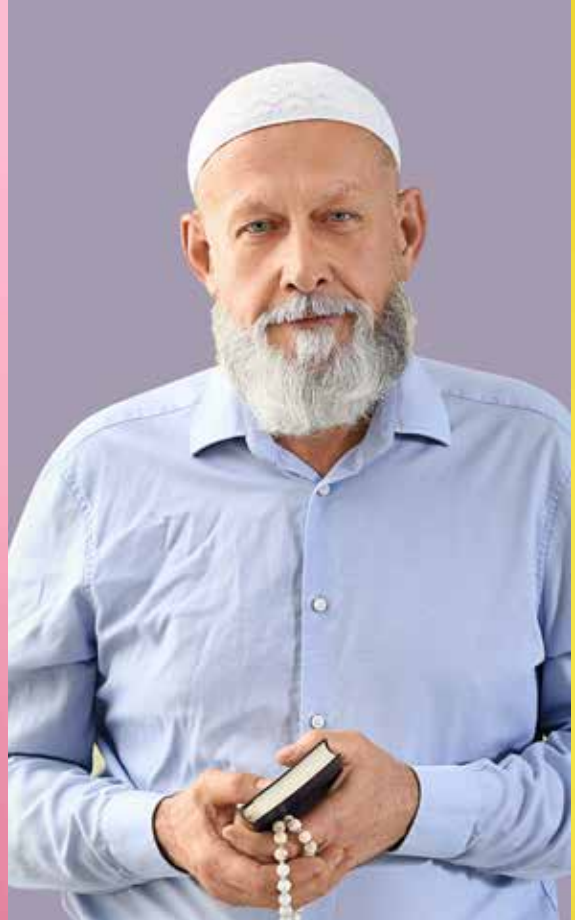
Gloucestershire
COUNTY COUNCIL

BEYOND COVID:

RACE, HEALTH AND INEQUALITY IN GLOUCESTERSHIRE

Report of the Director of Public Health **2020**



CONTENTS

FOREWORDS

BEYOND COVID:
RACE, HEALTH AND INEQUALITY IN GLOUCESTERSHIRE

We will all remember 2020. The COVID-19 pandemic has affected all areas of society and our physical and mental wellbeing, sometimes for the better but often for the worse. We quickly saw evidence emerging of a disproportionate impact on different parts of society; for example, older people, men and some geographic areas.

But by far the biggest impact was seen in people from Black, Asian and minority ethnic backgrounds. Sadly, we have seen a higher number of COVID-19 cases, deaths, hospitalisations and complications in members of these communities. Black and Asian people were between 2.5 and 3 times more likely to be admitted to hospitals in the county with COVID-19 than White people of the same age (Gloucestershire NHS Hospitals Foundation Trust).

This is my fifth annual report as the Director of Public Health for Gloucestershire and it was an obvious choice to focus this year on the impact of COVID-19 on BAME communities. My annual report provides a unique opportunity to shine a light on important issues affecting our local population and make recommendations for improvement. I am really thrilled that Gloucestershire County Council's Black Workers Network has agreed to co-author the report. The Black Workers Network has led the development of the recommendations and sourced a lot of the case studies.

One of the main drivers of the work of the Prevention, Wellbeing and Communities team within Gloucestershire County Council is tackling inequalities in health. These are persistent, avoidable and unjust differences in health across and between different groups in a population. We ensure our services are commissioned to reduce inequalities and work with partners across the county to improve health outcomes for all but with a focus on those experiencing the worst health outcomes.

This report draws heavily on the research by Public Health England into the impact of COVID-19 on BAME communities. We have structured the report around the main themes identified in the research and added further context by drawing upon local case studies that both illustrate the presence of inequalities in our county but that also demonstrate the strength in our communities. We will share stories that illustrate the desire in our communities to help each other during an unprecedented time.

The preparation of this annual report is a team effort and Althia and I would like to thank those who contributed to its design, drafting and content this year: **Maria Arthurs-Hartnett, Zoe Clifford, the Black Workers Network, Bilkis Bhula, Temi Folayan, Claudia Parry, Jennifer Taylor and Gloucestershire County Council's Design Team.**

My thanks also go to those who have shared their experiences and good practice:

- **Joe Green, Hannah and Anwar, Rebecca Ajulu-Bushell, Carol Sterling, Abbas Veshmia, Imran Atcha, Khady Gueye, Tracy Marshall, Hannah Gorf, Hannah Deacon, Joanne Bourne-Jones, Paul Roberts, Katherine Martin, Suzie Compton, Kirsty Dunleavy and Sarah Williams.**

I hope this annual report prompts you to think more about the inequalities and particularly those affecting our BAME communities and what you can do to address this. If you would like to continue the conversation, please get in touch by email: **sarah.l.scott@gloucestershire.gov.uk**

SARAH SCOTT,
DIRECTOR OF PUBLIC HEALTH
September 2020

As we look back on 2020, many of us will be reminded of two significant moments in history that drastically changed the world we live in. The COVID-19 pandemic changed our way of working, living and connecting with colleagues, family and community. It placed unprecedented pressure on health and social care and other essential services, and many experienced the loss of loved ones, friends and colleagues. Whilst many of us were able to work from home, BAME communities, who are over represented in key worker roles, were disproportionately out on the frontline, despite knowing the increased risks that they were exposed to.

At the same time, the killing of George Floyd in May and the resurgence of the Black Lives Matter movement ignited a new conversation around structural racism and its impact on communities of colour. This and the pandemic have shone a light on the stark reality and lived experience of BAME individuals and communities here in Gloucestershire, the UK and globally.

The transatlantic slave trade ended over 200 years ago and race equality legislation has been introduced in an attempt to level the playing field. However, for BAME communities the legacy of slavery and colonialism lives on in the very institutions that they rely on for health, social care, education, employment, criminal justice and housing, and they continue to be disproportionately impacted as a result (Cabinet Office, 2018).

At its worst, government policy reinforces the negative stereotypes that are held of people of colour, their needs and aspirations, and impacts on local decision making. The Windrush scandal and Grenfell fire are just two examples of how this has played out in reality.

BAME communities are often defined as hard to reach by those responsible for commissioning and delivering services. Conversely, this is regarded in BAME communities as an excuse to overlook and marginalise their needs and is a contributor to the institutionalised racism that they experience daily.

This report highlights some examples of good practice, for example, the listening event for BAME carers (section 9). However, we have a long way to go before we get to 'what good looks like' for BAME communities and individuals.

The BAME voluntary and community sector has contracted significantly over the last 10 years as a result of austerity. The loss of its infrastructure organisation Linking Communities and the Local Race Equality Council mean that most no longer have the capacity to apply for long-term funding to make them sustainable. Yet these communities contain diverse, skilled and committed individuals who have much to offer to make Gloucestershire a better place to live, work and grow for all of its citizens.

Black History Month is celebrated annually in the UK during October. Its theme this year is Let's End Racism. Now is the time to have conversations about race. These conversations are vitally important for us to have, no matter how uncomfortable, if we are serious about changing the lived experience of BAME people in Gloucestershire. Whilst this report does not hold all the answers, it aims to open a conversation about the issues and solutions which must continue.

As we face the second wave and look forward to recovery planning we must ensure that BAME communities and employees remain at the heart of the conversation and are able to guide the narrative. The council's Black Workers Network welcomes the opportunity to co-author this report and thanks colleagues in Public Health for making it happen.

We remain committed to working in partnership with colleagues across the system to improve the lived experience of BAME communities in Gloucestershire.

ALTHIA LYN,
CO-CHAIR OF THE BLACK WORKERS NETWORK
September 2020

01

BAME COMMUNITIES: **HEALTH INEQUALITIES AND COVID-19**

The recent Black Lives Matter protests and COVID-19 pandemic have shone a spotlight on the widespread structural inequalities faced by Black, Asian and minority ethnic (BAME*) people. The Health Foundation (2020) questions if this could be a watershed moment for health inequalities. Converting this awareness into long-term, sustainable change will require commitment, resources and partnerships beyond the attention of the news cycle.

Though the underlying issues are not new, the moral duty to take action has never been greater. The strength of feeling in the wake of George Floyd's death demonstrates the hurt felt by many in this country that these inequalities are not meaningfully tackled and have left BAME people overexposed and under-protected during a global pandemic.

Conversely, the crisis has brought out some of the best of humanity. Communities have come together and we have all played our roles in supporting one another. Individuals and voluntary groups have made and delivered food, shopped and collected prescriptions for those who were shielding, hosted online prayer groups, sewing groups, book groups, called in on neighbours and walked their dogs.

We have found that there is a lot of strength and resilience in our diverse communities.

Working together in partnership, listening, and using these strengths will be key to tackling the systemic and structural issues this report highlights.

* We acknowledge that the use of the term 'BAME' is not ideal and conflates together very diverse groups of people. It is used in this report as it allows us to make best use of existing research and captures the range of groups that are affected by structural racism. Where available, we have separated data on different ethnic groups.

INEQUALITIES PRE-COVID

The pandemic has highlighted longstanding health inequalities which already existed in our society. Health inequalities are the 'avoidable and unfair differences in people's health across different population groups' which are a result of social inequalities 'in the conditions in which people are born, grow, live, work and age' (Marmot, 2010).

These inequalities are influenced by differences and biases in the access, quality and experience of care and the 'wider determinants of health' or root causes, such as housing, education and employment. There are many overlapping factors which can lead to health inequalities and people are often affected by more than one (Figure 1).

The government's recent Race Disparity Audit found that people from BAME backgrounds continue to experience discrimination and inequality in education, employment, housing, pay and living standards, health, and the criminal justice system (Cabinet Office, 2018).

