and end of life care have been widespread.

Weekly deaths from all causes have declined steadily since their peak in April 2020 and are now lower than weekly average for this time of year. In spite of this drop in weekly deaths there remains an overall increase in All Cause deaths across all settings for this period – an overall trend which has persist to date.

A trend in a regional extract from national data supports this;

Geographic unit	Reported all-cause deaths	Expected deaths		Covid-19 deaths	Excess non-COVID-19 deaths	
	Number	Central estimate	95% confidence	Number	Central estimate	95% confidence

		(%)	interval (%)	(%)	(%)	interval
Yorkshire and The Humber	19,286	13,872 (71.9%)	12,729 - 15,136 (66% - 78.5%)	4,285 (22.2%)	1,129 (5.9%)	-135 - 2,272 (-0.7% - 11.8%)

Imperial College - Report 28: Excess non-COVID-19 deaths in England and Wales between 29th February and 5th June 2020

Whilst this cannot be attributed directly to the pandemic there is a recognised indirect impact that has required the end of life system as a whole to function well above normal levels.

End of Life Care in Sheffield

One of the most significant challenges in being able to assess the impact of Covid-19 on end of life care derives from the being unable to prospectively identify with accuracy, when the last year of life a person's life begins. This makes accurately quantifying end of life need difficult particularly in generalist services, as many patients with long term conditions are on a spectrum of frailty that is contiguous with end of life. As a result, death or mortality is often used as a proxy.

Whilst mortality is a defining feature of end of life care, it is not synonymous with it. In 2019 NICE published guidance and recommendations on End of Life Care: service delivery. The guidance recognised the delivery of end of life care as the remit of generalists, such as primary care teams or hospital based generalist as well as disease specific specialists or palliative care specialist in a range of settings.

Services providing end of life care

The table below provides examples of services delivering end of life care. It should be noted that this list is not definitive as all professionals and staff in health and social care have a role in the effective provision of palliative and end of life care services across all care settings.

For a fuller list of palliative and end of life care services in Sheffield see https://www.sheffieldccg.nhs.uk/Your-Health/end-of-life-care/palliative-care-services-in-sheffield.htm

Community Generalist/ Core Level Palliative and end of life care	Secondary Care Generalist/ Core Level Palliative and end of life care	Specialist Palliative Care
Fast Track Domiciliary Care Agencies: Bluebird Abbey Care Interserve	Sheffield Children's Hospital SCH Helena Team Sheffield Health and Social Care Trust includes e.g. Grenoside Grange G1	Bluebell Wood Children's Hospice STH: Hospital Support Team Macmillan Palliative Care Unit

General Practice STH Community Nursing Services* STH Intensive Home Nursing Service* STH GP Collaborative Care Homes	Dovedale ward Sheffield Teaching Hospitals Northern General Hospital Royal Hallamshire Hospital Weston Park Hospital	St Luke's Hospice: In Patient Centre Integrated Community Team • Active Intervention Centre • St Luke's Community Team • St Luke's Care Home and ECHO Support Team
Third Sector • Cavendish Centre • Cancer Support Centre • St Luke's Hospice • Sheffield CRUSE		
*Prior to Covid-19 STH Community and Intensive Nursing Services and STH GP Collaborative provided a dedicated end of life service, including an out of hours dedicated end of life help line and 24 hour last days of life nursing care respectively.		

The scale and nature of direct Covid-19 end of life need in our existing end of life system have made it a condition where service delivery has required direct management in a generalist rather than a specialist paradigm. This has been most notable in the acute hospital and care home settings, but the indirect impact of the Covid-19 pandemic can be recognised across all aspects of end of life care.

Care Homes and Acute Hospital End of Life Care

Whilst these settings potentially represent different ends on the spectrum of intervention in Covid-19 management, they have both been subject to notable increases in end of life need.

Care Homes

Prior to Covid-19, care home programmes such as the GP LES and Restore-2 programme have enabled elements of the care home sector to recognise and manage a deteriorating patient. Project ECHO created a channel through which engaged care homes could become part of a community of practice that allowed care home staff to share experience of caring for those at the end of life and learn from experts and each other.

In spite of these and other programmes providing the collective support of the health sector, heterogeneous governance arrangements and lack of direct access to a command and control infrastructure left care homes significantly challenged when having to respond to the speed and scale of the evolving Covid-19 pandemic. This was notable particularly in the earlier stages in Sheffield, where the care home client group as a whole was found to be at much higher risk of poor outcomes from Covid-19 and more likely to require end of life care. The struggle to process high volumes of rapidly changing guidance, variable access to PPE and application of IPC procedures, the altered presentation, pathophysiology and high infectivity of Covid-19 in the care home population, transmission from asymptomatic and peripatetic staff and the importing of Covid-19 infection from

other environments (e.g. patients discharged rapidly from acute settings) have all been recognised nationally as drivers for the high level of morbidity and mortality in care homes.

The combined response of Sheffield City Council, Sheffield CCG and Health and Care providers expanding the support and training offer to care homes enabled outbreaks to be recognised and an additional network of support to be put in place. This included ongoing and increased support from Care Home GP LES providers, STH Community Services for Care Homes and Implementation of the Covid-19 St Luke's Care Home VOICES programme, enabling direct access for care home managers to Health and Care decision-makers and allowing care home staff to collectively interface with a range of health and care providers and support services to address challenges as they arose.

Whilst generally viewed as a positive collaboration, in some instances the requirements of the acute response, led to some poor outcomes. Examples include families and carers being unable to visit individuals in care homes and supported living environments, leading to distress and suffering. The challenge has been further compounded in patient cohorts with conditions such as dementia and learning disabilities, where atypical presentation of Covid-19, rapid deterioration and death, coupled with an inability to have effective contact with family has diminished the usual support provided by informal carers and family members, and increased pressure on care home staff.

The high number of deaths in some care homes, requirements to deliver ongoing care, impact of isolation and staff themselves contracting Covid-19 has had a detrimental impact on staff – often leaving them unable to grieve for the loss of their clients. The true impact of this is yet to be realised and fully understood, but even in this initial phase it has required a bespoke response to support care home staff (through the Care Home VOICES programme) who often do not have access to similar resources provided to their NHS counterparts. The risk of a future and ongoing impact on their emotional wellbeing from these unprecedented circumstances is likely to be high.

These challenging experiences mirrored at national level are reported directly by care home managers and staff through the St Luke's Care Home VOICES Managers forum and Care Home ECHO.

Acute Hospital Experience

Whilst in the public domain great emphasis has been placed on the role of intensive treatment areas, the majority of deaths from COVID-19 in the acute hospital setting in Sheffield did not take place in critical care beds, but in general, and COVID-19 cohort wards. Within the acute hospital setting direct care of those dying from COVID-19 was not generally perceived to be complex and did not require complex interventions or treatment. However, as with care home environments, the delivery of holistic end of life care was complicated by COVID-19 related restrictions and infection prevention control requirements, which in many instances could be recognised to have a negative impact on the end of life experience. As with end of life care across in settings the potential for a particularly detrimental impact on minority groups and groups with particular religious and cultural practices around the end of life was recognised.

Going forward in hospitals, as with other settings, better community engagement could mitigate some of this impact, with faith communities well placed to serve the role of trusted sources of information, leadership and engagement.

As within other environments the high level of end of life activity from all causes with the added complexity of the pandemic made provision of end of life work harder and more emotionally challenging for staff. This was compounded by the difficulties of supporting relatives remotely. Given more time this is an area that requires more extensive exploration in consultation with clinicians, non-clinical staff, patients, relatives and carers.

End of Life Care in the Community

Throughout the COVID-19 pandemic the interface between Primary care, Community services and patients has varied significantly from previously accepted norms. In spite of this there has been a continuing need to provide face to face support.

Public perception and understanding of COVID-19 and the pandemic have played a role in altering how end of life care is both delivered and received. Reports of difficulties with social distancing, understanding and adhering to PPE rules, relatives 'stepping up' with great effect and conversely also refusing care with the intention of protecting (but to the patient's detriment) have been heard.

The impact of national directives and messaging around keeping patients out of hospital and potential for shortage of critical care beds was recognised in some instances as leading to poorly communicated, 'ceiling of care' conversations; where staff felt pressurised to undertake discussions causing potentially long term damage to relationships with patients and families.

These challenges have the potential to be magnified in vulnerable groups such as those with Dementia, serious mental health concerns, learning difficulties and patients and some families from BAME communities. Where there are negative consequences this may also be contributed to by additional communications challenges and limited cultural competence. There is currently no way to objectively verify or quantify this.

In addition to this, staff's concerns about availability of equipment and rapidly evolving PPE and IPC guidelines presented additional challenge as NHS, independent and third sector providers wrestled with inequitable access and inconsistent advice from different organisations working in people's homes. This concern was reflected by some patients and families receiving end of life care.

Over the course of the pandemic the stepping down of some community-based services, particularly home visiting, has been noted, having had a particularly detrimental effect on other staff groups (for example, those who work in services who have continued to provide home based care such as community nursing). Specifically, for community nursing providing end of life care, this has at times created a sense of separation, isolation and anxiety, as they have at times been required to deliver physical aspects of care often at more intensive levels. Other community facing services have been required to develop alternative and remote working practices and have been asked to delegate tasks to visiting professionals.

There is specific learning around this in terms of team working across services and support for staff who continue to deliver care in people's homes, on a background of having to move staff out of their usual services to meet anticipated need, and a commitment to reduce footfall through people's homes in a pandemic situation. Lessons around effective, multi-disciplinary team working have taken time to be learned and implemented, and this has had some negative impacts: whilst the required expertise was usually available, a clear understanding of how to access them was not. Challenging for

professionals, in the absence of clear, consistent communication, it has been even harder for patients to understand the changes in their usual model of service delivery.

This inspired Sheffield CCG to convene the cross-organisational, Sheffield Citywide End of Life Group and the End of Life Primary Care Clinical Reference Group, and St Luke's Hospice to develop and facilitate the Sheffield Primary and Community Care ECHO group in the hope of addressing the challenges that have arisen.

There continues to be a challenge communicating more widely to the public about the evolution of end of life services which needs to addressed. Delivering clear local messages in the face of rapidly changing, national messaging has been a significant challenge

Primary Care Experience

Throughout the pandemic an overwhelming amount of national guidance relevant to primary care has been developed. In spite of this, national guidance related to end-of-life care, particularly symptom control, verification of death and testing in care homes was late to arrive. This caused anxiety and concern amongst GPs and community nurses locally, some of which was mitigated by early action of the cross-organisational Sheffield End of Life Medicines Group, supported by St Luke's Community Palliative Care Consultants and Sheffield CCG Clinical Director for End of Life Care.

The requirement for rapid implementation of IPC procedures, PPE acquisition challenges and reconfiguration of services to enable individual practices to deliver COVID-19 secure care was perceived to have had an initial impact on capacity, including capacity for visiting patients at home. When combined with recommended, 111, COVID-19, self-referral processes, centrally-managed shielding notification, requests for mass, advance care planning of vulnerable patients by primary care and the alternative presentation and short natural history of COVID-19 in at risk individuals, developing a clear picture of the impact of COVID-19 in primary care is hard.

The majority of community COVID-19 cases occurred in care homes and the majority of deaths of care home residents were managed in that setting during the pandemic. This could be seen as a mark of success of Primary Palliative Care, that when combined with Community Nursing and other services such as Ambulance Services and Community Specialist Palliative Care Teams, patients were able to receive end of life care in their usual place of residence. Unfortunately, with the pre-existing lack of capacity to systematically evaluate this, we are unable to establish the quality of the experience for patients, their families and primary care teams.

Communication and relationships are thought to play a role in advance care planning and escalation discussions(1); the difference between normal, in-hours and out-of-hours Primary Care services has been noted by GPs experienced in supporting patients in care homes and Community Specialists in Care Home End of Life Care. This includes differences in the capacity for out-of-hours services to support advance planning, and face to face assessment and discussion in an emergency/out-of-hour context. This issue has been explored by Primary Care Sheffield and the STH GP Collaborative specifically in relation to care homes.

Pre-COVID there was recognition of variability in the delivery of end-of-life care by GPs, and medical care more generally to care homes at a national level. This is the focus of new primary care Direct Enhanced Services contracts locally and nationally.

In addition to direct delivery of end of life care, GPs have raised specific concerns about bereavement care and debriefing for care home carers, who themselves were involved in providing end-of-life care to a large number of residents. There are several notable examples of how GPs have proactively offered support to care home staff affected by the impact of multiple losses, moral distress over ethical issues and work within limited resources. The Care Home VOICES initiative was a valued source of support for care home staff throughout the COVID-19 pandemic which responded to this concern engaging representatives from Primary Care.

GPs themselves also expressed a desire for training and support for COVID-19 end-of-life care. In response to this St Luke's Hospice facilitated weekly ECHO community of practice sessions for Primary and Community care, which enabled teaching, support and reflective practice covering a wide variety of topics relevant to primary care during the pandemic.

Caring for patients and relatives in their own homes

GPs, community nurses and the Specialist Palliative Care Team working across Sheffield have been involved in providing care and support to families and carers. Anecdotal evidence suggests that at the peak of COVID-19 related mortality, patients and families, reluctant to accept health and social care professional into their homes (due to fear of contracting the virus), were managing complex, clinical situations which they would have previously received face to face, health and care assistance or admission to hospital for. This was complicated by changing modalities of primary and community care service delivery in the early stages of the pandemic. This has led to a significant, widening of types of support in the community, including telephone and video-conferencing support.

In some circumstances there are reports of patients, families and carers providing elements of COVID-19 end of life care with limited access to PPE and support due the rapidly evolving nature of the condition, and even on some occasions being asked to verify death.

The research literature describes the importance of debriefing for family members who were chosen by healthcare services to be responsible for aspects of patient care, as well as the need for services to be able to provide occasional relief for people with such responsibilities (2). In circumstances where carers and families 'self-select' to provide end of life care, there is a recognition that failure to consider and address this, adequately prepare, or shield relatives from aspects of end of life care, could risk a range of poor outcomes including adverse bereavement reactions and even COVID-19 infection-related morbidity or mortality.

There has been a recognition that supporting and enabling patients, families and carers to optimally manage 'self-care' not only provides an opportunity to mitigate poor outcomes but may be a necessity during future waves of COVID-19 and as we move into winter when the risk of inadequate capacity of Community and Primary Care staff may become an issue. With end-of-life care recognised as potentially care-intensive and highly emotive, there is a need to strike a balance

between overburdening unprepared carers and managing capacity in community healthcare services (both general practice and community nursing). In some instances, there have been concerns raised both in and out of hours about GP involvement including capacity to visit and verification of death over the course of the pandemic. This has been considered by the STH GP Collaborative and Primary Care Sheffield.

Whilst the level of need is not known, examples of practice and systems of support from across the UK that enable families to self-care are being actively explored and developed. These include carer administration of end of life drugs through the CARiAD process, the Compassionate Communities approach and STH Flow Academy looking at support for carers and families, all of which started pre COVID-19.

Isolation of patients in their own homes

Community Nursing services and Specialists in Palliative Care Day Services have observed that 'Shielding' and social isolation during the pandemic had worsened the experience for patients at the end of life (3). There were concerns in this regard about patients who were previously attending the St Luke's Hospice Active Intervention Palliative Care Day Centre (AIC); its closure preventing the 426 attendances which would have been expected by this time in the year. St Luke's introduced video and telephone support for this patient group to replace this weekly point of contact.

Other services provided by third sector organisations also sought to mitigate isolation for the frail and elderly. Whilst not be specifically for palliative and end of life care patients, they were accessible for patients in the last year of life. For example Independent Living Cancer Coordinator services provided by Age UK Sheffield and the Sheffield Cancer Support Centre have continued to operate with infection prevention and control procedures in place. Age UK People Keeping Well and Dementia Advice Service have continued to operate using the media of video and telephone.

Specialists in End of life Care during COVID-19 Pandemic

A number of different specialists have played roles across the acute hospital and a range of community settings providing leadership, specialist advice, training and support to the wider care team delivering direct, core-level, palliative care to COVID-19 patients at the end of life. These have included specialists in Palliative and Hospice care based at St Luke's Hospice and Sheffield Teaching Hospitals, Elderly Care, Infectious and Communicable disease specialists and a range of other clinicians with a special interest in both primary and secondary care – all actively contributing to urgently required, local policy and procedure developments for patients at the end of life. In addition to this, specialists have maintained usual end of life care for non-COVID cases where need has continued and increased and described earlier.

For specialist services delivering end of life care, the combination of national directives and system-wide risks and requirements has necessitated rapid service redesign as services have attempted to respond to patient need. One example of such is St Luke's Integrated Community Specialist Palliative Care service. Intended to minimise all but essential face to face contact, this initiative led to a

reduction of 1,238 face to face contacts in addition to the development of new services delivering 2,348 triage, telephone and video assessments in addition to 777 urgent home visits and additional support offers such as remote prescribing.

The ongoing demand for specialist services in the community in addition to resurgent hospital need probably represents a combination of patients emerging from shielding and late presentations of some conditions such as cancer. The delivery of these core functions of specialist palliative care has maintained pressure on services throughout the response to the COVID-19 pandemic. Sheffield specialist palliative care services collect significant data from those receiving their services, whilst the intelligence that can be gleaned is useful; it is not representative of the entire end of life population during the pandemic.

Children's and Young Persons' End of Life Care

Whilst end of life care for children and young people does fall under the broader scope of end of life care and bereavement in both COVID-19 and non-COVID-19 situations, the scale of change during the pandemic – both quantitative and qualitative - is relatively small in comparison to the adult population.

Exploration of the end of life experience for children, young people and their families during this time has principally served to highlight the gap in understanding of need in children's palliative care and end of life services, and the lack of business intelligence from which to draw objective conclusions. An important observation highlighted during this period is the fact that where services do exist in paediatric palliative and end of life care they tend to be focused around neurology, neuro-disability and oncology; end of life care provision for other conditions in paediatrics is very limited.

Currently end of life services for children and young adults are provided by Bluebell Wood Children's Hospice, Sheffield Children's Hospital and Sheffield Teaching Hospitals Teenager and Young Adults Cancer Services and Transitions services, but are not formally commissioned as such and further exploration of this is required.

It is of note that Bluebell Wood Children's Hospice, the sole service with the primary function of providing palliative and end of life services to children and young adults, suspended face-to-face care and support such as respite care, short breaks and wellbeing groups in March after the onset of the COVID-19 pandemic, and quickly adapted to a virtual model, offering counselling, sibling support and activity sessions remotely to patients and families in their care. Throughout the pandemic Bluebell wood have continued to provide emergency and end-of-life care, both at the hospice and in people's homes. Plans to institute normal face to face services were recommenced at the beginning of August 2020.

Mental Health, Dementia, Learning Disabilities and End of Life Care

In Sheffield, Specialist Mental Health, Learning Disability and Substance Misuse Services are principally provided by Sheffield Health and Social Care Trust. Early assessment of mortality data across clinical settings for patients who have had contact with their services demonstrated a pattern

of excess deaths in keeping with the ONS picture for Sheffield with a peak and overall increase in excess deaths in April and over the whole period respectively compared with previous years.

When deaths associated with COVID-19 were considered across all settings, higher proportions of COVID-19 associated mortality were seen in older adults, those with dementia (75%) and those in the community:

- The mean age at death was 80 (range was 56-93 years)
- 90% of the affected patients where under the care of outpatient services
- Place of death was known for 83% of patients: 58% in their own home, 38% in a care home, 10%, being hospital in-patients.
- 6% had been transferred from other setting and 4% having inpatients on an SHSC ward for over 6 months at the time of their death.

The table below highlights proportion diagnoses of those SHSC supported patients

Diagnosis	**%**
Dementia	75
Psychosis	11
Anxiety/depression	11
Opiate dependence	4

Dementia, end of life care and COVID-19

The natural history and protracted nature of the condition made advance care planning and delivering end of life care challenging before the pandemic. Covid-19 has brought a specific set of challenges to the end of life care for patients with Dementia, their families and professionals supporting them.

Emerging data from SHSC and nationally from the ONS identifies dementia as a frequent co-morbidity in their patient cohort with COVID associate deaths. At present we have no comparative data on the end of life experience of those with dementia in other settings including STH Dementia wards and EMI Care Homes.

ONS data demonstrated a peak in deaths due to Dementia that peaked slightly later than other conditions have fallen more slowly. One hypothesis is that this could indicate some deaths due to Dementia and Alzheimer's disease are linked to longer-term changes, such as changes in practice in care homes to combat COVID-19.(4)

Dementia often affects those of advanced age. Local clinicians (GP, Acute Physicians and Specialist in dementia care) have noted a 'non-typical' Covid-19 presentation in this cohort of patients. This can

often be non-specific with few or none of the well-recognised symptoms of COVID-19 being apparent. It can, however, lead to rapid deterioration and death. This has been noted across all care settings.

The comments below have been collated from experienced local clinicians (many with a special interest in Dementia care) from Sheffield Teaching Hospitals and Sheffield Health and Social Care Trust in relation to patients with Dementia. It is noted that many commented that these issues also relate to older people with frailty in general as well as those with dementia.

- *"Many people died with no family present as speed of deterioration and death could be rapid. This caused significant family stress especially as many had been unable to see their relative for weeks / months due to COVID restrictions. Sometimes relatives lost both parents".*
- *"Spouses were often in the high risk group themselves, so not allowed to be the one to visit even when there was time to allow an end of life visitor".*
- *"Difficulty using new technologies for communication (eg video calls) leading to increased isolation. Sometimes these technologies just led to increased confusion".*
- *"End of life / advance care planning discussions with patients and next of kin challenging, especially when not done face to face or done in PPE---sometimes not made easy by bad press relating to DNACPR etc."*
- *"Inability to understand the COVID situation and social distancing advice etc. led to a high risk of infection and of infecting others. Patients sometimes had to be kept in hospital longer than required to ensure non infections when discharged leading to risks associated with longer hospital admission. Also practical issues related to less family and informal community support available increasing length of stay".*
- *"Bereavement---many patients lost family/ loved ones also----impact of this can't be missed".*
- *"Social isolation is a major risk factor contributing to worsening of cognitive impairment and contributing to behavioural problems and agitation leading to increased hospitalisation for these patients when they have a social crisis which increases risk of contracting/spreading Covid. (Lack of other options when patients are deemed not safe to be at home, increasing risks of COVID.)"*
- *"I would agree……..that having Dementia and its more atypical presentation is a risk for our patients. Clearly we are more able to manage now that we were in March, with testing now available and the on the job learning that occurred".*

- *" … the report states that patients with Dementia may present with atypical symptoms. There is no 'may' about it; none of three patients who contracted Covid … had the symptoms of cough, temperature and loss of smell. One presented with a runny nose, one complained of feeling unwell but couldn't explain why and one didn't look well, one had worsening mobility and … (pathological cardiac signs)."*

GPs and specialists providing Dementia care outside the acute hospital setting during the early stages of the pandemic noted challenges e.g. access to COVID-19 testing, maintaining essential supplies (e.g. oxygen) and having staff with more limited physical health and end of life care experience and

limited integration with palliative care services and pathway. These all created additional challenges in supporting patients with Dementia at the end of life.

In an effort to address these challenges, extension of work that began prior to the onset of the COVID-19 pandemic looking at physical health in Mental Health and Dementia Care in-patient units operated by the Sheffield Health and Social Care Trust in a collaboration with STH is to consider end of life need and care, engaging with St Luke's Hospice. Furthermore, Specialist Dementia in-patient units and nursing homes operated by SHSCT have joined the St Luke's care home VOICES programme and have also been invited to join the Citywide End of Life Group.

Serious mental illness and learning disabilities

A significant deficit in life expectancy for those with serious mental health conditions has long been recognised at a national level. Reports describe those with serious mental illness (SMI) dying up to 20 years earlier than the general population (5); misinterpretation of symptoms and late presentation thought only to account for some of this. In addition there is also a recognised deficit in identification and assessment of needs at the end of life in this population.

Local data from SHSC demonstrates that whilst the overall numbers are relatively small, the proportion of people who died with COVID-19 who had a concurrent serious mental health diagnosis was disproportionately high. However, initial analysis reveals that the age range of those affected was 73-86 which is not typical of the distribution of people with SMI and thus may be explained by the fact that older people have a worse outcome from COVID-19 rather than indicating that people with psychosis are at increased risk.

In Sheffield, both before and since the onset of the COVID-19 pandemic there is a range of services involved in supporting those with SMI at the end of life, including acute hospital services, liaison psychiatry, community physical and mental health services, Primary Care and Specialist Palliative Care in Hospital and Community. However, there is no formal coordination or commissioning of services or pathways for patients with SMI with the end of life as their primary focus and no system that routinely quantifies end of life need in those with serious mental health problems.

Data for those with learning disabilities is collated in the Learning Disabilities Mortality Review-LeDeR. The focus of this work is on quantifying and preventing premature death not on understanding and addressing the need at end of life. It is hoped that a collaboration with the Transforming Care Partnership in Sheffield, Rotherham and Doncaster and Project ECHO at St Luke's Hospice is hoping will add to this an understanding of the quality of experiences at the end of life for those with learning disabilities. A further piece of work is being undertaken at STH along with SCCG and other partners considering escalation and do not attempt resuscitation decisions through the process of Structured Judgement.

