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''In airports and shops there is expected discrimination but this is NOT expected in the Health environment''

An exploration of the impact of COVID-19 on existing health inequalities in Calderdale

In Calderdale, coronavirus has further exacerbated existing health inequalities. Local insight and data has illustrated that a range of socio-economic factors that impact on people's health and wellbeing have worsened during the pandemic. To understand these issues further, People's Voice Media has been working with local organisations and people to use Community Reporting to gather people's lived experiences of life during the pandemic and explore the impact of it on their wider health and wellbeing.

Between September and December 2020, we have worked with a group of people from Central Halifax who are from the communities most affected by COVID-19, with a specific focus on engaging with different BAME communities in the area. We trained these individuals as Community Reporters and as part of this training, they have learned different storytelling techniques to enable them to share their own stories as audio and video recordings, and capture stories from across their peer networks. Working with People's Voice Media, they have curated these stories into a core set of findings that are evident in this report. Key topics within the stories include systemic racism, faith and spirituality, outdoors and the environment, creativity, isolation, advocacy, support services, and the political and global impact. This insight briefing sets out the key findings derived from these stories and links this learning to a set of recommendations aimed at supporting the commissioning of health and wellbeing interventions for the area.

''It needed to have people who have suffered racist attacks at the forefront'' Systemic racism and COVID-19

COVID-19 has brought to the foreground many structural and systemic issues within our society. Within the stories gathered and discussions around them, it was clear that racism is an on-going issue that impacts greatly on specific groups of people's health and wellbeing. One of the findings that regularly came up in the stories is that different members of the BAME communities feel as if there are **barriers or 'gatekeepers' preventing them from receiving compassionate care**, making visiting a healthcare provider an upsetting, and even traumatic experience. This is particularly apparent in one lady's story where she details how the "system failed me" after her GP's receptionists left her standing in the cold, feeling faint, carrying her two-year-old daughter and with no information on how long she might be waiting.

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The staff were too busy to even speak to her, while a Caucasian couple were politely directed to wait in their car. The lady describes her upset on eventually seeing her GP: "As we got to the consulting room, the doctor tried to start a conversation with me and I told her 'I'm not ready. I feel very upset.' Immediately, I broke down into tears." She discusses how she has come to expect this sort of treatment – stemming from systemic racism – in an airport, but not when accessing healthcare. More so, in another story one person outlines how language barriers when accessing services and support is an issue. As they describe, there is a "fear of not being listened to due to language barriers". This leads some people in the community to feel that they "don't have a voice - no one will speak up for us". In reference to **poor quality housing**, this is particularly the case - "they can't say how they are suffering." In the stories, it is identified that poor housing puts a massive strain on mental health, leaving people feeling trapped and sleep deprived in many cases. The damp conditions also contribute to respiratory problems, which has been of particular concern during the pandemic. This is an issue for specific groups in the area such as single parents, older people, and the BAME and refugee communities.

These feelings of being discriminated against, being marginalised and being positioned as voiceless by power structures and institutions, is further exacerbated by the Government's handling of the COVID-19 pandemic. Speaking about the perceptions of decision-making processes and actions of the Government during the crisis, people felt that there was a "deliberate-ness of detrimental government decisions", particularly for BAME communities and this has increased distrust in the governance and support structures in society. As one person suggests, perhaps messaging and leadership around this (centrally and locally) "needed to have people who have suffered racist attacks at the forefront".

''Covid has stopped us being able to go out''
Activities and COVID-19

Another point that came up across stories was the **lack of access to regular outdoor activity for older and people who are often marginalised in and by society**, which has particularly impacted BAME communities. One lady discussed how "Central Halifax is facing issues around lack of activity and constraints on mental health" with people unable to go out, while a lack of social support specifically for the older people and people with disabilities in the community has left them with no one to go out for a walk with. The immediate impact on mental health is, of course, concerning, but there are also longer-term implications to physical health that can arise from lack of activity. However, it also emerged that local walking groups exist for this exact purpose, but people don't know they are there. Across the stories and discussions with Community Reporters during the story curation activities, it became

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apparent that whilst services and support did exist it wasn't reaching certain groups of people. This was either due to lack of knowledge of what was available or other, more systemic barriers to access, not being removed to allow and encourage people to get involved.