OVERLAPPING DIMENSIONS OF HEALTH INEQUALITIES

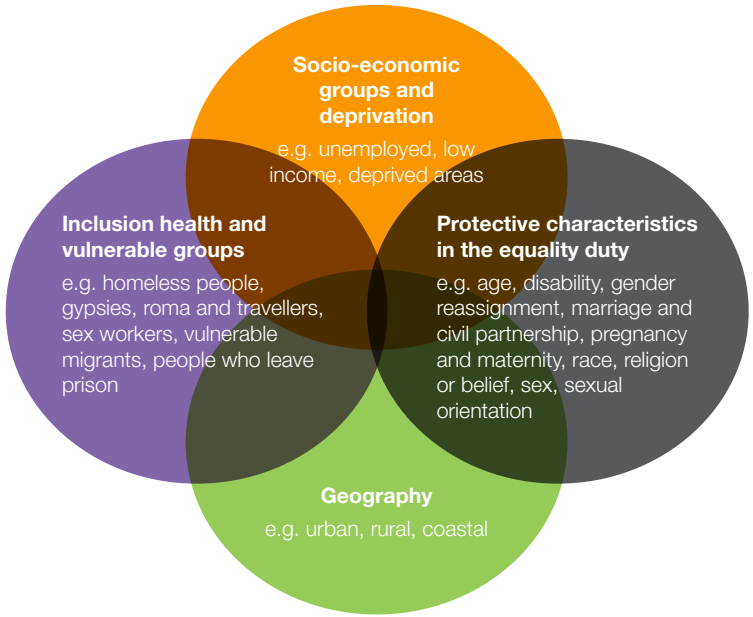


Figure 1. Overlapping dimensions of health inequalities (LGA, 2020)

Gloucestershire contains a huge diversity of cultures, languages, communities, abilities and experiences. Though far from a homogenous group, the structures and biases within our society mean that these inequalities based on race, nationality and cultural heritage are a daily reality for many in our county.

- 27,337 BAME residents in Gloucestershire
- BAME adults aged 25-49 are more likely to be unemployed than White British adults of the same age. For Black people, the rate is more than double.
- Amongst those aged 65 and over, Asian people and Black people were more likely than people from other ethnic backgrounds to have a long-term limiting illness and to be in poor health (Gloucestershire County Council, 2020).

THE IMPACT OF THE PANDEMIC

Though COVID-19 was initially viewed as a social leveller, pandemics rarely affect all populations in the same way. A Public Health England (PHE) review into differences in the risk and outcomes from COVID-19, published in June 2020, found that mortality rates in the most deprived areas were more than double the least deprived areas. Belonging to certain ethnic groups increases the likelihood of contracting COVID-19, developing severe symptoms, and dying from the virus.

Even after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British (PHE, 2020).

This does not take account of occupation, comorbidities (pre-existing health conditions) or obesity which may explain some of the disparity. However, a higher rate of obesity, comorbidities, and exposure through high-risk occupations among the most deprived and BAME populations is itself a significant health inequality issue.

Furthermore, the negative impacts of lockdown and social distancing measures to control the spread of COVID-19 have been felt disproportionately by those already experiencing inequality. The social and economic impact of the virus and lockdown measures has exposed people on low incomes and those living with other vulnerabilities to an even greater risk of physical and mental ill-health.

THE CASE FOR CHANGE

In June, Public Health England published a follow-up paper, 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' (PHE, 2020). This combined a review of the available data with feedback sessions involving over 4,000 people with a broad range of interests in BAME group issues. The paper makes seven recommendations to address BAME health inequalities, both in the short-term to mitigate the impact of future waves of COVID-19, and for long-term sustainable change.

This report makes the case for change for and with our BAME residents in Gloucestershire. Evidence, data and a range of lived experience has been brought together to show how these inequalities manifest in our county. It also draws attention to and celebrates the invaluable contributions made to the local pandemic effort by BAME organisations, individuals and volunteers. This informs local recommendations to act as a starting point for tackling race-based health inequalities in Gloucestershire.

ROOT CAUSES OF **HEALTH AND WELLBEING**

02

The circumstances in which we live, from the experiences of our early years to our working conditions, housing, education and support from local communities throughout our life, shape our health outcomes. These social, economic and structural determinants of health, often referred to as the wider determinants of health, can be described as the 'root causes' of ill health and inequality. The Dahlgren and Whitehead model (Figure. 2) shows the range of factors that impact on our health and wellbeing. These root causes are all associated with race and deprivation. Understanding the differences between BAME groups, compared to the general population in Gloucestershire, helps us to understand the driving force for health inequalities.

Underpinning this is the experience of discrimination. Structural, institutional and interpersonal forms of racism together shape the experiences of minority ethnic groups and contribute to the persistent differences in health and wellbeing that BAME people face.

The stakeholders engaged in the PHE study noted that these inequalities existed before the COVID-19 pandemic and that the virus both exacerbated and drew attention to them. As such, taking a system-wide approach to tackling the long-standing root causes of inequality will be particularly important if we are to prevent future harm.

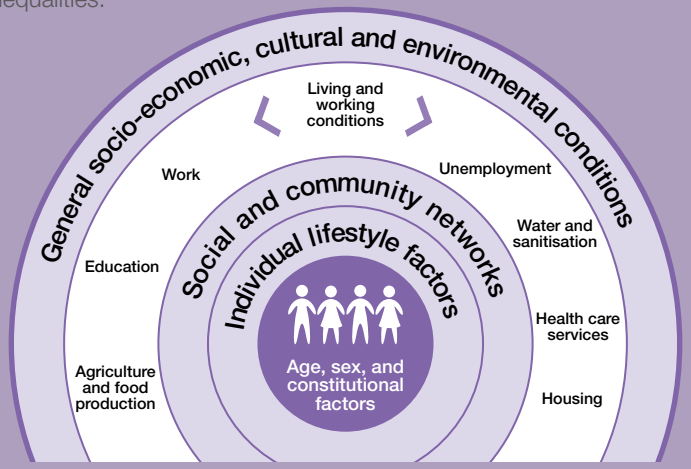


Figure 2. The Dahlgren and Whitehead model (1993)

> **Inequalities in health status and disease risk are associated with minority ethnic status; those in minority ethnic groups have poorer health outcomes compared to the majority of the population. Differences in cultural factors may play a role in disease risk, but it is more likely that the decreases in life expectancy and health outcomes are due to social, economic, and structural determinants of health.**
>
> (PHE, 2020)

What is it like living and working as a Black person in the Cotswolds?

My family moved to the Cotswolds in 2012. I have travelled and lived in other places since, but this is home and the place I always come back to.

There is a stark contrast between the large Cotswolds stone houses and sprawling housing estates and no real mixing between these demographics. This is very visible in Bourton-on-the-Water.

Rebecca Ajulu-Bushell,
Bourton-on-the-Water

In my family, we have had long-standing dealings with mental health challenges and have always been impressed by the mental health facilities we have been able to access in the Cotswolds. This is possible because we have more than one car and don't have to rely on public transport. Additionally, we have the knowledge, money, and the time to access these services. This is not afforded to everyone.

Mental health care in rural areas is about the isolation and dissipating sense of community, even more strongly felt by the BAME community in these areas. I'm half Kenyan but I've grown up in such a white world so it still affects me to see so many people of colour in the same place when I'm in London. This crisis of isolation is unique to rural areas and the BAME experience in Gloucestershire.

There are many interrelated determinants of health. This report highlights three key areas, which are particularly relevant in the context of COVID-19 and BAME communities:

- Education and training
- Housing
- Employment

EDUCATION

In Gloucestershire, there are significant gaps in academic attainment by ethnic group. From Key Stage 2 (ages 7-11) onwards, Chinese and Asian pupils are the best performing groups, with Black pupils producing the poorest results in six of the seven academic measures assessed throughout their education. The previous two Director of Public Health reports outline how school readiness and early educational attainment are incredibly important to someone's longer term outcomes, in work and in their lifelong health and wellbeing. Getting the early years right and enabling social mobility is one of the best preventative actions we can take.

In six of the seven key academic measures, Black pupils in Gloucestershire perform below the average for Black pupils in England. Figure 6 shows the downturn in Black pupils' performance, compared to other ethnic groups in Gloucestershire, as they progress through the different stages of their education.

Unless action is taken, school closures during lockdown will widen this gap even further. Nationally, pupils are on average three months behind on their learning as a result of the COVID-19 crisis, with the most deprived pupils and those from BAME backgrounds most likely to be affected, according to the National Foundation for Educational Research (NFER, 2020).

Narrowing this gap should be a key priority for Gloucestershire partners if we are to ensure that the long term outcomes for our Black pupils are the best they can be. It is also a vital step is maximising career development and progression opportunities that enable social mobility.

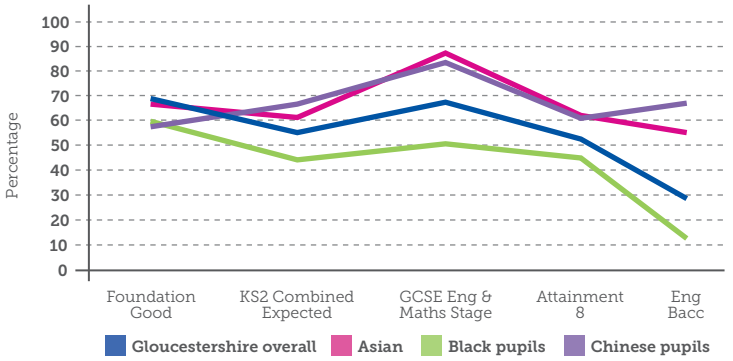


Figure 3. Gloucestershire attainment by ethnic group[1]

[1]KS2 Combined Expected - pupils achieving at least the expected standard in reading, writing and maths in Key Stage 2.
Attainment 8 - measures the average achievement of pupils in up to 8 qualifications at the end of KS4 (age 15-16).
Eng Bacc – English Baccalaureate is a set of subjects which pupils can take at GCSE.

HOUSING

There is no peer-reviewed evidence that directly correlates housing to COVID-19 outcomes but the PHE stakeholder report argues that the risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups. These include:

- Overcrowding
- Intergenerational households
- Housing insecurity.

Households in Gloucestershire headed by people from 'other White', mixed, Asian, Black and 'other' ethnic backgrounds were all more likely than households headed by people from White British backgrounds to have fewer bedrooms than required. People from White British and White Irish backgrounds were less likely than other ethnic groups to be living in private rented housing (Gloucestershire County Council, 2020). This suggests that the key housing challenges may be experienced by BAME communities in Gloucestershire, potentially contributing to the disproportionate impact of COVID-19 on these groups.

EMPLOYMENT

Whilst we often think of unemployment and low income as the key driver of health inequalities, in the case of COVID-19 and BAME communities, the nature of employment is a particularly important factor. People from BAME groups are significantly over-represented in the health and care workforce in England.

It is not possible for these and other key worker roles (such as food distribution, retail and cleaning) to be undertaken from home and so these frontline workers have greater exposure to COVID-19.

Other factors may play a part in this disproportionate risk, such as the use of public transport to travel to work and insecure employment, meaning that an employee is less likely to take time off sick with COVID-19 symptoms.

A key factor in making this happen is leadership and representation at a senior level. This is a pattern repeated across industries. Signing the Race at Work Charter (Appendix C) is one tangible measure that organisations can take to amplify their commitment to race equality and diversity. The charter outlines five key actions organisations can take to tackle these issues.