The opportunity to look at these populations' end of life experience through health intelligence analysis remains a strong possibility but is unlikely to yield results prior to the onset of winter 2020. Anecdotal evidence suggests that the evolution of the COVID-19 pandemic has deepened issues of health inequality in end of life care in those with serious mental health conditions and learning disabilities.

Staff and Mental Health

The impact of COVID-19 end of life care and bereavement on health and care professionals' mental health is not yet fully understood but is more broadly considered within the Mental Health Rapid Health Impact Assessment.

Impacts on other services

Legislation and guidance was released nationally to assist with the increased pressure Covid-19 had on death systems, examples being changed requirements for completion of the death certificate under the Coronavirus Act 2020 and new Verification of Death Guidance. However, the nature of the pandemic and increase in deaths still had a negative impact on services. Senior community clinicians acknowledged that due to infection control issues and a requirement to reduce foot fall, some General Practitioners were reluctant to physically visit and verify deaths in care homes and community settings where an outbreak was suspected. As a result other services such as Yorkshire Ambulance Service experienced a higher demand for death verification and in some instances for members of the public were called on to undertake this role. In turn this created a further increase in routine demand for South Yorkshire police to visit and carry out due diligence. This appeared to be due to the absence of robust record sharing, lack of advance care planning and DNACPR orders, thus increasing the inability to establish an 'expected death.' In turn this drove up the demand on coronial services across Sheffield and South Yorkshire and created numerous complaints within the system.

This became a key objective for the South Yorkshire Local Resilience Forum Excess Death Cell. The inability to verify the fact of death was instantly recognised as the initial gap in this multi-agency process, in particular in care homes. Training was developed for care homes wishing for their staff to be competent to carry out this simple function. Given that there is no legislation stating that a medical professional has to verify a death, this process should be considered to stay in place in the longer term (with all necessary checks and balances in place).

The Pandemic Multi Agency response Team (PMART) was enhanced to allow a collaboration between South Yorkshire Police and STH GP Collaborative to enable verification of death as 'normal and anticipated' in a range of more complex circumstances,

The South Yorkshire Local Resilience Forum has considered and continues to address a range of challenges in relation to the care of the deceased in response to actual and potential need that has

arisen. Ensuring that the considerations and mitigations proposed and implemented by the SY LRF are understood across the system is an important recommendation moving forward.

After Death Care

Significant concerns were expressed regarding potential problems with After Death Care in the early stages of the pandemic. Mortuary and crematorium capacity and attendance at funerals, all required rapid contingency planning in response to mathematical modelling which predicted the potential scale of the pandemic and its impact on Sheffield. Oversight of this process has been managed at the South Yorkshire and Bassetlaw Local resilience Forum.

The impact of required changes to after death care was noted to have an impact on relatives who had already been challenged by visiting restrictions and rapid, often unexpected bereavement. Local observation supported concerns that this was likely to have had a disproportionate impact on certain groups, particularly BAME and faith communities.

End of life need and bereavement

Prior to the pandemic, the issue of bereavement was considered by the Sheffield Health and Wellbeing Board within the document *Towards an intelligence-led End of Life strategy for Sheffield* (November 2019) and more recently, as part of the COVID-19 response along with a series of recommendations proffered within the *Supporting adults bereaved in Sheffield: bereavement care pathway, gaps in provision and recommendations for improved bereavement care* 2020). Bereavement is referenced briefly in this document and more fully in the Mental Health RHIA. The authors of the above documents recognise that, if not considered, planned for and supported effectively, the impact of bereavement risks being everyone's problem but no-one's responsibility. Prior to the pandemic it was acknowledged in Sheffield that not enough was known about the experience of care and loss at the end of life and anecdote suggests too many people are impacted more negatively than would be the case if communities were better supported. (6) The nature and scale of deaths associated with the pandemic, the impact of social distancing and the change in health and care delivery is acknowledged to have had an effect on the experience of the bereaved, thus increasing the risk of adverse bereavement reactions. The evidence that COVID-19 is having a disproportionate impact on BAME communities and areas of high socio-economic deprivation (7,8) means the increased risk of poor bereavement experiences is likely to further worsen health inequalities in Sheffield.

A partnership between Public Health, the Lab4Living at SHU and St Luke's hospice, invigorated by Sheffield's communities' clear ability and desire to care for its most vulnerable members and a small injection of cash has started to re-emerge through the reactive work related to the pandemic with an aim to develop and embed a Compassionate Community approach through second and subsequent waves of the pandemic.

The third sector

The end of life paradigm has, for some time included significant contributions from the third sector, taking the form of services, resources or funding. They can be stand-alone or integrated into existing health, care, research and evaluation services accessed by the wider health and care system. In the past they have included services such as bereavement care, social and financial support as well as more conventional clinical and care services.

Whilst delivery of this paradigm was rarely fully coordinated or integrated and is not comprehensively described, there has long been recognition that the end of life experience affects a broader range of individuals, conditions and communities than statutory and publically funded services have been able to support directly. This includes bereavement services and support services for children and young adults.

The full impact of COVID-19 and 'lockdown' on local and national third sector partners, their capacity to generate income and their contribution to end of life care in Sheffield is uncertain, as the full contribution of the third sector is not consistently described or comprehensively understood. However, the availability of third sector funding and services are being re-evaluated by the sector itself as the impact of the pandemic on fund raising is already starting to be felt. It is clear that that effective engagement of the third sector and development of a clearer understanding of its contribution to end of life care (both historical and potential) needs to play a role in the development of short and longer term responses to the COVID-19 end of life experience and end of life care generally in Sheffield.

Changes following pre-COVID 19 - End of life care in Sheffield

Standards for end of life care

Prior to the pandemic, organisations and services involved in end of life care in Sheffield, were at different stages of prioritising and implementing elements of the National Ambitions for End of Life Care and elements of the NICE guidance recommendations. 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, this fell short of the ambition of achieving the fully aligned and integrated approach to the end of life required to address known and perceived health inequalities recognised at national level and identified in the 2018 CQC Sheffield Local System Review.

The NICE Guidelines set out a series of recommendations for delivery of end of life care.

The recommendations covered the following areas:

- Identifying adults who may be approaching end of life, their carers and other people important to them
- Assessing Holistic Needs
- Supporting Carers
- Providing Information

- Reviewing Current treatment
- Advance Care planning
- Reviewing needs
- Communicating and Sharing Information between services
- Providing Multipractitioner care
- Transferring people between care settings
- Providing out-of hours care

Although there is no nationally or locally adopted end of life care evaluation standard across all clinical settings against which the fulfilment or impact of these recommendations are measured, there is general consensus that across different settings the pandemic has created challenges in fulfilling some or all of these recommendations.

The 17th March 2020 *IMPORTANT AND URGENT NEXT STEPS ON NHS RESPONSE TO COVID-19* mandate to free-up the maximum possible inpatient and critical care capacity and to prepare for large numbers of inpatients requiring ventilator support generated nationwide policies to discharge and avoid admission of patients with poor prognoses and/or risk factors for very poor outcomes from COVID-19. Since then identifying patients approaching the end of life, advance care planning, communicating and sharing information between services have gained greater priority in both the acute and community setting.

There is evidence that Advance Care Planning (ACP) improves end of life care for patients and family satisfaction, and reduces stress, anxiety and depression in surviving relatives (12). COVID-19 provides an important context and opportunity for more ACP discussions (13).

However, in the early phases of the pandemic a system focus on hospital capacity, specifically critical care, and a perception in community and primary care that hospital admission should be avoided if at all possible, was perceived to lead to challenging and sometimes inappropriate care planning conversations or letters about DNACPR forms, which in themselves where damaging.

With the ethical risks of instituting discharge and admission avoidance interventions driven solely by a need to ensure current and future capacity is considered, the development of a range of safeguards including ethical processes and frameworks have been developed to guide this element of end of life care practice. This has included the development of a clinical ethical frame work to support decision-making across settings and the reforming of the STH Clinical Ethics Group. Other examples in the acute setting included the development of the STH Advance Care Planning Summary. In the community this led to a rapid escalation of ACP in LES practices supporting nursing homes and progression of the Model Do Not Attempt Resuscitation Policy.

Identifying and quantifying need at the end of life

Whilst not perfect, Primary Care end of life registers probably give the broadest indication of the size of the population of people known to primary and community services approaching the end of life.

For the purposes of this RHIA it is not possible to extract that data to look for trends in how patient known to be at end of life have been impacted directly and indirectly by COVID-19 and how COVID-19 has impacted the content and population of these registers and delivery of end of life care. Similarly, there is limited capacity to determine qualitatively, the end of life experience relating to COVID-19 in the acute hospital setting in the immediate aftermath of phase 1 of the pandemic.

In some settings Mortality data and Death in Service data provides insights into the impact of the pandemic on services supporting patients at the end of life.

Prior to the pandemic end of life intelligence development work in Sheffield was underway. By linking different data sets it should be possible to describe and compare need at the end of life rather than just monitor mortality. Analysis against the Index of Multi-Deprivation will provide an impression of the influence of deprivation on end of life experience and COVID-19 in community. Local pre-COVID-19 intelligence work also suggests that recording of ethnicity in GP and HES systems is very limited presenting a challenge to drawing any conclusion regarding the impact in BAME communities from these resources alone. Similar concerns may arise around other areas of concern being examined in the Rapid Health Impact Assessments such as Mental Health or LGBTQ+ people.

It is of note that prior to the pandemic there had been recognition by Public Health England that the work being undertaken at local level in Sheffield had the capacity to describe end of life experience and care in more granular detail than the existing national data collection system. The current national system does not capture enough data to enable evaluation of end of life experience across settings or populations. With all independent hospices across the UK now submitting data into the national capacity tracker and all NHS palliative care inpatient units registered to submit data - an ambition to add specific palliative care and end of life data submissions for hospitals and the mandated community services data set, if realised is likely to lead to a change in focus to enhance data collection for use locally. Representatives from the end of life intelligence programme in Sheffield have been invited to contribute to this national development.

Opportunities for development

In November 2019 the Health and Wellbeing Board supported the proposal contained within *Towards an Intelligence-led End of Life Strategy for Sheffield* seeking to combine and coordinate generalist and specialist palliative care services with a Compassionate Communities and Civic approach to the end of life with the ambition of future-proofing Sheffield's capacity to manage the anticipated increased need at the end of life.

The rapid growth in end of life need triggered by COVID-19; pre-empted implementation of some elements of this strategy and has further highlighted vulnerabilities and pre-existing inequity in the system, as well as demonstrating interdependence and the ongoing need for collaboration to deliver effective end of life care across the health, care and third sectors.

In addition to assimilating learning from the pandemic since its onset, considering the developing Accountable Care Partnership priorities and the requirements of Phase 3 recalibration there are also a range of new national palliative and end of life programme priorities to consider:

During 2020 – 2021, the National Palliative and End of Life Care Programme will focus on the following work streams of the Palliative and End of Life Delivery Plan 20/25:

1. **Clinical Excellence –** Support and enable the provision of outstanding clinical care based on best available evidence to ensure personalised palliative and personalised care for all ages in all settings

2. **Commissioning, contracting and finance -** Explore, make recommendations and support development of commissioning and contracting arrangements, to increase choice, flexibility and control to people and ensure optimal use of funding

3. **Digital -** Establish a clear digital blueprint for the, definition, development and implementation of information standards for PEoLC in England

4. **Patient Experience -** Identify mechanisms to systematically embed the requirement and ability to understand and learn from patient experience into the commissioning and delivery of PEoLC services

5. **Stakeholder Engagement & Comms –** Oversee the development and delivery of a strategic approach to communications and engagement across the national programme, and into the regions

6. **Workforce** - Support the development of a world class PEoLC workforce that is confident, capable and responsive to the needs of the individual.

The combination of emerging Accountable Care Partnership, regional and national priorities, the Health and Well-being Board commitment to an Intelligence Led end of life strategy, the re-initiation of the Citywide End of Life Group with the spontaneous emergence of many elements of the Compassionate City model provides an exciting opportunity to consider a further improved response to the impact COVID-19 might have as winter looms.

The following key lines of enquiry provide an opportunity to further interrogate the learning and focus on recommendations for the city's future end of life response.

Key Lines of Enquiry

What are the overarching impacts brought about by Covid-19 and the response to it?

- The rapid escalation, changing pattern and mode of deaths attributable directly and indirectly to COVID-19, notably affecting care homes and the acute hospital setting.

- The system wide requirement for infection prevention control (IPC) procedures, shielding and social distancing have altered the delivery and experience of end of life care for patients facing COVID-19 and non-COVID deaths, families facing bereavement as well as staff

delivering care across all settings. This includes changes in conduct of consultations, with the need for personal protective equipment (PPE) and substantial numbers of consultations conducted by telephone or videoconference (12).

- The rapid progression of direct and indirect COVID-19 deaths for some patient cohorts and in settings, coupled with a range of visiting restrictions has created a potential wave of complex social and bereavement issues, which themselves may add to future morbidity and mortality in the system.

- End of Life care was affected by the requirement to rapidly develop new ways of working: including redeployment, remote clinical care and training. This required rapid evolution of command and control, governance processes and collaboration to minimise the number of clinicians interfacing with patients in a range of clinical settings including patients' homes as a direct response to:

    - Patients and those important to them declining visiting health and care staff in an attempt to shield due to perceived and actual threat of COVID-19 transmission

    - Attempts to optimise numbers of health and care staff in a range of settings and entering patients' homes

        - To respond to loss (relative and actual) of workforce to shielding and IPC isolation requirements

        - To reduce the risk of cross infection from and to health and care staff

- Primary healthcare services (general practice and community nursing services) in Sheffield have changed their service delivery models significantly over a short period of time during the pandemic. One of the most important aspects of their work has been palliative and end-of-life care in the community, including in care homes where the highest number of COVID-related community deaths have occurred (4, 9).

- Community Specialist Palliative Care Services based at St Luke's have significantly reconfigured their services

- In spite of services attempting to work more remotely to reduce the foot fall into patients' usual place of residence which required new ways of working e.g. rapid development of guidance around transcribing to reduce the need for GP visits; STH Community Nursing and Specialist Palliative Care services at St Luke's continued full home visiting arrangements to EoL patients over this time.

- Development of extended access services from Community Nursing and Community Specialist Care services to meet increased and continued COVID-19 and Non-COVID-19 end of life care need,

- Recognition of PPE requirements of professional health and care staff and informal/ unpaid carers in delivery of end of life care.

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

- All patients approaching the EoL and their families, notably large family groups
- Bereaved relatives
- Care home residents, notably Dementia patients
- People with serious Mental Health conditions
- Carers
- BAME communities
- People with Dementia and Learning Disabilities in supported living and own homes
- Frail people with health conditions who have been shielding
- Cancer and end stage, long term conditions patients
- Health and Care Staff
    - Staff working in Care Homes
    - Staff working in Community Based Services
    - General Practice
    - Staff working in ward environments
    - Staff working in Intensive Care and High Dependency Units
    - Ambulance services
    - Bereavement teams

How is each of the identified groups being differentially affected?

- All patients approaching the EoL and their families, notably large family groups
    - The altered pattern of service delivery, IPC requirements and visiting restrictions has altered end of life experience. Notable changes include:
        - Delayed presentation or alerting for assistance
        - Reluctance to be admitted
        - Diminished social and health support – whether perceived or real
        - Diminished access to family and friend support due to shielding leading to increasing isolation and visiting restrictions in inpatient and care settings
        - Removal of choice with preference to access hospital for end of life care being diminished
- Bereaved relatives
    - Increased morbidity and mortality due to poor end of life and bereavement experience
    - Limited capacity to access funerals due to evolving restrictions
- Care home residents, notably Dementia patients
    - Limited access to family and friend support due to visiting restrictions
    - Risk of pre-defined treatment options limiting choice
- Carers

    - Diminished social and health support – whether perceived or real
    - Diminished access to family and friend practical and social support
    - Lack of clarity over access to PPE for unpaid carers
- BAME Communities
    - Disproportionate impact on some communities due to visiting restrictions directly impacting on willingness to access support, admission and terminal care experience
    - Challenges in accessing culturally compatible advance care planning discussions in some communities
- People with Learning Disabilities in supported living and own homes
    - Already existing health inequities identified by the national LeDeR/ Learning Disabilities mortality review perceived to be worsened by COVID
    - perception that de-escalation Advance Care Planning and DNA CPR decisions may be disproportionately made for LD patients
- People with Dementia
- Frail people with own health conditions who have been shielding
    - less likely to seek medical attention for their own health, also less likely to visit people in hospital, less social contact leading to isolation
- Cancer and Long term conditions
    - Late presentation and referral to end of life generalist and specialist services due to lockdown and shielding likely to be associated with catch up surge in late presentation with advanced disease associated with higher physical, social and psychological complexity
- Health and Care Staff
    - Health and care staff affected by COVID-19 as carers too
    - Psychological impact of increased and persistent need and uncertainty and constantly evolving and rapid introduction of new ways of working – ie. new guidance, service hours, remote working
    - Reconfiguration of services – e.g. redeployment into services, services changing to remote working, shielding staff.
    - Ambulance services noting a doubling of requests to verify death and an increase in category 1 calls

What is the scale of the impact now? Can we predict what it will be in the medium and long term?
More data, both qualitative and quantitative, is required to understand the medium and long term impact of the COVID-19 pandemic across all settings of community end-of-life care, including the role and response of general practice and impact on inequalities. Work to address this need for data includes:

- Monthly quantitative data collection from GP practice systems.
- The CCG as key partners in the Health Needs Assessment work proposed prior to the COVID-19 pandemic.

- The CCG are considering a survey of GP views on their role in end-of-life care to inform service design locally.

- Dr Sarah Mitchell and Dr Catriona Mayland (University of Sheffield) are leading a national survey on the experiences of GPs and community nurses in COVID-19 end-of-life care.

In the absence of fuller intelligence, mortality and activity data provides some impression of the level of need for end of life care:

- Local Authority data from the Sheffield Registry demonstrates peaks from all-cause mortality in mid-April 2020 with an earlier peak in hospital COVID-19 deaths in early April 2020.
- From June 2020 a deficit in all-cause mortality was identified which persists to date.
- The peak in end of life care delivery at home was mid-April in STH Community Services.
- Community and Hospital Specialist Palliative Care Services saw a fall in episodes of care followed by a resurgence in May 2020 which has persisted to date.
- Sheffield has made strides towards developing an Intelligence-led approach to end of life strategy development utilising linked data sets which should enable evaluation and impact assessment
    - It is anticipated that if fully realised it should be possible to assess the impact of deprivation and ethnicity on end of life need through enabling data linkage of pseudonymised data.
    - Themes that are emerging suggest that expected factors such as deprivation may have an impact on morbidity and mortality in COVID-19 but it is not clear if this strictly replicates end of life care need as patients with in higher Index of Multiple Deprivation (less deprived areas) tend to live to older age which is, in itself a predictor of end of life need.
- There will be immediate effects as well as long term effects, including:
    - Impact on cancer patients due to fall in 2 week wait referrals and temporary reduction in diagnostic services
    - Impact on bereavement, potentially multiple bereavements – both medium and long term effects
    - Impact on mental health of people, including staff
    - Impact on people required to self-isolate
    - Impact of isolation
    - Impact of reduced face to face contact with health care professionals
    - Impact of people less likely to attend hospital or attend GP with significant symptoms

What services/support is already in place (including community response) to mitigate any negative impacts? Can any judgements be made about the sufficiency of this?

In Sheffield, a range of individual, cross-organisational and system-wide responses were made to address burgeoning end of life need in the face of the pandemic.

- Growth and development of Primary Care Virtual and Telephone Clinics
- Continuation of visits by STH Community nurses, Out of hours GPs, St Luke's Community Team with PPE and intensified IPC
- Care Homes VOICES project – Virtual Open Access Clinic and ECHO support for COVID-19 and End of Life Care for Nursing Homes and Domiciliary Care Services: Delivered by St Luke's Hospice Nursing Home and ECHO Support Team and Sheffield ACP partners.
    - Provides COVID-19 End of Life Outbreak support and guidance
    - Provides Tele-mentoring and bereavement support.
    - Clinicians Care Home COVID-19 and End of Life programme
    - Manages Care Home Managers ECHO Forum
- Care Homes: STH community nurses remained in regular contact with care homes and continued to visit as required. Prioritise the care of EoL patients as part of essential visiting
- St Luke's Hospice Community Team Nursing Home and ECHO Support Team Visiting service
- Sheffield Primary and Community COVID-19 ECHO programme
- Yorkshire Ambulance Service/St Luke's Hospice Newly Qualified Paramedic COVID-19 and YAS EOL ECHO support programmes
- STH Palliative Medicine Out Patient and Virtual Clinics (BT Anytime Anywhere)
- St Luke's Hospice In Patient Centre and STH Macmillan Palliative Care Unit remain open to manage end of life and specialist palliative care patient need
- Active communications to encourage people to seek medical help if needed
- Revised iterative visiting guidance nationally and locally at:
    - Sheffield Teaching Hospitals NHS Foundation Trust
    - St Luke's Hospice
    - Care homes guidance
- Listening Ear/ Sheffield Psychology Board COVID-19 Counselling and support service
- Sheffield Psychology Board COVID-19 response
- St Luke's Hospice Bereavement Service Enhanced
- St Luke's Hospice and Sheffield MIND Bereavement Training ECHO programme for non-bereavement professionals
- Sheffield COVID-19 End of Life Medicines Group – a groups of Medicines Management providers and Commissioners and front line clinicians coming together to support policy and procedure development to ensure access and timely administration of end of life medicines
    - Changes to 'pink cards' to support prescribing (verbal orders, and pink card prescribing at time of discharge)
    - STH GP Collaborative (GPC) already use palliative care drug packs to increase responsiveness to patient need. COVID-19 End of Life Medication Packs produce to allow optimal use of end of life medications during peak demand
    - Also provided support to the locally established PMART service.
- Increased community nursing staffing out of hours to support increased demand and maintain response times has continued
- St Luke's Hospice Community Team Extended Hours Trial programme

- City wide weekly End of Life meetings involving STH, St Luke's and CCG took place to co-ordinate response
- COVID-19 Health and Care Gold Cell Care Home's Task and Finish Group with representatives from Sheffield City Council, Sheffield CCG, STH, St Luke's Nursing Home and ECHO support Team and other ACP partners
- Shielded nurses redeployed to call handle on the STH palliative care line via Single Point of Access during the peak
- GP Collaborative – close monitoring of demand and capacity with surge planning in place. Close working with the Primary care hubs and 111 to ensure patient waiting times were minimised.
- Clarification around Verification of death/ Life extinct process approved by SYB Local Resilience Forum Excess Death Cell Chair
    - Community nurses and some care home staff now trained in Verification of life extinct in expected cases
    - Yorkshire Ambulance Service enhanced capacity delivering additional support to enable Verification of life extinct
    - St Luke's ECHO Team and STH developed Verification of Life Extinct Training for Care Homes
- STH Advance Care Plan development which follows the patient swiftly from hospital to home improving communication.
- Evaluations underway of all 'new' tests of change during peak. Some of these interventions have continued.
- Change to CHC processes
- No changes to recurrent capacity. Current position is that the IHNS service is full, and fast track providers, with additional overnight support provided by community nursing.
- STH Flow Academy work already looking at support for Carers/families which started pre Covid-19
- Sheffield COVID-19 Memorial development

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?

- Listening Ear Support Service commissioned by Sheffield CCG on behalf of Sheffield Psychology Board
- Organisation specific responses to support staff psychologically including reflective sessions, provision of 1-1 counselling, and offers to care homes
    - STH promotion of support to promote well-being
    - St Luke's Care Home VOICES Bereavement support for Care Homes
- The Development of the proposed Compassionate Cites and Compassionate Communities Model.

- Consideration of GP surgeries as “hubs” in Compassionate Communities is outlined in the RCGP / Marie Curie Daffodil Standards and has been highlighted in the Sheffield primary care Quality Contract 20/21 (11).

What local, community-level intelligence do we have to substantiate our findings?

- Sheffield Organisations have a range of ONS, Sheffield Registry and Organisational Demographic and Activity Data at its disposal but this does not constitute a fully realised Intelligence process
    - Sheffield Population and Activity Data available from
        - Sheffield City Council Sheffield Registry
        - ONS Data
        - Sheffield Teaching Hospitals
        - St Luke’s Hospice
    - ICS and Region wide data available from
        - Yorkshire Ambulance Service Power BI Tool
    - Missing or poorly populated intelligence elements include
        - BAME EOL Intelligence
        - Mental Health Learning Disabilities Data
        - Children’s and Young Adults Data
- Sheffield Health and Wellbeing Board have approved an intelligence project proposal using data linkage and Healthcare and Council data and other potential datasets that will allow the development of an intelligence-led end of Life Care Strategy for the city. If fully realised this will enable Sheffield to substantiate its findings. Partners expressing interest in supporting the Intelligence proposal:
    - Sheffield CCG
    - Sheffield City Council and Public Health Department
    - St Luke’s Hospice
    - Sheffield Teaching Hospital
    - Yorkshire Ambulance Service
    - University of Sheffield
    - Sheffield Hallam University
    - Compassionate Cities UK
    - Public Health England End of Life Intelligence Network Team
    - Organisations yet to be engaged:
        - Sheffield Children’s Hospital NHS Foundation Trust
        - Sheffield Health and Social Care Trust
        - Bluebell Wood Children’s Hospice
- Sheffield CCG, Sheffield Teaching Hospitals, Sheffield health and Social Care Trust and St Luke’s Hospice are exploring options to implement Structured Judgement Reviews to provide qualitative data about equity of access to ethically applied advance care planning in Acute Hospital and Community settings

- Patient and carer feedback and complaints are collated are routinely collected within elements of the system. This enables a direct response through individual organisations clinical governance processes to address concerns and improve services. There are weaknesses in this system, most notably in Community, where patients and families receive care simultaneously from multiple organisations and teams working together. Whilst there is a system to jointly manage complaints there is an opportunity to retrospectively collectively assess feedback and complaints that related to end of life care in joint care scenarios to assess opportunities to both substantiate our finding and implement new learning and systems.