It also emerged from the stories that **multi-generational creative activities** are seen as vital for both adult and child mental health. As a storyteller stated, "creativity is positivity". Another storyteller highlighted how "creativity across generations through the Creativity Club was mutually beneficial". However, it was felt that these **services are currently being overwhelmed** and are unable to cope with demand. Also, many services are operating in 'crisis' mode and are trying to cope with immediate needs such as providing food and that wider wellbeing issues and activities that support wellbeing may be not at the forefront of what is being offered. More so, the restrictions brought about by the pandemic mean that many religious buildings and sites of worship have closed. This has had a big impact on many faith communities, as religion is a fundamental part of their lives and wellbeing – as is meeting people from their community in these spaces that feel safe, secure and welcoming. When thinking about how services and support can help bridge and overcome these wellbeing and social isolation issues, simple things, as one storyteller explains like "going out /chatting on zoom can help with mental health". Another person explained how adapting activities could also support people – "Trying to support people in a different way - over the phone instead of in person". Interventions such as these that focus on creating these connections and relationships could have a long-lasting impact on people's wellbeing in the area.

"I didn't have to do any of the normal running around. It was all about the spirituality and spending time praying."
The unexpected positives in the pandemic

Rather unexpectedly, some Community Reporters and storytellers involved in this piece of work **found positive effects of the pandemic**. Many had felt a sense of peace and calm as everything stopped and found it was actually *good* in the short term for their mental health, as well as their family and their faith. In one story, for instance, a lady points out that despite the difficulties of lockdown, she really enjoyed Ramadan: "I didn't have to do any of the normal running around. It was all about the spirituality and spending time praying." This suggests that as well as looking at what the pandemic has exacerbated, we also need to examine what aspects of life improved and question whether we want those to return to normal.

Recommendations

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Based on the insights gleaned from stories, the following recommendations for commissioning health and wellbeing interventions are being put forward:

1. **Language:** More appropriate language needs to be devised for use in COVID guidance, as well as more generally in how services communicate. This should be produced in collaboration with the groups who it is aimed at to ensure it is relevant. In reference to BAME communities, this should be co-produced with community and religious leaders. The aim of this is to reduce fear and anxiety around coronavirus, which current language and messaging has created, alongside confusion and growing distrust. Co-producing messaging in this way will also help to overcome access barriers, and this way of working can also be applied to other sectors of the community who are often marginalised, such as disabled people. This should also go hand-in-hand with stronger collaboration with local media to better disseminate information in a way that's accessible, clear and gives voice to the silent minority.

2. **Leadership and Visibility:** Groups led by those who have frontline or grassroots experience of discrimination or marginalisation should have a seat and voice at the table when health decisions are being made and interventions being determined. Furthermore, it was felt that services and activities that are targeting specific demographics or are aiming to be more inclusive and accessible, should be led and/or delivered by people from that community through involvement of people with lived experience of the issues the service seeks to address.

3. **Clarity, Parity and Empathy:** There needs to be clarity and parity when accessing healthcare. This should include standardised services across all GP practices in the area, with awareness training in empathy and kindness delivered to all surgery staff including healthcare professionals and support staff (such as receptionists). Members of the BAME communities and other groups who are often marginalised, such as a disabled people and older people, should be included in co-producing the training so that their voices are heard. Working with communities to collect stories to share with GPs, the CCG and so on would be one way to do this as stories help to build empathy and understanding.

4. **Addressing Structural Racism:** There should be some form of cross-sector community advisory group on structural racism that local organisations and institutions support and most importantly, listen to. It could act as a place to report incidents of racism outside of other more formal channels and build-up

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trust in specific sections of the Calderdale community that their experiences will be investigated independently and fairly. This will require buy-in from the highest levels of leadership.

5. **Creating Connections:** On one hand, more awareness needs to be raised of *existing* support and services. In some cases, there's no need to reinvent the wheel when great services are already out there. However, it is essential that people who could benefit from them need to be made aware of them and services need to make a better effort to connect with communities. Part of this is looking at whether existing services truly reflect the communities that they serve and also services taking responsibility to look at and address structural barriers to engagement and unconscious bias. It also involves looking at very basic barriers such as lack of internet access – things like this are more common than we might think. One way to address these types of issues is to look at what communication tools or methods the community uses and use these to reach them. As part of this, more funding and resources should be allocated to voluntary, community, grassroots groups and individuals who have *already* been successfully delivering creative and wellbeing projects to enable them to expand to their full potential providing that this focuses on reducing barriers to engagement in active ways. The sharing of resources between groups should also be encouraged as a way of actively connecting with parts of our communities who have been underserved.

Conclusion

The recommendations in this insight briefing do not necessarily seek to reinvent anything - rather they aim to use people, assets and resources that are already *in* the community in order to enable them to reach their full potential. The approaches recommended rely on *true* co-production techniques and are underpinned by *real* equity and a commitment to addressing structural issues present in our society. It is not just about listening to the community – although this is important – but also about shifting power, resource and control to people within the community over how services look, feel and act in order to create health and wellbeing interventions that actually address this issues that people from specific communities see as important.