- In Gloucestershire Hospitals NHS Foundation Trust 14.1% of staff are from a BAME background and of these, 15.7% are occupied in clinical roles, with the highest representation in medical, dental, nursing and midwifery.
- BAME people make up 31% of band 1 non-clinical roles, such as cleaners, drivers and catering staff. There are no BAME employees in the top 5 clinical bands. (GHNHSFT, 2019)
- 100% of Gloucestershire's MPs are White and less than 2% of county and district councillors are from a BAME background.
- 1 female BAME police officer in Gloucestershire. There are no BAME police officers at Chief Inspector rank or higher. (Gloucestershire Constabulary, 2015)
- 1.4% of FTSE 100 leaders in one of the top three positions (CEO, Chair and CFO) are black
- There are no High Court Judges (out of 39), no Court of Appeal Judges (out of 30) and only one Deputy District magistrate (out of 80) of a black ethnic background
- 62% of the top 500 charities (by income) have all white boards
- < 1% of journalists are black (BITC, 2020)

THE IMPACT OF COVID-19 ON GLOUCESTERSHIRE'S BAME RESIDENTS

03

As described in this report so far, inequalities in the wider determinants of health between population groups have meant that people faced the pandemic from uneven starting points. This has been widely reported at a national level and local intelligence shows a similar picture in Gloucestershire.

This section brings together evidence to try to understand how BAME residents have been impacted by COVID-19 and outlines the gaps in the available data. The pandemic has shown how important it is to have comprehensive equality data that includes faith and ethnicity. Moving forward, improving routine equality data collection and using it to inform our actions must be a priority.

The data only tells part of the story. Each statistic denotes real Gloucestershire families and people all facing their individual challenges, heartbreaks and recoveries. Understanding how this is experienced and how this might be different for different communities is essential.

HANNAH AND ANWAR'S STORY

Hannah and Anwar* are a Muslim family of South Asian background, living in Gloucestershire. Anwar became seriously ill with COVID-19 and had to stay in hospital for almost a month. Anwar is in his mid-50s and has no underlying health conditions.

A few days after lockdown began in late March Anwar experienced a temperature and was immediately concerned that he may have contracted COVID-19. He decided to isolate in his room to protect the rest of his family. After five days, Anwar woke up feeling better but by the evening he struggled to breathe and could not walk the few metres to the bathroom.

Hannah contacted her GP who advised her to call an ambulance. Anwar was frightened of going to hospital and initially refused, partly due to the TV coverage. Hannah could not go with him due to the restrictions and found this very tough.

On Facetime the next day, Anwar indicated he was breathing a little better, though clearly frightened as some patients had sadly died overnight. However, later on Anwar was put on a ventilator as his oxygen levels were so low.

On day 11, he successfully came off the ventilator but he was terrified of the staff in their PPE, especially as he had no memory of being put on the ventilator. He experienced hallucinations and was sometimes abusive, scared, emotional and tearful.

The staff were wonderful at settling him and regularly called Hannah to help if things become challenging and she helped to put him at ease. The support of the Muslim staff was invaluable, including a cleaner in ICU and a nurse who prayed by Anwar's bedside, set up qur'anic audio so that he could listen to verses and advised the nurses to give Anwar drops of 'Zam Zam water', which originates from a well in Mecca as Muslims believe it has healing properties.

The family Facetimed him daily to remind him that they loved him and prayed for him. Although it was difficult not being able to see him, they understood the reasons. Thankfully, a couple of weeks later, he recovered enough to come home.

Hannah would like to stress the importance of listening to advice, including on self isolating and quarantine, and give her thanks to NHS nurses and doctors who supported Anwar during this very challenging time.

A strong belief in faith and support from family and community has helped them come through this and the second chance that Hannah feels they have been given encourages her to live in the present.

* Their names have been changed.

COVID-19 ETHNICITY DATA

Locally, data from the community and acute hospitals in Gloucestershire, found that Black and Asian people were between 2.5 and 3 times more likely to be admitted to hospital with COVID-19 than White people of the same age.

In Gloucestershire, a multi-agency team are tasked with collecting intelligence to inform our emergency response. Ethnicity information is not always completed, which limits what we can draw from the data.

The information we have suggests that Asian, Black, White Other, and other ethnic groups are overrepresented in positive COVID-19 cases compared to the county's population at the time of the 2011 census.

However, as 11.2% of cases have no ethnicity recorded, it is not possible to determine to what extent BAME and White Other groups are overrepresented. For contacts of cases, nothing definite about ethnicity can be concluded.

	Contacts 29/05/20-26/08/20	**Cases** 26/02/20-25/08/20	**Population** 2011
White British	55.1%	75.2%	91.6%
White Other (including Irish)	3.6%	4.7%	3.9%
Asian	2.2%	4.4%	2.1%
Mixed/Multiple Ethnic Groups	2.2%	0.9%	1.5%
Black/African/Caribbean/ Black British	0.0%	2.4%	0.9%
Any other ethnic group	0.0%	1.3%	0.2%
Unknown/Not recorded	36.9%	11.2%	0.0%
Total	**100.0%**	**100.0%**	**100.0%**

Table 1. COVID-19 cases and contacts in Gloucestershire by ethnicity

COMPREHENSIVE ETHNICITY DATA RECORDING

Collecting and using data and intelligence to inform action is a cornerstone of public health. Robust equalities data is necessary to identify the root cases of inequality, determine whether interventions are working, attribute any outcomes and prevent inequalities.

We know that COVID-19 disproportionality affects BAME people, older people, those living in deprived areas and/or with pre-existing conditions because researchers have been able to look at the data in a timely way and share their findings. As it has become so important, the pandemic has also highlighted gaps and much needed improvements to our routine data collection and recording.

> **It makes me sad that 20+ years later in my career we are still talking about data being collected, which is the basics of science. Surely that has to be fixed forever going forward. Recording of ethnicity and occupation on death certificates has been an issue for too long – a change in legislation is urgently needed.**
>
> PHE, 2020

Death registration is a county council responsibility and currently ethnicity data is not recorded in the register nor collected as part of the confidential statistics at the time of registration of deaths. Personal data revealing racial or ethnic origin is considered sensitive and is subject to specific conditions under GDPR and associated legislation but where there is a clear justification for collecting and using personal data, it is possible to do so.

Collecting ethnicity and faith data at the time of death registration would allow better analysis of causes of death and whether certain groups were more at risk.

As part of NHS England's recovery plans, it has recommended that all local NHS organisations:

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.
- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September. (NHS England, 2020)

This is a significant and much needed change that other public services should also be aiming for. While acknowledging that collecting personal data is time-intensive and has to meet the requirements of legislation, there is a clear case for mandatory equalities data in directly provided and commissioned services.

At the point of collection, the reasons for collecting the data and how it will be used need to be clear and the questions and options given should be inclusive as possible, using up-to-date terms and language. This is an important step to increase response rates by building confidence in marginalised groups who may not have had the best experiences with public services.

[2]The ONS produces best practice guidance on ethnicity recording: ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion

RESPONSE – COMMUNITY RESILIENCE

04

As described in the previous section, the impact of COVID-19 has been greater in those communities already experiencing inequality. This has been the case even where individuals or families have not been directly affected by the virus itself.

Whilst the impact has been negative for many, there is much to be proud of in the way that Gloucestershire residents have supported one another

In March and April, our communities sprung into action to prevent further spread of COVID-19 and to support key workers, those who were shielding, home-schooling or were made redundant. Later, the Black Lives Matter movement brought into the public eye a generation of young Black Gloucestershire citizens who are pushing for positive change.

There is a wealth of knowledge, experience and agency in our BAME communities and they have a huge role to play in making Gloucestershire a more prosperous, healthy and inclusive place to live.

This section highlights some of the experiences and actions of our diverse communities over these past months and includes contributions from Imran Atcha from the Friendship Café, who has helped to support and feed local people, and Rebecca Ajulu-Bushell who has been involved in the Black Lives Matter movement in Gloucestershire.

The Friendship Café, a normally bustling community hub in Barton and Tredworth, has been closed to the public but behind the scenes they have worked with Fair Shares and 37 volunteers to coordinate food donations, deliver 122 food parcels and support 435 people in the local area.

Barton and Tredworth is the most ethnically diverse ward in Gloucestershire. 41.4% of its population are from an ethnic minority group and 10.3% from a white background other than White British. Community figures in the area have been proactively supporting residents throughout the pandemic.

Faith leaders from the mosques and churches, as well as local doctors have provided information in many languages. The churches have delivered online services and WhatsApp prayers, while volunteers supported those going through bereavements.

37
volunteers

deliver
122
food parcels

and support
435
people in the local area

How has the Friendship café supported the wider community through the pandemic?

There has certainly been a lot of confusion and uncertainty, as nobody was sure at first what to do and how to do it. We wanted to adapt to the need in the area, as we are here for the community. People from the area organised themselves and came together to create a street rep scheme; there are 102 streets in the area, so that's a lot of volunteers all coordinating through social media. They distribute leaflets and organise support for anyone on their street who needs it, such as food and meal deliveries, and we are helping with this effort.

Imran Atcha,
Friendship Café, Barton and Tredworth

We filled the Friendship Café with donated supplies from locals as well as supermarkets, and the street reps come to collect and distribute it. We also have two kitchens here, so we have been working with Fair Shares, Black Elders and others to cook about 300 hot meals each week for the local community. We've found that a lot of our established connections have been invaluable at this time, and we've also forged many new connections too. 6,000 hot meals were provided between March and August alone.

"I have to stress that Friendship Café hasn't been working alone – it's lots of different people and organisations getting together, so credit to everybody – it's not something that one person or group can work alone on. We have learned how to adapt and how useful it is to have a central base to work from. If there was no community centre, I don't know how we could have done this work.[1]

"The Café's sewing studio has also been used by volunteers to make scrubs and masks to donate to Gloucester hospital. In response to COVID-19, Aysha has started online sewing tutorials called 'sew with me', streamed on YouTube. She delivers kits to people in advance who want to take part.

"Thank you to Gloucestershire County Council's Growing Your Communities grant for giving us funding to help us re-open St James' City Farm. Also, from 'Gloucestershire Funders' who came together to step in and help organisations like ourselves. Aside from this and contact with a few local councillors, there has not been enough support from some key public sector organisations. Some departments in the public sector are not proactive enough with BAME communities so the café and volunteers have had to step in and provide that support for people.