Recommendations:

During the peak mortality of the COVID-19 pandemic, health and care services developed and galvanised their response through collaboration, information sharing and training, development of clinical and strategic communities of practice and expansion of services. The approach of winter, an impending 2nd wave of COVID-19 and the publication of the Phase 3 response letter by the NHS all bring their own risks and pressures. This Health Impact Assessment responds to these pressures by including a number of short term recommendations focusing on maintaining clinical services and mitigating the immediate risk winter and a potential COVID-19 second wave. Recovery and recalibration of services requires medium to longer term recommendations acknowledging that COVID-19 will continue to play a significant role in the shape of health and care services and Health and Wellbeing in Sheffield for the foreseeable future.

1) Establish effective reporting of End of Life Care Need and Developments within the Accountable Care Partnership and Health and Social Care Governance structures.

2) 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.

3) 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 and enhance representation of the adult social care sector within future command and control and decision making bodies considering end of life care within the Accountable Care partnership

4) Develop approaches to care enhancing communication with the General Public to support understanding and access to the range of options in end of life care and enhance multi-disciplinary working between clinicians' services and organisations providing end of life care.

A common theme emerging from the COVID-19 pandemic is that it has shone a light on pre-existing gaps in intelligence, demonstrated deficits in system coordination and care pathways and highlighted the need for collaboration across health and social care and with civic aspects of society. In end of life care these 'gaps' have been recognised at national and local level for many years. One remarkable impact of COVID-19 is that as well as identifying these deficits there have also been notable

demonstration of how these deficits could and are being addressed by work already underway pre-pandemic and innovation that has occurred as a direct result of collaboration driven by the COVID-19 'burning platform'.

Prior to this, a significant contributor to the lack of progress in end of life care was the failure to recognise the experience at the end of life as modifiable, with system-wide opportunities to improve Health and Wellbeing in Sheffield. That changed somewhat with the refresh of the Health and Wellbeing strategy in the 2nd half of 2019.

The strategic ambition for everyone to reach the *end of their life with dignity in the place of their choice* enabled consultation and created developments designed to address many of the gaps and inequalities identified at national level where deficits in intelligence leave uncertainty about the level of those gaps locally.

The pre-pandemic ambition and Health and Wellbeing Board approval of *Towards an Intelligence-led end of life Strategy* created both the opportunity and solutions to many of our challenges – the pandemic has created the motivation and necessity to move into implementation at scale and pace.

Medium to longer term recommendations are as follows:

5) Maintain and develop a representative Citywide End of Life Care Group

   The Citywide End-of-Life Care group and a Primary Care Clinical Reference Group have been reconvened urgently in Sheffield in direct response to the need to coordinate the end of life care COVID-19 pandemic response and are well placed to highlight concerns and potential negative impacts as well as provide a forum for responsive collaborative working ensuring where possible that end of life care development occurring here is recognised by, and accountable to, the system. The group should be expanded to include Mental Health services, Children's services and BAME communities.

6) Develop Sheffield End of Life Intelligence collaboration

   The development of effective intelligence and outcome-based strategy and operations provide an important opportunity to monitor consistency and quality in EoLC, manage health inequalities in end of life care and learn from both positive and negative effects of future EoL decision-making in Sheffield. This further enhances the potential to understand in greater detail the ongoing impact of COVID-19. This aligns with the work of the developing Office for Data Analytics and should support Clinical Commissioning Group decision making and be accessible to provider organisations to support collaboration and individual service development.

7) Implement a public health approach to end of life care.

   This alternative approach to end of life care expands the health care focused approach to include the community as genuine partners rather than as targets of service provision expanding from direct services, clinical, face-to-face, bedside, acute care, or institutional

approaches to include communities and neighbourhoods, civic partnership approaches, and the promotion of health and wellbeing. Many of these partners have been engaged during the COVID-19 pandemic but not specifically in relation to end of life care and can add capacity in the medium to long term. 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.

8) 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.

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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.

Aims

- To review the currently available evidence on medium-to-long-term Covid-19 symptoms and complications
- To attempt to review the predicted impact these could have for Sheffield's population
- To consider potential inequalities of the impacts
- To make recommendations for potential ways to address these impacts

Key considerations

Four main areas of consideration are covered:

- Prolonged Covid-19 symptoms
- Medical complications of Covid-19 with medium-to-long term health consequences
- Rehabilitation and recovery from severe Covid-19 requiring ICU admission
- Inequality of impacts

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

Notes on the evidence and data

The evidence around the longer term-consequences of Covid-19 is limited and rapidly evolving[1]. Much of the predicted outcomes are based on those from previous coronavirus outbreaks e.g. SARS and MERS and other comparable illnesses[2]. Studies on complications of Covid-19 are typically single centre studies, often from abroad, focusing only on the very small percentage of Covid-19 patients

that are hospitalised and often only on those admitted to intensive care. They therefore may not give representative figures for our population. Furthermore, much of the evidence on prolonged symptoms for patients in the community relies on self-selected patient samples and case reports, of which many had not even been tested for Covid-19 and were merely suspected cases. Detailed demographic data for this group is not yet available[3].

Estimates of numbers for Sheffield are also limited by the lack of community testing early in the pandemic and therefore the true number of cases is likely to be much higher than the approximate 4,900 positive tests that have been recorded in our population. The Office for National Statistics currently estimates that 1 in 16 over-sixteens in England have had the virus[4]. This could mean around 30,000 adults in Sheffield have had Covid-19.

306 patients were admitted to hospital in Sheffield with Covid-19 and 906 were diagnosed with Covid-19 while they were inpatients between 13th March and 1st September 2020. This equals a total of 1,212 hospitalised patients with Covid-19, of which around 228 have died. Many of those diagnosed as inpatients could have been detected on asymptomatic screening and therefore this number may overestimate those that required hospital treatment for Covid-19. However, considering only those admitted with the virus would underestimate those needing hospital treatment for Covid-19 as it would miss any that developed it as inpatients, those where there were delays to diagnosis (before patients were screened on admission) and those that had false negative tests on admission that then later tested positive.

Taken together, it is important to acknowledge that there are many question marks around how many people who survive Covid-19 infection will continue to be affected in the medium to long-term. The figures presented are rough estimates, applying frequencies reported elsewhere uniformly to the Sheffield population. The ranges for post hospitalisation complications and symptoms use survivor numbers if only those admitted with Covid-19 were considered hospitalisations as the lower limit, and survivors if all patients testing positive in hospital were considered hospitalisations as the upper limit.

The post-Covid Steering Group, a collaboration between Sheffield CCG and Teaching Hospitals, has been collecting data at the local level and will provide more accurate local information in due course.

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].66 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]

Inequalities in impacts

Age

Older adults are particularly at risk of severe disease and have a higher mortality with Covid-19[34]. Furthermore, their recovery is more likely to be complicated by delirium, which can result in longer hospital stays[35], as well as depression, loss of muscle mass, malnutrition and chronic pain[2,33].

Older adults are more likely to be vulnerable to functional decline and advancing frailty as a result of Covid-19 infection. They are therefore more likely to need input from health and social care, require inpatient or intermediate care rehabilitation or require new institutional care as a result of Covid-19 infection[36].

However, young working-age adults are disproportionately more likely to be in unstable employment e.g. zero-hours contracts[37] and therefore more likely to be impacted financially, were they to be taking prolonged time off work due to long-Covid symptoms.

Within Sheffield, Greenhill and Beauchief People Keeping Well has raised concerns that some of their post-retirement service users were experiencing ongoing symptoms after having Covid-19 and that social isolation and anxiety were preventing full recoveries[28].

Sex

Men were more likely than women to be admitted to hospital with Covid-19 and to have more severe disease[34]. As rates of prolonged symptoms following hospitalisation are high[3], men may be more likely to be having prolonged symptoms following hospitalisation for Covid-19. However, data from the Covid Symptom Study suggests that long-Covid is twice as common in women as in men[38]. It may be that men are less likely to report ongoing symptoms than women, particularly through the Covid Symptom app, or this disparity may be due to the two proposed separate entities of long-Covid: one being prolonged recovery from severe disease (potentially more common in males) and the other being persistent milder disease (potentially more common in females).

Black and minority ethnic (BAME) communities

As people from Black ethnic groups were more likely to be diagnosed with Covid-19 [39] it is possible that this may also be reflected in the numbers of those affected by the longer-term consequences of the virus.

There may also be inequalities in access to post-Covid services. The Sheffield BAME Communities Inequalities group reported that people from BAME communities felt more vulnerable to catching coronavirus when attending health appointments during the crisis and were not attending appointments as a result. The group also highlighted concerns about services moving online or remotely due to digital inequalities[28]. While having had Covid-19 already may mean that fear of catching the virus for a second time would be less of a barrier for post-Covid services, there may still be an increased risk of people from BAME communities not accessing services for that reason or due to digital barriers.

Income and employment

As mentioned previously, those in unstable employment, such as zero-hours contracts are likely to be more negatively impacted financially by taking prolonged periods of leave for sickness.

There is also a risk of people with long- Covid leaving or losing employment due to prolonged periods of being unable to work. In a report released by the government last year, 9% of people who had a spell of long-term sickness absence (sickness absence lasting over four weeks) of any cause, did not return to work after that absence. The likelihood of not returning to work increases the longer the absence from work. People with disabilities are also more likely to not return to work after a period of long term sickness absence than those without[40].

Deprivation

People who live in deprived areas were more likely to be diagnosed with Covid-19 up until August 2020[39]. Though there is not yet any demographic data regarding those more likely to suffer from

prolonged symptoms or complications, it is possible that those from deprived areas may be disproportionately affected by long-Covid. It is also possible that, as they are more likely to be in insecure employment, people in deprived areas may also be more seriously affected financially, if they are unable to work as a result.

Homelessness and rough sleeping

Data from Public Health England suggested that rough-sleepers had a higher diagnosis rate of Covid-19 compared to the general population[34]. It is therefore reasonable to presume that they could be disproportionately affected by its longer-term consequences. The homeless population, particularly rough-sleepers, are less likely to be registered with a General Practitioner compared the general population[35], which could result in barriers to accessing specialist post-Covid services.

People without recourse to public funds

People without recourse to public funds will not have access to the same financial support that others are if they are unable to work due to poor health following Covid-19 infection.

People without recourse to public funds may also be liable to be charged for some NHS services. Covid-19 was added to the list of communicable diseases meaning that testing and treatment for Covid-19 is free regardless of immigration status[41]. However, depending on how widely this is known and how far this goes to include post-Covid support services, charges, or perceived charges, could still present barriers to people seeking support for long-Covid symptoms.

Refugees and asylum seekers

In April, Healthwatch reported that cost of technology and lack of Wi-Fi in asylum housing presented barriers for refugees and asylum seekers accessing remote healthcare services. Other barriers to accessing services include language and potential charges [28].

Informal carers

57,000 people in Sheffield provide unpaid care[42]. The long-term effects of Covid-19 infection could mean that those already receiving care on an informal basis have increased care needs, potentially impacting on the physical and mental wellbeing of carers. It may also be that there is a rise in the number of unpaid carers in Sheffield, as previously independent people could develop care needs as a result of Covid-19 infection.

Access to and experience of services

The NHS has launched “Your Covid Recovery”, an online recovery programme requiring referral from healthcare providers. Due to the online nature of the resource, there is a risk of digital exclusion affecting people’s access to this service. Groups that are more likely to be digitally excluded include older people, the unemployed, those on lower incomes, those in social housing, refugees and asylum seekers, people with disabilities, homeless people, those whose first language is not English, and people with fewer educational qualifications[28,43].

Many people reporting long-Covid symptoms had mild initial illness, not requiring hospitalisation[6]. Nationally, the majority of CCGs have not yet set up post-Covid clinics for patients who were not admitted to hospital with the virus[44], therefore there is a risk of inequality between those hospitalised versus those not in terms of access to post-Covid services.

The Covid-19 Recovery Pathway Patient Group in Sheffield suggests that men are less likely to request follow-up support and that younger patients were less likely to receive community physiotherapy despite being much below their pre-Covid level of function [28].

Regarding experience of services, the Covid-19 Recovery Pathway Patient Group highlighted a number of suggestions following discharge from hospital. This included the need for more communication following discharge and for assessment and screening to identify needs and requirement for specialist input. Normalisation and validation of symptoms and improved understanding of what symptoms were to be expected following prolonged hospitalisation and what was Covid-19-sepcific was also requested.

21% of respondents to the Prolonged Covid-19 Symptom Survey, a patient-led survey advertised through social media support groups and word of mouth, felt unsupported in their symptoms and some suggested that they felt dismissed by medical staff[1]. While this survey's respondents were primarily US-based and the sampling methods have resulted in a very biased sample, it does highlight the risk that the current unknowns surrounding long-Covid could result in people experiencing these symptoms feeling dismissed or stigmatised by medical staff.

Recommendations

This impact assessment is limited by the fact that the evidence around long-Covid is rapidly emerging and evolving, with limited available evidence or data relating to the local community. What it demonstrates, is the potential scale of the issue and the urgent need for more research in this area. Work is currently being undertaken by the Post Covid Steering Group, looking at the long-term health impact of Covid-19 at a local level. Therefore, a repeat impact assessment with local data and experience should be undertaken.

Designated post-Covid services should make every effort to address inequalities in access to such services, particularly digital exclusion and for those not hospitalised with the virus.

Contributors

This report was developed in haste at a late stage in the overall Rapid Health Impact Assessment process and therefore time did not permit collaboration with other organisations. It is being fed into the work of the Post Covid Steering Group who, it is recommended, should report more fully to the H&WB board in due course.

Methods

An initial rapid review of published literature of long-Covid was conducted in August 2020. This was later compared to quantitative data held by the City Council on hospitalisations and deaths, and

estimates were made regarding the potential scale of the issues for the Sheffield population. This was compared to issues raised in the Sheffield CCG Covid Community Impact Log and disparities raised in the PHE paper "Disparities in the Risk and Outcomes of COVID-19" to consider potential inequalities in the impacts from long-Covid for the Sheffield population.

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Chapter 13

Mental Health

Contents

Abbreviations	
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AMU	Acute Medical Unit
BAME	Black Asian and Minority Ethnic
CAMHS	Child Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CLES	Centre for Local Economic Strategies
CMI	Common Mental Illness
CYP	Children & Young People
DPS	Department of Psychological Services
GP	General Practice
H&WBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Services
LA	Local Authority
LD	Learning Disability
LTC	Long Term Condition (physical health)
MDT(s)	Multidisciplinary Team
MH	Mental Health
MHLDDADB	Mental Health, Learning Disability, Dementia, Autism Delivery Board
MHPN	Mental Health Partnership Network
MHW	Mental Health and Wellbeing
NHSE	NHS England
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
PICS	Post Intensive Care Syndrome
PTSD	Post-Traumatic Stress Disorder
PHE	Public Health England

PPE	Personal Protective Equipment
PHIG	Physical Health Implementation Group
RIA	Rapid Impact Assessment
SACMHA	Sheffield African Caribbean Mental Health Association
SCC	Sheffield City Council
SCH	Sheffield Children's Hospital NHS Foundation Trust
SHSCFT	Sheffield Health & Social Care Foundation Trust
SMI	Severe Mental Illness
SOHAS	Sheffield Occupational Hearing Advisory Service
SPA	Single Point of Access
SPB	Sheffield Psychology Board
SYEDA	South Yorkshire Eating Disorder Association
SYB ICS	South Yorkshire and Bassetlaw Integrated Care System
UKHLS	UK Household Longitudinal Survey
VAS	Voluntary Action Sheffield
VCSE	Voluntary Community Social Enterprise
WHO	World Health Organisation
Y&H	Yorkshire and Humber

1 Mental Health Rapid Impact Assessment: Executive Summary

What was the situation before Covid-19?

Mental ill health represents up to 23% of the total burden of ill health in the UK and is the largest single cause of disability. Nearly 13% of England's annual secondary care health budget is spent on mental health.

Mental health and wellbeing pathways are not considered on the same par as physical health pathways and there is often not adherence to evidence based 'time to treatment' times.

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 Covid-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 were 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 VCSE 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 VCSE 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 has made a number of recommendations, the core of which being the establishment of a clear coherent bereavement pathway for Sheffield. 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.

- There needs to be a review of the level of engagement with digital technology, particularly of people with severe and enduring mental health issues.

- 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 VCSE 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.

Introduction

We are fully aware that mental ill health accounts for nearly 25% of the illness and disability that the NHS deals with but currently has approximately 13% of resources allocated.

Also only a quarter of all those with mental illness are in treatment, compared with the vast majority of those with physical conditions. Currently in Sheffield we have approximately 90,000 people living with depression or anxiety conditions, yet three quarters of these receive no treatment.

We are also already aware of groups across our population that are at risk of poor mental wellbeing and the development of mental health conditions, including anxiety, depression, psychosis, self-harm and suicide.

In addition, we already know a range of risk factors for the development of poor mental health including unemployment, deprivation, poor physical health and substance misuse. 50% of lifetime mental health problems have established by the time a child reaches the age of 14 and 75% by the time a young person reaches the age of 20.

During the unprecedented times of the Covid-19 pandemic and government response, mental health and wellbeing is likely to be significantly challenged, as some risk factors for the development of mental illness and poor wellbeing will be exacerbated - for example social isolation, financial strain, deterioration of physical health and the exacerbation of inequalities for both children and adults.

Nearly a third of all people with long-term physical conditions have a co-morbid mental health problem like depression or anxiety disorders. These mental health conditions **raise the costs** of **physical health-care** by at least 45% for a wide range of conditions including cardiovascular, diabetes and respiratory diseases.

Covid-19 has revealed, confirmed and exacerbated the **health and social inequalities** that were already known.

Context to this paper

This RIA is part of a suite intended to be of benefit beyond commissioning and service planning for Sheffield. It will provide intelligence which can be widely used to aid recovery planning and decision-making during and post Covid-19. We expect that the number of people who are identified as disadvantaged will increase significantly as a result of the pandemic. It will be important to use the RIA 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.

This RIA is also underpinned by the view that communities in Sheffield have shown incredible levels of resilience during this pandemic and that this RIA is not just trying to quantify an assumed surge in demand for mental health services, but is also an attempt to identify and target mitigating and preventive actions and interventions that will strengthen communities and do all we can as a city to maintain levels of positive mental health and wellbeing. Therefore, some of the focus of this RIA will be to harness and learn from some of that innovative development so that it is developed further as the city moves into its recovery and recalibration phases.

Methods and sources of intelligence for the RIA

There are four main sources of intelligence for this RIA:

1. A rapid **review of the available literature**. Given the emerging nature of Covid-19, this will include peer reviewed journal articles and papers, briefings and comment from leading organisations and charities operating in this field.

2. **Review available data** on the impact of Covid-19 on our local primary, secondary and VCSE/3rd Sector health and wellbeing services.

3. The task and finish group recognises that an increased demand is not yet being measured at the service activity level and so, this RIA will **review the emerging modelling databases** to establish the appropriateness of using them to quantify local demand.

4. By seeking the **views and contributions of key stakeholders** and providers in the city, we will:
    a. gather service level intelligence and data from sector providers to identify emerging issues, demands and the capacity of providers to respond to needs particularly in relation to population groups and risk/protective factors.

    b. identify interventions to promote wellbeing and prevent mental illness, which can be sustained or developed as we move on form the crisis response phase.

We will do this in a number of ways including;

- Working in collaboration with the Mental Health Partnership Network lead, we will conduct a survey and focus group of its member organisations to gather local qualitative intelligence

- A citizen space survey to all Sheffield General Practices

- A survey of Children & Young People

- Zoom calls to key stakeholders as identified by the task and finish group

Impact of coronavirus on mental health will be identified in a number of the other RIA themes as mental health is such a cross cutting issue. Consequently, we will also **consult with other RIA theme leads t**o ensure that any relevant evidence is considered. However this report acknowledges but will **not specifically expand on issues relating to Domestic Violence, Adverse Childhood Experiences, Housing and Employment.**

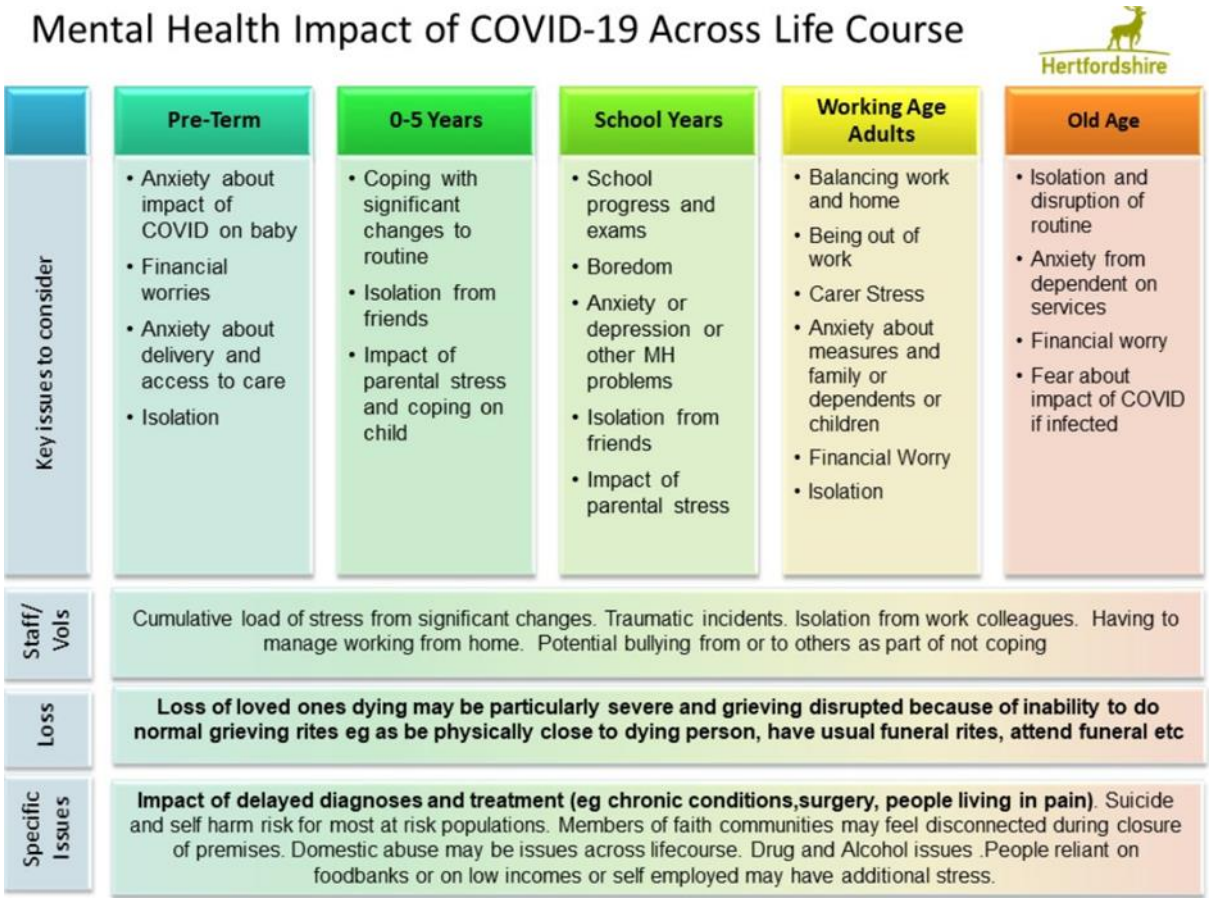
RIA Findings

Literature Review

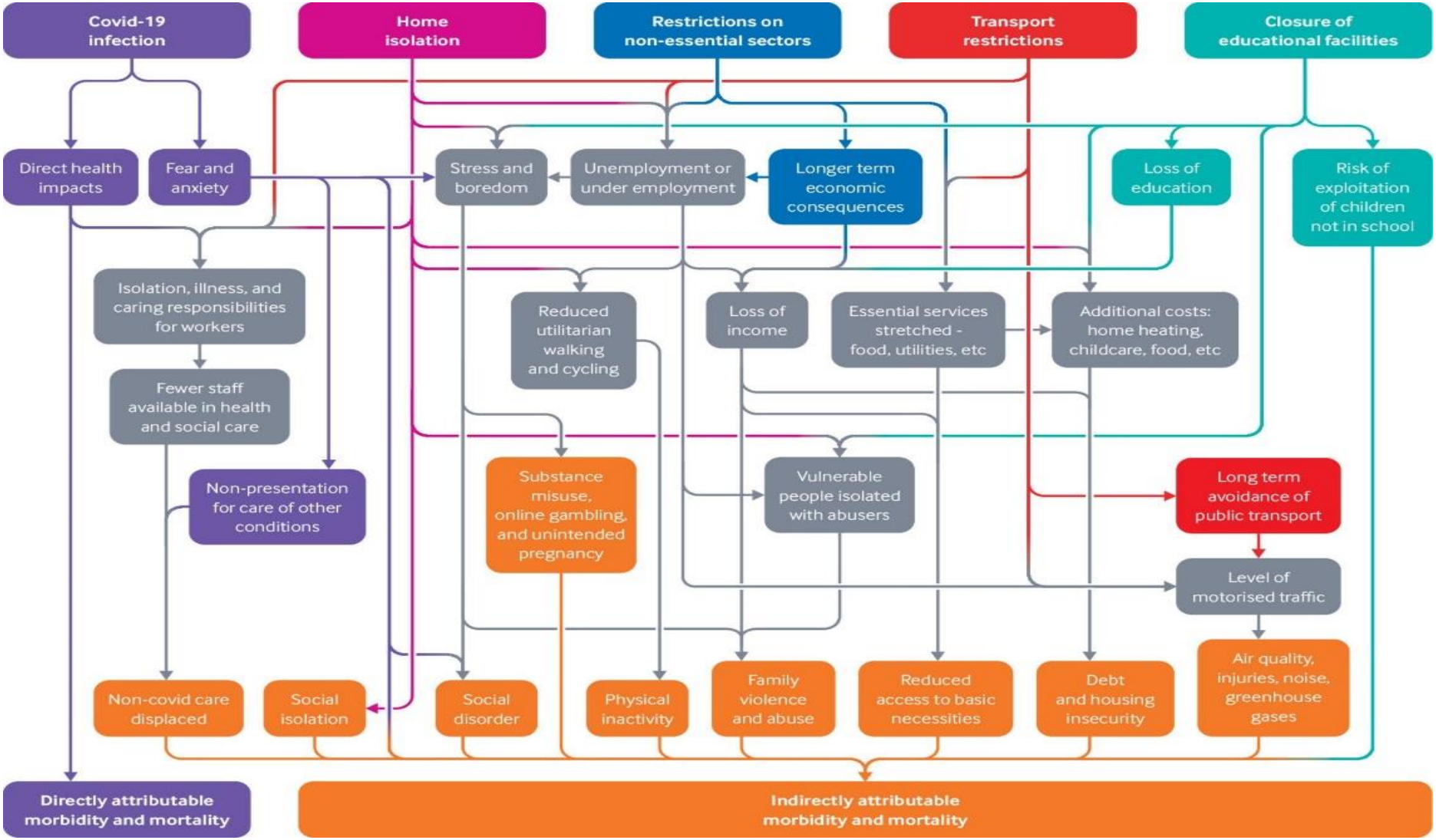
This section presents an overview of some of the key themes identified in the literature regarding the impact of Covid-19 and a consideration of some of the key population groups affected. Appendices provide further information and summaries of the wider literature collated as part of the RIA.