"Everyone has a role to play and one organisation cannot do this work alone. We need to work together, the voluntary sector, communities, businesses, councils, NHS and police to address the inequalities and deprivation we see locally. There should be specialist teams in public sector organisations who can act as a bridge between the organisation and the community, who understand that BAME residents are not homogenous. There needs to be proper community development backed up by resources."

What made you want to get involved with the Black Lives Matter movement?

NKG, as a Black-owned company, took stock after George Floyd's murder and decided to use our research, media and design skills for community projects, to ensure that Black voices and ideas would be given the tools needed to convert that energy into a longer-term programmatic agenda. Broadly I found people's engagement with this BLM movement surprising and really heartening; but the lack of discourse around connecting the underlying systemic issues really troubling.

Rebecca Ajulu-Bushell,
NKG, Bourton-on-the-Water

"I reached out to Khady because of the parallels of our stories; we are both mixed race in a middle-class area. We talked about what would help the Gloucestershire area address racial and economic injustice. We had a conversation about the term BAME – BAME becomes more relevant when our numbers are so low. There needs to be a sense of political Blackness, drawing dividing lines is counterintuitive. Economic justice and health care are relevant to all of us and the white working-class people in Gloucestershire. We badly need a sense of unity and ability to rally together. The cycle of poverty and trauma is generational, and divisions have brought us to despair. I have hope that we can bring people along.

"The Local Equality Commission (LEC) was born out of Khady's courage and energy. It came together after we reached out and talked about what we thought we can offer the Gloucestershire community. This involved taking steps to address the fractures that have occurred on a macro level through austerity over the last decade and on a micro level, through the cultural opposition that occurred over the Lydney protest. Our aim is to have more conversations on racial justice in rural England. How do we meet that challenge in a place that is hyper-conservative and doesn't feel relevant to many because 'there are no black people here'?

"Our plan is to democratise access to resources by working with schools, youth groups and institutions instead of trying to create a separate space. We hope to provide a model for rural race-based equality work. Khady has been asked to look over local council equality reports, sit on diversity panels, and produce race-based resources for local schools. The LEC are working with the Ragman's Farm Market Gardens, Land Workers Alliance and Land in Our Names on a youth agriculture initiative for BAME kids, and the Forest of Dean Sculpture Trail to create an installation."

[1] Read more here: glosfunders.org/2020/07/glosfunders-spotlight-with-friendship-cafe/
[2] Khady Gueye was one of the organisers of the Black Lives Matter protest in Lydney and has since set up a Local Equality Commission for the Forest of Dean.

SUPPORTING BAME COMMUNITY GROUPS

It is clear that BAME and faith volunteers and community groups have played a huge role in supporting their local communities through the pandemic. As the Race Equality Foundation states: "Many of them are doing this against a background of declining funding, rising demand, and challenging commissioning arrangements" making their future uncertain. (Race Equality Foundation, 2020)

Locally, BAME voluntary organisations are predominantly run by unpaid volunteers and lack the necessary organisational infrastructure to apply for funding that can enable them to become sustainable in the long term. Due to these constraints, their work is largely reactive and action-based. Yet, these organisations are best placed to provide culturally responsive support to those most in need and who are unable or unlikely to access mainstream support.

The crucial role that BAME groups and individuals have played in preventing harm, disseminating information and supporting vulnerable people should be applauded. To carry on playing this vital role effectively, it is essential that the sector receive the necessary support and recognition to ensure long-term viability.

RESPONSE – **WORKPLACE HEALTH AND WELLBEING**

05

As described earlier in this report, the nature of BAME people's employment has been a key factor in the disproportionate risk faced by them during the pandemic. As early as April, the NHS Confederation released a paper highlighting the emerging evidence that BAME health and care professionals were overrepresented among coronavirus fatalities.

The paper called for immediate action to be taken to mitigate risks to BAME communities and health and care workers, including an examination of the availability of personal protective equipment (PPE), testing, cultural and religious observances, and better and more transparent collection and reporting of ethnicity data to understand the full impact of COVID-19 on BAME patients (NHS Confederation, 2020).

This section will outline some of the challenges BAME staff have faced as part of the implementation of the two main measures designed to support workplace health and wellbeing during the pandemic: PPE and occupational risk assessment tools.

PPE

Though BAME people represent 20% of the NHS workforce, analysis in April showed that 64% of COVID-19 fatalities in the NHS were BAME employees (Cook, 2020). Participants in the PHE stakeholder engagement felt too little had been done to protect these staff.

Some were unaware of the work that the NHS has been doing and others felt it was insufficient. Some had personally experienced or received reports from colleagues about racism, bullying and harassment at work. This meant that they were reluctant to speak up about concerns, such as PPE shortages, which placed them at higher risk.

Others believed that BAME frontline workers were sometimes given substandard quality or inadequate PPE due to the nature of their roles. Numerous examples were given in which staff were not able to access appropriate PPE to protect themselves in line with national guidance and being afraid to speak up about this. Stakeholders called for an environment that enables staff to express concerns and have these met effectively. (PHE, 2020)

This is a long-standing issue that existed prior to COVID-19. BAME staff are often concerned about raising concerns because of past experiences and fear of consequences for speaking up. In Gloucestershire, BAME employees in the hospitals trust are 1.87 times more likely to enter formal disciplinary investigation than White colleagues (GHNHSFT, 2019).

In Gloucestershire County Council last year, 9.30% of formal disciplinary procedures involved BAME staff members, though BAME staff represent 6.23% of the workforce (Gloucestershire County Council, 2020).

The PHE stakeholder engagement highlighted even greater concerns about frontline essential workers outside of health and care settings, such as transport workers, security staff and carers. Some stakeholders felt that there was initial confusion on risk and the levels of PPE required for those working outside of health and care settings, which may have led to BAME key workers being poorly protected. (PHE, 2020)

RISK ASSESSMENT TOOLS

Evidence-based occupational risk assessment tools have been widely adopted across the health and care system to help employees and managers to identify those who may be at increased risk of developing severe symptoms of COVID-19. Support and guidance must accompany the use of these tools to ensure that workers do not feel discriminated against and ensure that they feel safe to identify risks and issues without fear of losing their job. (PHE 2020)

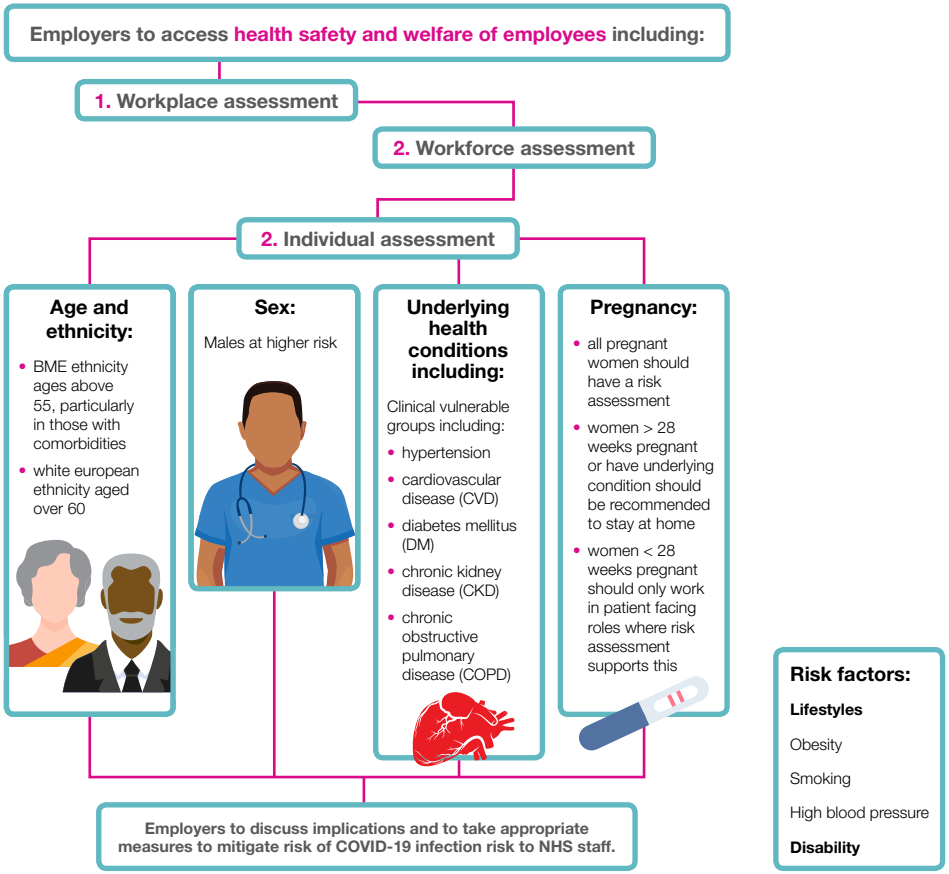


Figure 4. Example COVID-19 risk assessment process (Salford CVS, 2020)

NHS England issued guidelines that local NHS trusts must implement workplace risk assessments for all employees and audit the process. Stakeholders involved in the PHE review welcomed the inclusion of ethnicity as a risk factor but questioned variance in completion.

> **We are pleased that steps have been taken in NHS services to ensure risk assessments are carried out on a precautionary basis and that being of a non-white ethnicity has been included as a risk factor in the risk assessment frameworks and guidance. However, there is significant variation in how these are carried out**
>
> PHE, 2020

In the absence of any guidance around developing a culturally competent risk assessment (see section 8 for a definition of cultural competence), NHS organisations have adapted the guidance to suit local requirements. NHS trusts in Gloucestershire have started to implement assessments and are currently auditing the process. The audit is running through two cycles and results will be available in Autumn.[4]

Gloucestershire County Council has a two-stage process to risk assessment that involves an initial check list to determine vulnerability, followed by a full COVID-19 risk assessment undertaken by Occupational Health. It uses a process supported by the Faculty of Occupational Medicine for use in local authority settings.

'COVID-age' summarises vulnerability for combinations of risk factors including age, sex and ethnicity and various health problems. It works by translating the risk associated with each risk factor into years, which are added to (or subtracted from) an individual's actual age. This then gives a single overall measure of vulnerability.

[4]Results not available in time for this report.