Determinants of Mental Illness

The behaviours and environments needed to curtail the spread of Covid-19 are known risk factors for mental health difficulties. The diagram below sourced from Hertfordshire, shows potential mental health impacts of Covid-19 across the life course. There will be additional impacts for people with a learning disability and/or autism which will need careful consideration. Students and frontline staff are likely to have additional impacts too.



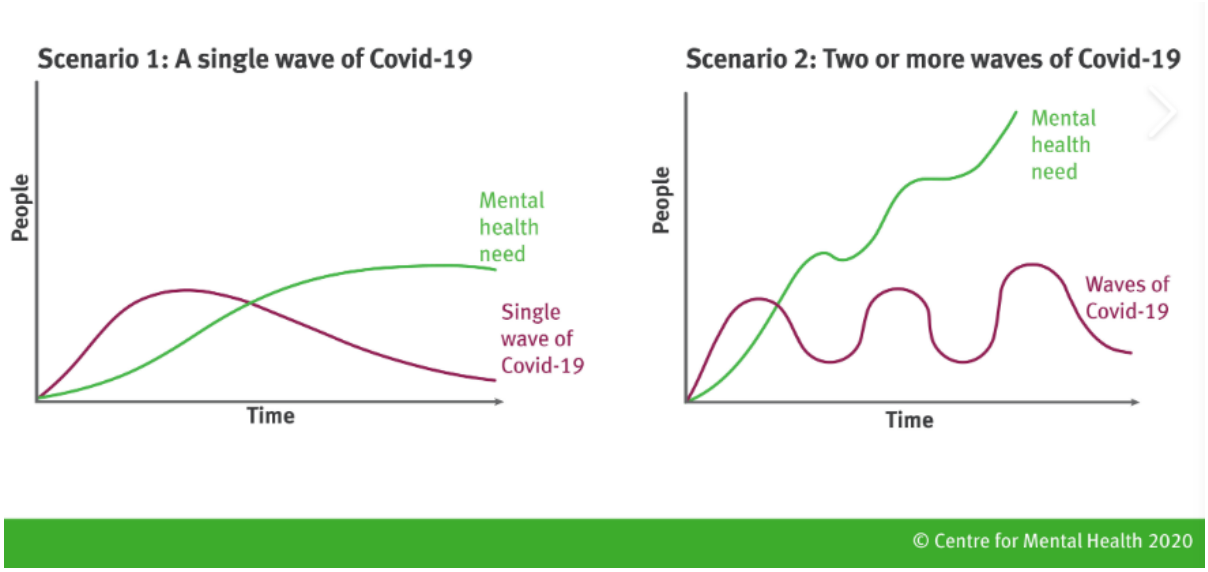
The below table shows the complexity of the pathways through which the multifactorial effects of Covid-19 may arise.



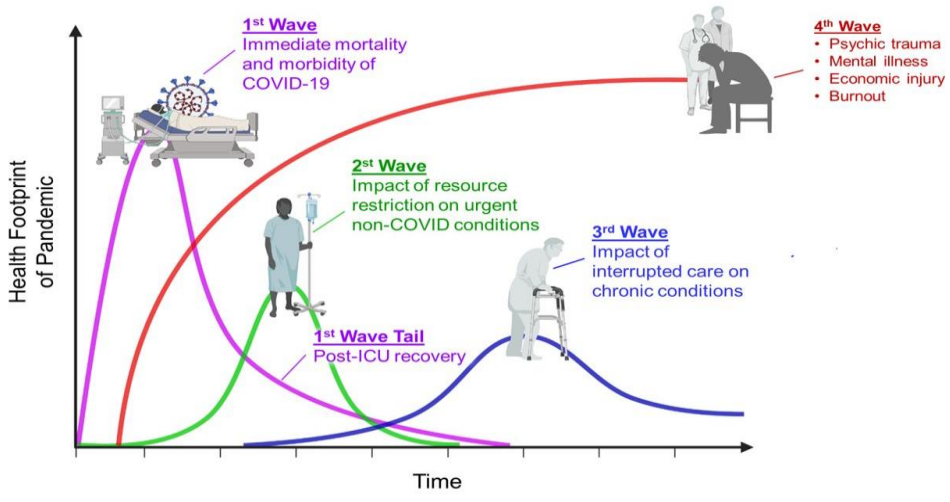
BMJ (2020) https://doi.org/10.1136/bmj.m1557 **(Published 27 April 2020)**

Impact – over time

The impact of mental health problems upon populations will likely be variable over time, with some impacts of the Covid-19 pandemic emerging early and in line with the main response to the pandemic in the UK. Other impacts may emerge at a later stage, when the initial, ostensibly physical health response to Covid-19 has largely passed, but when the economic and social consequences are likely to become more apparent. The Centre for Mental Health has proposed at least two scenarios:



In addition to the above from the Centre for Mental Health, this conceptual illustration has been offered of how we might need to handle later effects of a pandemic as they ripple outwards.



Ref: https://twitter.com/VectorSting

Both of these charts are included in this RIA to illustrate the point that, unlike physical health services, we are yet to see the full impact of Covid-19 on our mental health and wellbeing services. Recovery planning for mental health services in Sheffield needs to span the next 18 months to 3 years.

Impacts- which risk factors and aspects of mental health are likely to be exacerbated in the immediate response to Covid-19?

(These impacts are based purely on application of existing knowledge to the context surrounding Covid-19);

Immediate impact

- Isolation and loneliness
- Stressful living circumstances, child abuse, domestic violence
- Alcohol and drug use
- Health related anxiety (both directly attributable to Covid-19 and indirect consequences of the response such as delayed treatment)
- Bereavement
- Food poverty/insecurity
- Carer stress/Young carers
- Concern over academic achievement, employment and unemployment, significant financial worries, suicide
- Exacerbation of anxiety and depression (AND/OR new anxiety and depression diagnoses)
- Children's mental health will also be impacted by all the above conditions with the added pressure of having little agency to change their situation.

Of immediate impacts, some may resolve following the 'peak' of the outbreak, and a return to normal living circumstances. This might include aspects of isolation, concern over food and medical supplies, and acute Covid -19 health anxiety. However, it is currently unknown how long the return to normal circumstances will take, and for some, the economic and social impact of Covid-19 will not allow a return to normal life.

Likely longer-term impact

- Impacts related to likely economic downturn including further unemployment, loss of business, homelessness, ingrained poverty, suicide.
- Children and young people struggle to manage their emotional regulation across the school day as current informal strategies are restricted through social distancing and protective bubbles.
- Children and young people's increase in depression, anxiety and sleep disorders with reduced activity, productivity, social contact and sense of purpose.
- Children experiencing adverse childhood experiences are likely to experience heightened levels of stress and trauma and a reduction in contact with other protective adults and activities.
- Ongoing distress due to bereavement
- PTSD- particularly health care workers, those in areas of high outbreak, members of the public having lost family members in particularly tragic circumstances.
- On-going depression and anxiety triggered by the initial Covid response
- Some health-related anxiety may continue (e.g. delayed treatment or diagnosis of cancer)

Specific population groups that have been differentially affected about by the response to Covid-19

The Centre for Mental Health published a paper in May 2020 that highlighted the following population groups that the emerging evidence suggests will be impacted significantly following the pandemic:

People **directly affected** by Covid-19:

- Patients – hospitalised (including those ventilated) during the pandemic
- Patients – accessing mental health services
- People affected by grief, loss and bereavement
- Health and care workforce
- People from BAME backgrounds

People **indirectly affected** by Covid-19:

- People with existing mental health difficulties
- People with Long term physical health conditions
- People who experience heightened risks from being locked down at home
- People on lower incomes and with precarious livelihoods
- People from BAME Communities
- Children and Young People
- People with learning disabilities or autism

Impacts - How have changes to employment and finances impacted mental health during lockdown?

A report by The Health Foundation in June 2020 explored how changes in people's economic circumstances relate to their mental health during the early lockdown period. It used data collected in a YouGov survey of 6,005 respondents between 6 and 11 May 2020. Their main findings are summarised below;

- In the early lockdown period survey results show that, overall, people of working age (18–65) were more concerned about their own or their family's mental health (62%) and physical health (65%) than they were before the outbreak began. And people were more concerned about these than their household finances (48%).

- People experiencing a worsening in their family's finances during lockdown were more likely to be highly or very highly concerned with their family's mental and physical health than when finances had stayed the same or improved.

- 46% of respondents were found to have poor mental health. This was more common among young people (aged 18–24), women, single people and renters. While these patterns pre-date the current crisis, other research suggests greater deterioration in mental health for young people and women relative to other groups since lockdown.

- Regardless of income, the likelihood of poor mental health was higher if families had experienced a deterioration of their finances during lockdown or expected one in the next 3 months. However, in the poorest 20% of families almost three-quarters (72%) reporting a

worse financial position had poor mental health, compared to around half (48%) in the richest 20%.

- People who were still working or had been furloughed were less likely to report poor mental health than those who had lost their jobs since lockdown. Retaining a job through being furloughed may have helped prevent a rise in unemployment-related mental health problems. Given the negative health consequences of unemployment, the government should be ready to extend the furlough scheme as necessary to prevent a sharp rise in unemployment. This could better protect household incomes and ultimately our nation's health.

What has been the impact on local services?

Data from Sheffield Health & Social Care NHS Foundation Trust

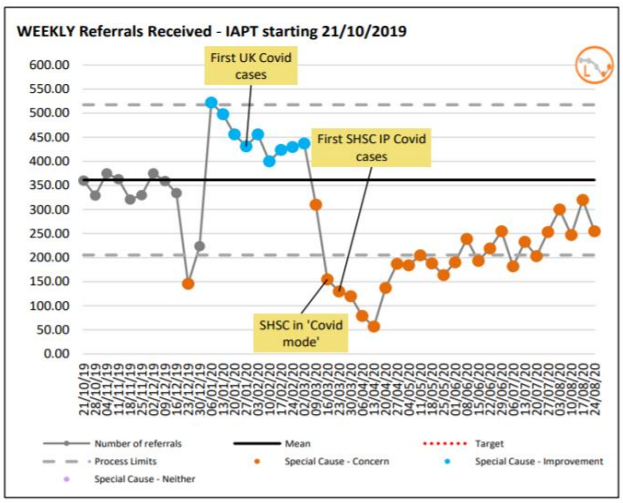
The following data has been taken from the Situation Report that has been produced daily by SHSCFT. The data included here does not reflect the entirety of the available data, just what was selected as the most relevant for this RIA.

There was little surprise that referral rates and activity for mental health services rapidly declined in the initial phase of lockdown. Improving Access to Psychological Therapies (IAPT) activity declined by 50% and most other mental health services had a decline of up to 40%, including for children and young people.

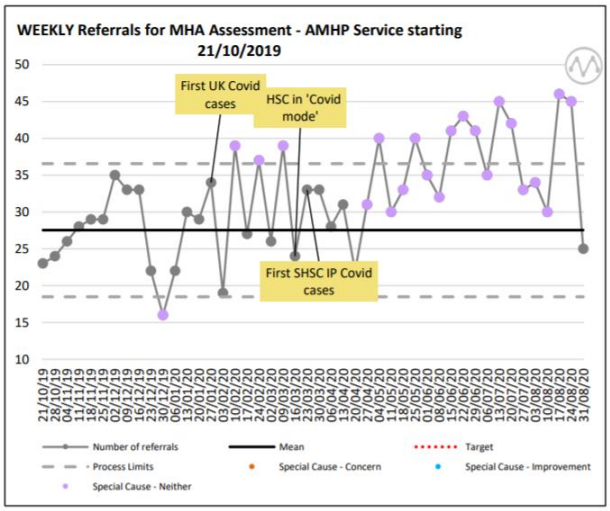
As of the 28th August 2020, the Single Point of Access (SPA) waiting list for assessment was 1,041 which include safeguarding and Attention Deficit Hyperactivity Disorder (ADHD). In order to stabilise the system and allow more capacity and more ability to deal with any upsurge in future demand, it would be reasonable and sensible to tackle existing waiting lists with the aim clearing them as far as possible.

As well as an initial drop in presentations, which has since risen back to pre-Covid levels, providers are also reporting an increase in acuity and complexity of cases, often leading to the use of the Mental Health Act and necessitating out of area placements. This is unprecedented as Sheffield has had no out of area placements for 5 years previously.

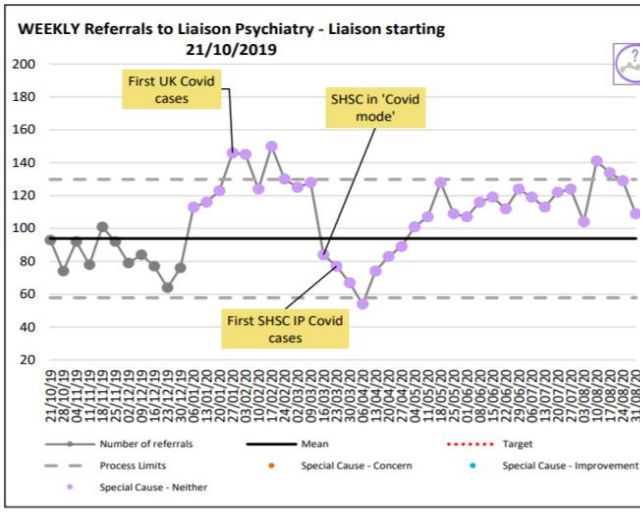
Referrals to IAPT



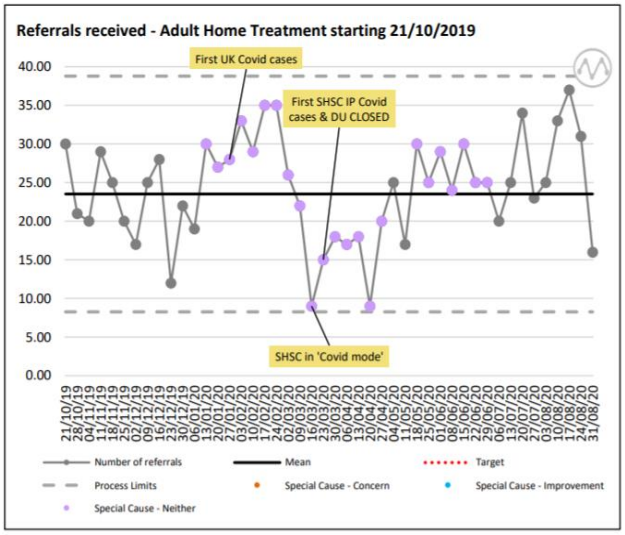
Weekly referrals for MHA Assessment



Weekly psychiatry liaison referrals



Weekly referrals; Adult home treatment



Improving Access to Psychological Therapies (IAPT)

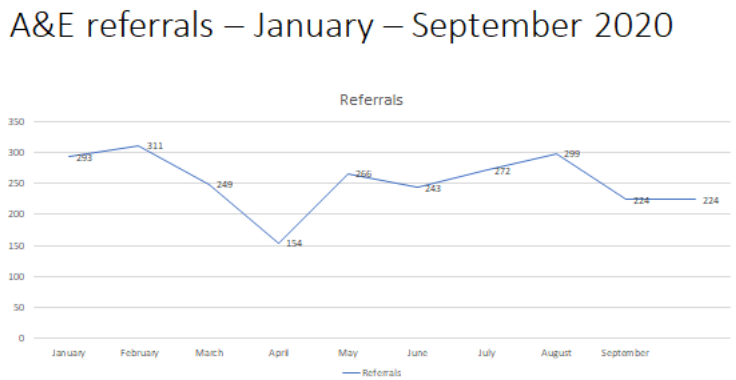
Existing provision	Concerned that existing plans to expand IAPT provision from 15k to 22k referrals as part of the NHS long term plan will be sucked up by Covid demand and there will be a need for additional provision to cope with both existing and new demand, especially in capacity to meet a rise in demand for interventions relating to depression.
	Referral from GP's dropped during the lockdown, which was to be expected. However, work is needed to increase referrals GP's in the future. Just prior to lockdown, referrals also dropped for OCD and Health Anxiety. Believe this was due to clients being worried about catching the virus – more are presenting now.
	Already a strong offer regarding long term conditions (LTC). Currently includes health worries and respiratory. IAPT are currently considering what courses will need in the future.
Changes made during the pandemic to service delivery	IAPT are now offering : • Psychological First Aid course (aimed at frontline workers) • Coping with Covid course There is capacity for further take up of these courses given the online nature of delivery.
	IAPT staff are currently being trained to deliver online 1 to 1 and group work.
	Moved to telephone support and online group delivery. No face to face contact with patients.
	IAPT are currently undertaking a piece of work to better understand the demographics of people accessing their services, but do not believe there have been any untoward negative impact on access from the changes to delivery.
BAME	Interpreters are available for both telephone and video based sessions. BSL interpreters are also able to join video based sessions.
	IAPT staff have recorded videos in key languages regarding Covid and accessing IAPT. In addition, IAPT staff are proactively contacting GP practices to increase awareness of the videos.
	IAPT are currently developing Improving Wellbeing group work session in both Arabic and Urdu, informed by focus groups.

Looking to the future	Need to normalise peoples responses and not pathologise.
	IAPT intend to develop further 'phases' of the coping with Covid course to include emerging issues e.g. fatigue.
	Existing IAPT LTC courses will be developed further to respond to issues as the pandemic impact is better understood. This is likely to reflect the view that there may be an 18 month recovery period from the effects of having Covid-19.
	More work needed to raise the profile of IAPT services in GP practice and increase referrals. This would be a key mitigation measure in managing future surge.
	IAPT believe they will not be going back to face to face delivery in the near future and that remote service delivery is here to stay. Believe that people prefer the convenience and anonymity that online platforms offer, but acknowledge that it doesn't remove all barriers in access for clients.

Data from Sheffield Teaching Hospitals NHS Foundation Trust

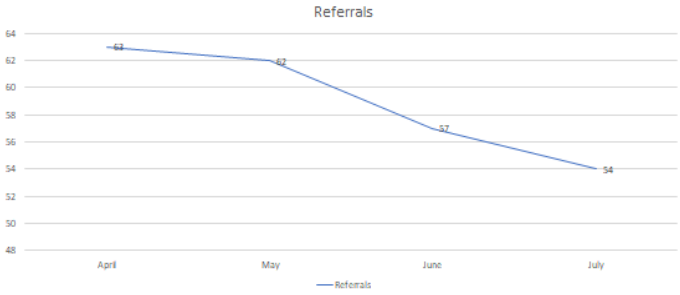
The charts below show the numbers of referrals from Accident and Emergency and from the Acute Medical Unit (AMU) into the Liaison Psychiatry Service over time since the start of the pandemic.

As seen with other providers, referrals from A&E dropped off significantly at the start of the pandemic, but quickly returned to very near pre pandemic levels over the summer.



However, this pattern has not been seen with referrals from AMU which has continued to fall throughout the summer.

AMU referrals – April – July 2020



In line with other providers, staff from Liaison Psychiatry also report having seen a lot of patients with Covid related mental ill health as a result of isolation and resulting hardship. Some of these patients have been psychotic/depressed and some suicidal.

Primary Care Data

General Practice similarly recognised an initial reduction contact for non-respiratory/infection related Covid-19 activity. This was short lived as General Practice quickly began using remote consultation techniques such as telephone and video consultations. This rapidly revealed psychosocial need particularly related to depression, anxiety, insomnia and the consequences of loneliness. 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.

A survey of General Practice was carried out (Appendix D) and whilst the numbers of responders was relatively low, the findings triangulate with national data.

Some narrative responses from the survey illustrate some key issues:

- *Patients felt really uncomfortable about the lack of face to face contact with health practitioners especially if the problems were related to loneliness etc.*

- *IAPT moving to an entirely digital platform could be beneficial **IF** it genuinely increases capacity and responsiveness **BUT** digital poverty is a significant problem and we must not increase inequality of access.*

- *We feel in my practice that my team has been really drained by management of huge number of mental health problems and we feel that we need support in the near future, especially if there will be a second wave of the Covid-19 as we may not be able to maintain this level of care for much longer.*

- *I worry about issues related to potential domestic abuse and safeguarding issues with children that have been 'hidden' over the last four months…*

- *Most anxiety cases have been more acute and severe with difficulty accessing secondary care services. Cases have been more complex as many lifestyle measures we would discuss have been more challenging due to lockdown restrictions. Some people have had difficulties balancing pressures from work and childcare during the pandemic. Myself and patients have had difficulty accessing the SPA crisis team. GP*

Data from Sheffield Children's Hospital NHS Foundation Trust

At an early stage in the pandemic it was recognised that additional resources would be required to meet the mental health needs of children and families post Covid & to support the emotional impact on staff. All of the following services have been involved in developing an overview of the expected impact of Covid-19 on the mental health of their patients: which has been provided for a Sheffield Psychology Board (SPB) paper:

- Paediatric Psychological Services
- Neuro-Disability & Neurology Psychology (Ryegate)
- Chaplaincy
- Bereavement
- Administration
- Re-deployed resource into staff support

An overall increase of 40% in mental health presentation across these services has been predicted, 20% presenting in physical health services & 20% in mental health services. This increase in demand is additional to existing pre-Covid-19 waiting lists/legacy waits in Paediatric Psychological Services.

The nature of the Covid-related demand is expected to include:

- Increased urgency of referrals
- Increased trauma from witnessing or experiencing domestic violence & sexual abuse and resulting from Covid-19 pandemic
- Increased Health Anxiety due to threat of Covid-19
- Presentation of physical health difficulties which have a psychosomatic base
- Increase in atypical bereavement reactions
- Increased demand for chaplaincy services

Older Adults in Sheffield Health and Social Care NHS Foundation Trust

Older adults have experienced an extremely harsh form of lockdown. The report on the emerging evidence of the detrimental effects of confinement and isolation on the cognitive and psychological health of people living with dementia during Covid-19, and mitigating measures provides a helpful summary of the emerging impacts for this population cohort.

Included below are a number of reflections from older adult psychiatrists from both the community and home treatment teams in Sheffield:

- "*I've not particularly issued more prescriptions except for a small number of ones for anxiolytics related to Covid / lockdown pressures, and also to ease stress for families who are having difficulty getting prescriptions from GPs. I would say my few extra ones have been equally divided between functional and organic patients."*

- *"I can't really comment on increased prescriptions compared to pre-Covid. However, I have seen an increased caring burden on families, and increased symptoms of loneliness and isolation (as expected). Carers of people with Dementia have struggled to cope with not having any activities/day centres."*

- "*From a hospital liaison perspective, there was initially a lull in referrals and liaison assessments (this was the case in Rotherham and I've heard that the situation was similar in Sheffield) at the outbreak. However we are seeing a lot of Covid-related delirium in hospital which is likely leading to an increase in prescriptions."*

- *"We may be seeing an increase in prescriptions for more acute medications such as benzodiazepines particularly in organic cases for symptom management. This is in part due to lockdown restrictions and reduction input from social care services such as day respite. I've also had occasional prescriptions for patients who have been shielding and concerned about being able to access medication from GP but there's only been a couple of those. I should also point out a lot of the pharmacies across the city have been helpful in allowing us to fax prescriptions and supply medication quickly, especially when I had a patient who urgently needed medication on Good Friday. Our admin team have also been amazing at sorting out all the prescriptions to get them to the right place."*

- *"I am not sure that I have suggested starting medication much more than pre Covid, however, I may have issued more scripts than pre Covid, trying to ease pressure on GPs and make sure the patient gets their medication ASAP."*

- *"I think there may be evidence for more first onset functional mental health problems in older people."*

- *"I also work onto Dovedale ward (ward for OA with functional MH problems) and I would say that for the majority of people who have been admitted during Covid has been a significant factor in their admission, either exacerbating a pre-existing MH difficulty or triggering due to really high levels of anxiety or psychotic/paranoid symptoms".*

Both Dovedale and G1 are experiencing high levels of clinical activity and staff report that service users are more unwell than pre-Covid.

National data and evidence

There are a number of tools being developed at the national level by NHSE and PHE designed to support local rapid impact work and in particular to support surge modelling and forecasting. Unfortunately, many of these tools are not yet available to local areas. Local bespoke tools have been created in the meantime in some areas and the SYB ICS is exploring the robustness of these tools and how we might use one to model future prevalence of MH conditions across Y&H.

In Sheffield, we have asked our SCC Business Intelligence service to explore the possibility of using a tool developed by the **Lancashire and South Public Health Collaborative**, and applying Sheffield data.

The Lancashire and South Cumbria tool recognises that while our systems (health and local government) are focused on coping with the pandemic, demand for future mental health services is increasing. They define this demand in two ways:

- Covid-19 suppressed. This is demand that would have occurred had the pandemic not happened, and

- Covid-19 generated. This is demand that is directly attributable to peoples' experiences of the pandemic.

Emerging findings from the Mental Health and Wellbeing Surveillance Report

PHE has developed a new routine Covid-19 mental health and wellbeing (MHW) surveillance report. It aims to provide data and information in as near to real time as possible and provide a timely sense of the impacts on people and communities. The intention is for local systems to use this information to deliver a timely response and inform policy decisions for the recovery phase.

Published in September 2020, a link to the full report is provided here and a summary of the emerging findings for this RIA is provided below.

Changes in population mental health and wellbeing

There is evidence that self-reported mental health and wellbeing worsened during the Covid-19 pandemic. The decline was largest in April. There is evidence of some recovery since then, but not yet to pre-pandemic levels.

Data from longitudinal cohort studies provide useful information about change over time. Longitudinal cohort studies return to the same sample of people at regular intervals – often to see how responses to the same questions change over time. Data from the UK Household Longitudinal Survey (UKHLS) suggests that, among adults:

- mental distress (measured using GHQ-12) was 8.1% higher in April 2020 than it was between 2017 and 2019[1]

- mental distress in April 2020 was 0.5 points higher than expected (on the GHQ-12 scale), after taking into account increases in mental distress since 2013[2]

- in April 2020 over 30% of adults reported levels of mental distress indicative that treatment may be needed, compared to around 20% between 2017 and 2019[3] [4] [5]

- estimated prevalence of common mental disorders was lower in May 2020 than in April 2020, but still higher than between 2017 and 2019[5]

Considering emerging differences across population groups:

- young adults and women have been more likely to report worse mental health and wellbeing than older adults and men

- adults with pre-existing mental health conditions have reported higher levels of anxiety, depression and loneliness than adults without pre-existing mental health conditions

- adults who were not in employment before or since the lockdown were more likely to report worse and increasing loneliness, higher levels of anxiety and mental distress

Other population groups that appear to be disproportionally affected include adults:

- with low household income or socioeconomic position
- with long term physical health problems
- living in urban areas
- living with children
- who have had coronavirus related symptoms

The evidence of the impact of the pandemic on mental health and wellbeing of BAME communities continues to emerge and PHE intends to continue to track the impact and report as more evidence becomes available.

Suicide Prevention and Self Harm intelligence

The mental health effects of the coronavirus pandemic might be profound and there are suggestions that suicide rates will rise, although this is not inevitable.

Suicide is likely to become a more pressing concern as the pandemic spreads and has longer-term effects on the general population, the economy, and vulnerable groups.

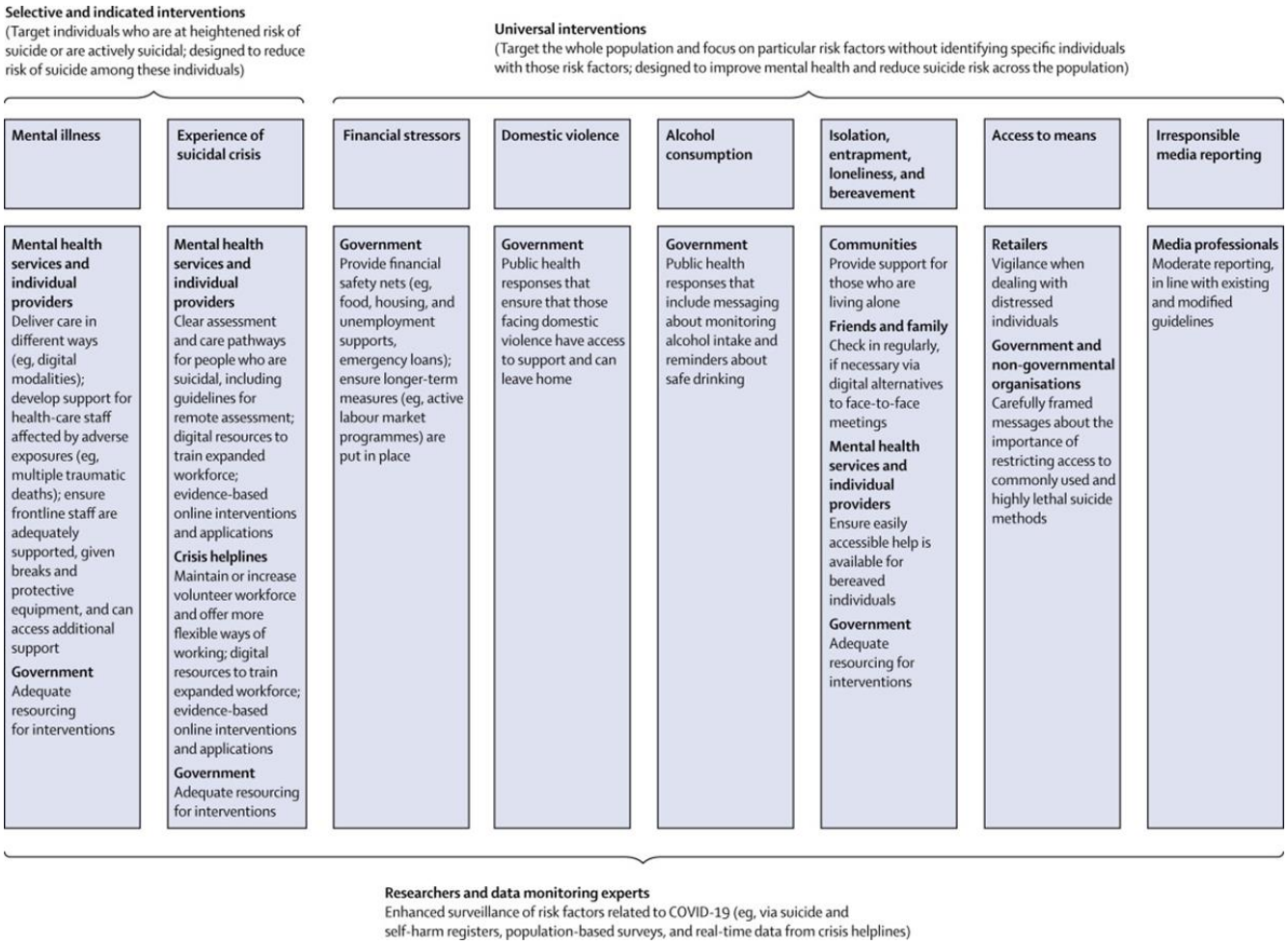
Preventing suicide therefore needs urgent consideration. The response must capitalise on, but extend beyond, general mental health policies and practices.

Suicide risk factors during Covid-19

A recent paper indicated that many of the emerging consequences of the coronavirus pandemic and the policy response are known risk factors for suicide (Gunnel, 2020). These include;

- Loss of employment and financial stressors
- Increased alcohol use and domestic violence
- Social isolation, loneliness and entrapment
- Anxiety, depression, PTSD

The paper presented a range of suicide prevention strategies during Covid-19, including actions that could be taken by government, mental health services, retailers, communities and the media.



Key messages for local suicide prevention plans from NHSE

- Too early to see change in suspected suicide numbers
- NCISH are collating real time surveillance data from local areas to monitor this
- Increase in suicide rate is not inevitable
- NHSE - have asked local areas to review their plans in light of the risks and see what is feasible re delivery
- Updated guidance to inform local delivery plans will be published in September 2020

Information and intelligence from the Sheffield Psychology Board (SPB)

Established as part of the response to the Covid-19 pandemic, SPB was tasked with oversight of the psychological offer and information available to Sheffield citizens during the pandemic. SPB delivers this remit through a number of work streams, each with a named lead and tasked with leading projects within their remit and reporting on progress to weekly SPB meetings. SPB is accountable to the Mental Health, Learning Disabilities, Dementia & Autism Delivery Board (MHLDDADB). The work of some of the work streams most relevant to this RIA has been summarised below:

Communications work stream

As a key part of the Communications work stream, a suite of information resources were developed in collaboration with VCSE sector partners and made available to Sheffield residents via a number of channels (see here.) More recently SPB produced a video that highlights the various sources of mental health support available to Sheffield residents and can be viewed here.

Bereavement work stream

The initial focus for this work stream was to clarify the bereavement offer in Sheffield. However, it became evident that there was no strategic oversight for the bereavement pathway therefore the work stream undertook to address following:

- What are the requirements for a comprehensive bereavement support offer for Sheffield citizens, in the context of Covid-19?
- What is the existing bereavement provision in the city?
- What are the gaps and shortfall?
- Recommendations for improved provision of bereavement care

The work stream made a number of recommendations to SPB in September 2020;

Strategic

- Agree strategic direction, Sheffield Strategy for Bereavement Care, and city-wide oversight of bereavement care provision for adults, children and young people.
- Align with Compassionate Cities and 'Towards an intelligence-led End of Life strategy for Sheffield'
- Ensure meaningful engagement of service users in shaping bereavement care

City-wide join up

- Establish a Sheffield Bereavement Forum/Community of Practice
- Clarify interface between bereavement care and mental health services

Sheffield Bereavement Care Pathway

- Ensure existing services have capacity to meet demand in context of Covid-19, and ensure timely equity of access to components 2 and 3
- Ensure consistent provision of timely, high quality communication, information and resources
- Provision of information on existing services that is good quality, easy to access and easy to navigate

Knowledge and skills

- Ensure all relevant agencies and services understand their role in providing component 1 support, and have the knowledge, skills and confidence to do so

- Ensure knowledge and skills to assess or triage need

- Ensure culturally competent bereavement care

These recommendations will be discussed at Mental Health and Learning Disabilities Board in October 2020.

Health and Social Care staff resilience and support

Sheffield Health and Social Care NHS Foundation Trust

- Support to staff in care homes during Covid:
    - A number of resources were developed to support staff working in care homes (specifically older adult care homes within Sheffield) and sent to all care homes and uploaded onto the Council's website for easy access. The resources included ideas for staff to think about their own well-being, that of their residents and of family and friends and were a mix of practical tips, links to websites and signposting to existing services.

    - Following this a couple of sessions were provided through the care homes network a by a psychologist on Psychological First Aid approach for staff to think about resilience and self-care/how they support each other in more detail.

    - There are a small number of care homes who have engaged with more intensive support for staff where there have been specific issues related to a service user.

- Staff Support
    - A 24/7 helpline was established by SHSC for the staff within the city. On a 9-5, Monday to Friday basis this was run via SHSC Workplace Wellbeing service with additional counselling staff supporting this work from Sheffield MIND and IAPT. The Covid-19 Professional Helpline is open to all staff who are working with Sheffield and exposed to Covid 19 related difficulties. These staff groups include members of the different NHS Trusts, Care staff, police and ambulance workers.

    - Staff were also supported within teams within SHSC by Psychological practitioners beneficial in:
        - Providing staff with support and the opportunity to decompress following difficult and challenging situations at work.

        - Allowing staff the opportunity to problem solve during the telephone / group support would help with stressful team dynamics, ensure that difficult situation are not personalised.

        - Help staff to maintain a positive work life balance, allowing staff to leave behind difficult and challenging work situations.

        - Work to prevent the development of PTSD.

Sheffield Children's Hospital NHS Foundation Trust;

- Staff support has focused on an individual level (e.g. 'drop in' support sessions in the anticipated high-pressure areas such as the Emergency Department, Paediatric Critical Care

and Theatres) alongside team/group interventions (e.g. supporting senior leaders in managing change, facilitating rapid communication within teams, piloting supervision structures, and building and sustaining peer support relationships within teams). Broader organisational strategies have also been implemented (e.g. signposting to existing support options, establishing divisional structures to support staff wellbeing and developing organisational wide training). There are ongoing plans to invest in organisational structures to benefit staff wellbeing (e.g. considering expanding existing debriefing structures).

Sheffield Teaching Hospitals NHS Foundation Trust

- From March 2020 the Department of Psychological Services (DPS) at Sheffield Teaching Hospitals (STH) redeployed a significant number of psychologists to focus on staff support across the organisation, with the aim of fostering resilience, enhancing staff wellbeing and responding to any key areas of need during the peak phase of the pandemic. This included providing over 500 STH staff with Wellbeing and Resilience training prior to redeployment to Critical Care or Covid wards, of which over 200 were provided with ongoing support through provision of reflective practice sessions during their redeployment. Key areas such as Critical Care and the Emergency Department were provided with a bespoke package of support for staff, with examples including consultation for senior leaders and managers, provision of reflective practice groups and psychology attendance at Calm rooms. A number of managers and senior leaders from settings across the organisation were also offered consultation on how to support staff wellbeing during the pandemic and reflective practice sessions were provided on request. This has provided an opportunity for DPS to work with a wider range of staff teams than we would not normally get to work with and the feedback we have received has been positive. Key themes identified in reflective practice sessions have also been passed on to senior leaders for consideration in future planning.

- During the initial wave of the pandemic, in order to support STH psychologists through the period of their redeployment and changed roles, including their work with the broader Trust staff teams, a number of DPS initiatives took place. These included creation, maintenance and dissemination of up to date self-care and wellbeing resources; introduction of regular Reflective Practice groups for psychology staff; and, via Sheffield Psychology Board, provision on a significant scale of support and supervision by SHSC psychology staff to their STH psychology colleagues, work that proved invaluable and was much appreciated by staff.

In its paper to MHLDDADB in June 2020, the SPB highlighted some of the estimated impacts on mental health echoed elsewhere in this RIA and proposed a stepped care approach to building a Psychological resilience model in Sheffield.

<u>Estimated impacts from SPB paper</u>

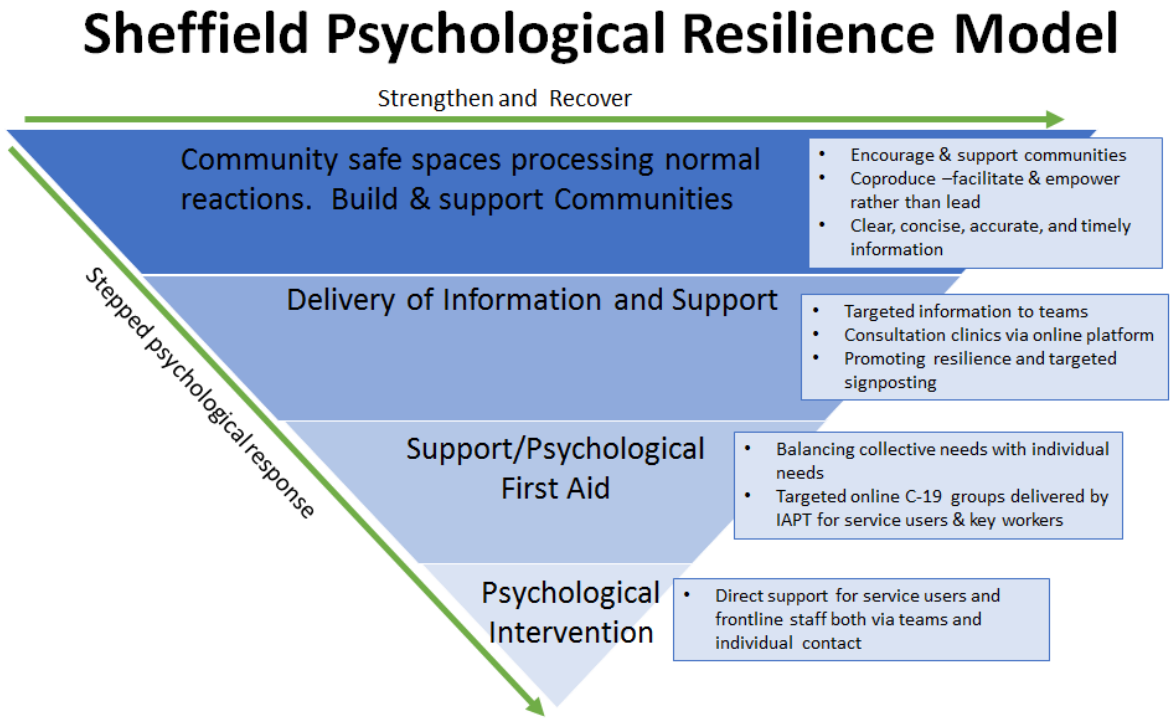
- Using the figure that NHS England suggested, that there could be an increase in emotional and mental health problems associated with Covid-19 of up to 40%, the SPB suggest a best estimate of between 1400 – 1800 extra referrals per month for adults in Sheffield, and that this is mirrored by an estimated 40% increase in referrals for children and young people per month.

- Statutory services across Sheffield give estimates of a Covid-19 lockdown reduction in referrals and service usage between 20- 50%. SHSC Trust have continued to deliver a clinical service throughout the Covid period but noted a reduction in the number of referrals over the last three months. However, they are starting to see a stepping up in demand particularly in IAPT services around 300 referrals per week and in SHSC's Liaison Mental Health (LMH) service (LMHS). LMH for example, already show an increase of 20% of referrals for the first two weeks of May 2020. Psychology services in Sheffield Teaching Hospitals Trust (physical health for adults) stepped down all services to non-essential clinics to attend to Covid-19 demands; they are currently reconfiguring its resources again to attend to a Trust-wide Covid-19 service in addition to areas of urgent clinical need.

Proposed Sheffield Psychological Resilience Model

In line with the WHO Psychological First Aid model, SPB has been clear in its fundamental approach to Covid-19 in not to pathologise normal psychological reactions to unprecedented circumstances. SPB also recognises that not everyone has been affected equally by this pandemic; some will have remained reasonably unaffected whilst others have suffered extensively. As this means psychological needs are on a continuum, the mental health stepped-care model differentiates level of need appropriately and matches need with corresponding clinical expertise. Some people may benefit from good quality information and self-help resources, whilst others may need individual interventions for complex problems such as post-traumatic stress disorder.

It is therefore important to ensure matching the right level of intervention with the right psychological need, and it is equally important to do so at the right time. If this is done prudently we would prevent incremental drift to higher levels of need, including an incremental drift to formal mental health services. The following illustrates a stepped care approach to building a Psychological resilience model:



The stepped-care model also proposes new integrated approaches by bringing people together in physical and virtual community spaces. We can apply learning from both what has worked locally during the outbreak phase, as well as by translating learning from national leaders and projects that have strengthened partnership working with communities and community organisations. For example:

- Grenfell Tower Community engagement and outreach work supported communities to thrive following collective and individual trauma https://www.acamh.org/blog/grenfell-tower-fire/
- Centre for Local Economic Strategies (CLES) considers the impact of progressive procurement on community wealth building and the wider determinants of community health https://cles.org.uk/community-wealth-building/what-is-community-wealth-building/

Psychologists and mental health experts in the VCSE sector can support key community leaders and organisations to set up safe physical and virtual spaces for people to share experiences, have conversations, start to heal, and to think about how to build on positive social action. Communities can be both geographical communities and city-wide communities of interest. Health Watch and others can be engaged to co-create inviting, welcoming, non-stigmatising environments where, in non-judgmental, trusted and accepting settings, people can witness each other's stories and start to knit together collective hopes.

The support offered in the community would also meet the needs of individuals for whom group support options are not suitable. The VCSE sector, with its strength in diversity, is well placed to provide such community support and psychological interventions. With a wide range of organisations and services in its fold it can flex and adapt in a timely way to meet changes in service

demand. It could innovate and provide community MH services and support both during the recovery phase if resourced appropriately.

Good quality information is key to a stepped-care approach. This is so within itself if that is the only level of need, but also true when dovetailing information with other levels of intervention in the model.

Psychological interventions increase in complexity to match the needs of the people presenting in line with NICE guidelines. IAPT are running a Covid-19 recovery group and have a website with targeted self-help information with good feedback from service users. VCSE sector providers are able to offer a range of psychological interventions via telephone, video calls or email. At the apex of the stepped-care model there will be need for specialist skills sets to provide services for a range of problems such as complex trauma/PTSD, significant depression, anxiety/OCD, fatigue, neuropsychological symptoms, persistent physical symptoms, etc.

Summary of qualitative intelligence from local stakeholders

One of the key ambitions of the RIA was to capture the views from VCSE organisations working in Sheffield on the impact Covid-19 had had on the people they work with. To do this, we worked with the Coordinator of the Mental Health Partnership Network to develop a short survey that was sent out to all members of the partnership and complemented by a focussed discussion at one of their weekly zoom Network meetings. The survey was sent to all members of the Network and 15 organisations replied.

A copy of the survey and a list of the contributors can be found in Appendix E and the key findings are summarised in the table below.

Overall, while there is evidence that the Covid-19 pandemic has negatively impacted on people's mental health, it is difficult to assess and predict exactly what shape this will take in the short, medium and long-term future. Early community-based intervention and flexibility in service provision are crucial, so that people can access services in a timely way to receive the help they need in a community setting.

Concern/Issue or population group highlighted	Comments from the survey
BAME communities	• Lockdown has increased stress, community disconnection and cultural separation. • Especially hard for: people with existing MH conditions refugees and asylum seekers who have found lockdown triggering due to previous traumatic experience mothers stuck at home with small children who may be fearful of leaving the house older BAME people men, would normally have met up in cafes, etc.