Locally, colleagues have expressed some concerns about the risk assessment process:

> **I have a slight worry that raising concerns as a Black employee about COVID-19 risks may result in Black/BAME employees being required to have any subsequent vaccine as a condition of their employment. Hopefully this will never happen.**

> **I believe I have been expected to essentially self-mitigate any COVID-19 risks as per the rest of my team to meet the requirements of my role.**

> **I didn't understand the purpose of the assessment based on the information I was given. However, from what I have heard through the media, family and friends, I am aware of the need for a risk assessment to be completed and protective equipment to be provided by my employers who have a duty of care towards all employees.**

> **I had an idea of what was happening and that I was more susceptible but the way it was worded and the type of questions asked were more about how I felt about returning to work and if was I scared.**

Anonymous, Black Workers Network

Key to improving the lived experience of BAME staff in the workplace is developing honest and open channels for communication within which employees are safely able to raise concerns and share ideas around process and practice. It relies on a culturally competent approach to service development and delivery. This ensures that those being risk assessed understand the implications of the assessment and that those conducting them don't inadvertently drive stigma and discrimination towards employees who may be vulnerable, not just due to ethnicity but due to age, gender or long-term conditions.

Guidance should enable managers to be able to fulfil their role to carry out risk assessments in a meaningful and sensitive way that results in a personalised outcome. Equally, employees need to understand the purpose of the assessment and put themselves forward without fear of reprimand or negative action.

FUTURE ACTION

The key to addressing these challenges is working with BAME employees to create healthy and supportive workplaces that have zero tolerance for discrimination and empower BAME staff to raise concerns about occupational risk and safety. Gloucestershire's multi-agency BAME COVID-19 Task and Finish Group (see section 8) calls on public sector organisations to work with them and their BAME employees to:

- Work collaboratively to raise awareness of the issues faced by BAME employees and communities in light of COVID-19 and share examples of good practice to encourage consistency.
- Work with community groups and organisations to promote and encourage a culturally competent approach to risk assessment.
- Encourage employers to create open and honest listening channels that promote co-production and co-design with the people most affected.
- Encourage assessment of workforce planning to ensure that it does not have a negative impact on BAME employees, contracted staff and volunteers.
- Encourage organisations to examine how their new working policies and practices impact on BAME staff and volunteers and consider how they can provide additional support.
- Secure membership of NHS Confederation BAME Leadership Network and Black Southwest Network.
- Keep abreast of emerging research to improve and share understanding of equality, diversity and inclusion.

PREVENTION – COVID-19 AND COMMUNICATION

06

As we respond to further waves of COVID-19, there are lessons to be learned and immediate steps we can take to reduce or prevent the impact on BAME groups in Gloucestershire.

The PHE stakeholder research highlighted the need to change the way public sector organisations communicate and engage with BAME communities on matters relating to the prevention of COVID-19 and other health protection and promotion measures. If we are to prevent further impact, this action must be taken swiftly. Locally the same issue has been identified during the research phase of this report.

The Runnymede Trust commissioned a national poll of 2,585 adults about experiences during the pandemic, including whether they were aware of health protection and economic measures rolled out by the government, including:

- The request for people to 'Stay Home, Protect the NHS, Save Lives'
- The request for people to 'Stay Alert, Control the Virus, Save Lives'
- Making Statutory Sick Pay (SSP) available from the first day of self-isolating
- Paying 80% of employees' wages if they are unable to work during the crisis

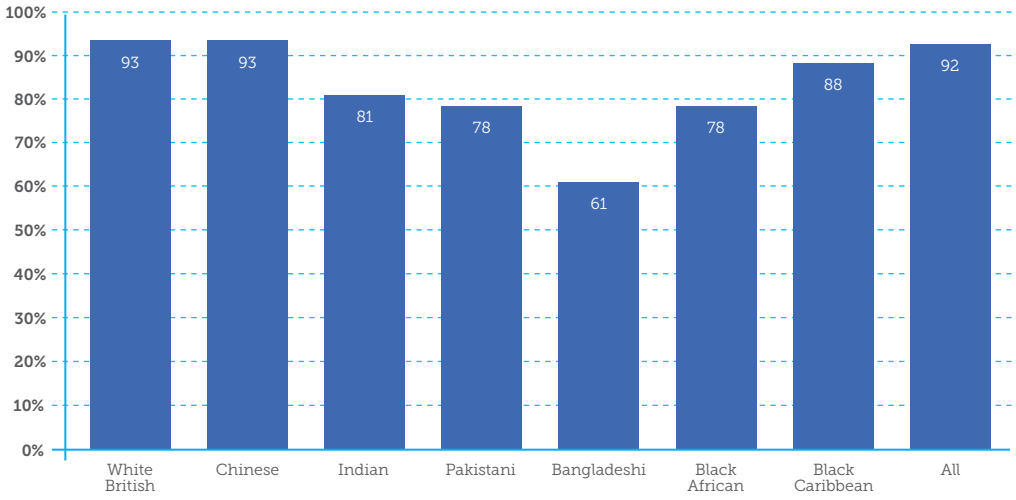


Figure 5. Awareness of government economic measures during COVID-19 by ethnicity (%)

There are significant differences between ethnic groups (Figure 4). The average awareness of all of these measures was particularly low among Bangladeshis at 61%, compared to 93% among White British. 29% of Bangladeshis reported that they were not aware of any of these measures (Runnymede Trust, 2020). People are less likely to access financial support or follow guidance if they are not aware of it.

The poll found that present messaging, which describes BAME people as at increased risk of complications and death from COVID-19 is compounding pre-existing mistrust and fear of public services felt by many BAME people. This mistrust is based on a legacy of racism and discrimination in health care.

For example, the unethical medical experimentation on African slaves and more recently in the Tuskegee Study[5]; the disproportionate number of people from Black and minority ethnic groups detained under the Mental Health Act (DHSOC, 2018), and that Black women in the UK are 5 times more likely to die during pregnancy and childbirth than White women (Anekwe, 2020).

[5]From 1932-72, the US Public Health Service, in trying to learn more about syphilis, withheld adequate treatment from a group of poor black men who had the disease, causing needless pain and suffering. cdc.gov/tuskegee

> **This has contributed towards a lack of trust in the health system and apathy among ethnic minorities towards health information, and consequential decisions among communities who didn't trust the system and were apathetic about health messages.**
>
> PHE, 2020

IMPROVING AWARENESS AND BUILDING TRUST

Building confidence in the messaging and public services generally, requires culturally competent (see section 8) and easy to understand versions of guidance in multiple languages. There is a need to dispel myths, explain why it is important to follow the guidance and explain what exactly is involved during testing, treatment and vaccination. This should encourage people with symptoms to present earlier, which means individuals can receive appropriate treatment and help prevent complications and can isolate sooner to protect those around them.

We need to get across that testing or presenting with COVID-19 is not going to be the end of the story and that there is no conspiracy to hospitalise.

Abbas, Gloucestershire County Council

Messages should also come from a trusted source. These include but are not limited to; Gloucester FM radio, church groups, the mosques, the Jewish community groups, and grassroots volunteers and organisations. During the pandemic, many communities established a 'street rep' scheme for their areas to coordinate volunteers and ensure no one fell through the gaps. Educating and equipping the volunteer street reps is another way to help ensure that the right information is reaching people.

Gloucestershire Local Resilience Forum's (LRF) COVID-19 emergency response included developing a communications plan that involved working with BAME and faith communities. The multi-agency communications cell worked directly with leaders within the Muslim community to help shape messages around religious holidays and respond with information and advice on areas of interest or concerns. The BAME COVID-19 Task and Finish Group (see section 8) has developed a section on the county council website with information and resources for BAME communities.[6]

Future COVID-19 communication plans, both those of the LRF and its constituent organisations, should build on this and incorporate these PHE stakeholder requests:

- ensure that all communication and marketing include culturally specific imagery and content, using voices of communities with lived experiences to shape future public messaging;
- work with community and faith leaders to develop a communication plan to mitigate the fears and stigma in communities arising from media headlines around BAME and COVID-19;
- public bodies to continue to develop and strengthen their advocacy roles;
- highlight and disseminate models of best and promising practice; and
- continue with proactive community engagement throughout the next phase of the pandemic.

[6]gloucestershire.gov.uk/Covid-19-information-and-advice/information-and-resources-for-bame-communities

07

PREVENTION – COVID-19 AND PRE-EXISTING CONDITIONS

It is clear that while anyone can catch COVID-19, people who already suffer from poor health are more vulnerable to developing severe symptoms and have a higher risk of dying from the disease.

As outlined in this section, the occurrence of pre-existing conditions in BAME populations is likely a significant factor to explain some of the differences in outcomes from COVID-19. With the likelihood of COVID-19 cases increasing, it is essential that we act now to ensure the lessons learned from the first wave are not repeated and that we put in place actions that reduce or prevent the disproportionate and unacceptable impact of a second wave on BAME people.

Health improvement campaigns and services support and encourage people to make healthier lifestyle choices and manage chronic conditions but are not always delivered or promoted in a way that meets the needs of BAME populations. The Healthy Lifestyles Service in Gloucestershire is given as a local example which has done some targeted work with BAME people in Gloucester. More consistent and culturally competent (see section 8) targeting and delivery of health improvement programmes is necessary to mitigate the impact of future waves of COVID-19 and the long-term health inequalities faced by BAME people.

COVID-19 AND PRE-EXISTING CONDITIONS

There was at least one pre-existing condition in 91% of the COVID-19 deaths in England and Wales (ONS, 2020). Diabetes was mentioned on 21% of death certificates where COVID-19 was also included; for Asian people this rises to 43% and for Black people 45%. The same disparities were seen for hypertensive disease (PHE, 2020).

> **Excess weight affects all population groups but is higher for those people aged between 55-74 years, people living in deprived areas and in some Black, Asian and minority ethnic (BAME) groups compared with the general population. It is established that the health risk of excess weight for some BAME groups occur at a lower BMI than for White populations.**
>
> PHE, 2020

Evidence is also emerging on the relationship between excess weight and COVID-19. 60.7% of adults in Gloucestershire are reported as being overweight or obese and 17.3% are physically inactive* (PHE fingertips).

While better than the national average, there is significant potential to have a greater impact on the lives of these individuals and our local health and care system. What's more, PHE (2020) highlighted the disparities in excess weight between people from different ethnic groups:

> **Living with excess weight is a risk factor for a range of chronic diseases, including type 2 diabetes, cardiovascular disease, many cancers, liver and respiratory disease. Obesity is also associated with reduced life expectancy, and lower quality of life.**

TARGETING HEALTH IMPROVEMENT

Health improvement, including lowering obesity, improving mental wellbeing, smoking cessation and effective management of chronic conditions, has a number of benefits for all population groups, as well as reducing the severity of infectious diseases. There are multiple factors that contribute to health which could be personal, such as a history of trauma or mental health conditions, or linked to the wider determinants of health, such as deprivation or long working hours. 42% of people of BAME backgrounds live in England's most green space-deprived neighbourhoods, compared to 20% of White people (Friends of the Earth, 2020).