	• Intergenerational homes have limited the opportunities for quiet time and space apart from other family members • The lack of social contact has been made worse due to lack of access to phones, social media, ESOL and confidence dealing with services • Difficulty understanding national Covid-19 guidance • Feelings of guilt about not being able to honour deceased relatives due to Covid restrictions on funerals, etc. • "The pandemic has highlighted clearly the impact of disadvantage and inequality in society. In particular we have seen this in the groups identified at greatest risk from the disease as a result of health, lifestyle and wider societal inequality (i.e. BAME, income, etc.). This along with other events that have occurred during the pandemic such as the prominence of Black Lives Matter must result in meaningful change as without it we will see the same issues return and occur again and again".
Asylum seekers and refugees	• For those who were traumatised it has exacerbated their MH distress, increased their isolation and impacted on integration. Some are unable to continue to access therapeutic services as they did not want to do trauma work from their home due to partners/children or their home becoming associated with past traumas. • Many have coped well as they are pragmatic and have endured many years of difficult living conditions elsewhere • Older Syrian refugees who have chronic health problems have become very isolated due to shielding • Rarely seen within IAPT and so therapy offered via VCSE sector, given few services are appropriate and accessible to our clients.
People with pre-existing mental health needs	• Covid has exacerbated existing mental health needs. • Harder to access services as many are not interested in/don't have access to video conferencing, including those with: severe mental illness. • Increase in people needing to access food banks. • Anecdotally, it would seem that many people with mental health problems have responded to Covid-19 with fear – they are isolating and shielding and this has affected their ability to get their own food, manage their money and interact with other people. People who find it difficult at the best of times to interact with their local community are now very isolated. In addition, many do not use / cannot afford / are fearful of digital technology, so their independence has decreased. • Lockdown had the effect of "trapping" many people with hoarding disorder in their hoarded homes. Now with the easing of lockdown this is enabling people to be able to go out more to get away from the situation, which is often a strategy used. It has had the effect of cutting off some people's acquiring methods e.g. charity shops were shut. But some have been ordering online and are now in financial difficulty as a result. • It has been hard to engage with people with a mental health disorder due to not understanding or wanting to use technology. Many have not even wanted to talk on the phone.
People who have experienced complex trauma	• For clients with complex trauma they have been impacted greatly by the COVID pandemic as it has re-traumatised them. Themes that have come up for these clients include: being told what to do, feeling locked up, feeling controlled and things being unfair. These were often things that the client had experienced as part of their abuse.
Young Carers	• The level of caring has increased in the crisis, as well as levels of family

	conflict. The VCSE sector have been able to support young carers and their families to manage their mental health within the lockdown, but also supported them to seek help before a crisis is reached.
Women	• Hard for single parents to keep everyone safe and motivated • Some felt safer during lockdown as staying at home, could be new challenges as lockdown eases • Those with complex trauma have been re-traumatised by the pandemic. Previous coping strategies were removed due to lockdown conditions. • Impact of increased levels of domestic abuse. Many women who are current victims of domestic abuse often also have histories of trauma and abuse, and that the current crisis has potential to cause additional trauma, will increase the risk of abuse, and also exacerbate trauma symptoms.
Children and Young People	• Increase in child safeguarding concerns and an increase in calls to the safeguarding hub for those who were in touch with services. • There is a lot of concern about C&YP who have been more hidden during this time and for whom there may be safeguarding issues which would normally have been picked up when the C&YP were accessing other services, not necessarily mental health focused. • Concern about C&YP and impact of ACEs during this time: family break up, death, domestic violence, deprivation, etc. • Concern about the impact of parental mental health on C&YP. Many vulnerable children did not take up a place at a school due to a variety of reasons: fear of Covid, parental loneliness, lack of structure, parental mental health. • Impact of educational attainment and employability due to schools closing and economy shrinking
Employment and mental health	• Jobs more insecure due to Brexit and Covid. • People are fearful of raising their mental health issues at work for fear this may increase their chances of being selected for redundancy • People feel they have been “abandoned” by their employer and have received no support to do their work. • Less referrals from GPs to employment advice. • Job security/vulnerability and financial insecurity will be a driver of workplace health issues over the next 6 months. Many organisations are telling their employees that they will be working from home for at least another 6 months, if the lack of self-risk assessment continues. • There may be mental health repercussions of Covid impacting on people’s employment e.g. Increased bereavements, job losses, trauma of being/relatives being in ICU, changes to working practices (the blurring of home/work life), MH impact on children not being in school/needing to be reintegrated back to school. • An increase in number of homeless people needing support, as people have lost jobs and many were in insecure tenancies. Whilst they are assured tenancies at present this is likely to change after lockdown lifted. Expectation that: • MSK will be a driver of mental health issues • Job security/vulnerability and financial insecurity will be a driver of workplace mental health issues in the future

How MHPN members have adapted their services to support people living with MH issues	• 2 organisations reported having to close their services and furlough staff which will have impacted directly on their clients • Others introduced new systems in order to prioritise those service users most at risk • Most members had to cease face to face and group work though one group reported that it was currently co-producing with members an online group format • Families were a group that members struggled to engage with especially as they normally receive face to face support, Some orgs adapted and offered activity packs for children Many members also reported stepping up of existing services such as • increasing the number of wellbeing checks on their users • some also saw an increase in the number of calls for support • interpreting guidance for users and distributing this alongside packs of masks, gloves, hand sanitiser All members reported flexing their services to maintain maximum provision to users, this included; • expanding their online content esp. for young people • Therapy was offered via zoom and telephone for refugees and resettlement support continued throughout • Other members were exploring the potential for offering video therapy led by the needs and wishes of their service users • Providing or arranging essential food/medication, bill pay and mobile phone top up services esp. for people who were shielding • Continuing to offer 1 to 1 support to women suffering from abuse via the phone • Offering signposting and support even where clients preferred not to engage during lockdown New activities were also developed at pace including • the establishment of community WhatsApp groups for service and peer support • WhatsApp based chairobics session • Pen pal scheme to support isolated people • Weekly newspaper with contributions from service users
Adapting to online service delivery	In addition to those comments included above • 1 member established a phone line for over 50's to support people coping with loneliness and isolation • 1 member reported seeing a drop in DNA's since adapting to using zoom Overall there were mixed views about the preferences of service users to online service delivery. Some reported that users preferred telephone as a method, others preferred video. Trend is not clear Concern about the long term impact on service users of the lack of face to face support esp for traumatised people such as refugees, but also for families where the means of support is as important as the support itself. • A number of members reported that some clients had chosen to wait for face to face support

Looking to the future	• A number of members reported that they will continue to utilise video technology for networking e.g. keeping in touch with volunteers, and especially for networking with other organisations. Suggestions included sharing skills and training via this platform • There was a desire for greater and continued collaboration with statutory services to aid early intervention and prevention to minimise escalation of crises • There was a desire for more involvement in planning and policy making structures for BAME voices • In the event of future lockdowns, that the ability of local communities to communicate and use their voice and influence should be part of the development of national strategy, not left to underfunded VCS orgs • A number of members reported that they will continue to offer remote therapy as part of their core offer, increasing choice, flexibility and accessibility • The suggestion was also made though, that there needs to be a review of the level of engagement with digital tech for people with severe and enduring mental health issues • Felt that there was a need for more mental health support, but not just more, there is also a need for services to be more joined up and in contact with other services to maximise impact • Concerns raised about capacity and burnout of staff in the VCS due to the additional pressures caused by the pandemic • Need for the development of more capacity within VCS organisations so that they can support people, keep them stable and prevent demand on statutory services

Sheffield Flourish Public Survey

Sheffield Flourish also conducted a survey during the lockdown period. The survey was completed online and was designed to explore the challenges people were facing in lockdown, what they were doing to support their mental health and their thoughts and related experiences. 66 people responded. A link to the full report is below. Key findings included;

- In response to the statement – 'Covid-19 and the response to it has made my mental health', 54.5% and 6.1% of responders reported their mental health had either got worse or a lot worse
- When asked to reflect on what were the biggest concerns responders had about their mental health and wellbeing, responses grouped into the following themes
    - Physical exercise and mental health
    - Fear of isolation especially those who are elderly or more vulnerable
    - Depression
    - Previously dormant mental health conditions being triggered
    - Fear of family or friends getting ill and dying
    - Stress related to education/job insecurity
    - Home schooling, especially for working single parents
    - Fear of financial impact
    - Unsure of what services are running or available

    - Fear about what the future will look like
- When asked to reflect on why their mental health had been better due to social isolating or Covid-19, responders reported the following
    - More time for friends and family
    - A break for yourself, time to think and process
    - Time to get creative
    - It has been good for the environment
    - Less pressure to do social things
    - Fewer expectations from family or work
    - More control at home
    - More civility/friendliness in the street

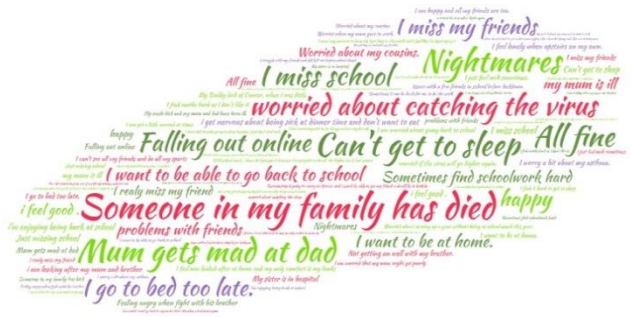
Findings from the Sheffield Children's Hospital Healthy Minds Covid-19 Children and Young People Survey

The loss of structure, activities and social contact combined with the pressures on families within an uncertain and anxious context are a toxic mix which can eat away at even the most resilient of young people. It will exacerbate underlying conditions both for young people with low level mental health concerns and the most vulnerable, surviving adverse childhood experiences and trauma.

50% of lifetime mental health concerns start by age 14. There is therefore an **urgent need to offer early intervention and prevention measures** to address children and young people's mental health to protect them against enduring mental illness. As Covid-19 measures strips CYP of their normal coping mechanisms it is likely more will struggle with their mental health.

The key protective factor for children is the **quality of interactions and relationship**s around them and it is possible that the adults in their lives both parents /carer and school / nursery staff may be struggling with their own emotional regulation at this time and therefore are struggling to offer reliable support.

Other protective factors for emotional wellbeing for children are a **sense of agency, productivity**, and **self-worth**. Social connectedness, physical health, appropriate emotional regulation strategies, supportive relationships – all which have been challenging during Covid measures, particularly lockdown.



An effective and efficient way to **reach *all* children** and young people in Sheffield is to **offer support to the key adults in their lives** who can then best support them no matter what the emerging

concern is – bereavement and loss, anxiety, low mood. We can do a lot by shoring up the key adults in their lives so they can best support them which will ensure a greater reach and free up specialist service provision to meet the needs of the CYP who need it most.

We know children and young people can adapt and even thrive in the face of stressful events with appropriate levels of protection, comfort and the opportunity to process and learn from their experience. The children and young people we would be most concerned about are those without these protective factors.

It is likely that the effect of Covid-19 measures will increase social disadvantage as children and young people who feel well supported by family and friends and who have access to activities, learning and physical exercise will best be able to cope with the measures and in some instances thrive and those who do not have these levels of support are likely to experience a more significant impact on their emotional wellbeing and their developing executive functioning and emotional regulation skills.

7% of primary children and 12% of secondary students who responded to these surveys report not feeling very well looked after by their family, possibly these children would rate themselves similarly pre-Covid but lockdown will have increased their sense of isolation and lack of contact with other possible protective relationships.

Covid-19 related findings from the Physical Health Improvement Group (PHIG) engagement survey

As part of finalising the development of the Sheffield Strategy to improve physical health for people with severe mental illness, learning disabilities, and autistic spectrum condition, PHIG invited people with lived experience, family carers, staff working with people living with SMI/LD/ASC, and wider stakeholders (e.g. advocate organisations and forums) to provide feedback. Below is a summary of some of the comments received from contributors when asked about the impact of the pandemic (including lockdown) on people with SMI/LD/ASC and their physical health.

- “I am part of a group that has been organising walks and picnics to encourage autistic adults to get outside and to get exercise. Maybe institute a specific 'park walk' - same time same place each week, not too early in the day.”
- “Alternatives to telephone helplines - e.g. somewhere you can email and that a responder will arrange to talk to you via some mechanism.”
- “We have been running weekly zoom exercise classes for our cyclists.”
- “Depending on the individual, perhaps more contact over the phone by professionals asking how you are.”
- “Encouragement and support to do small activities that can be done at home or locally for example going for a walk or cleaning the house.”
- “Encouragement to take part in exercise & practical information on healthy eating.”

- “More options available to them to actively take part not just Facebook and videos. Zoom groups and social distancing walk and talk small groups set up near where they live.”
- “Support and contact from others”
- “Access to online resources including remote video support from health advisors”

Recommendations

Services and organisations in both the statutory and VCSE sector that support the mental health and wellbeing of people living in Sheffield have responded in an unprecedented way to the impact of the Covid-19 pandemic and social policy measures put in place to restrict its spread. This RIA has brought together the available literature on the likely impacts on mental health of Covid-19 with local intelligence and information from VCSE organisations, community, primary and secondary care services and has used that evidence to make the following recommendations to inform the future planning and commissioning of mental health services as we move into the next phase(s) of our response.

1. 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. Currently, mental ill health accounts for 25% of the morbidity and mortality demand for NHS services, yet it only receives approximately 13% of the NHS target set for the Minimum Mental Health Investment Standard (MHMIS). This does not currently enable the city to meet the demand for mental health services that existed prior to the predicted impact of the pandemic. Greater investment will be required to meet the predicted upsurge in demand in the coming 18 months – 3 years.
   This additional investment should be targeted towards the areas of greatest needs and the H&WBB should give seriously consideration to disproportionate allocation in order to tackle inequalities and support prevention.

2. The development of national tools to support the forecasting and modelling of future mental health need has been slow and tools have not been available to local areas in time to inform RIA's. 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 this 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.

3. Covid-19 has revealed and confirmed the **health and social inequalities** that were already known. These same groups will also be the most vulnerable to mental health difficulties longer term, as the pandemic leaves behind an unequal legacy of complicated bereavement, trauma and economic repercussions which will push more people towards financial insecurity and poverty, significant risk factors for poor mental health. Unequal experiences of grief, loss, trauma, injustice and abandonment all add to the psychological damage caused by Covid-19. Mental Health is a cross cutting issue and many of the recommendations of other RIA's (e.g. **Loneliness** and Isolation, **Domestic Violence**, **Adverse Childhood Experiences, Housing** and **Employment**) will also have a significant impact on mental health and wellbeing of Sheffield residents and it is important that those recommendations are acknowledged here.

4. People from BAME communities have been disproportionately impacted by Covid-19. This has coincided with the Black Lives Matter protests and a greater awareness of the impact of

structural racism on the mental health of people from BAME communities. This impact has been evidenced in both the national and local intelligence gathering as part of this RIA. If we assume that this disproportionate impact will result in a disproportionate future need for mental health support by people from BAME communities, then it is imperative that we **work with and invest in BAME-led VCSE organizations to understand community needs and develop culturally competent services.** H&WBB is asked to prioritise working with BAME led community organisations to carry out safe and culturally appropriate action-research to assess the impact that Covid-19 has had on the well-being of our most vulnerable and wider community members. The development of future services should be informed by partnership and co-production. This should dovetail with the BAME Health Needs Assessment work already in progress.

5. The VCSE sector should **be resourced to enable an ongoing community conversation** between the people of Sheffield and the health system. People's environment, and therefore their needs, are changing rapidly and are likely to continue to do so for some time. Therefore, regular co-production with the population of Sheffield is necessary in order to ensure that people's needs are addressed in the most effective and efficient ways. This could be done with VCSE partners who have pre-existing relationships of trust in local communities around Sheffield, including with those who are less often heard. The results from these workshops would be relevant to health, social care and VCSE organisations (amongst others), and therefore a great value could be drawn for them regarding Sheffield's response as a whole.

6. To recognise that we need to capitalise on the strengths that are emerging in grass roots, community initiatives, and deepen partnerships with the voluntary sector, universities, and schools to develop community-based service models. 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**. There is an opportunity to look at an alliance model between the statutory and third sector providers with integrated pathways.

7. 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 VCSE sector to further development interventions **that de-stigmatise & encourage easy access to wellbeing support.**

8. Covid-19 has provided an urgent and timely opportunity to review the provision of bereavement care in Sheffield. Sheffield Psychology Board has begun this work. 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.

9. The City should prepare 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.

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.

11. 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.

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6 Steering Group Members

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Heather Burns, Head of Mental Health, Learning Disability, Dementia and Autism Commissioning Portfolio, NHS Sheffield Clinical Commissioning Group

Professor Chris Burton, GP & Professor of Primary Care, University of Sheffield

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Michelle Greville, Project Management Officer, NHS Sheffield Clinical Commissioning Group

Greg Hackney, Service Manager CAMHS, Sheffield Children's Hospital NHS Foundation Trust

Dr Johann Labuschagne, Consultant Psychologist & Head of Psychology, Sheffield Teaching Hospitals NHS Foundation Trust & Chair of Sheffield Psychology Board

Sam Martin, Head of Commissioning Vulnerable People, Sheffield City Council

Jim Millns, Deputy Director for Mental Health Transformation NHS Sheffield Clinical Commissioning Group ,Sheffield City Council & Sheffield Health & Social Care NHS Foundation Trust

Jason Rowlands, Director of Strategy and Planning, Sheffield Health & Social Care NHS Foundation Trust

Joanna Rutter, Health Improvement Principal, NHS Sheffield CCG & Sheffield City Council

Dr Shatha Shibib, Consultant Child Psychiatrist & Clinical Director CAMHS, Sheffield Children's NHS Foundation Trust

Professor Brendan Stone, Professor of Social Engagement and the Humanities & Deputy Vice-President for Education, University of Sheffield

Dr Steve Thomas, GP & Clinical Director, NHS Sheffield Clinical Commissioning Group

Julia Thompson, Public Health Principal, Sheffield City Council

Completed the RIA survey, shared written feedback or attended the feedback workshop:

1. City of Sanctuary (via VAS)
2. Element Society
3. Hoarding Disorders UK (North)
4. Maan Somali Mental Health
5. Refugee Council
6. Saffron
7. Share Psychotherapy
8. Sheffield Flourish
9. Sheffield Mind
10. Sheffield Young Carers
11. SOHAS
12. St Wilfrid's Centre
13. SYArts
14. Terminus Initiative
15. VAS
16. Co:create
17. Big Issue North
18. Chilypep
19. SYEDA

Additional organisations who contributed via the earlier network survey:

20. Art House Sheffield
21. Heeley City Farm
22. No Panic Sheffield
23. SACMHA Health and Social Care

Mental Health Rapid Impact Assessment Appendices

7.1 Appendix A

Baseline mental health disorders in Sheffield

This section outlines baseline levels of diagnosed mental health disorders in Sheffield, mostly drawing upon data from 2017-2019. Local data to indicate socio-economic inequalities across these mental disorders (for example, by socio-economic status, or ethnicity) are not available and these rates therefore represent averages across the age groups.

Table 1: Mental health disorders in Sheffield populations across the life course (Data source: PHE Fingertips: Mental health, dementia and neurology unless otherwise stated)

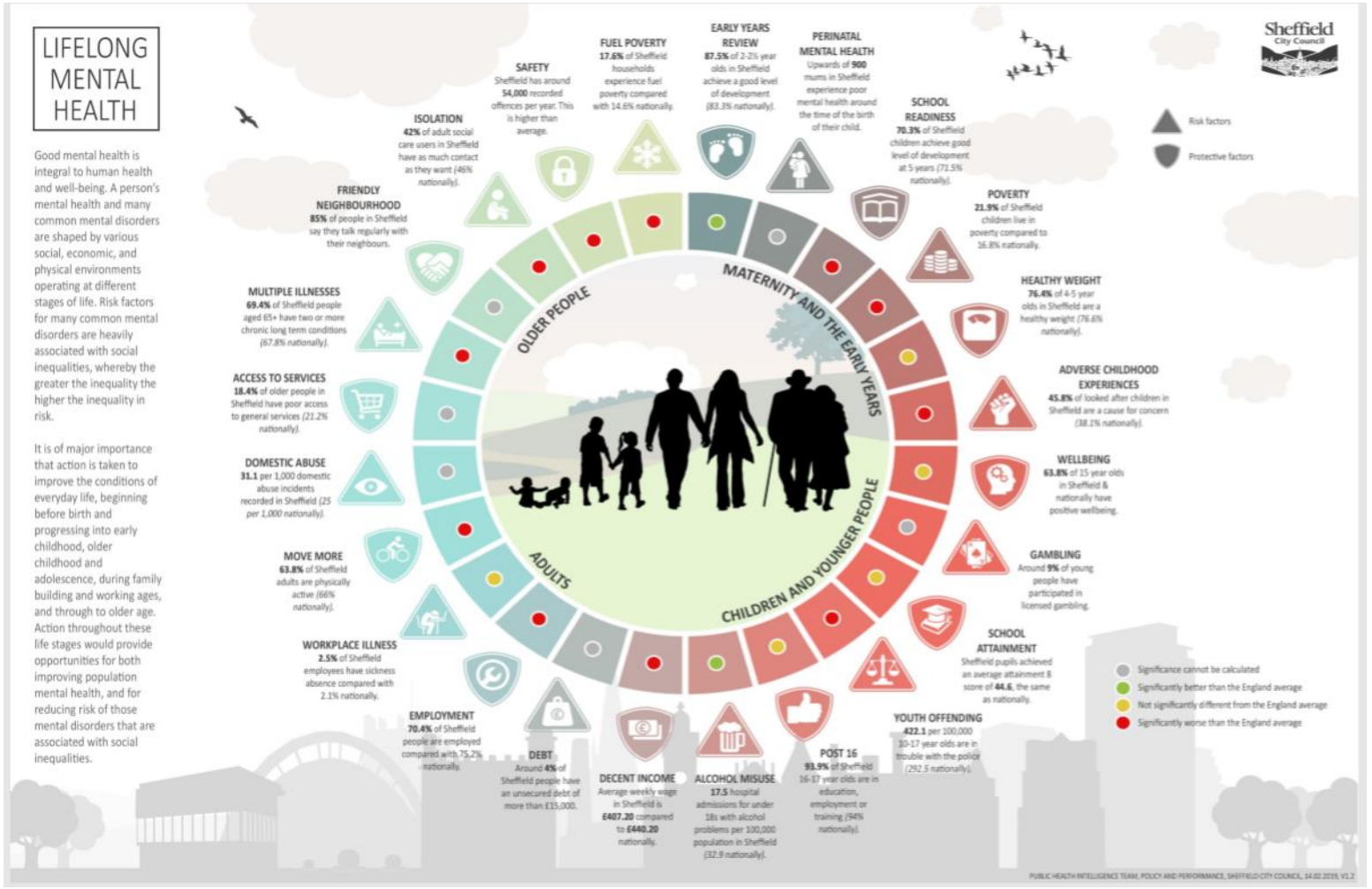
Population group	Mental health condition/ situation	Estimated count	Estimated frequency (prevalence / incidence/ count)	Notes
Pregnancy and perinatal period	Postpartum psychosis	10		2017/2018. Estimated number of women.
	Severe depressive illness in perinatal period	149		2017/2018. Estimated number of women.
	Mild- moderate depressive illness and anxiety in perinatal period	495 - 743 (lower-upper estimate)		2017/2018. Estimated number of women.
Children and Young People (CYP)	Mental disorders (total)	10,190		2017/2018. Estimated numbers of CYP with mental disorders. (5-17 years)
	Emotional disorders (anxiety disorders and depression)	Estimated 2,832 based on ONS populations	3.7%	Estimated prevalence, aged 5-16 years. 2015 data.
	Hospital admissions as a result of self-harm.	365	297.1/ 100,000	2018/19 data. 10-24 years.
	Percentage of looked after children whose emotional wellbeing is a cause for concern	69	48.6%	2018/19 data.

	Autism			Children with autism known to schools in Sheffield
	Learning disability	4,489	5.6%	Pupils with Learning Disability: % of school aged pupils (2017)
Working age adults 16-64 years	Psychosis (new cases)		26/100,000	2011 data. Estimated incidence from modelling data.
Adults (all ages) ≥16 years	Common mental disorder (CMD) prevalence	Estimated 87,458 based on ONS populations	18.5%	2017 data. CMD= any depression or anxiety
	Depression	49,431 person	10.2%	2018/19 recorded prevalence age 18+
	Serious mental illness (SMI)			SMI includes major depressive disorder, schizophrenia and bipolar disorder. 2018/19 prevalence QOF. District estimate.
	Autism			National estimate (Brugha *et al.*, 2016)Data source: Adult Psychiatric Morbidity Survey (2007) and Intellectual Disability Case Register study (IDCR) (2010) combined,
	Suicide	Average 40 deaths per year	8.1 per 100,000 120 over three year period.	Suicide rate (persons) 2016-2018
Adults (all ages) ≥18 years	Learning disability – adults receiving long term support from the			

	LA			
Older population ≥65 years	Common mental disorder (CMD) prevalence	Estimated 10,438 based on ONS populations	11.2%	2017 data. CMD= any depression or anxiety
	Dementia	5,039	5.17%	Prevalence. 2019 data. Highest in Y&H
Whole population	Learning disability (QoF)	4,288	0.7%	2018/19 QoF data – Same as YH proportion

1.2 Appendix B

Baseline risk and protective factors for mental health across the life course in Sheffield



Appendix C Literature Review

Emerging evidence of the impact of coronavirus in the UK

In a recent position paper outlining mental health research priorities during Covid-19 (Holmes et al, 2020) authors theorised that the likely consequences of Covid-19 would be to increase **social isolation and loneliness**. These symptoms of poor mental health are themselves strongly associated with further mental health problems including anxiety, depression, self-harm and suicide attempts (Elovainio, 2017 and Matthews, 2019). They suggest that tracking loneliness and intervening early on risks and buffers for this symptom would be an important priority.

Two surveys conducted by the UK Academy of Medical Sciences and the research charity MQ: Transforming Mental Health informed the position paper- one, of over 2000 people with lived experience of mental health, and the other- a nationally representative sample of the general population, aged 16-75 years. Those with previous experience of mental health issues expressed concerns about **social isolation, increased feelings of anxiety and depression** and particular concerns about exacerbation of pre-existing MH issues. There were also **reported difficulties in accessing MH services** and support during the coronavirus pandemic. Concerns over the effect of Covid on the mental health of children and older people were also expressed (Holmes et al, 2020).

Further recent surveys within the UK expand on these findings. The 'Life Under Lockdown' survey (Ipsos Mori and Kings College London) found that nearly half of participants had felt more anxious or depressed than normal as a result of Covid. **Younger people were more likely to find it very difficult to cope** (42% of 16-24 year olds stated they were finding it extremely difficult to cope, compared to 15% overall). There appeared to be a **financial impact** already- 22% were either very likely or certain to experience difficulty affording basic essential and housing costs or had already experienced this. 16% of workers had already lost their jobs or were certain/ very likely to.

Change in health- related behaviours: Findings from 'Life Under Lockdown Survey' of the UK general population:	
Risk behaviours for mental health	Protective behaviours/ help seeking
• 38% slept less or less well than normal. • 35% ate more food or less healthy food than normal • 19% consumed more alcohol than normal • 19% argued more with their family or housemates than normal • 7% Used non-prescription drugs to deal with stress or anxiety	• 83%: Contacted family and friends more by phone or video calls and texting apps. • 49% Exercised outside home • 42% Exercised at home, for example, using online tutorials/videos • Help seeking: 6% had phoned a counselling or support service • Social support: 60% have offered help to others, and 47% have received help from others.

The ONS is conducting weekly surveys into the social impact of coronavirus. The most recent survey found that **coronavirus was affecting wellbeing to a greater extent in those with an underlying health condition** (55.6%) compared to adults in general (49.9%). This figure was slightly lower for those aged 70 years and

over, at 45.5%. Nearly one in four (23.9%) of those whose well-being has reportedly been affected said it was making their mental health worse (ONS, 2020a).

Suicide risk factors during Covid-19:

Suicide is a tragic aspect of mental health and beyond the loss of individual life, can significantly impact the lives of family and friends. A recent paper indicated that many of the emerging consequences of the coronavirus pandemic and the policy response are known risk factors for suicide (Gunnel, 2020). These include;

- Loss of employment and financial stressors
- Increased alcohol use and domestic violence
- Social isolation, loneliness and entrapment
- Anxiety, depression, PTSD

The paper presented a range of suicide prevention strategies during Covid-19, including actions that could be taken by government, mental health services, retailers, communities and the media (Gunnell, 2020).

Emerging evidence globally

SARS, 2003. Evidence relating to the impact of previous epidemics has been commonly referred to in the literature. Whilst not perfect, this may give an indication of common mental health impacts and effective interventions. Following the SARS outbreak in 2003, patients who had experienced severe illness were at risk of depression and PTSD and around 50% of recovered patients remained anxious. There was a 30% increase in suicide in those aged 65 years and older and probable emotional distress occurred in 29% of healthcare workers (Holmes et al, 2020).

Literature review: Covid-19 and mental health (Rajkumar, 2020)

A recent review paper (Rajkumar, 2020) gathered evidence and opinion from 28 publications on mental health and Covid-19. Most of the pieces were commentary or correspondence, with 2/3 originating from China. One online survey of the general population in China indicated rates of moderate to severe depression occurring in 16.5% of their sample, as well as moderate to severe anxiety symptoms being expressed in 29%. Anxiety was seen to be the predominant psychological response to Covid in this review. Symptoms of severe stress were also reported by 8% of those completing the survey.

Collated sources for the Literature Review

Reports

Title: Covid-19 and the nation's Mental Health: Forecasting needs and risks in the UK

Source: Centre for Mental Health | 15th May 2020

This briefing looks at specific groups of people whose mental health will be put at risk as a result of the virus and the lockdown. These include people who have been bereaved at this time, those who have received intensive hospital treatment for the virus, and staff working in health and care services. Many people who have been through these experiences will experience serious grief and trauma symptoms over a long period of time.

The briefing also notes that some groups of people face an especially high risk to their mental health. They include people facing violence and abuse, people with long-term health conditions, and people from Black, Asian and minority ethnic communities. People with existing mental health difficulties also face significant risks that their health will worsen at this time.

Full report: Covid-19 and the nation's mental health

Title: Loneliness, social isolation and Covid-19: practical advice

Source: Local Government Agency | published 21st May 2020

The LGA and Association of Directors of Public Health (ADPH) have jointly produced this practical advice for Directors of Public Health and others leading the response to the loneliness and social isolation issues arising from the Covid-19 pandemic.

Intervening early to tackle loneliness and social isolation during the Covid-19 pandemic and beyond will help to prevent more costly health and care needs from developing, as well as aiding community resilience and recovery. This can only be done at the local level through partnerships between the council, voluntary and community sector, councillors, primary care networks and relevant others. Councils have a key role to play in this, because they own most of the assets where community action could or should take place, such as parks, libraries and schools, with councillors creating the localised neighbourhood partnerships to deal with a range of mental and physical health issues. There is also an opportunity to harness and develop the positive changes that we are seeing, such as greater awareness about the impact of personal behaviours on mental wellbeing.

Full document: Loneliness, social isolation and Covid-19: practical advice

Title: The impact of Covid-19 on mental health trusts in the NHS

Source: NHS Providers | 3rd June 2020

NHS trusts providing mental health and learning disability services have been playing a critical role, both to maintain services and to respond to the current environment alongside their colleagues in the acute, community ambulance and primary care sectors. While the main public, media and political focus has been on the impact of Covid-19 on hospitals, it is important to put the spotlight on what is happening in other parts of the NHS frontline.

This briefing sets out the immediate challenge of Covid-19 for mental health trusts, how the sector has responded and what is needed to navigate the next phase.

Full briefing: Spotlight on… The impact of Covid-19 on mental health trusts in the NHS

Title: Covid-19: Looking after your mental health during pregnancy and after birth

Source: Maternal Mental Health Alliance | 7th May 2020

This is understandably a difficult and stressful time for many people. And it may be particularly so if you are pregnant or have recently had a baby. This is why it's important to take care of yourself and use support services if you have any concerns about your health or your baby's health.

To help you do this, the Maternal Mental Health Alliance have created the following guidance:

- Mental health and wellbeing tips for women who are pregnant or have recently given birth during the pandemic
- Guidance if you are concerned that you or a loved one are unwell with a maternal mental health problem during the pandemic

Title: Trauma, Mental Health and Coronavirus: Supporting healing and recovery

Source: Centre for Mental Health | May 2020

The Centre for Mental Health has released a briefing that emphasises that when the acute phase of the physical health crisis has passed, addressing these social and psychological consequences of coronavirus must be made a priority. Careful thought needs to be given to how we can repair the social fabric and support those who have experienced the most distress. A trauma-informed approach to both collective and individual recovery will be needed.

Full document at Centre for Mental Health

Title: Public Mental Health and Wellbeing and Covid-19

Source: Local Government Association

The LGA and the Association of Directors of Public Health (ADPH) have jointly produced this briefing for Directors of Public about the public mental health and wellbeing issues arising from the Covid-19 outbreak. Effective responses to the public mental health and wellbeing impact of Covid-19 will be essential to sustain the measures necessary to contain the virus and aid recovery.

Full document: Public Mental Health and wellbeing and Covid-19

Title: Coronavirus: Impact on Young People with Mental Health Needs

Source: YoungMinds | March 2020

YoungMinds carried out a survey with young people with a history of mental health needs between Friday 20 March 2020 (the day that schools closed to most children) and Wednesday 25 March 2020 (when there had been a further tightening of restrictions) in order to establish the impact of the pandemic on their mental health and on their ability access to support. The survey also asked respondents about helpful and unhelpful coping strategies and for advice to other young people.

The report found that the coronavirus and the public health measures designed to prevent its spread are having a profound effect on many young people with a history of mental health problems. When asked what impact the pandemic was having:

- 32% agreed that it had made their mental health much worse
- 51% agreed that it had made their mental health a bit worse
- 9% agreed that it made no difference to their mental health
- 6% said that their mental health had become a bit better
- 1% said that their mental health had become much better

Full report: Coronavirus: Impact on Young People with Mental Health Needs

Title: Life Under Lockdown: Coronavirus In The UK

Source: King's College London | April 2020

The survey is based on 2,250 interviews with UK residents aged 18-75, and was carried out between 1 and 3 April 2020. The survey found that the threat from the virus and restrictions on behaviour are having an impact on some people's wellbeing:

- Half of people say they have felt more anxious or depressed than normal as a result of coronavirus.
- 38% have slept less or less well than normal.
- 35% have eaten more food or less healthy food than normal.

- 19% have drunk more alcohol than normal.
- 19% have argued more with their family or housemates than normal.
- 6% have phoned a counselling or support service.
- 25% of people are checking social media several times a day for updates on coronavirus, and 7% are checking once an hour or more.

However, people are supporting each other more:

- 60% have offered help to others, and 47% have received help from others.
- 6% say they have signed up to NHS Volunteer Responders, and a further 11% say they will.

Full publication: Life Under Lockdown: Coronavirus In The UK | King's College London

Title: Understanding people's concerns about the Mental Health impacts of the Covid-19 Pandemic

Source: Academy of Medical Sciences (AMS) | April 2020

The AMS, together with the research charity MQ: Transforming Mental Health, are working with researchers and those with lived experience to ensure that mental health is at the heart of research into the impacts of Covid-19.

This report describes the findings of a consultation undertaken in late March 2020, the week that the Prime Minister announced the UK lockdown in response to the Covid-19 pandemic.

Full report: Survey Results: Understanding people's concerns about the Mental Health impacts of the Covid-19 Pandemic

Title: Mental health and psychosocial considerations during the COVID-19 outbreak

Source: World Health Organisation | March 2020

The considerations presented in this document have been developed by the WHO Department of Mental Health and Substance Use as a series of messages that can be used in communications to support mental and psychosocial well-being in different target groups during the outbreak.

Full document: Mental health and psychosocial considerations during the COVID-19 outbreak

Title: Implications of the broader impacts of Covid19 for healthcare

Source: The Strategy Unit | 29th May 2020

Emerging evidence suggests long -term effects for Covid -19 patients. However, there are also impacts on health outcomes for the general population to consider. For example, negative impacts associated with continued stress and reduced physical activity but potentially also positive impacts from reported improvements in air quality. This rapid scan has been created to collate new and emerging evidence on broader health outcomes of the pandemic, providing a high level summary of some of the key insights.

Full document: Implications of the broader impacts of Covid19 for healthcare

Title: The Covid-19 pandemic, financial inequality and mental health

Source: Mental Health Foundation | May 2020

The distribution of infections and deaths during the Covid-19 pandemic, the lockdown and associated measures, and the longer-term socioeconomic impact are likely to reproduce and intensify the financial inequalities that contribute towards the increased prevalence and unequal distribution of mental ill-health. This briefing discusses the mental health effects of these financial inequalities in the context of the Covid-19 pandemic.

Full briefing: The Covid-19 pandemic, financial inequality and mental health

Title: The mental health effects of the first two months of lockdown and social distancing in the UK

Source: Institute for Fiscal Studies Working Paper W20/16 | 10th June 2020

This working paper found that mental health in the UK worsened substantially as a result of the Covid-19 pandemic – by 8.1% on average and by much more for young adults and for women which are groups that already had lower levels of mental health before Covid-19. Hence inequalities in mental health have been increased by the pandemic.

Even larger average effects are observed for measures of mental health that capture the number problems reported or the fraction of the population reporting any frequent or severe problems, which more than doubled for some groups such as young women.

Full document: The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK

Research

Title: Impact of coronavirus outbreak on psychological health

Journal of Global Health. 10 (1):010331 | Published June 2020

This paper that argues it is imperative to evaluate and develop strategies to address psychological health and psychiatric aberrations caused by direct or indirect exposure to the situation. These strategies are specific to target the communities or entire populations as well as the individuals with psychiatric symptoms resulting from the actions taken by the government against coronavirus epidemic, viral infection, and fear of infection.

Full paper: Impact of coronavirus outbreak on psychological health

Title: Handling uncertainty and ambiguity in the Covid-19 pandemic.

Source: Psychological Trauma: Theory, Research, Practice, and Policy | Advance online publication

The 2019 novel coronavirus outbreak is unprecedented. Yet some look to ready-made models to address it. This creates confusion about more adaptive responses that reflect an uncertain and ambiguous context. Those assessing associated mental health challenges must be wary of overdiagnosis. Handling the pandemic well, requires engaging the public as mature partners.

Further detail: Handling uncertainty and ambiguity in the Covid-19 pandemic.

Title: Global mental health and Covid-19

Source: The Lancet Psychiatry | 2nd June 2020

The Covid-19 pandemic has disrupted the delivery of mental health services globally, particularly in many lower-income and middle-income countries (LMICs), where the substantial demands on mental health care imposed by the pandemic are intersecting the already fragile and fragmented care systems. The global concern regarding the psychosocial consequences of Covid-19 has led major funding bodies and governments to increasingly call for proposals to address these effects.

Full document: Global mental health and Covid-19

Title: How mental health services are adapting to provide care in the pandemic

Source: BMJ 369: m2106| 2nd June 2020

As the NHS rapidly ramped up critical care capacity to deal with the surge of severely ill Covid-19 patients, other specialties quickly had to rethink how to manage routine care while avoiding face-to-face contact with patients when possible. For mental health services this has meant a host of changes, the biggest being the rapid adoption of video and phone consultations— an approach that had rarely been used in a field where

relationships and trust between clinicians and patients are vital, and where body language and eye contact are a key part of assessment.

Full detail: How mental health services are adapting to provide care in the pandemic

Title: Mitigating the psychological effects of social isolation during the Covid-19 pandemic

Source: BMJ | 2020; 369: m1904 | Published May 21st 2020

This article offers an approach to identifying and managing adults impacted by the psychological effects of social isolation during the Covid-19 pandemic, and to mitigate the adverse effects of physical distancing.

Full paper: Mitigating the psychological effects of social isolation during the Covid-19 pandemic

Title: The potential impact of Covid-19 on psychosis

The potential impact of Covid-19 on psychosis: A rapid review of contemporary epidemic and pandemic research | Schizophrenia Research | 6th May 2020

Abstract:

The Covid-19 outbreak may profoundly impact population mental health because of exposure to substantial psychosocial stress. An increase in incident cases of psychosis may be predicted. Clinical advice on the management of psychosis during the outbreak needs to be based on the best available evidence.

We undertook a rapid review of the impact of epidemic and pandemics on psychosis. Fourteen papers met inclusion criteria. Included studies reported incident cases of psychosis in people infected with a virus of a range of 0.9% to 4%.

Psychosis diagnosis was associated with viral exposure, treatments used to manage the infection, and psychosocial stress. Clinical management of these patients, where adherence with infection control procedures is paramount, was challenging.

Increased vigilance for psychosis symptoms in patients with Covid-19 is warranted. How to support adherence to physical distancing requirements and engagement with services in patients with existing psychosis requires careful consideration.

Full article*:* The potential impact of Covid-19 on psychosis: A rapid review of contemporary epidemic and pandemic research

Title: The psychological impact of quarantine and how to reduce it: rapid review of the evidence

Source: The Lancet | February 2020

A review of the psychological impact of quarantine.

Full document at The Lancet

Title: The Covid-19 pandemic and its impact on mental health

Source: Progress in Neurology and Psychiatry | May 2020

Similarities exist between our past experience of viral diseases and Covid-19 concerning the mental health issues of sufferers of an epidemic, frontline health workers and the social and psychological impact on society. There is significant evidence that a novel illness such as Covid -19 can cause widespread fear, panic, anxiety and xenophobia. Dr Chakraborty explores the latest literature and what it means for mental health.

Full document: The Covid-19 pandemic and its impact on mental health

Title: Addressing the public mental health challenge of Covid-19

Source: The Lancet Psychiatry | 9th June 2020

The Covid-19 pandemic presents a triple global public mental health challenge: (1) to prevent an associated increase in mental disorders and a reduction in mental wellbeing across populations; (2) to protect people with a mental disorder from Covid-19, and the associated consequences, given their increased vulnerability; and (3) to provide appropriate public mental health interventions to health professionals and carers.

This challenge is compounded by the inadequate population coverage of evidence-based public mental health interventions before Covid-19, even in high-income countries. However, a key opportunity exists to mitigate this challenge through early action to increase coverage of public mental health interventions.

Full paper: Addressing the public mental health challenge of Covid-19

Title: Coronavirus and anxiety, Great Britain: 3 April 2020 to 10 May 2020

Source: Office for National Statistics | Last updated: 15th June 2020

The number of people reporting high levels of anxiety has sharply elevated during the coronavirus (Covid-19) pandemic. This article will provide insights into which socio-demographic and economic factors were most associated with high levels of anxiety during the first weeks of lockdown.

Full detail: Coronavirus and anxiety, Great Britain: 3 April 2020 to 10 May 2020

Title: Supporting young people and parents: the impact of Covid-19 on adolescents, parenting and neglect

Source: The Children's Society | June 2020

This briefing explores the challenges that adolescents and their parents face during the Covid-19 pandemic. It offers advice for professionals on how to reduce the likelihood of neglect occurring or to mitigate its effects and includes recommendations for national and local decision makers around prevention and responses to adolescent neglect.

Full briefing: Supporting young people and parents: the impact of Covid-19 on adolescents, parenting and neglect

Title: Covid-19: understanding inequalities in mental health during the pandemic

Source: Centre for Mental Health | 18th June 2020

The Covid-19 pandemic has brought health inequalities into sharp focus. The unequal impacts of the virus are also extending inequalities in mental health.

This briefing paper, produced by Centre for Mental Health and supported by 13 other national mental health charities, explores the mental health inequalities that are associated with the pandemic in the UK. It finds that the virus and the lockdown are putting greater pressure on groups and communities whose mental health was already poorer and more precarious.

Full paper: Covid-19: understanding inequalities in mental health during the pandemic

Title: How might the mental wellbeing of older people living in the community be supported when shielding and social distancing has been recommended for an extended period of time?

Source: Public Health Wales Evidence Service | June 2020

Four systematic reviews were identified from a search of the literature conducted in June 2019. Most provided data from qualitative research and captured the perceptions of older people on quality of life, meaningful occupations and experience of technology.

Full document: How might the mental wellbeing of older people living in the community be supported when shielding and social distancing has been recommended for an extended period of time?

Research

TITLE: Preparing for the aftermath of Covid-19: shifting risk and downstream health consequences

Source: Psychological Trauma: Theory, Research, Practice, and Policy | Online First Publication, 1st June 2020

Due to the Covid-19 pandemic, the public is currently living through a collective continuous traumatic stressor. Objective risk levels shift with each new piece of data regarding the coronavirus. These data points are communicated through public health officials and the media, easily accessible through modern advanced technology including online news and push notifications.

When objective risk changes, individuals must reappraise their subject risk levels. Updating subjective risk levels several times per week is linked to ambiguity of the situation and uncertainty in daily life.

The uncertainty and potential feelings of uncontrollability is linked to heightened anxiety. The continuous stress, anxiety, and uncertainty may have several negative downstream mental and physical health effects nationwide. The health care sector must begin preparing for the long-term consequences of the pandemic.

Full document: Preparing for the aftermath of Covid-19: Shifting risk and downstream health consequences

Title: Lessons learned from 9/11: Mental health perspectives on the Covid-19 pandemic

Source: Psychiatry Research | Volume 288, June 2020

Abstract

The Covid-19 pandemic will likely lead to high rates of PTSD, depression, and substance misuse among survivors, victims' families, medical workers, and other essential personnel.

The mental health response to the 9/11/01 terrorist attacks, culminating in a federally-funded health program, provides a template for how providers may serve affected individuals. Drawing on the 9/11 experience, we highlight effective prevention measures, likely short and long-term treatment needs, vulnerable subgroups, and important points of divergence between 9/11 and the Covid-19 pandemic.

Mental health monitoring, early identification of at-risk individuals and treatment irrespective of financial barriers are essential for minimizing chronic distress.

Full document: Lessons learned from 9/11: Mental health perspectives on the Covid-19 pandemic

Title: Resilience is spreading: mental health within the Covid-19 pandemic

Source: Psychological Trauma: Theory, Research, Practice, and Policy | Advance online publication

The Covid-19 global pandemic is in many ways unchartered mental health territory, but history would suggest that long-term resilience will be the most common outcome, even for those most directly impacted by the outbreak. We address 4 common myths about resilience and discuss ways to systematically build individual and community resiliency. Actively cultivating social support, adaptive meaning, and direct prosocial behaviours to reach the most vulnerable can have powerful resilience promoting effects.

Full document: Resilience is spreading: Mental health within the Covid-19 pandemic.

Title: The Psychosocial Impact of Covid-19 Pandemic in Italy: A Lesson for Mental Health Prevention in the First Severely hit European Country

Source: Psychological Trauma: Theory, Research, Practice, and Policy | Advance online publication

Italy was the first European country severely hit by the Covid-19 pandemic. While the containment measures were relatively effective in the acute phase, the current post emergency phase addressing the long-term psychosocial consequences is the key challenge for our healthcare system, where the importance of mental health prevention is not sufficiently recognized.

Full document: The Psychosocial Impact of Covid-19 Pandemic in Italy: A Lesson for Mental Health Prevention in the First Severely hit European Country

Title: The benefits of meditation and mindfulness practices during times of crisis such as Covid-19

Source: Irish Journal of Psychological Medicine | published online 14th May 2020

Meditation and mindfulness are practices that can support healthcare professionals, patients, carers and the general public during times of crisis such as the current global pandemic caused by Covid-19. While there are many forms of meditation and mindfulness, of particular interest to healthcare professionals are those with an evidence base such as mindfulness-based stress reduction (MBSR).

Systematic reviews of such practices have shown improvements in measures of anxiety, depression and pain scores. Structural and functional brain changes have been demonstrated in the brains of people with a long-term traditional meditation practice, and in people who have completed a MBSR programme.

Mindfulness and meditation practices translate well to different populations across the lifespan and range of ability. Introducing a mindfulness and meditation practice during this pandemic has the potential to complement treatment and is a low-cost beneficial method of providing support with anxiety for all.

Full document: The benefits of meditation and mindfulness practices during times of crisis such as Covid-19

Title: Covid-19 & clinical management of mental health issues

Source: Oxford Precision Psychiatry Lab | updated 11th June 2020

This focussed summary of guidance is about key Covid-19 questions that frontline mental health clinicians are facing every day. This is not a legal or NHS approved document, but follows a rigorous methodological approach to search and select the information (published and unpublished) needed to answer these specific questions.

Full detail: Covid-19 & clinical management of mental health issues

Title: The psychological impact of pre-existing mental and physical health conditions during the Covid-19 pandemic

Psychological Trauma: Theory, Research, Practice, and Policy | 11th June 2020

This study recruited 620 young adults to determine whether there were differences in self-reported anxiety and depression in the weeks following the pandemic declaration by gender (male, female, or nonbinary) and health status (i.e., the absence of health conditions, the presence of either physical or mental health conditions, and the presence of both physical and mental health conditions) using a 3 × 4 analysis of variance.

For both depression and anxiety, nonbinary participants reported the highest levels, followed by female participants. For health status, those with both mental and physical health conditions reported the highest anxiety and depression, followed by those with mental health conditions, physical health conditions, and no health conditions. These findings call for resources to be directed toward individuals who fall into groups reporting greater emotional distress, so that clinicians can intervene as early as possible to prevent mental health decline.

Full document: The Psychological Impact of Pre-existing Mental and Physical Health Conditions during the Covid-19 Pandemic

Title: Impact of the Covid-19 pandemic on patients with pre-existing anxiety disorders attending secondary care.

Source: Irish Journal of Psychological Medicine | June 2020

Semi-structured interviews were conducted with 30 individuals attending the Galway-Roscommon Mental Health Services with an ICD-10 diagnosis of an anxiety disorder to determine the impact of the Covid-19 restrictions on anxiety and mood symptoms, social and occupational functioning and quality of life.

The study concluded that the psychological and social impact of COVID-19 restrictions on individuals with pre-existing anxiety disorders has been modest with only minimal increases in symptomology or social impairment noted.

Full document: Impact of the COVID-19 pandemic on patients with pre-existing anxiety disorders attending secondary care.

Appendix D – Qualitative Intelligence gathering - Survey sent to GP's

Mental Health Rapid Impact Assessment

Survey questions for general practice

Background

Sheffield Health and Wellbeing Board have asked for a suite of rapid impact assessments to be conducted to assess the impact of the Covid-19 pandemic on a number of different policy and theme areas; one of these is **mental health**.

We are already aware of groups across our population that are at risk of poor mental wellbeing and the development of mental health conditions, including anxiety, depression, psychosis and suicide.

In addition, we already know a range of risk factors for the development of poor mental health including unemployment, deprivation, poor physical health and substance misuse.

During the unprecedented times of the Covid-19 pandemic and government response, mental health is likely to be significantly challenged, as some risk factors for the development of mental illness and poor wellbeing will be exacerbated- for example isolation and financial strain.

The MHRIA will rapidly review the available data and intelligence to help us identify these key risk factors for development of poor mental health and wellbeing during Covid-19 and the sub populations that are most likely to be affected.

The ask

As part of the qualitative intelligence gathering, we are seeking your contribution to this RIA and would ask that you respond to the following questions:

1. **Impact of Covid on people and communities:**

How has the Covid-19 pandemic affected your practice in terms of patients' experience of mental health & wellbeing?

	INCIDENCE			**COMPLEXITY OF CASES**[1]		
	More	Less	Same	More	Less	Same
NEW PRESENTATIONS						
Anxiety						
Depression						
Psychosis						
Self-harm (actual,						

threatened)						
Alcohol or substance use						
WORSENING OF CHRONIC PROBLEMS						
Anxiety / Depression						
Personality Disorder						
Psychosis						
Alcohol or substance use						
CONTACT ABOUT OTHER ISSUES						
Loneliness/Isolation						
Insomnia or sleep disturbance						
Domestic violence or abuse						
Relationship problems						
Money worries/debt						
Other (please specify)						

Complexity of cases – a mixture of severity, impact on patient and their environment, and difficulty for GP of providing or accessing appropriate solutions.

In what ways that this has changed during the easing of lockdown?