Another systemic factor highlighted by stakeholders in the PHE report are the shortcomings in the way that we, as the public sector, engage with our diverse communities. To be most effective, preventative health promotion has to be strengths-based, working with individuals and the community assets that already exist in Gloucestershire. This means letting go of a one-size-fits-all service and using evidence and external input to proactively target a culturally competent programme for those who face increased risk.

> **There is a lack of awareness in the West Indian community. There is no guidance for them on diet or sleep. They feel powerless to do anything about lifestyle factors. Messages are generic and not culturally targeted. Things should be shared in other languages and in a format for ordinary people."**
>
> Carol, Community Builder

* Physical inactivity is defined as engaging in less than 30 minutes of physical activity per week.

WE CAN MOVE

In 2018, Active Gloucestershire started the 'We can move' place-based pilot project in Barton and Tredworth, funded by Sport England. It aimed to decrease levels of physical inactivity, utilise community connections to create networks of champions, and build a positive movement of individuals and organisations making physical activity the norm in the area.

To begin with, they brought together 60 local stakeholders to increase awareness about physical health and wellbeing, map local assets, highlight gaps, barriers and underused facilities, and build networks and connections.

Many women, particularly but not exclusively, from BAME backgrounds, felt that there were very limited opportunities that were accessible to them. There were very few female only/ culturally appropriate activities.

Active Gloucestershire partnered with the Health Lifestyles Service (HLS) to fund a six-week exercise class with support for women in the community to overcome cultural and religious barriers, led by HLS Coach Khatija Mehter:

> **The outcome was really positive as most of the ladies went on to eventually take out gym memberships. Two of the women went on to the Making Every Contact Count Training and have encouraged other women to be more active. They are now part of the Barton and Tredworth active ladies' group and have been working with Active Glos to get funding to set up small projects like couch to 5k, fitness classes and beginners cycling courses.**

Throughout the project 283 women actively engaged in physical activity that was delivered by the Barton and Tredworth Steering Group; the majority of whom were from BAME groups and were inactive (less than 30 minutes a week) prior to engaging.

This pilot project has been extended until July 2022; the next phase will build on the learning from Barton and Tredworth but will include additional capacity and experience via a partnership with Gloucester Community Building Collective and their six Community Builders. This will reach new areas with a focus on two wards; Barton and Tredworth and Kingsholm.

WHAT DOES CULTURALLY COMPETENT HEALTH IMPROVEMENT LOOK LIKE?

Culturally competent: 'the ability of providers and organisations to effectively deliver services that meet the social, faith, cultural, and linguistic needs of service users'

(PHE, 2020).

The benefits of health promotion have long been recognised but COVID-19 has increased the urgency to make improvements. The public sector in Gloucestershire has many levers to influence the health and wellbeing of its residents, including green space in planning, district council-owned leisure centres, county council commissioned services, primary health care and social prescribing and many NHS health promotion services and campaigns.

The work of the Healthy Lifestyles Service (HLS) and Active Gloucestershire shows what can be achieved when using a strengths-based approach with BAME communities. To have a more widespread impact, this approach needs to be more consistent and scaled-up, alongside research into the differences in outcomes for BAME people accessing support for their weight. In the future, HLS are looking to publish profiles of their coaches to show the diversity of their workforce and encourage a wider range of people to come to them for support.

Across the board, health improvement should be informed by the views and experiences of BAME service users and all groups who face health inequalities, their families and communities. Ideally services should be co-developed with the target audience to help identify and address barriers to access and participation. Communication strategies need to be culturally sensitive and use community resources to publicise the intervention. Further training and research are needed in order that those involved in health improvement can understand how conditions present in BAME populations and learn what has worked in other areas to encourage positive lifestyle change.

08

RECOVERY – **BECOMING A CULTURALLY COMPETENT ORGANISATION**

This report refers to some of the immediate action that must be taken to communicate effectively and to prevent conditions which increase COVID-19 related risk. These actions must be carried out in a culturally competent way, considering the culturally-specific concerns of BAME communities.

However, it is also vital that in the longer term, public sector organisations become more culturally competent so that this understanding is embedded throughout organisations' policy and behaviours.

In the wake of George Floyd's death, lots of organisations nationally and internationally sought to demonstrate what they were doing to respond to racial injustice, ranging from the superficial to genuinely reflective. Many local organisations have seized the opportunity presented by the significant changes to working culture during the pandemic to build back differently and have begun new initiatives to further this internal improvement process on racial equality.

The NHS trusts in Gloucestershire are establishing a steering group, working with Diverse City, BAME community advocates and staff members. Eight senior leaders across the county's NHS trusts will take part in a reverse mentoring scheme. They will also embark on a programme of learning from BAME people on individual services and health conditions.

A new independent Community Legitimacy Panel has been launched to help Gloucestershire Constabulary address issues of racial inequality. It will look at areas such as recruitment and promotion, use of force, and stop and search.

Gloucester City Council is setting up a commission with partner organisations and community representatives to review race relations with a view to producing recommendations to improve the lives of BAME communities. The council will also review all monuments, statues and plaques in the city connected with the slave trade.

In June, Gloucestershire County Council established a BAME COVID-19 Task and Finish Group, which is now multi-agency to help drive change on racial equality.

This section explores the concept of 'cultural competence' and what it means for individuals and organisations, as well as the steps required to develop cultural competence.

CULTURAL COMPETENCE

Cultural competence is the ability to understand, communicate with, and effectively interact with people across cultures and encompasses four components:

1. Awareness of one's own cultural worldview
2. Developing positive attitudes towards cultural differences
3. Gaining knowledge of different cultural practices and worldviews
4. Cross-cultural skills

Cultural Destructiveness	Cultural Incapacity	Cultural Blindness	Cultural Pre-Competence	Cultural Competence	Cultural Proficiency
→	→	→	→	→	→
Forced assimilation, subjugation, rights and privileges for dominant groups only.	Racism, maintain stereotypes, unfair hiring practices.	Differences ignored, "treat everyone the same", only meet needs of dominant groups.	Explore cultural issues, are committed, assess needs of organisation and individuals.	Recognise individual and cultural differences, seek advice from diverse groups, hire culturally unbiased staff.	Implement changes to improve services based upon cultural needs.

Figure 6. Continuum of Cultural Competence[7]

As Figure 5 shows, cultural blindness or 'treating everyone the same' is not the same as inclusion and equality as giving no consideration to how decisions and actions impact on marginalised groups generally means that only the needs of the dominant group will be met. Improving the lived experience of BAME individuals relies on a culturally competent approach to everything, including recruitment, training, workforce development, service development and delivery, and public engagement.

This tasks individuals and organisations to examine how the existing structures combined with their own understanding of the world leads to decision making that can exclude people of colour. It requires a shift away from the current way of thinking, seeing and doing, towards an approach and organisational strategy and value base that sees the world through the lens of diversity, inclusion, and belonging, so individuals of all backgrounds feel included to either work within the organisation or use its services. It's about facilitating an environment of open and honest communication in a diverse setting. Being a culturally competent organisation means actively and vocally investing in continued learning, listening, and change. This benefits all employees, allowing people from all backgrounds to thrive.

STEPS TOWARDS ACHIEVING CULTURAL COMPETENCE

- Evaluate where your organisation is now in order to understand where you need to go next e.g. do you have a diverse leadership and senior management team? Diverse teams make better business decisions (McGregor Smith, 2018).
- Provide cultural intelligence training for senior leadership teams and decision makers.
- Provide unconscious bias training for the workforce.
- Foster a cross cultural listening and learning environment within the organisation and for use with staff networks and communities.
- Review recruitment processes to ensure a diverse employee base.
- Develop cross-cultural relationships in order to understand the history and needs of the communities that you serve.

[7] pinterest.com/pin/815644182495981456

BAME COVID-19 TASK AND FINISH GROUP

In early June, prior to the publication of the PHE report, Gloucestershire County Council's Black Workers Network, in collaboration with Public Health colleagues instigated a Task and Finish Group to help understand and respond to the emerging evidence of the disproportionate impact of COVID-19 on BAME communities.

It was not clear at the time how this evidence translated into the lived experiences of BAME communities in Gloucestershire and what measures should be put in place moving forward to minimise this impact.

> **We all knew that many of our BAME residents, colleagues, family and friends had been galvanised and were involved in volunteering and working with agencies such as Gloucestershire County Council and district councils to support vulnerable and at-risk groups in the community, as well as supporting each other. However, as the evidence of the disproportionate impact began to emerge, we also observed a level of fear, misinformation and lack of awareness about where to go for help.**

> **We knew that BAMEs would have been working in essential frontline roles and as a result more vulnerable but we didn't know what was happening locally to respond to that increased vulnerability. Knowing what we know about those communities we recognised that additional measures that were culturally competent would need to be put in place.**

Althia Lyn, Co-Chair of the Black Workers Network

Membership to date includes Gloucestershire County Council's Black Workers Network leads, Public Health, the Older People's Hub, mental health commissioners, district council, Community Help Hubs, Barnwood Trust, Gloucestershire Clinical Commissioning Group, and Gloucestershire Constabulary to name a few.

In the first few months, the group has worked on improving the accessibility and availability of culturally appropriate information; providing evidence-based information on vitamin D; contributing to the BAME workforce risk assessment; and working with community leaders and networks to better engage and reach BAME communities.

In identifying and raising awareness of the impact of COVID-19 on BAME communities and individuals, in the longer term our focus is to ensure improved access, experience and outcomes for BAME people in public services and contributing to a reduction in health inequalities. The publication of PHE's stakeholder engagement report provided a framework for action going forward. To help us do this, we will work collaboratively to encourage stakeholders to commit to:

- annual equality reporting to target positive action initiatives;
- conducting EIAs and using them in a meaningful way;
- integrating race equality in to commissioning, quality systems, reviews and contract monitoring;
- setting targets to ensure that the workforce is representative of the communities they serve at all levels of the organisation;
- developing a diverse and inclusive approach to leadership and progression;
- culturally competent workforce development and employment practices; and
- continuing dialogue with BAME communities and users of services in order to build trust and increase engagement with mainstream services.

The journey for the group has just begun.
If you would like to find out more please contact **bwn@gloucestershire.gov.uk**

RECOVERY – CO-OPERATION AND CO-PRODUCTION

09

Another longer-term ambition must be for public sector organisations to improve the way they collaborate and co-produce services and support with BAME people. COVID-19 has shone a light on how the inter-related dynamics of socio-economic disadvantage and institutional racism can lead to a tragic loss of life but these inequalities are not new.