2. Changes you made:

Please give one or two examples of changes you had to make which had beneficial effects for patients (and may be worth retaining)

Please give one or two examples of changes you had to make which had negative effects on patient care (and which are worth learning from in the future)

3. Changes other services made:

Please give one or two examples of changes which other services made which you were able to use to benefit patients (and may be worth retaining)

4. What else do you think is important and want to share?

Appendix E – Qualitative intelligence gathering – Survey sent to Mental Health Partnership Members

RAPID IMPACT ASSESSMENT SURVEY – TO BE RETURNED BY MON 29 JUN

Firstly, what intelligence have we already developed:

1. **Intelligence already gathered** - Please share any information you have already gathered about the below topics. This could include: quantitative and qualitative data, anecdote, case studies, stories and literature reviews. For ease, share any information in its existing format.
   - the impact the Covid pandemic has had on the people and communities you work with
   - the impact of your services during the Covid pandemic
   - the contribution of your services to the citywide mental health response during the Covid pandemic

Secondly, what are the mental health needs of people/communities, and how is your organisation responding to changing needs? Please include any case studies, quotes or anecdotal evidence. You do not need to repeat information in this section which you have already shared in response to Question 1, unless you would like to highlight key points.

2. Impact of Covid on people and communities: – Describe the people/communities who your organisation works with and supports. – What were the mental health needs of the people/communities you work with pre-Covid and how have these needs been impacted by Covid-19? – How has this impact changed during lockdown and the easing of lockdown? Can you predict how this impact may change in the medium to long term future? – Please share any information about service users who have chosen not to engage during Covid-19 and any potential impact to the service user/health system.

Third and final topic, future possibilities. Stepping back from your organisation, what are your views on future possibilities across all different levels, including: individuals, organisations, sectors, systems and networks.

3. Future developments: – What changes or initiatives do you think could have the most positive impact on the mental health of the people and communities of Sheffield? – What are the good things happening that we want to keep and develop? How could we do this?
Your response:

4. What else do you think is important and want to share?

Appendix F – Sheffield Children's Hospital – Post Covid Summary

Paediatric and Neuro-Disability arm (PANDa)

Post Covid-19 Summary

Services included:

- Paediatric Psychological Services
- Neuro-Disability & Neurology Psychology (Ryegate)
- Chaplaincy
- Bereavement
- Administration
- Re-deployed resource into Staff support

- All the above services, as part of the wider CWAMH Division, have significantly contributed to the Sheffield Psychology Board SPB paper which reported on the expected impact of Covid-19 on the mental health of the populations we serve (see additional papers for SCH response to SPB & the SPB final paper). This group is considering a city wide stepped care model response involving the voluntary sector & SCH is part of this working group for both patient & family work and staff support. However, services within PANDa extend wider than Sheffield City in their remit.

- Waiting list validation/revalidation, including risk assessments will continue to take place alongside the triage of new referrals.

- Escalation of referrals will be based on patient need & staffing capacity

Expected Service Impact

Sir Simon Steven's letter of the 29th April acknowledged that:

"IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO Covid-19

We are going to see increased demand for Covid-19 aftercare & support in community health services, primary care, & mental health ……The pressure on many of our staff will remain unprecedented, & they will need enhanced & active support from their NHS employers to ensure their wellbeing & safety."

- SCH is looking to meet this demand in a stepped care model utilising to full capacity early intervention, voluntary sector & online resources & services in an attempt to limit number of referrals to specialist services.

- PANDa staff will continue to work with Sheffield Psychology Board & the work streams, i.e. post Covid response, bereavement & staff support

- Staff support is key to maintaining all SCH Divisions & services

It is clear that additional resources will be required to meet the mental health needs of children and families post Covid & to support the emotional impact on staff.

Key PANDa Service Considerations

- **Pre Covid 19 waiting lists/legacy waits in Paediatric & Ryegate Psychological Services:** which resulted from low current staffing levels/underfunding per referrals

- **Patient Waits during Covid-19** that have resulted from being unable to continue face to face working during the Covid-19 pandemic

- **Predicted 40% increase in Mental Health presentation**, with a prediction that 20% would present in physical health services & 20% to mental health services which would require:
  Increased staffing in Paediatric & Ryegate Psychological Services,
  Increased staffing for Chaplaincy & Bereavement:
  - Increased urgency of referrals
  - Increased trauma from witnessing or experiencing domestic violence & sexual abuse AND resulting from COVID 19 pandemic
  - Increased Health Anxiety due to threat of Covid 19
  - Presentation of physical health difficulties which have a psychosomatic base
  - Increase in atypical bereavement reactions
  - Increased demand for chaplaincy services

- **Accommodation** - both office & therapy rooms across PANDa services don't allow for social distancing so therefore access to new accommodation is essential.

- **PPE** required if we move to face to face working particularly with vulnerable children & young people

- **IT** access & virtual platforms – need increased reliability & security for both 1:1 and group work.

- **Psychological support to front line staff support** - Source & secure funding for the continued provision of this in various forms and to roll out across the whole trust

Paediatric Psychology: Current Patient Position and Post-Covid Predictions

The current position of Paediatric Psychological Services in terms of demand, capacity & backlog is presented below & the resource required to address this. The paper then sets out the resources required to meet the predicted increase in demand due to Covid-19.

Assumptions

For the purpose of this paper, the following assumptions have been made:

- 42 week year
- Calculations are based on job plans
- All appointments will be carried out by single clinicians. This is not always the case due to joint assessment models, use of reflective teams in family therapy & joint working where clinically indicated.
- Accommodation concerns are addressed
- Where there is no current waiting list in a speciality, it is assumed that current capacity can meet current demand.
- An estimated increase in referrals of 15 % will be seen in Paediatric Psychology following Covid-19 (the remaining 5% increase will be at Ryegate & further 20% in MH services).
- A WNB/ last minute cancellation rate of 15% (data taken from Generic Psychology Service Evaluation) needs to be factored into staffing
- To calculate patient input, the assumption is that on average a patient is seen for a 90 minute assessment appointment and 6 x 60 minute follow up appointments. Therefore, on average, it takes one patient 7.5 hours to complete their journey through paediatric psychology.
- These calculations do not take into account year on year increase in referral rates. For example, the Generic Service Evaluation indicated a 35% increase in accepted referrals between 2016-2018.

Backlog

As of 6 May 2020, Paediatric Psychology had 163 patients on the waiting list & 25 patients on internal waiting lists for therapy. 188x 7.5 hrs = **1410 hours of clinical face to face time.**

Using the patient contact estimates per week from our job plans (see Table One below) to calculate capacity, it is estimated that it would take **2.5 full-time Band 7 psychologists/ family therapists** one year **to clear the current backlog in Paediatric Psychology** (13.3 clinical hours x 42 weeks per year).

	7	8a	8b	8c	8d
Outpatient	5.3 sessions 13.3 hours	4.5 sessions 11.3 hours	3.8 sessions 9.5 hours	3 sessions 7.5 hours	2.3 sessions 5.8 hours
Inpatient	4.2 sessions 10.5 hours	3.6 sessions 9 hours	3 sessions 7.5 hours	2.4 sessions 6 hours	1.8 sessions 4.5 hours

Table One. Patient contact estimates per week based on 1.0wte

Demand

QSM data indicates that in the period April 2019 to March 2020, 1238 referrals were made to the Paediatric Psychology Service.

If we anticipate a 15% increase in referrals due to COVID-19, this is a potential **increase of 186 referrals for the year**. Earlier intervention may reduce the hours of intervention required. This increase in referrals will require an **additional resource of 1393 hours of patient care** (186 x 7.5 hours) equivalent to **2.5 full-time Band 7 psychologists/ family therapists/art therapists**

Admin Support

Process mapping indicates that, on average, 8 hours of administrative time is required from start to end of a patient's journey through paediatric psychology. To support the increase in referrals post COVID-19, **1488 hours (186 x8) of admin time will be required.** This equates to a full time member of admin staff, probably at Band 2 grade due to the staffing structure.

Ryegate Psychology – Current Patient Position and Post-Covid Predictions

Pre-Covid	Post-Covi
Neurodisability Significant waits for psychology. • Emphasis on assessment (autism pathway) • Less capacity for therapeutic intervention Neurology • High number of referrals for cognitive assessment. • Prioritisation of children on the epilepsy surgery pathway (• No dedicated funding/provision for therapeutic input	Neurodisability Capacity calculations (based • Waiting lists could be eradicated referrals were accepted & no furth psychologists to multi-disciplinary post-diagnostic workshops. • Clinical time remaining would be number of referrals into the service 18 weeks. • Calculations do not account for 1) with Covid-19 & 2) legacy referr reflection of need in previous years The recruitment of: • **Two psychologists (band 8a/band 7)** • **An assistant psychologist (band 4)** would allow us to develop models to manner Neurology • The Trust may wish to consider inv meet the therapeutic intervention especially given that following Covi children presenting with functional epileptic attacks) & exacerbatio neurological diagnoses. Admin • Increased referrals of 5% and back **admin**

Chaplaincy

- Chaplaincy currently runs on 1.4 WTE
- In conjunction with on call collaboration with STH the service operates 24/7 service
- Staffing falls below NHS Chaplaincy guidelines.
- To manage Post Covid-19 demand **a full time chaplain at B6** would fulfil staffing requirements.
- This would significantly reduce the risk of burnout & continue to provide the much needed staff support post Covid.

Bereavement

- Anticipated increase in demand for bereavement co-ordination though at present no Covid related deaths in SCH.
- It is anticipated that work will result from deaths of family members or multiple deaths

Staff Support

- As noted above during the Covid-19 pandemic some staffing in PANDa has been redeployed to provide additional emotional support & reflective space to front line workers.
- This has been delivered alongside the existing resources in the trust of Occupational Health, work place well-being,viuup, Mental Health first Aiders
- **Additional staffing investment is required to maintain the provision in the Trust going forward**. Calculations, at the request of Nick Parker, are underway to cost the current additional input that has been provided during Covid-19.
- This will then be considered in terms of
    - what as a Trust we would like to provide going forward
    - Potential funding for PANDa staff to undertake and oversee and supervises this work to ensure a robust governance model
    - A stepped care model which will include training/supporting other staff in SCH to provide staff support
    - Any additional capacity that services the Trust already purchases may have (e.g. OH, viuup, work place well-being) and the viability of funding this.
    - How the voluntary sector can support the work.
    - Ensuring equity across acute staff and MH and Community staff going forward.
    - This work in part will need to be done in collaboration with the work being undertaken by Sheffield Psychology Board with Local Commissioners

Modifications to Service Delivery and Additional Resources

Paediatrics only / Ryegate only / PANDa wide (inc. Paeds/Ryegate/Chaplaincy/Bereavement services)

Multi-Disciplinary Assessments involving staff from CWAMH & MEDICINE (AUTISM PATHWAY)	Multidisciplinary assessments with multiple clinicians with a family in one room	Pre-assessment of families to assess if technology is viable (e.g. access to technology, internet access/connectivity, battery life, & also families preferences with regards to input). This pre-assessment of suitability will increase the number of contacts & therefore impact on waits. Cross Divisional / professional agreement required. Trial of assessing selected older teenagers via telephone/Attend Anywhere. If successful roll out to 11yrs+ Face to face assessments will be required to assess: • younger children • those who do not have access to appropriate technology • those with English as an Additional Language (EAL) & significant communication difficulties Multiple perspectives on a child's behaviour are central to making accurate judgement service will require • installation & use of one way mirrors, • access & use of video recording • Trial of Attend Anywhere in clinic room with one clinician with other professionals calling in from a separate room/location. • Trial of setting family a specific task within their home which is observed via a video link (e.g. Attend Anywhere)
Multi-Disciplinary/Family Therapy Assessments involving CWAMH, medicine & SCC	Multidisciplinary assessments with multiple clinicians & family in one room	

		Any modifications to multidisciplinary assessments may increase the time they take., impacting on capacity & waiting times Trials of Attend Anywhere already underway with some MDTs Increase availability of one way mirror facilities Face to face assessments will be required to assess: • younger children • those who do not have access to appropriate technology • those with EAL & significant communication difficulties
Therapeutic Intervention Cases inc. family therapy	Seen face to face	Access to Attend Anywhere with appropriate support/training with regards to use Pre-assessment of families to assess if technology is viable (eg access to technology, internet access/connectivity, battery life) & also families preferences with regards to input). This pre-assessment of suitability will increase the number of contacts a family will receive & therefore impact on waits. Post trauma patients will require access to a venue outside of the home In the case of "high risk" patients (mental health &/or safeguarding concerns), or families who do not have suitable IT access face to face appointments will likely be required. Hard to reach "vulnerable" families & those with EAL. Suitable rooms that allow social distancing

		& PPE will be required to accommodate these people
Cognitive assessments cases for ND & Neuropsychology Will apply also to a small number of paediatric patients also	Seen face to face	Assessing virtually is problematic which will negatively impact on the validity of results. Face to face appointments will be required & require: • Suitable rooms that allow social distancing • Purchasing of psychometric tests for IPADS • Increase service access to IPADs • Use of Q-global to administer questionnaires to support assessments. This limits the use of paper questionnaires & infection risk. The platform also scores so reduces clinical time. • History taking/feedback appointments can take place over the telephone/via video conferencing for some patients. • Dynamic risk assessment between the staff member & the young person (balancing clinical need vs Covid risk)
School Observations/school meetings	Clinician goes into the classroom & observes at a distance/attends to face to face meeting	Ability to continue these will depend on school situation & guidance from the government/LA/school.
Workshops	Face to face with groups of parents & multiple clinicians	Delivering these virtually in a webinar format requires a trust approved platform & IT support. Alternative of • re-recording the presentation • Providing families with the slides & a voice over. • Offer a follow-up telephone/video

		call. • Reducing size of face to face workshops to allow appropriate social distancing. This would significantly increase clinical time & would negatively impact on waits.
In patient / Ward work	Face to face assessment & intervention work	• PPE availability • Availability of rooms on main site to allow for social distancing • Facility to change clothes after visit This work due to the additional considerations is likely to be more time consuming
Use of Volunteers / Therapists in training	Face to face assessments & intervention work	• This will need to be reviewed in light of Government guidance & in light of foot fall counts • Cost/benefit analysis will have to be undertaken • If they are no longer used this will impact on capacity to see patients/ families & waiting times
Families requiring an interpreter		• Possible use of ENABLE to allow some telephone/video appointments. • Currently liaising with SALT who have used this
Staff support	Usually face to face either individually or in groups	Option of telephone/video conferencing
MDT/Professionals meetings	Face to face	• Option of telephone/video conferencing • new accommodation to facilitate social distancing
Consultation & Supervision	Face to face/telephone	Option of telephone/video conferencing
PPE	Not required	Maybe required for face to face appointments depending on government/trust advice. Children & families would need to be prepared for this ie development of appropriate information & adjustment to standard letters.

		Use of PPE may confound the results of some assessments & therapeutic outcomes The emotional impact of PPE on the child will also have to be considered as it may impede therapeutic alliance.
Technology	Service not set up for **agile/home working** with very few clinicians having Trust Laptop, VPN token & mobile phone	Mobiles, VPN tokens & laptops for all staff (with smart card reader to allow access to System 1 to help in the assessment of cases)
General infection control measures		• Hand sanitisers • Alcohol wipes & sprays • Uniform for staff offering face to face • Additional environmental deep cleaning • Increased supply of pencils for cognitive assessment as will need to be disposed after each patient

Chapter 14

Black, Asian and Minority Ethnic (BAME) Communities

Summary of Impacts

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

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

Out of scope: Migrants and Asylum seekers

Faith Communities and groups

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

Summary COVID19 Health Impact Assessment on BAME Communities in Sheffield

Black, Asian and Minority Ethnic communities have been disproportionality impacted by Covid19, are more likely to be at increased risk of infection and test positive for Covid19 and experience more severe disease and death from Covid19. Covid19 has exposed and shone a light on existing inequalities and has exacerbated them.

The national position

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

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

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

higher in this period in black, mixed and other females and 2.4 times higher in Asian females compared with 1.6 times in white females.

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

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

Data issues

Due ethnicity not being recorded on the death certificates we do not have information on Covid19 deaths at a national and local level by ethnicity, other than via analysis and reports focusing on outcomes for England conducted by various bodies such as PHE as outlined above.

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

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

Sheffield position

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

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

Please note there is no data on the Yemini Community and limited information on the Roma Slovak community. The Yemini community are not featured in the national 2011 census data collection so we don't know exactly how many people from the Yemini community live in Sheffield this is estimated to be between 3500 and 5500. Although ironically the Yemeni community is probably the oldest migrant communities in Sheffield and there is evidence in local Cemeteries of the Yemeni community being present in the late 18th century.

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

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

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

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

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

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

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

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

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

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

Sheffield BAME Communities' lived experience of Covid19

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

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

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

The impacts the group have described are as follows:

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

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

Overcrowded Housing Impacts on Health

Children in overcrowded housing are up to 10 times more likely to contract meningitis than children in general. Children living in overcrowded and unfit conditions are more likely to experience respiratory problems such as coughing and asthmatic wheezing.

Overcrowded housing conditions during childhood are linked to long term impacts on health. Growing up in overcrowded conditions has been linked to respiratory problems in adulthood and children missing school. Poor housing affects children's ability to learn at school and study at home. These factors exacerbate the risks of Covid19 (a respiratory disease) for families who live in overcrowded homes.

Poverty, Income and Employment

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

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

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

Career and employment opportunities for members of the BAME community are compounded by their lack of access to job opportunities and continued professional development in their careers. This is reflected in the fact that across the city when it comes to the leadership positions in the NHS, Council, University and VCF sectors they do not reflect the diversity of the city.

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

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

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

Health Conditions

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

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

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

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

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

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

Health Behaviours

Diet and Obesity

There is evidence that people who are obese have a higher risk of catching Covid 19 and a higher risk of being severely ill with it. In a study of nearly 17,000 hospital patients with Covid-19 in the UK, those who were obese - with a body mass index (BMI) of more than

30 - had a 33% greater risk of dying than those who were not obese

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

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

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

Food security is discussed later on in the paper.

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

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

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

Smoking prevalence data is not available at a local level by ethnicity only by geography and certain sub populations: such as mental health and routine and manual workers. However we know that this is problematic as national evidence indicates the some ethnic groups have a high proportion of smokers. Our services and communications need to be tailored to meet these needs effectively.

Smoking in pregnancy

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

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

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

Food Security

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

Free School Meals.

Children's entitlement to a Free School Meals (FSM) is used as a proxy indicator for family income and deprivation. In Sheffield 25% of school children claim FSM. However when this is broken down by ethnicity the data reveals stark variation in the proportion of families who are entitled to FSM**.** 21% of families with white children claim FSM compared to significantly more children in all BAME groups. The highest proportion of FSM entitlement claims are amongst Roma families with 59% of Roma children claiming FSM, followed by 47% of Yemini children and 46% of Somali children, 32% of Black African children and 23% of Pakistani children. This further highlights the disparities in income and deprivation of different communities in the city.

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

Some vulnerable children are in school and can still access meals. A small number of schools are doing food parcels rather than vouchers. FSM vouchers have been extended to cover school holidays including over the summer which should help families financially. In Sheffield there is also "Healthy Holidays" a DFE funded programme to provide targeted additional healthy meals to families identified by schools as in greatest need.

Of the 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 there only hot meal of the day. The demand for emergency food parcels and foodbanks has been significant during this period.

Emergency Food Parcels

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

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

This meant many of the vulnerable BAME community members had to rely on BAME community organisations to meet their needs at a grassroots and local level. BAME

community organisations delivered hundreds of food parcels, some also provided hot meals to vulnerable people during that time and also during Ramadan - Frontline workers were also included in the response. Sharrow Community Forum, Faithstar, Darnall Wellbeing, Pakistani Muslim Centre delivered significant food responses.

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

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

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

Communications, mixed messages and misinformation

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

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

Hoax rumours circulating included:

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

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

use of community radio.

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

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

Education

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

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

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

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

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

This compounded the fear in BAME communities about having to make choices about sending their children back to school .The additional impact of these decisions also related to the fact that many BAME parents work in frontline job roles and therefore had to take into account the implications of falling ill themselves.

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

Many young people within BAME communities have not had access to the digital technology to enable them to access educational facilities and online lessons as many families may only have one laptop per family. This has put schools under a lot of pressure

to provide additional tech for families that may need this. Digital poverty has compounded many of the structural inequality that BAME communities face.

Mental Health and Wellbeing, Loss and Bereavement

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

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

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

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

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

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

Where referrals have been made to statutory services, the waiting lists are prohibitive, and the community workers have no choice but to do their best at the front line. A Lack of interpreters is another challenge faced by many people within BAME communities in accessing mental health treatment and support. It was cited that free Mental Health First Aid Awareness training for staff and volunteers in the community would help enormously and was urgently needed.

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

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

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

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

Isolation and Mental Health

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

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

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

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

Isolation and loneliness

COVID-19 will likely exacerbate isolation and loneliness in Black, Asian and Minority Ethnic groups. According to British Red Cross research, BAME groups are at a higher risk of being isolated/lonely. The research shows that people from BAME backgrounds are more at risk of experiencing certain factors that cause loneliness and can often face greater barriers to accessing support. When we feel we belong, we feel less alone - feeling valued, included, safe and able to join in community activities helps to tackle loneliness.

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

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

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

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

Places of worship were closed during lockdown, so for some, not being able to socialise or talk with people will have led to them feeling more isolated/lonely. Some services have been online but not everyone is able to access them due to digital exclusion. There doesn't seem to be specific research on religion/isolation and loneliness

Social isolation and loneliness are risk factors for poor mental and physical health (Santini, 2020). A study (Steptoe, 2013) highlights isolation as one of the main risk factors that worsen pre-existing conditions, comparable to smoking. Research has found that

feeling lonely, being physically isolated or living alone were each associated with a risk of early death (Holt-Lunstad, 2015)

Carers

A high proportion of the BAME community are carers however they do not always identify themselves as carers. It is traditional part of culture and family life to look after older relatives and extended family. A lower proportion of the BAME community take up residence in care homes in the city. However this then means that a larger proportion are unable to work due to caring responsibilities and are more likely to be on a low income.

The Carers service is working to improve the data collection and quality of data they hold by ethnicity to further support the Sheffield picture on Impacts of health and covid.

BAME Communities and Trust with the Public and VCF sector

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

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

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

Organisations were/are wary of the Council and other organisations but wanted to move forward work collaboratively together.

There was a huge amount of mistrust between the communities and public and VCF sector bodies. Covid19 has shone a light on the decimation of BAME VCF sector services. Many have volunteered and used their own funds to support communities with food and self-isolating and accessing services during lockdown.

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

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

they don't feel confident and welcome"

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

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

Racism directly due to epidemic

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

Funding and lack of BAME community infrastructure

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

Lack of resources and community infrastructure, was an overarching theme of the BAME Inequalities PH Community meetings. Community organisations feel that there is an unequal access to community funding for BAME organisations in the city and this has led to many being under resourced and less equipped to deal with the epidemic. They have used their own money and volunteers to respond. It was felt that there has been chronic underfunding of BAME infrastructures in the city and capacity building. 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 re: applying for funding; they are so busy delivering services that some VCF organisations neglect giving funding applications the priority they need.

There's a huge amount of frustration that the issues that impact on BAME organisations are well known, yet there is still a "lack of confidence in us" "we would like to see more acknowledgement (from SCC and NHS) of how we have risen to the challenge.... BAME communities have been hit harder with covid than other communities, it's a double whammy when you factor in deprivation and racial abuse"

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

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

Domestic Abuse

In 2019/20 34% of IDAS service users were BAME. In Q1 of 20/21 the proportion is 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.

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. Some of the problem will be in relation to language barriers. The majority of social media messages have been in English however at the time of writing a card translated into community languages is being printed for distribution via food banks and other community outreach provision.

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

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

would be arrested. The woman was from Iran, English was her second language, so she believed him. Children's Social Care got involved and she was then able to leave.

Positive aspects occurring due to the epidemic

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

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

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

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

Recommendations:

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

2. Commit to developing, collecting and analysing ethnicity data on a range

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

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

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

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

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

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

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

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

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

Gaps in knowledge/ further work required

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

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

Collaborators and sources of intelligence

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

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

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

Black, Asian and Ethnic Minority Public Health Community Group (Lived Experience)

SCC Community Response Team

Sheffield Carers Centre

Sheffield Citizens Advice

Sheffield Health Impact Assessments (Poverty, Health Behaviours, Isolation, Domestic Abuse)

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Belinda Shiu - Sheffield Chinese Community Centre
Yvonne Witter - Senior Health and Wellbeing Worker, Darnall Wellbeing
Nighat Basharat -Thalassaemia South Yorkshire foundation
Tomas Tancos and Gulnaz Hussain from Firvale community projects
Waseem Althulaya, Hallam Homecare Services
Enoch Karimba and Baillor African Voices
Navet Reid - Sickle Cell Anemia
Irshad Akbar, FSB
Adam Yusuf, ISSRAC
Nelson Company ACM
Helen Mulholland CCG
Pauline Williams SCHFT
Elaine Goddard SCC
Jane Ginniver ACP
Sally Edwards STH
Clare Lodder – CAB
Diane Owens SCC
Maddy Deforge, CEO of VAS
Liz Johnson SHSC
Holly Robson, Healthwatch
Clive Clark SHSC
Jason Rowlands SHSC

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?

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