A combination of discriminatory policies and processes, unconscious bias among staff, and a lack of representation of BAME people at all levels of organisations has a detrimental impact on the access, experiences and outcomes of BAME residents in public services.

The Equality Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low. (Equality and Human Rights Commission, 2014)

Collecting equality data, consulting with residents and completing Equality Impact Assessments is second nature to many in the public sector and there is undoubtedly a lot of good work being undertaken across the county in partnership with underrepresented groups. However, research for this report failed to find an example of an Equality Impact Assessment that had used the findings on ethnicity or religion to influence the design or delivery of a service.

While inequality persists, more consistent collaborative action is required that works with individuals and communities, recognising the assets they have to contribute. Residents are often 'done to' or consulted with but then sometimes do not see the outcomes from their time and input.

Consistent equalities data collection is important but another key aspect of addressing health inequalities is the interpretation of data and translating it into implementable solutions. BAME researchers and members of communities with lived experience of discrimination and structural racism should be a part of this process at every stage.

On the next page are three sources of feedback from BAME residents, refugees and asylum seekers, gathered in the last year: Healthwatch conducted a BAME feedback session which focused on the NHS and primary care; Gloucestershire Action for Refugees and Asylum Seekers (GARAS) produce monthly stakeholder reports on their activities and challenges; and a joint BAME carers event was held in the Friendship Café.

The third of these describes future plans to expand this feedback activity and crucially, explains what is being done with the insights received. To ensure the best use of everyone's time and to have the necessary impact on health inequalities, this often underdeveloped next stage has to become standard practice.

RECOVERY – CO-OPERATION AND CO-PRODUCTION

HEALTHWATCH BAME FEEDBACK SESSION, FEBRUARY 2020

- Language barriers - despite being assured that there will be interpreters available for them, often this is not the case and the women have to rely on younger members of the family to come to the appointments with them to act as interpreters.
- In particular, Barton Gate surgery was mentioned numerous times. There used to be Hindi speaking receptionists but not anymore.
- GP appointments - If offered an appointment at a different surgery, often the times didn't correspond with public transport so they would be unable to get there. BAME residents and those living in deprived areas are more likely to rely on public transport.
- Inappropriate treatment - the husband of one of the group, who is a taxi driver, picked up a man who had been given diabetic treatment though he isn't diabetic.

GLOUCESTERSHIRE ACTION FOR REFUGEES AND ASYLUM SEEKERS (GARAS), APRIL-JULY 2020

Those in the asylum system or with no recourse to public funds often face additional barriers. Helpfully, some of these barriers have been suspended during lockdown as part of the humanitarian response. GARAS and their work with refugees and asylum seekers seek to work in partnership with other agencies to better support refugees and asylum seekers. Ongoing collaboration with Gloucester Job Centre has facilitated fast tracking of Child Benefit claims, which helps alleviate difficulties low income families face.

In June, GARAS helped a woman apply for Gloucestershire County Council's COVID-19 Emergency Living Fund (a recently expanded version of the former Welfare Support Scheme). She and her children have now moved out of temporary accommodation into an affordable tenancy.

Changes to working arrangements and service provision have also presented new challenges. Not all asylum seekers and refugees have the level of English or digital connectivity required to access the services and support which have moved online.

BAME CARERS EVENT, OCTOBER 2019

Gloucestershire County Council and Gloucestershire Clinical Commissioning Group (CCG) held an event in October 2019 with the Friendship Café to share information about numerous organisations and services with carers from BAME communities. It was also an opportunity for these organisations to hear what support carers from BAME communities wanted and what specific issues and challenges they face. Interpreters were present for people speaking Gujerati, Bengali, Arabic and Polish. 96 carers attended and the event was a success:

> **It has been a fantastically informative occasion.**
>
> **I really enjoy this kind of event. I want more like this.**

People found the information shared useful. Many registered with the Carers Hub. The main issues brought up by the carers regarded translation. The organisers have since held a meeting with the CCG and the hospital to discuss this and have agreed to work together to address this issue. One of the carer's case studies will soon be used as part of a clinical training tool.

The team have also been in conversation with Gloucestershire Health and Care NHS Foundation Trust (GHC) about supporting carers from BAME communities to be filmed as case studies for this training tool, to help share their voices and stories.

There are plans to hold more events around the county to share information and get more feedback. However, these were scheduled for spring and due to COVID-19 they have been postponed.

BEYOND COVID-19 IN GLOUCESTERSHIRE

10

FROM RESPONSE TO RECOVERY

In July of this year, the Gloucestershire Health and Wellbeing Board pledged to tackle health inequalities, and in light of COVID-19, particularly amongst the county's BAME communities, through an 'anchor institution' approach[8]. This approach capitalises on the significant leverage of organisations such as local authorities, the NHS and educational institutions as employers, purchasers, land and asset owners and community leaders.

The Board is developing its Gloucestershire anchor institution approach, to:

- accelerate efforts to improve workplace race equality and promote, value and support diverse leadership across systems and institutions;
- ensure employment practices (including training, internships, apprenticeships and progression opportunities) are inclusive; and
- use local public sector 'purchasing power' to promote an inclusive local economy that encourages and values diversity.

Gloucestershire partners have also been working to address social mobility in the county. It began with a particular focus on school readiness, where Gloucestershire was an outlier, but the increased focus on COVID-19 and BAME communities suggests that the group's attentions should move to this area and recommend improvements to improve the social mobility of residents from BAME groups.

As Gloucestershire moves out of the response phase of the pandemic, it is even more important to honour and expand on longstanding commitments to tackle the root causes of health inequalities. As organisations develop their recovery plans, we have a critical opportunity to rethink the approaches of the past that led us to this point and to instead work in partnership with communities to create long-term, sustainable change.

The impact of COVID-19 on BAME people in our communities has been stark. It has exposed and amplified deep seated inequalities, their root causes and the structural racism that underpins them. If we are to prevent further hurt and harm, we must be prepared to challenge ourselves as the Black Lives Matter movement has challenged the world. This is the time to act.

[8]Anchor institutions share a number of key characteristics: geographic immobility (strong ties to the geographic area in which they are based through invested capital, mission and relationship to customers and employees); size (they tend to be large employers with significant purchasing power); and non-profit)while there are examples of for-profit organisations, these institutions tend to operate not-for-profit)

RECOMMENDATIONS

1. a) Require comprehensive and good quality ethnicity data collection in all public services (directly provided and commissioned), including at death registration.

   b) Put in place cultural intelligence training and messaging to improve response rates

2. a) Provide the capacity and resource for collaborative research with BAME employees, organisations and community representatives to understand the social, cultural, structural, economic, religious, and commercial factors related to COVID-19.

   b) Using the output from this research, co -produce and fund interventions to reduce the risk of catching COVID-19 and improve health outcomes.

3. Review commissioning procedures and practice to make sure that Equality Impact Assessments, BAME service user data and feedback are routinely used in a meaningful way to inform services. Training for commissioners should explicitly cover the differences in access, experience and outcomes for BAME residents and their responsibilities in addressing these.

4. System-wide commitment to the implementation of culturally competent occupational risk assessment tools, including assigning the required capacity and resource. Use our influence in the pubic sector to gather knowledge and share best practice to support the occupational health of key workers in the private sector.

5. Proactively work with BAME and faith community representatives to develop and distribute culturally competent COVID-19 prevention and health improvement communication plans at an organisation level and through Local Resilience Forum infrastructure.

6. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health. The Recovery Coordination Group should regularly review the equality implications within its remit and seek input from BAME staff, residents and other marginalised groups.

7. Undertake a stocktake of the BAME voluntary sector, examining further the contribution that it makes towards reducing health inequalities in Gloucestershire. Seek to build capacity and sustainability longer term within this sector.

8. Establish a Race Equality Panel for Gloucestershire, complementing the work of Gloucester City Council, to drive forward this agenda and create long term sustainable change.

APPENDIX A

GLOUCESTERSHIRE'S POPULATION AND HEALTH INDICATORS

	Total Black, Asian and Ethnic Minority	Mixed/ Multiple Ethnic Group	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other Ethnic Group	Total White
Cheltenham	5.7	1.6	3.2	0.6	0.3	94.3
Cotswold	2.2	0.8	1.0	0.3	0.1	97.8
Forest of Dean	1.5	0.6	0.6	0.2	0.1	98.5
Gloucester	10.9	2.9	4.8	2.9	0.3	89.1
Stroud	2.1	1.1	0.7	0.2	0.1	97.9
Tewkesbury	2.5	0.9	1.1	0.3	0.1	97.5
Gloucestershire	**4.6**	**1.5**	**2.1**	**0.9**	**0.2**	**95.4**
England	14.6	2.3	7.8	3.5	1.0	85.4

Table 4. Population by ethnic group, Gloucestershire 2011 (% of population)

Race	Percentage of Workforce	Population of Gloucestershire	Variance
Asian	2.24%	2.10%	0.14%
Black	2.12%	0.90%	1.22%
Mixed	1.39%	1.50%	-0.11%
Other	0.54%	0.20%	0.34%
White British	91.53%	91.60%	-0.07%
White Other	2.18%	3.90%	-1.72%
Workforce stated	83.40%	-	-
Unstated	16.60%	-	-
TOTAL	**100.00%**	**100.0%**	**-**

Table 5. The proportion of Gloucestershire County Council workers from a BAME background (6.29%)

Indicator	Group	Measure	Baseline Period	Baseline Value	Reporting Period	Reporting Value	Absolute change	Trend
Life expectancy at birth-Male		Value	2011 - 13	79.8	2016 - 18	80.2	0.4	↑
	LSOA deprivation deciles	Slope index of inequality	2011 - 13	7.6	2016 - 18	8.4	0.8	↑
Life expectancy at birth-Female		Value	2011 - 13	83.7	2016 - 18	83.7	0.0	→
	LSOA deprivation deciles	Slope index of inequality	2011 - 13	6.1	2016 - 18	5.4	-0.7	↓
Healthy life expectancy at birth-Male		Value	2011 - 13	63.3	2016 - 18	68.1	4.8	↑
Healthy life expectancy at birth-Female		Value	2011 - 13	66.2	2016 - 18	67.2	1.0	↑
School readiness: percentage of children not achieving a good level of development		Value	2012/13	48.0	2018/19	28.1	-19.9	↓
	Free school meal status	Relative Gap	2012/13	1.5	2018/19	1.8	0.3	↑
	Free school meal status	Absolute Gap	2012/13	20.7	2018/19	21.5	0.8	↑
16-17 year olds not in education, employment or training (NEET) or whose activity is not known		Value	2018	7.4	2018	5.8	-1.6	↓
Gap in the employment rate between those with a long-term health condition and the overall employment rate	long term health condition and the overall employment	Absolute Gap	2013/14	9.8	2018/19	9.2	-0.6	↓
Children in low income families (all dependent children under 20)		Value	2012	13.0	2018	12.3	-0.7	↓
Statutory homelessness - Eligible homeless people not in priority need		Value	2012/13	0.4	2017/19	0.4	0.0	→
Low birth weight of term babies		Value	2011	2.4	2018	1.9	-0.5	↓
Reception: Prevalence of obesity (including severe obesity)		Value	2015/16	8.7	2018/19	9.2	0.5	↑
Year 6: Prevalence of obesity (including severe obesity)		Value	2015/16	17.7	2018/19	18.6	0.9	↑
Smoking Prevalence in adults (18+) - current smokers (APS)		Value	2013	18.1	2019	13.0	-5.1	↓
	Routine and manual occupations vs Other occupations	Odds ratio: Socio-economic gap	2013	2.8	2019	3.6	0.8	↑
Admission episodes for alcohol-related conditions (Narrow)		Value	2012/13	655.0	2018/19	673.8	18.8	↑
Self-reported wellbeing - people with a low satisfaction score		Value	2013/14	5.0	2014/15	5.1	0.1	↑
Infant mortality rate		Value	2011 - 13	3.4	2016 - 18	3.3	-0.1	↓
Percentage of 5 year olds with experience of visually obvious dental decay		Value	2011/12	28.0	2019/20	19.5	-8.5	↓
Under 75 mortality rate from all cardiovascular diseases		Value	2011 - 13	66.9	2016 - 18	59.7	-7.2	↓
Under 75 mortality rate from cancer		Value	2011 - 13	130.9	2016 - 18	119.9	-11.0	↓
Suicide rate		Value	2011 - 13	12.9	2016 - 18	10.4	-2.5	↓

Table 6. Health Inequalities Dashboard, Gloucestershire (PHE, 2020)

APPENDIX B

PUBLIC HEALTH ENGLAND RECOMMENDATIONS

1. Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
3. Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.
5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
6. Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
7. Ensure that **COVID-19 recovery strategies** actively **reduce inequalities caused by the wider determinants of health** to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

APPENDIX C

THE RACE AT WORK CHARTER, FIVE CALLS TO ACTION TO ENSURE THAT ETHNIC MINORITY EMPLOYEES ARE REPRESENTED AT ALL LEVELS IN AN ORGANISATION.

1. **Appoint an Executive Sponsor for race**
   Executive Sponsors for race provide visible leadership on race and ethnicity in their organisation and can drive actions such as setting targets for ethnic minority representation, briefing recruitment agencies and supporting mentoring and sponsorship.
2. **Capture ethnicity data and publicise progress**
   Capturing ethnicity data is important for establishing a baseline and measuring progress. It is a crucial step towards an organisation reporting on ethnicity pay differentials.
3. **Commit at board level to zero tolerance of harassment and bullying**
   The Race at Work Survey revealed that 25 per cent of ethnic minority employees reported that they had witnessed or experienced racial harassment or bullying from managers. Commitment from the top is needed to achieve change.
4. **Make clear that supporting equality in the workplace is the responsibility of all leaders and managers**
   Actions can include ensuring that performance objectives for leaders and managers cover their responsibilities to support fairness for all staff.
5. **Take action that supports ethnic minority career progression**
   Actions can include embedding mentoring, reverse mentoring and sponsorship in their organisations.

Sign up to the Race of Work Charter here:
https://www.bitc.org.uk/race/

APPENDIX D

PROGRESS UPDATE FROM THE 2018/19 ANNUAL REPORT

In my 2018/19 annual report, I set out seven recommendations that would help partners across the system to drive inclusive growth to tackle health inequalities and increase productivity.

Inevitably, the COVID-19 pandemic has had a significant impact on the capacity of local organisations to respond to these recommendations since the publication of the report in late 2019.

However, progress has been made in a number of areas – as set out below – and the recommended actions are arguably even more important as Gloucestershire embarks on its social, health and economic recovery from COVID-19. Indeed, there is a clear thread between the recommendations of my report last year and those I make in this report.

PROGRESS AND ACHIEVEMENTS

- There is now greater alignment of health and economic strategy and policy in the county: GFirst LEP's Chief Executive has joined the Gloucestershire Health and Wellbeing Board and the inclusive growth theme has been incorporated into the Local Industrial Strategy for Gloucestershire.
- The 2018/19 report was presented to a range of groups, including the GFirst LEP Board, the Education and Skills Board and the Economic Growth Joint Committee, providing a new audience for and engagement in key public health messages and opportunities for collaboration.
- In January 2020, the Health and Wellbeing Board agreed to further explore their role as 'anchor institutions' in driving inclusive growth through their employment and spending power. The Board has revisited this opportunity in the light of the COVID-19 pandemic and its impact on health inequalities and a small task and finish group is identifying potential actions, including maximising social value from procurement and increasing inclusive employment and career development opportunities.
- GFirst LEP has also recognised the potential for anchor institutions to play a role in the county's economic recovery from COVID-19, incorporating the approach in its proposed interventions that will enable Gloucestershire to reimagine and restart.
- The Public Health team has established a 'Planning Healthy Places' community of practice to support planners and others working in the built and natural environment to maximise opportunities to build healthy communities with the infrastructure to support inclusive growth. As well as supporting developing local plans and other policies, the team has developed a Health Impact Assessment tool, which it has tested with Stroud District Council and intends to roll out across the county in due course.
- Healthy Lifestyles Gloucestershire has launched Healthy Workplaces Gloucestershire, a range of dedicated resources to support local employers and a workplace accreditation scheme. Healthy workplaces are just one aspect of 'good work' as set out in last year's report and this development provides a solid foundation for employers to build on, including to improve the flexibility of the workplace in line with the ambitions of the Local Industrial Strategy. This year's lockdown restrictions are already changing the way people think about where and how they work and there are both opportunities and challenges in this for inclusive growth.

REFERENCES

Anekwe, L. (2020) Ethnic disparities in maternal care. The British Medical Journal.
https://doi.org/10.1136/bmj.m442

Cabinet Office (2018) Race Disparity Audit
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686071/Revised_RDA_report_March_2018.pdf

Cook, T. et al. (2020) Exclusive: deaths of NHS staff from COVID-19 analysed
https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-COVID-19-analysed/7027471.article

Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried? Reproduced by the King's Fund:
https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

DHSOC (2018) Modernising the Mental Health Act
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

Equality and human Rights Commission (2014) Meeting the Equality Duty in Policy and Decision-Making
https://www.equalityhumanrights.com/en/publication-download/meeting-equality-duty-policy-and-decision-making-england-and-non-devolved

Friends of the Earth (2020) England's Green Space Gap
https://policy.friendsoftheearth.uk/download/englands-green-space-gap-full-report

Gloucestershire Constabulary (2015) Equality Duty
https://www.gloucestershire.police.uk/SysSiteAssets/media/downloads/force-content/gloucestershire/about-us/201415-equality-document-v2.pdf

Gloucestershire County Council (2020) Population Profile
https://inform.gloucestershire.gov.uk/media/2097102/equality-profile-2020-final.pdf

Gloucestershire County Council (2020) Workforce equality and diversity report (February 2020)
https://www.gloucestershire.gov.uk/media/2099440/gcc-workforce-equalities-report-2020docx.pdf

GHNHSFT (2019) Equality Report 2018/19
https://www.gloshospitals.nhs.uk/media/documents/Equality_Report_2018-19_v5.pdf

REFERENCES

Health Foundation (2020) Will COVID-19 be a watershed moment for health inequalities?
https://www.health.org.uk/publications/long-reads/will-COVID-19-be-a-watershed-moment-for-health-inequalities

Marmot, M. et al (2010) Fair Society, Healthy Lives.
www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-themarmot-review/fair-society-healthy-lives-full-report-pdf.pdf

NFER (2020) Schools' responses to Covid-19. The challenges facing schools and pupils in September 2020
https://www.nfer.ac.uk/schools-responses-to-covid-19-the-challenges-facing-schools-and-pupils-in-september-2020/

NHS (2020) NHS Workforce Race Equality Standard
https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

NHS Confederation (2020) The impact of COVID-19 on BME communities and health and care staff
https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf

NHS England (2020) Third phase of NHS response to COVID-19
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf

NICE (2017) Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality
https://www.nice.org.uk/guidance/qs167/documents/briefing-paper

ONS (2020) Deaths involving COVID-19, England and Wales: deaths occurring in June 2020
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingCOVID19englandandwales/deathsoccurringinjune2020

ONS (2020) Which occupations have the highest potential exposure to the coronavirus (COVID-19)?
https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronavirusCOVID19/2020-05-11?hootPostID=2d50118712f89284665a982f9600e276

PHE (2020) Beyond the data: Understanding the impact of COVID-19 on BAME groups
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

PHE (2020) Disparities in the risk and outcomes of COVID-19
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

PHE (2020) Excess Weight and COVID-19
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907966/PHE_insight_Excess_weight_and_COVID-19__FINAL.pdf

PHE (2020) Health Inequalities Dashboard, Gloucestershire
https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/

PHE fingertips (2020) Public Health Outcomes Framework
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000042/pat/6/par/E12000009/ati/102/are/E10000013/cid/4

Race Equality Foundation (2020) Black and minority ethnic voluntary sector organisation are coping and adapting to the coronavirus pandemic for now, but their future is unsure
https://raceequalityfoundation.org.uk/health-care/black-and-minority-ethnic-voluntary-sector-organisation-are-coping-and-adapting-to-the-coronavirus-pandemic-for-now-but-their-future-is-unsure/

Runnymede Trust (2020) Over-Exposed and Under-Protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain
https://www.runnymedetrust.org/uploads/Runnymede%20COVID19%20Survey%20report%20v3.pdf

Salford CVS (2020) Risk assessments resources and guidance
https://www.salfordcvs.co.uk/risk-assessments-resources-and-guidance

The Colour of Power Index (2020)
https://thecolourofpower.com/

Report of the Director of Public Health **2020**

Gloucestershire
COUNTY COUNCIL

GCC_2967 10.20